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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1978

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HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-FIFTH CONGRESS

FIRST SESSION

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

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PART 4

Printed for the use of the Committee on Appropriations

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87-499 O WASHINGTON : 1977

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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR FISCAL YEAR 1978

WEDNESDAY, MARCH 2, 1977.

CENTER FOR DISEASE CONTROL

PREVENTIVE HEALTH SERVICES

WITNESSES

WILLIAM C. WATSON, JR., DEPUTY DIRECTOR, CENTER FOR DISEASE CONTROL, ACCOMPANIED BY—
DR. WILLIAM H. FOEGE, ASSISTANT TO DIRECTOR, CENTER FOR DISEASE CONTROL
DR. JOHN F. FINKLEA, DIRECTOR, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH
DR. J. D. MILLAR, DIRECTOR, BUREAU OF STATE SERVICES, CENTER FOR DISEASE CONTROL
JAMES D. BLOOM, EXECUTIVE OFFICER, CENTER FOR DISEASE CONTROL
CLAUDE F. PICKELSIMER, JR., DIRECTOR, FINANCIAL MANAGEMENT OFFICE, CENTER FOR DISEASE CONTROL
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

Mr. FLOOD. We will now consider that part of the Labor-HEW bill which deals with the Center for Disease Control.

The presentation will be made by Mr. William C. Watson, Jr., the Deputy Director of the Center for Disease Control.

We have a biographical sketch of you, which we will place in the record at this point.

[Mr. Watson's biographical sketch follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Center for Disease Control

Biographical Sketch

NAME	:	William C. Watson, Jr.
POSITION	:	Deputy Director, Center for Disease Control
BIRTHPLACE AND DATE	:	Marion, South Carolina, November 1, 1924
EDUCATION	:	University of South Carolina, 1946-48, B.A. Harvard University, 1963-64, M.P.A.
EXPERIENCE		
1976-Present	:	Deputy Director, Center for Disease Control, PHS, DHEW
1970-1976	:	Assistant Director for Operations, Center for Disease Control
1964-1970	:	Executive Officer, Center for Disease Control
1960-1964	:	Assistant Executive Officer, Center for Disease Control
1957-1960	:	Program Management Officer, Venereal Disease Control Program, Center for Disease Control
1948-1957	:	Public Health Service, Venereal Disease Division, with assignments in Maryland, Arkansas, South Carolina and Washington, D. C.
SPECIAL ASSIGNMENTS	:	February-May 1974 WHO Consultant, Smallpox Program, Delhi, India
		June-September 1970 Deputy Director, Office of Child Development, ASAM-DHEW
		July-September 1956 assigned to U.S.-Mexico Border to initiate STS Screening Program for Migrant Laborers
AWARDS	:	DHEW Superior Service Award, January 17, 1968

Mr. FLOOD. Do you have some people with you that you would like us to meet? Incidentally, where is the Center for Disease Control located?

Mr. WATSON. In Atlanta, Ga.

Mr. FLOOD. Now we can meet your staff.

Mr. WATSON. Mr. Charley Miller, from the Department, I think you know.

Mr. FLOOD. Yes, I do.

Mr. WATSON. Dr. William Foege, the Assistant to the Director; Dr. Don Millar, who is the head of our Bureau of State Services; Jim Bloom, our executive officer; Dr. Jack Finklea, who is the head of the National Institute for Occupational Safety and Health, and Claude Pickelsimer, our financial management officer.

Mr. FLOOD. All right. Now I see you have a prepared statement, Mr. Watson. How do you want to handle that?

Mr. WATSON. We have a 10-page statement I would like to insert in the record and a shorter one I would like to read, if that is all right.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT BY DEPUTY DIRECTOR, CENTER FOR DISEASE CONTROL

"PREVENTIVE HEALTH"

Mr. Chairman, members of the committee, it is a pleasure for me to appear before you for the first time to present the budget for Preventive Health Services for Fiscal Year 1978.

The Preventive Health Services Appropriation is a primary source of funding for the Center for Disease Control. The Center is the operating health agency that is charged with responsibility for prevention and control aspects of public health. We are the only Federal health agency with its headquarters located away from the metropolitan D. C. area. We believe that this geographic separation has helped to foster the dedication to responsiveness that is characteristic of the Center's way of doing business. To extend our impact, we work closely with other health agencies and most importantly, CDC has traditionally worked with and through State and local health departments to prevent and control illness and debilitation.

As a means of highlighting some of our accomplishments and new directions, I have chosen to point out ways in which CDC is responsive--responsive to (1) finding new approaches to long standing problems; (2) the need to solve disease enigmas; and (3) the need to take positive preventive action.

NEW APPROACHES

Immunization

Immunization is one of the most basic of our preventive health measures. On the whole, this country has been successful in maintaining, over the last few years, a relatively high and stable level of immunization among the population. This has resulted in a remarkable record of preventing disease among children. Reported cases of diphtheria, pertussis, tetanus, and mumps were the lowest reported since records have been maintained. Measles alone showed an increase in 1976 over 1975, and that increase was significant from 24,374 to 39,585. But it must be remembered that in 1964 there were an estimated 4,000,000 cases of measles. There has been an apparent change in the epidemiology of measles during the last two years--a large increase in the number of outbreaks among junior and senior high school students. To respond more rapidly to these largely unexpected outbreaks of measles among junior and senior high school students, the Center is employing a new strategy for controlling the disease. This strategy stresses early identification and control. Some population segments do not fully participate in community-wide campaigns and pockets of susceptibles remain forming a foci for localized outbreaks of disease.

To meet this challenge the Center developed methodologies to search for areas where immunization levels are lower than desirable. When these areas are identified community resources are mobilized to carry out intensive immunization efforts to raise the immunity levels. The additional funds made available in 1977 for immunization project grants

are being used to extend these outbreak control activities in all States and to bring this newer approach to bear on the problem of teenage measles. In 1978, further increases are requested to permit even greater emphasis on providing protection through immunization to poor children.

Occupational Safety and Health

In a similar vein, the National Institute for Occupational Safety and Health is faced with an overwhelming job, and it must be able to respond quickly to an increasing number of occupational safety and health crises while maintaining a steady flow of scientifically valid criteria documents to the Department of Labor. To assure that it remains responsive to immediate problems without jeopardizing important longer term research projects, the Institute has developed a sophisticated program planning and tracking system.

Recognizing that it is impossible to develop specific criteria documents for each hazardous substance the Institute has begun to develop recommended standards for industrial processes. In 1978, these will include roofing, welding, and cementing operations.

In Fiscal Years 1977 and 1978, special emphasis is being given to programs in occupational carcinogenesis, women in the workplace, occupational respiratory disease, safety, analytical methods research, and research and training grants. In response to direction from the House Appropriation Committee, the National Cancer Institute has made $3 million available in 1977 to support jointly approved occupational health projects carried out by NIOSH.

Beginning in 1977, the Institute will be able to support, with training grants four or five occupational safety and health educational resource centers to serve as regional resources for training in occupational medicine, nursing, toxicology, industrial hygiene, and safety.

Sex Education

The Center has requested an additional $2 million for its Health Education activities in order to take part in a PHS-wide initiative to deal with the problem of teenage pregnancy. The Center's contribution to this effort will be to identify and develop effective sex education models that can result in the prevention of unwanted pregnancy among the nation's teenagers.

DISEASE DILEMMAS

Legionnaire's Disease

On January 18, 1977, the Center ended six months of intense public interest when it announced that it had isolated a bacterium which caused the epidemic among Legionnaires in Philadelphia. This highly publicized medical mystery provides a good case study of the way CDC responds to an epidemic situation. The Center worked with the State and local health agencies in Pennsylvania as well as scientists in the Food and Drug Administration and sought expert advice from consultants from both within and outside of Government. The long, hard hours of intense study and investigation paid off. We isolated the bacterium, implicated that same organism with an outbreak at St. Elizabeth's Hospital ten years ago and an outbreak in a health department in Pontiac, Michigan. We are proud of the accomplishment, but we are also aware that the job is not finished--we do not know how the disease is spread.

African Hemorrhagic Fever

Our disease detectives ranged from the streets of Philadelphia to the villages of Southern Sudan and Northern Zaire; investigating two epidemics of what has come to be known as African Hemorrhagic Fever. The scope of each of these epidemics combined with the ever increasing international travel has caused the Center to redouble its efforts to finish the development of a high containment laboratory so that our scientists can begin to conduct laboratory experiments with this extremely "hot" virus. African Hemorrhagic Fever can now take its place alongside Lassa Fever and Marburg Fever as newly identified, highly deadly diseases for which we must develop rapid methods of diagnosis and effective means of control.

Penicillin Resistant Gonorrhea

Less exotic and deadly, but possibly representing a public health problem of more immediacy and scope, has been the introduction into this country of a new strain of gonorrhea that resists treatment from all forms of penicillin. To meet this threat and to minimize spread of this new strain, intensive screening and contact tracing have been undertaken with <u>each</u> reported case of gonorrhea that has been caused by a penicillin-resistant organism. If the spread of penicillin-resistant gonorrhea cannot be limited, the cost of gonorrhea control will skyrocket bankrupting the already strained resources available for venereal disease control in this country.

POSITIVE PREVENTIVE ACTION

Swine Flu

Last February illness among 500 soldiers at Fort Dix, New Jersey, marked the beginning of an extraordinary chapter in the chronicles of public health. The nation embarked on one of the most ambitious and problem ridden immunization programs of its history. Mr. Chairman, we have faced problems, endured criticism, and have been confounded by the unexpected medical dilemmas, but I am proud of the responsiveness of the public health apparatus of this country. If we see a need for action in the future we will recommend that action be taken. We stand ready to accept criticism and Monday morning quarterbacking about administrative details -- but we will not hang our heads because of this episode. The basic choices remain the same: to act and run the risk that an epidemic will not occur or to wait and possibly be too late.

I have not mentioned some of the other changes such as those involving laboratory improvement, diabetes, and training of State and local health workers. These decreases are explained in the budget justification.

Thank you Mr. Chairman and my colleagues and I will be happy to answer any questions that you and members of the Committee may have.

Mr. FLOOD. Proceed.

Mr. WATSON. Mr. Flood, it is a pleasure for me to appear before you for the first time to prevent the budget for preventive health services for fiscal year 1978.

The preventive health services appropriation is a primary source of funding for the Center for Disease Control. The Center is the operating health agency that is charged with responsibility for prevention and control aspects of public health. We are the only Federal health agency with its headquarters located away from the metropolitan District of Columbia area. We believe that this geographic separation has helped to foster the dedication to responsiveness that is characteristic of the Center's way of doing business. To extend our impact, we work closely with other health agencies and most importantly, CDC has traditionally worked with and through State and local health departments to prevent and control illness and debilitation.

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Thank you Mr. Chairman, and my colleagues and I will be happy to answer any questions that you and members of the committee may have.

BUDGET REDUCTION

Mr. FLOOD. When we take a look at your budget we find a reduction of $58,728,000. Will you explain how that happened?

Mr. WATSON. Most of that reduction, sir, is as a result of the one-time swine flu program.

BUDGET INCREASES

Mr. FLOOD. Which one of your programs received an increase in the 1978 budget?

Mr. WATSON. There is a sizable increase in immunization; we have an increase in health education, and we have an increase, not very large, for certain occupational health programs.

RECENT DEATHS OF CDC EMPLOYEES

Mr. FLOOD. You touched on it, but you know very well, of course, that we have heard reports almost overnight about two of your employees who died from the illness, same symptoms, so we understand, as the Legionnaires' disease. Can you tell us about this situation? And how are you going to identify the exact cause of this illness?

Mr. WATSON. Yes, sir, let me say that they have some of the same symptoms, not all.

Dr. Foege has been in touch with Atlanta today on the question and can tell you exactly what we know and what is being done and where it stands.

Dr. FOEGE. Both employees developed symptoms about 1 week ago. One employee died on Monday morning early; one died yesterday morning, early. One employee was a custodian and one worked with glassware, taking glassware from the lab to a washing facility.

They did have some symptoms in common; that is, they gave evidence of central nervous system involvement, and gastronintestinal symptoms, but one patient died with gastrointestinal hemorrhage. He had surgery for what was thought to be a bleeding ulcer and expired afterward. The other died with acute renal failure. Some symptoms are similar, some are not.

At this time, I think we have no way of ruling in or out any specific cause.

Mr. FLOOD. Could the whole thing be caused by inadequate safeguards in the laboratory?

Dr. FOEGE. One of the things we have tried to do is identify if there have been any breaks in laboratory procedures. We have not been able to identify, at this time, any breaks in laboratory procedures.

Mr. FLOOD. By procedures, you mean safeguards?

Dr. FOEGE. Safeguards. We are also reconstructing in the last 2 days every movement that we can for these people in the last several weeks, but we have not been able to identify a problem there. We have at the moment intense batteries of tests which are underway in microbiology and toxicology, but we don't know whether it is a disease; we don't know whether it is a toxin; and we simply don't know what this represents.

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Mr. WATSON. We don't know whether both of them had the same disease.

Mr. FLOOD. It is just a coincidence that this hearing would take place at this time; I understand that, but you can be sure this committee wants to be apprised of this entire situation. You keep in touch with the committee.

Mr. WATSON. We certainly will.

PROGRESS REPORT ON IMMUNIZATION

Mr. FLOOD. Last year, the committee requested a report from HEW on its progress in raising the immunization levels of the population in general, and we asked at that time that a report be submitted prior to the 1978 budget hearings.

Now, I don't know whether you know, but we started the 1978 budget hearings several weeks ago and, as of now, we didn't get your report. What is the matter; couldn't you put the three acts of your show together?

Mr. WATSON. The report has been prepared, is now in the Public Health Service, and I am told will be transmitted to your shortly.

Mr. FLOOD. I know, but last year we made a point that we wanted that report before the 1978 budget hearings. Is this just another classic example of the inability or failure of HEW to reply to a very simple request from the committee?

Mr. WATSON. No, sir; I don't blame the department. We were waiting for the very latest figures from the Census Bureau to include in that report, so that it could be as current and up-to-date as it possibly could be. And that is the reason that it has not arrived here yet. It has been prepared.

IMMUNIZATION PROJECT GRANTS

Mr. FLOOD. In your budget justification you state that immunization project grants will be used—let me quote from your justification, "carry out targeted immunization programs to improve the level of protection against preventable diseases among preschool and school children." Tell us something about that effort, and how you plan to accomplish that objective?

Mr. WATSON. I would like to ask Dr. Millar, who heads up that program, to talk about it.

IMMUNIZATION LEVELS AMONG URBAN AND RURAL POOR

Dr. MILLAR. Mr. Chairman, what we have observed in this country is that, for several years, our immunization efforts were directed toward making available to the public new vaccines that had not previously been used. This is true of polio, measles, and subsequently rubella vaccines in which the primary strategy was one of eliminating a large reservoir of susceptible people in as short a time as possible. In 1972, as you well know, through the support of this committee, we saw a change in that strategy to one of general support to immunization activities throughout the country. We got out of playing catch-up ball and into supporting general immunization activities.

The problem is this. Although we have achieved great control of a number of these diseases, measles being an exception that I will come back to, there has also been a decline in the amount of public interest

in the disease, and hence significant amount of apathy regarding continuing to keep up immunization levels in the country. Hence, we end up with a situation where, for the past several years, immunization levels have been essentially stable.

Although the diseases in each case have been dramatically reduced in incidences following the introduction of new vaccines, the diseases that continues to occur is very much a problem of people who are underserved, the poorer people. Epidemics that occur are generally more likely to occur among the poor than the rest of the population. The problem is what we have is a paradoxical situation in which immunization levels are lowest in the poor and highest in the well-to-do. The reverse is true of disease incidences. The incidence of disease is highest in the poor and lowest in the well-to-do.

We would like very much to try to change this situation by focusing more attention on those persons who are underserved generally, who are being cared for at public expense with regard to immunization and other preventive services. This is not an easy task. The concept of a hard-core group was delineated 20 years or more age, indicating that it is not an easy job to achieve delivery of preventive services, particularly in central cities and among the poor.

PHS IMMUNIZATION PROGRAMS

Mr. FLOOD. Let me ask you, how will you be using the other PHS programs, such as the community health centers and maternal and child health programs, and we have migrant health programs, to increase this immunization level among the urban and the rural poor?

Dr. MILLAR. Of course, I think the newer concept that we are speaking of currently is the idea of an audit of children being served in such settings so that whoever is delivering the service, whether it be a private physician or neighborhood health center, or migrant service, would, in fact, at intervals audit the records of the children being cared for.

Mr. FLOOD. That would be under the PHS programs?

Dr. MILLAR. Well, PHS programs——

Mr. FLOOD. I am talking about how will you be using other PHS programs?

Dr. MILLAR. We have, for instance, met with the people who run the maternal and child health programs. They, in fact, are doing these audits now among people they care for. At the local level, we have, as you well know, Federal assignees who are responsible for coordinating activity in local health departments so that the various service people in a community are brought together and are talking the same language and attempting to do the same sort of things. So we think that there has been some progress made along these lines. Indeed, the recent survey information that we have on immunization levels suggests rather encouragingly that we have seen a decline in the number of children who are completely unimmunized since 1975.

TRENDS IN MEASLES

Mr. FLOOD. Mr. Watson, you mentioned in your opening statement the matter of the increase in the number of reported measle cases. Is that trend continuing, or has PHS brought the situation under control?

Mr. WATSON. No, sir; it is not under control. We are doing things about it, and the money that we now have in the 1977 budget and the money we are requesting in 1978 will permit us to mount a nationwide effort in measles control.

Mr. FLOOD. You talk about $19 million. Will that entire $19 million immunization program be used to purchase vaccine?

Mr. WATSON. No, sir; it will not. It will be used to pay for people who do the kind of things Dr. Millar is talking about in community settings, and so on.

Mr. FLOOD. For the record give us a breakout of the vaccines that you intend to purchase, and show us the quantity, and the dollars, associated with the purchases of vaccine.

Mr. WATSON. All right. We will provide that.

[The information follows:]

TYPES, QUANTITIES, AND COST OF VACCINES, FISCAL YEAR 1978

Vaccine	Quantity (millions of doses)	Cost
Polio	6.0	$1,920,000
Measles	1.0	860,000
Rubella	1.0	570,000
Measles/rubella	2.0	2,400,000
Measles/mumps/rubella	1.5	3,630,000
Total cost		9,380,000

IMMUNIZATION STRATEGY

Dr. MILLAR. Could I make one further point, Mr. Chairman? There are really three elements that we envision that need emphasis. One is the search for susceptibles to find—even if it takes in certain parts of our largest cities, door-to-door interviews—the kids who have not been immunized.

Second, to assure that the service is available for those kids to be immunized whether they attend health department special clinics, private physicians, or whatever.

And finally, to emphasize outbreak control which means very rapid response to measles outbreak and intense investigation and attempts to vaccinate around outbreaks. Those three elements are critical to the strategy.

INCIDENCE OF VENEREAL DISEASES

Mr. FLOOD. In prior years on this section here, Dr. Sencer told us that the incidence of syphilis was on the decline, but that the incidence of gonorrhea was increasing. Is that still the case?

Mr. WATSON. No, sir, Gonorrhea has plateaued out, we think.

Mr. FLOOD. Plateaued out?

Mr. WATSON. It has topped out, not turned down yet, but we believe that curve has topped out, and we have hopes of turning it down.

In syphilis, we do believe we are seeing a real albeit small, decline in early syphilis.

PENICILLIN-RESISTANT GONORRHEA

Mr. FLOOD. We have heard a lot of discussion about a new strain of penicillin-resistant gonorrhea. How serious is that problem, and what are you doing to control that problem?

Mr. WATSON. All right; that is a very serious problem, and we are quite concerned about it. Even that kind of threat is not without its spinoff in that we have attempted to find every case of this kind of gonorrhea that has occurred in this country, and we have just literally thrown the book at it in terms of epidemiological followup. We are encouraged that today it looks like we have been able to contain these cases that have been introduced in the United States and maybe again Dr. Millar can elaborate on this.

Dr. MILLAR. Yes, sir. We have documented a total of 94 cases of gonorrhea due to this particular organism.

Mr. FLOOD. Is that a lot?

Dr. MILLAR. Well, it is certainly more than we would like.

Mr. FLOOD. I know that.

Dr. MILLAR. But in view of the overall problem of gonorrhea, it is really a very small proportion. The very encouraging thing about this is that we have in each instance where an outbreak of this particular type of gonorrhea has occurred, been able to interrupt the transmission of it, that is to——

Mr. FLOOD. To what?

Dr. MILLAR. Interrupt the transmission of it. So that as of this moment in this country we do not know of a single case of this particular kind of gonorrhea.

Mr. FLOOD. Did you say you have been able to interrupt this?

Mr. WATSON. We have been able to stop the spread, Mr. Chairman. It is costing a lot more per case.

STRATEGIES TO REDUCE INCIDENCE OF VENEREAL DISEASE

Mr. FLOOD. I read recently, and I am sure you did, too, where the head of the Salt Lake City Health Department was prepared to ask the county prosecutor to issue warrants to bring in and to isolate anyone having this new strain of penicillin-resistant gonorrhea. Do you think that is an effective way to put the lid on that disease?

Mr. WATSON. No, sir; we do not believe police approach is the proper approach to this. If you go that route, my experience, and I have had some personal experience in VD field work, you just drive it underground, and that is the last thing we want to do.

Mr. FLOOD. In the past now, we have quarantined all kinds of people for all kinds of diseases. Why wouldn't you quarantine people for this one?

Mr. WATSON. It is true that quarantine has been used for VD.

Mr. FLOOD. We have quarantined people for other diseases, and it has been effective; why not for this?

Dr. MILLAR. I think there is no need to do so. This new penicillin-resistant strain can be adequately and quickly treated with spectino-

mycin. In fact, in each instance where this organism has appeared and been identified, the approach of very intense investigations, acquainting people with the information that this is a new strain, there has been good cooperation and through treatment of contacts the spread has been curtailed to that particular outbreak.

So I think it is really not necessary to quarantine and in general we have found in this field, as Bill indicated, some methods we might apply in other diseases don't work quite as well.

COORDINATION WITH AGENCIES ON CONTROLLING VENEREAL DISEASE

Mr. FLOOD. In what way do you work with the Department of fense on the business of controlling the spread of VD?

Mr. WATSON. Yes, sir, and we have collaborated with them in studies both in this country and in the Philippines.

Mr. FLOOD. In what way do you work witth the Department of Defense to control VD? What do you do?

Mr. WATSON. The people working in VD in areas close to military bases have very close day-to-day working relationships in terms of reporting contacts back and forth. They work very closely at the community military base level, if you will.

Also, we have had some joint research projects with them, with the gonorrhea problem in the Philippines. We work closely with them.

Mr. FLOOD. Isn't it in the Philippines that this new resistant strain developed?

Mr. WATSON. That is one place.

Dr. MILLAR. That is our understanding. The first case in this country was identified in the State of Maryland, but we know that the strain is prevalent as a consequence of joint studies with the military in the Philippines.

VENEREAL DISEASE EDUCATIONAL PROGRAMS

Mr. FLOOD. What type of educational programs about venereal disease do you support here?

Mr. WATSON. I know we do it at clinic level with individual patients, provide them with facts about VD, the things they need to do.

Mr. FLOOD. That is after the fact.

Mr. WATSON. That is after the fact. We do have community-type information programs, but I am not aware that we have anything——

Mr. FLOOD. What kind do you support in this budget? This is the Appropriations Committee.

Dr. MILLAR. I can give you, Mr. Chairman, a general overview of what——

Mr. FLOOD. I want to know what types of these educational programs about VD you support in this budget, period.

If you don't have it now, supply it for the record, because we want to see that.

Maybe you can tell us now, and if not, get it for the record, how much you plan to spend for VD information programs?

Mr. WATSON. I don't think we break that out. It is such an integral part of epidemiology, clinic operation, and so on, that we normally don't break out the educational part, but we will.

[The information follows:]

VENEREAL DISEASE EDUCATION PROGRAMS

During fiscal year 1978, venereal disease education programs will be targeted to patients in public clinics, other providers of venereal disease services and the general public. The overall objective of these educational efforts is to prevent the transmission of disease by influencing individuals to avoid venereal disease, to recognize the possibility of infection when exposed and to take appropriate action; and by encouraging providers of services to participate in all aspects of venereal disease control. With the major focus being these areas, we estimate that $2.2 million will be utilized for venereal disease education in 1978.

SEX EDUCATION PROGRAM

Mr. FLOOD. On health education, and also in your opening statement, you said $2 million is going to be spent on sex education programs. Can you tell us what kind of program like that you intend to support?

Mr. WATSON. Yes, sir; we had a meeting this Monday, and, to my knowledge, this is the first time that the Federal Government has ever taken an active role in sex education, and we do have $2 million in this budget for that purpose.

Mr. FLOOD. What kind of programs?

Mr. WATSON. One, we are going to gather facts about what is being done in sex education, what is going on in the country. We know that a lot is going on, but, to our knowledge, nobody has ever assayed the situation over all in the country to find out what is being done, what works, what doesn't work. We plan to work with people who are already active in this field, such as the clergy, the health people, primary health care centers, youth group leaders that are doing a lot, we understand. We are going to be working with them.

IMPLEMENTATION OF SEX EDUCATION PROGRAM

Mr. FLOOD. Now, how do you plan to implement the sex education programs that we are talking about, and what role will you and the other PHS agencies play in carrying out this kind of activity?

Mr. WATSON. We are going to work with the people who are already active in this field. We are going to assess what they are doing. We are going to find out what is going on in the country, what works, what doesn't work; we are going to have experimental community programs, not in every community in the country, but we will have some.

We will support some community programs. We estimate at this time there will be three to five of these.

Insofar as the other agencies are concerned, in the Public Health Service we have worked closely with them in other aspects of health education, and we would anticipate we will continue to do so with this.

Mr. FLOOD. Have you talked to them, met with them; are you going to meet tomorrow morning?

Mr. WATSON. No, sir; we have had one meeting on sex education this past Monday, and that is the only one to date. That was with people outside of Government.

Mr. FLOOD. But you are going to do it?

Mr. WATSON. Yes, sir.

LEGISLATIVE AUTHORITIES FOR HEALTH EDUCATION

Mr. FLOOD. Take a look at page 130 of your justification, your revised budget justification. We become pretty confused about the legislative authorities that you cite for the health education program.

Mr. WATSON. Yes, sir.

Mr. FLOOD. By the way, there is no mention at all of title 17.

Mr. WATSON. That is right.

Mr. FLOOD. That is the new Health Information and Health Promotion Act, passed by Congress in June 1976. We want to know why you are using all these general authorities of the Public Health Service act instead of title 17.

Did you read the law and just decided it was a bad piece of legislation, and that you were going to ignore it, or what?

Mr. WATSON. No; with the exception of the sex education increase, all of the activity that we are talking about are the kinds of activities that we have done before in the Bureau of Health Education, and none of this is proposed for inclusion under the new legislation. There is no request in the budget for moneys under that legislation.

Mr. FLOOD. Well, under this budget request do you intend to carry out any specific programs that are called for in title 17?

Mr. WATSON. Yes, sir; most of the programs we are talking about in the health education budget are——

Mr. FLOOD. Give us some examples of the programs that you intend to support as mandated by title 17.

Mr. WATSON. We are not asking for any money under that legislation.

Mr. FLOOD. I asked if you were. In this budget request my question was, do you intend to carry out the specific programs that are in title 17? You said you did.

Mr. WATSON. Some of them we will not be able to.

Mr. FLOOD. Some you will.

Mr. WATSON. Yes, sir.

Mr. FLOOD. Are you asking for money to do it?

Mr. WATSON. Not under that authority; no, sir.

Dr. MILLAR. I am not sure this is clear, Mr. Chairman.

Mr. BLOOM. Mr. Chairman, the legislation, as I understand it, is written in such a way that it encourages the Public Health Service to make full use of other authorities under which health education programs can be supported. There is a provision of the act which provides for this. That is the philosophy we are taking with respect to our health education activity. We do have authorities which we have been using, and we will continue to use them.

So when we say we are supporting programs that are authorized, we are. But, we are supporting them under other authorities, and this is within the spirit, as we understand it, and the intent, of the legislation.

Mr. FLOOD. There are no programs you are carrying out dealing with this specific subject you considered are mandated by title 17; is that it?

Mr. WATSON. That is correct.

Mr. FLOOD. You can get a difference of opinion about that provision. You had better consult about that and if you have a different view, be sure to have the record indicate it and let us know.

I am talking about what programs you are going to carry out and what budget requests you are going to ask for to carry out such programs that are mandated by title 17.

If there is any doubt about that, you find it and establish it for the record. All right.

[The information follows:]

HEALTH EDUCATION PROGRAMS MANDATED BY TITLE 17 (PUBLIC LAW 94-317)

We feel passage of Public Law 94-317 (title 17) emphasized the interest in and importance of health information and health promotion activities by placing in one title many of the authorities previously dispersed in other legislation. However, section 1701.9 specifically states:

"The Secretary shall use such other authorities for programs respecting health information and health promotion, preventive health services, and education in the appropriate use of health care as are available and coordinate such use with programs conducted under this title."

The provision of grant authority for health information and health promotion purposes is the most significant change in title 17 authorization.

CDC like other agencies was and is carrying out health education activities specifically authorized in title 17. In fact, all health education activities currently being performed by CDC can be covered under title 17 authorization.

Continuation of current projects of BHE at CDC as well as the new initiative, sex education, in this appropriation will be structured and implemented to be responsive to the specific mandates of title 17.

As an example of a new initiative mandated by title 17, section 1705(b), funds from the fiscal year 1978 appropriation will be used to conduct the study to determine the coverage of health education and preventive health services under public and private health insurance programs including the nature and extent of such service and cost-sharing requirements.

OFFICE OF HEALTH EDUCATION

Mr. FLOOD. I notice in the Office of the Assistant Secretary for Health there has been established an Office of Health Education. All right; why is it necessary to appropriate money to the Center for Disease Control for health education? Why not appropriate the money directly to the Assistant Secretary for Health? In that way you can do what we are all trying to do, consolidate the health education programs.

Mr. WATSON. I can't answer the question.

Mr. MILLER. I think the answer to that is that the program at CDC is the program that is the operating program which will spend the money, and that the Office in the Assistant Secretary for Health is a coordinating Office for the whole Public Health Service, and does not administer any operating programs.

COORDINATION WITH OFFICE OF HEALTH EDUCATION

Mr. FLOOD. All right. How do you plan to coordinate your activities with the Office of Health Education?

Mr. WATSON. We are going to work closely with that office.

Mr. FLOOD. How?

Mr. WATSON. This week, when we had our meeting on sex education, Miss Fullerton, the head of that office, was invited and came to that meeting and participated. We work closely with them and will, with their staff, gather facts as to what is going on in health education in the Public Health Service.

Mr. BLOOM. Also, there is a report required under the legislation. It is going to be the responsibility of that Office to make the report to Congress, and we, of course, would have to feed information into that office at least once a year.

Mr. FLOOD. Is there a target date for that report?

Mr. BLOOM. I believe there is, but I don't know what it is.

Mr. FLOOD. Establish that for the record, if there is.

[The information follows:]

REPORT ON IMPLEMENTATION OF TITLE 17 (PUBLIC LAW 94-317)

Title 17 requires report to President for submission to Congress 2 years after enactment (June 23, 1976), and annually thereafter.

Mr. BLOOM. This will serve, if nothing else, as a means for coordinating with that Office.

Mr. FLOOD. You be sure we get a copy of that report when filed. You be responsible for that, even though they do it as well, out of an abundance of caution.

HEALTH EDUCATION PROGRAMS

Mr. FLOOD. Your own health education program is supposed to maintain information on the current health education activities that are supported or conducted by the other HEW agencies. Do you have a complete list of those?

Mr. WATSON. I don't know whether we have it with us, but that has been done; yes, sir.

Mr. FLOOD. How many programs are currently involved in health education activities all through HEW? How much do they spend annually on health education?

Mr. BLOOM. We have a very rough figure on that.

Mr. FLOOD. Can you define specific figures?

Mr. BLOOM. No, sir; because it is not a line item of expense in the various programs.

Mr. FLOOD. Can you tell us the number of programs?

Mr. BLOOM. Yes, sir.

Mr. FLOOD. Can you approximate how much you spend annually for health education?

Mr. BLOOM. We can come up with a gross estimate.

Mr. WATSON. In the Department of HEW.

Mr. FLOOD. And, by the way, when you are doing that, put in the record a list of the programs you find and the amount that is spent for health education.

Mr. BLOOM. May I add, when we went through this inventory, one of the most useful results was that we developed effective contacts and relationships with the appropriate people in the other agencies.

[The information follows:]

Health Education Programs in DHEW

The attached tables summarizes findings of a preliminary inventory undertaken in fiscal year 1975 of health education activities within the Department. One major result of this inventory was the development of cooperative relationships with other agencies and the identification of specific individuals with responsibility and/or interest in health education activities.

Because health education activities are an integral part of many health service delivery programs and cannot readily be separately identified and quantified, budget estimates for this group of programs include all program funds, where available. Health education-related activities represent, thus far, an undetermined portion of these program resources.

Since fiscal year 1975, the expiration of the regional medical programs under the Health Resources Administration resulted in an apparent decrease in health education related activities funded by the Department. However, many of the better regional medical program educational projects have been continued with a variety of funding sources, both public and private.

The need for a system to provide current and accurate information regarding magnitude and scope of information/education activities in health throughout the Department is well recognized. A priority objective of the Center for Disease Control, in close cooperation with the new Office of Health Information and Health Promotion, is to develop and implement such a data system this year.

DHEW HEALTH EDUCATION AND RELATED PROGRAM ACTIVITIES

TABLE I.—IDENTIFIABLE HEALTH EDUCATION PROJECTS AND ACTIVITIES BY AGENCY

Organization	Number of projects	Budge (thousands)
PUBLIC HEALTH SERVICE (PHS)		
Center for Disease Control (CDC):		
BHE	32	$2, 574
BSS	274	10, 141
Subtotal	306	12, 715
Food and Drug Administration (FDA)	16	553
National Institutes of Health (NIH):		
NCI	18	1, 955
N.H. & L.I.	11	1, 798
Subtotal	29	3, 753
Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA):		
NIMH	27	1, 602
NIDA	36	3, 830
NIAAA	23	6, 563
Subtotal	86	11, 995
Health Resources Administration (HRA):		
RMP	394	21, 775
Other	15	681
Subtotal	409	22, 456
Health Services Administration (HSA):		
Indian Health		1, 963
BCHS (family planning and maternal and child health)	14	1, 044
Subtotal	14	3, 007
PHS, subtotal	860	54, 479
Office of the Assistant Secretary for Planning and Evaluation (OASPE)	3	237
Office of Consumer Affairs (OCA)	2	225
Grand total	865	54, 941

TABLE II.—DEPARTMENTAL PROGRAMS WITH SIGNIFICANT HEALTH EDUCATION COMPONENTS NOT SEPARATELY IDENTIFIED

Organization	Number of projects	Budget (thousands)
Office of Education (OE)	3	$113,900
Social and Rehabilitation Service (SRS): Medical Services Administration (MSA)		
Social Security Administration (SSA): Bureau of Health Insurance (BHI)		
Office of Human Development (OHD):		
Head Start	8,368	430,000
Nutrition for elderly	665	100,000
Aging	412	96,000
Subtotal	9,445	626,000
PHS/Health Services Administration:		
Bureau of Community Health Services:		
Community health centers	157	
Maternal and child health/sudden infant death syndrome	20	
National Health Service Corps	260	
Migrant health centers	105	23,750,000

OCCUPATIONAL SAFETY AND HEALTH RESEARCH GRANTS

Mr. FLOOD. A reduction of $1,100,000 in research grants is called for. Is that due to the expansion of the intramural research operations? Is that why there is a cutback in grants?

Mr. WATSON. It is true. There have been sizable increases in their budget.

Mr. FLOOD. Is that why the reduction?

Mr. WATSON. No, sir; this reduces that grant item back to the level of the previous year and does maintain the level of funding we had in 1976.

Mr. FLOOD. What impact will this reduction have on your research program? Is it going to result in some projects which will be terminated half way through the job; or what?

Dr. FINKLEA. The impact of this proposed budget will be following on the grant program. There will be no new research grants funded during the fiscal year 1978 and we will be required to reduce the existing grants by somewhere between 15 and 20 percent.

Mr. FLOOD. If we restore the cuts, say the million dollars, how would you use it?

Dr. FINKLEA. We would support the continuation of the grants which have been approved for 3-year funding and we would be able to continue to fund a modest number of new grants submitted each year. These new projects would be chosen from among the approved but unfunded backlog we have now and from the new grants submitted through the National Institutes of Health.

Mr. FLOOD. Mr. Natcher.

DIABETES PROGRAM

Mr. NATCHER. This committee added $1,500,000 in the 1977 appropriation bill for diabetes control activities. What have you been doing since the committee added this additional money? Can you tell me how you are spending this money and, also, if you will, what do you intend as far as 1978 is concerned?

Mr. WATSON. We have run into some problems with this program in terms of our internal budget processes. If they are straightened out, we anticipate we will have a full-blown million and a half dollar program underway this year. This is complicated by the fact we are not requesting funds to continue this in 1978. So, this will be a one-time demonstration effort as to what can be done on a community level as to diabetes.

Mr. NATCHER. Are you backing away from diabetes control? Are you really trying to confront this program? As I understand it, this is one of the more serious problems we have as far as health is concerned. Do you feel you are really trying to face this situation?

Mr. WATSON. If the money can be available in this year's budget, yes, sir, we are. But there was not enough money to fund everything, so in 1978 we are not asking for a continuation of the diabetes program. But we could have an active program in fiscal year 1977.

LABORATORY IMPROVEMENT

Mr. NATCHER. Last year we talked about the need to encourage States to expand their own programs as far as laboratory improvement is concerned. How much will be spent on this effort in 1977?

Mr. WATSON. I think a million plus dollars which will be going out to the States for their use in development.

Mr. NATCHER. What about 1978? That's from 1977.

Mr. WATSON. There is a decrease in that item from 1977 to 1978 in the amount of $998,000.

MONITORING OF INTRASTATE LABORATORIES

Mr. NATCHER. Tell me what progress has been made as far as having the States monitor the States insofar as intrastate laboratories?

Mr. WATSON. We have a very active program. Contracts are being developed. We have made a survey of the program in each State. All the States have now been visited. We know what kind of activities they have. We have attempted to quantify, on a ranking kind of system, how well each State is doing, and we are going to use this as a guideline as to where we put the money we have to improvement in States.

Mr. Natcher, there is a big range, the system for ranking which we developed is on a scale of a thousand, a thousand being our idea of what an ideal State program should be. There are States up to 850, there are States below 100. So there is a tremendous variation as to performance among States at this time. There has been improvements, but we have a long way to go.

LABORATORY IMPROVEMENT STANDARDS

Mr. NATCHER. Are the States using the same standards for intrastate labs that you apply in evaluating the performance of interstate labs?

Mr. WATSON. Not in all instances. no, sir.

Mr. NATCHER. Are most State evaluation programs up to the CDC standards, or is there a considerable amount of work that still needs to be done?

Mr. WATSON. There is a considerable amount of work that still needs to be done.

Mr. NATCHER. How many laboratories did you evaluate in fiscal 1976?

Mr. WATSON. Under our authority to monitor labs, it was a little less than a thousand.

Mr. NATCHER. How many met the standards?

Mr. WATSON. All these were licensed and met the standards.

Mr. NATCHER. Can you give us an idea of how many you checked upon and they failed?

Mr. WATSON. Eleven that we denied a license. There were many that withdrew their applications but out of the 800 and some, we denied only 11.

Mr. NATCHER. How frequently do you evaluate a laboratory's performance?

Mr. WATSON. Annually. The licenses are renewed annually.

SCREENING FOR LEAD-BASED PAINT POISONING

Mr. NATCHER. Is the material you submitted to the committee—in that, you state in 1977, 400,000 children will be screened by the lead-base paint program and an additional 300,000 will be screened by other programs of HEW. This is about the same level we had in 1976; is that correct?

Mr. WATSON. I defer to Dr. Millar.

Dr. MILLAR. The number of children screened under the lead-base poisoning prevention program has increased substantially during fiscal year 1976, including the transition quarter, it was 512,000 children screened. We would anticipate the level would be approximately the same in fiscal year 1977.

Mr. NATCHER. As far as screenings are concerned?

Dr. MILLER. Yes, sir.

Mr. NATCHER. Should more be done along this line?

Dr. MILLAR. Well, the situation is this: Where we look at children living in dilapidated housing, we consistently find difficulties with lead poisoning, but I think it is fair to say now with the EPDST program and other supporting programs going on and a general acceptance for lead-base poisoning, there has been a tremendous increase of awareness of this throughout the country. One would have to say at the present time we don't know of major areas in the country where activities are not going on to identify the problems.

In 1976, the percent of children who were identified, for instance, with lead problems, that is a high result on a lead test, 94 percent of those children were, in fact, referred and were given the necessary pediatric management for that. That indicates, I think, a rather high level of response to the problem. I think we would have to say in overview that we think the problem is being addressed, although not entirely by this particular program we are responsible for. There is a good deal of attention to lead-base poisoning and a lot of activity in several different agencies.

COORDINATION OF LEAD-BASED PAINT POISONING EFFORTS

Mr. NATCHER. Who in the Government coordinates the full range of services required for a successful lead-based poisoning program? Who has the responsibility for this matter?

Dr. MILLAR. I think the prime responsibility for this rests, Mr. Natcher, at the community level where the people actually performing the work must be the people who bring together the various activities, the State and local activities which go into this.

We think this job is being well done. For instance, again, if one looks at the number of dwelling units in which the problem has been abated, that is, in which the problem has been removed, that proportion has risen from 39 percent in fiscal 1973 to 80 percent in fiscal 1976. This suggests that, not only are the kids being identified, but the people responsible for housing codes and other matters of that sort are now involved. So not only can we identify the kid and get him treated but take the perhaps more important step of preventing further exposures.

Mr. NATCHER. As I understand it, HUD and, also, Community Services Administration is involved. Is that correct?

Dr. MILLAR. Yes, sir.

Mr. NATCHER. Now, if you would, at this point, and, Mr. Chairman, with your permission, I would like to have in the record a list of all the agencies involved as far as lead-base paint screening treatment and abatement is concerned. If you will, at this place in the record, place that information in the record for me.

Dr. MILLAR. CDC, Social and Rehabilitation Service and Bureau of Community Health Services. They are the major agencies connected with that. Of course, there is HUD connected with this in correcting the housing sources.

Mr. NATCHER. Mr. Chairman, at this point in the record I would like to insert the report prepared by the Center on Disease Control as to lead poisoning.

Mr. FLOOD. Without objection, that will be done.

[The information referred to follows:]

AGENCIES INVOLVED IN LEAD-BASE PAINT SCREENING, TREATMENT, AND ABATEMENT

The full list of departments and agencies involved in the screening and treatment of children as well as abatement of lead-based paint is as follows:

Department of Health, Education, and Welfare—

Health: Center for Disease Control; Health Services Administration; Food and Drug Administration; Health Maintenance Organizations; and National Institutes of Health.

Welfare: Social and rehabilitation services (early and periodic screening, diagnosis and treatment).

Department of Agriculture; Department of Commerce; Department of Defense; Department of Housing and Urban Development; Department of the Interior; Department of Justice; Department of Labor; and other agencies.

ACTION: Consumer Product Safety Commission; and National Science Foundation.

Mr. FLOOD. Mr. Patten.

OCCUPATIONAL SAFETY AND HEALTH INDUSTRYWIDE STUDIES

Mr. PATTEN. Do you have any leads to want to have OSHA look at roofing, welding and cement? Was there a good reason for requesting that?

Dr. FINKLEA. Yes, sir. In the case of roofing, the roofing contractors and workers requested the Institute develop safety and health recom-

mendations so they could deal with these on either through voluntary compliance or through regulations, if necessary.

Here is a clear case where management and labor recognized certain safety and health problems and were especially concerned about certain of the tar volatiles and fibers present in roofing materials. It is a good example of where Government, management and labor are working together.

In the case of welding, we have for sometime considered the physical and chemical hazards encountered in welding operations, you are probably aware of the ultraviolet light problem but there are a number of gaseous fumes that are encountered by these workers, too. In cementing operations, I think our concern there is as one moves from one kind of cement to another, one may have a variety of particulates with differing chemical and biological characteristics. It is best to look at the whole range of cement products and operations rather than concentrate on one product, as an example, asbestos cement. Failure to look at the operation producing the product and uses of the product might lead people to substitute one hazard for another.

CRITERIA DOCUMENTS

Mr. PATTEN. As I look back over the past 50 years it would strike me these safety factors should be of importance to large insurance companies. It is of prime interest to the industry themselves. I think they have done some work.

Will industry cooperate with your efforts?

Dr. FINKLEA. Yes, sir. In our criteria documents program, we have had a good response from this industry. The Portland Cement industry itself has been interested in sponsoring health research. They talked to us about sponsoring that research and we had talked to the university that they were going to become involved with. They were a little slow getting this off the ground because of the economic situation. However, there has been a great deal of research work done in this area in Western Europe. We have access to those reports through our relationship as a collaborating center with the World Health Organization.

Mr. PATTEN. Dr. Rauscher quit as head of NCI.

Dr. FINKLEA. Yes sir, but he is still coordinating cancer research for the American Cancer Society, a private voluntary health organization.

Mr. PATTEN. Last year we asked if he wouldn't spend a few dollars in New Jersey checking out certain industries, particularly the chemical industry and the relation to cancer. I know you don't have that money, $800 million, but a lot of people expected OSHA to get into the medical business. Some felt it a big justification to vote for OSHA, so that they would look for safety factors.

Dr. FINKLEA. We have had a number of problems involving long-term exposure to certain chemicals which adversely affect the health of employees. A number of our people have met with the health people of New Jersey. We have spoken to them about the research planned by the Institute and sought areas for joint involvement. That effort is in process now. I don't think it's been completed.

NIOSH TRAINING GRANTS

Mr. FLOOD. You want to decrease training grants by $1,500,000. Is that reduction being made because the new Health Manpower Act administered by the Health Resources Administration includes an authorization for funding occupational health training centers?

Mr. WATSON. No, sir. That is not related to it.

Mr. FLOOD. What is the relationship between the two?

Mr. WATSON. There is a section in the Occupational Safety and Health Act which provides for occupational health training centers.

Dr. FINKLEA. The training grants established in the Occupational Safety and Health Act are of two types. One type grant is intended to get universities and colleges started in occupational safety and health programs or to train specific specialists in short supply.

The second part of the program, after appropriations by this committee last year, were for establishing the educational resource centers which you mentioned. It is true that the activities of these centers are also described under the Health Manpower Act. When we were working with the Office of Management and Budget for the fiscal year 1977 budget, a discussion as to training grants came up. It was suggested that we go and work with the committee which was drafting this legislation. We worked with the committee on that legislation, so it is not unexpected that the section on Education Resource Centers would be just like the center you approved a year ago.

IMPLEMENTATION OF HEALTH MANPOWER LEGISLATION

Mr. FLOOD. Has the decision been made as to which agency will have the responsibility for administering the occupational health program?

Mr. BLOOM. There will be a meeting tomorrow to discuss implementation, but within the Public Health Service, CDC has been given the responsibility for administering occupational safety and health programs.

Mr. FLOOD. What efforts are you making to involve other health manpower programs in producing the personnel who will be needed in occupational employment?

Dr. FINKLEA. As long ago as 2 years we met with people from the Health Resources Administration when this concept of educational resource centers was being developed to seek joint development and perhaps joint funding. At that time the Health Resources Administration did not feel it had resources to devote to this activity. Our professional personnel in nursing have also met with the nursing services within the Pubilc Health Services——

Mr. FLOOD. Other health programs, such as nurses specifically.

Dr. FINKLEA. The Health Resources Administration is responsible for the training of other professionals as well. We have also met with the accrediting groups of medical societies—

Mr. FLOOD. Will they help you to get the people you need in occupational medicine?

Dr. FINKLEA. We were attempting to get their continuing cooperation——

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Mr. FLOOD. Where will you get the personnel needed in occupational medicine?

Dr. FINKLEA. We feel the universities can make a real impact by training people at the graduate level and, also, by providing training courses to people who entered the field laterally without specific training in occupational safety and health.

PROTECTIVE DEVICES

Mr. FLOOD. Also, in your justifications there, you state that in 1977 you will test 400 protective devices and, also, the industrial hygiene monitoring devices. Are these things that are available right now in the marketplace or are they developed by your own organization?

Dr. FINKLEA. These are devices being marketed now. This program also includes testing sample and analytic equipment used by industrial hygenists.

Mr. FLOOD. Is there more you could be doing in developing this equipment?

Dr. FINKLEA. We are doing research in the area. Mr. Chairman, there are two different aspects to the program: Research and development on one hand, and testing and certification of marketed devices on the other.

TOXIC SUBSTANCES CONTROL ACT

Mr. FLOOD. In the material you submitted to the committee, you tell us that new procedures are required to establish a system of present market screening of all these new chemicals. Isn't that the responsibility of the EPA under the Toxic Control Act?

Dr. FINKLEA. I don't think we submitted a large request in our budget here. We do have involvement with the Toxic Substance Control Act. We are to participate in the interagency testing activity.

Mr. FLOOD. What is your agency's involvement?

Dr. FINKLEA. We participate on the Interagency Committee for Testing of Chemicals. We will be working with EPA in doing research to support the Toxic Substances Control Act. We will be trying to test in the laboratory some of the materials collected from the workplaces, and to monitor the health of workers exposed to toxic substances.

RESPIRATORY DISEASE RESEARCH

Mr. FLOOD. Take a look at page 165. You say you intend to strengthen the Institute's respiratory disease research program in the so-called noncoal areas.

Dr. Levy testified last year from the Heart Institute of NIH, he told us that he was supporting a research center in respiratory diseases. As a matter of fact, his research center was studying the effect of prolonged exposure to harmful dust and fumes. Now, you are not intending to duplicate that work, are you?

Dr. FINKLEA. No, sir. We try to work closely with the National Heart, Lung and Blood Institute.

Mr. FLOOD. Tell us how your efforts will differ from those of Dr. Levy.

Dr. FINKLEA. Our Institute's responsibility is to exploit the more basic research conducted by the National Heart, Lung, and Blood Institute. We develop and utilize new techniques which can be used to screen workers in the workplace. We do workplace studies because we have right-of-entry under the Occupational Safety and Health Act and the National Heart, Lung, and Blood Institute does not. We are primarily responsible for doing health and environmental studies in the workplace. The Heart, Lung, and Blood Institute is more involved in research treatment and understanding the mechanisms of disease.

COORDINATION WITH NIH

Mr. FLOOD. That is very, very important to know. How do you plan to coordinate your efforts with those of Dr. Levy?

Dr. FINKLEA. Dr. Claude L'Enfant is on the advisory group which deals with coal workers' pneumoconiosis and other respiratory problems. We have also encouraged our staff to work with the National Heart, Lung, and Blood Institute in their reviewing research proposals submitted to that Institute. Sometimes grants are assigned either to our Institute or their Institute with a secondary responsibility given to the other Institute.

NEW POSITIONS FOR NIOSH

Mr. FLOOD. Now, you are asking for 15 new jobs. Why do you need these positions and what kind of people are you going to be recruiting?

Mr. WATSON. Those are the people who will run the Taft Center which NIOSH occupies. The building and the people will be transferred from EPA to NIOSH.

Mr. FLOOD. What about the amount of money requested? Does that represent a full-year cost for those jobs?

Dr. FINKLEA. Yes, that is correct.

EPIDEMIC INTELLIGENCE SERVICE

Mr. FLOOD. Subsequent to that Legionnaires' outbreak we received a lot of comments as to the way the situation was handled. Some people have indicated very strongly that there is a need for the Epidemic Intelligence Service, you call it the EIS, to develop expertise in the area of toxic substances. Are you planning to expand that staff to include toxic substances? I know since we first began to read about this, that outbreak was caused by bacteria. But, even so, in spite of that finding, right or wrong, wouldn't it be helpful for some additional expertise on your staff for toxic substances?

Mr. WATSON. Let me first say, much of that criticism is unfair and unfounded.

Mr. FLOOD. I am sure of that. I am sure you think so.

Mr. WATSON. Thirteen percent of the epidemics we investigated last year involved toxic substances rather than infectious diseases. We have a lot of epidemiological expertise in that area. Also, we work very closely with NIOSH.

Mr. FLOOD. Do you have a formal plan for handling emergencies such as this Legionnaires' disease outbreak, that you can put into action in order to coordinate and control the activities of your staff?

The second wave of criticism we received was as to the handling of the Legionnaires' problem. A lot of these complainants seem to think a formal plan is essential, as such.

Mr. WATSON. We have a manual about 4 inches thick which spells out exactly what people——

Mr. FLOOD. I don't want anything four times thick right now. Tell us briefly about that and then you can insert in detail, within the rule of reason, that plan.

Mr. WATSON. It does spell out what all the people in the center, the lab people, the epidemiologists and all, do. We have spelled out how we manage these situations. We think we have developed a system which formalizes what we have done and we have it there when a problem with a toxic substance develops.

Mr. FLOOD. Don't forget now, you touched briefly on that formal plan. You told us you had that extensive report. Be sure to send to the committee a copy of that report.

[The information referred to follows:]

EPIDEMIC INTELLIGENCE SERVICE

Environmental hazard investigations are handled in basically the same manner as infectious disease problems, although some of the tools (laboratories, etc.) and background knowledge needed are obviously different. We hear of problems from a wide range of sources—health departments, private physicians, public inquiries, and at times in conjunction with NIOSH occupational sources. We respond as quickly as possible, assess the problem as seems best, and conduct whatever epidemiological inquiry seems indicated. This may include a simple description of cases and/or environmental conditions, a cross-sectional survey of health effects and exposures, a long-term follow-up study, a case-control analysis, or any combination. Laboratory backup is usually essential, either from CDC, or from other Government or private laboratory sources, depending on the kinds of analyses needed. Almost always investigations are of a combined epidemiology-laboratory sort. The usual procedures of communicating before, during and after investigation with local, State, and regional health authorities, as well as others who "need to know," are observer.

Mr. WATSON. Do you have anything to add?

Dr. FOEGE. An epidemic could be infectious, toxic, and so forth we have tried to clarify what specimens have to be collected.

Of the 15 or 16 hundred epidemics investigated last year, between 11 and 13 percent did involve toxic substances. We do have a plan on how to react.

Mr. FLOOD. Thank you very much, gentlemen.

[The following questions were submitted by members of the subcommittee with the request that they be answered for the record:]

IMMUNIZATION

Mr. MICHEL. In your statement you refer to a larger increase in the outbreak of measles among junior and senior high school students. What is the reason for that, do you have any explanation?

ANSWER. Children now in junior and senior high schools were in school before laws were generally available and enforced requiring measles immunization for school entry. These children were not vaccinated in infancy or prior preschool vaccination efforts, were vaccinated either too young, or with vaccine and

gamma globulin. Those who were not adequately immunized have a greater risk because they are exposed to larger numbers of people than infants.

Mr. MICHEL. Do the immunization project grants go to communities that have not undertaken communitywide campaigns to immunize children, and if so, doesn't this unfairly reward the laggard communities as against those who have met their responsibility on their own?

ANSWER. Immunization project grants are awarded to State and local health departments based on the level and extent of problems as defined by birth rate, immunity levels, disease incidence, and the capabilities of the health agency to conduct needed services. Immunization grant funds are awarded to all States. All of the States have had some communitywide programs. While not all of the States have placed as much emphasis on communitywide programs as others, all are carrying out quite effective immunization programs.

The immunization levels of the children in a State is only one factor considered when awarding grant funds. Others are the number of births, the design of the program prepared, and the effectiveness of the program, and we believe that there is a fairly equitable distribution of funds among the States.

Mr. MICHEL. How many immunization project grants are going into Illinois during the current year, and can you tell us which communities are receiving them?

ANSWER. In 1977 there are two immunization project grants awarded within the State of Illinois. One has been awarded to the city of Chicago, department of health, in concurrence with the State health department, and one has been awarded to the State of Illinois, department of health, which assists all communities within the State other than Chicago.

VENEREAL DISEASE CONTROL

Mr. MICHEL. We seem to keep hearing conflicting reports as to whether venereal disease is on the rise or decline. What can you tell us?

ANSWER. In calendar year 1976, reported cases of primary and secondary syphilis declined by 7.4 percent. This trend has continued for the first 8 weeks of calendar year 1977 with a decline of 15.1 percent.

Although reported cases of gonorrhea increased in calendar year 1976, that increase was less than one-half of 1.0 percent. For the first 8 weeks of 1977, reported cases have declined by 5.9 percent.

However, the incidence of syphilis and gonorrhea remains at unacceptable high levels with 23,506 cases of syphilis and 996,404 cases of gonorrhea reported in calendar year 1976.

Mr. MICHEL. Last year, you told us how much California and Florida were contributing to venereal disease. Can you tell us what the figure is for the Nation as a whole (State contributions) and how this compares with previous years?

ANSWER. We estimate that States contribute between $20 million and $25 million yearly to the control of venereal disease. This level of support has been relatively stable for some years.

URBAN RAT CONTROL PROGRAMS

Mr. MICHEL. The Department indicated last year that the rat control grants are intended to be used as seed money to initiate or stimulate comprehensive rat control programs at the State or local level. Federal funds are gradually reduced over the life of the project and the local community is expected to support an increasing share of the project's activities with the eventual withdrawal of all Federal funds. Does that continue to be the basic criteria governing the operation of this program?

ANSWER. Rat control grants were originally funded under section 314e of the Public Health Service Act as demonstration projects. The GAO report on the national urban rat control program dated September 29, 1975, directed CDC to stress implementation of the seed money concept. CDC has done this. The gradual reduction and eventual termination of Federal support coupled with the increase of State and local support has made it possible to divert funds to additional communities with severe rat infestations. In 1969, 20 communities received grant support. Since that time, a total of 78 communities have received or are receiving grant funds through appropriations for the rat control program have not increased. It is anticipated that there will be five new grants initiated this fiscal year.

Mr. MICHEL. The term "maintenance level" is used to describe the progress of the program, and it basically refers to blocks in a community which have successfully reduced the level of rat infestation to certain defined levels. What are these defined levels and how are they determined?

ANSWER. A block is at a maintenance level when 2 percent or less of the premises have active rat signs and either: 15 percent or less of the premises have exposed garbage or 30 percent or less of the premises have unapproved refuse storage. Comprehensive surveys, that is premises-by-premises, are conducted twice yearly to determine the status of individual blocks. On the average block, one rat infested premise will keep a block from achieving maintenance. Therefore, a block in mainteance is rat free.

Mr. MICHEL. At the end of fiscal year 1975, 23,000 city blocks were considered in maintenance. This represented 64 percent of the total blocks in the project areas. By the end of fiscal year 1976, however, this figure dropped back to 21,000, I was advised by the Department, or just 59 percent of the total. This appears to indicate that the program is digressing. Why is this the case?

ANSWER. The program has not regressed but continues to show progress. The 21,000 maintenance blocks do not include an additional 5,421 blocks which were designated as environmentally improved during fiscal year 1976. Environmentally improved blocks are a new measure of program accomplishment. They are contiguous blocks where maintenance has been achieved and sustained for at least 1 year. They have been removed from the federally supported target area and placed under local surveillance and control.

The program's ultimate goal is to have all operational blocks placed in this environmentally improved status.

Mr. MICHEL. When blocks reach the maintenance level, does Federal funding for these blocks stop, or does it continue on indefinitely? I note, for instance, that Philadelphia has 91 percent of its blocks in maintenance, but is still receiving $1.5 million from the Federal Government. When does the Federal funding end?

ANSWER. When a program reaches its maintenance goal, guidelines permit Federal funding to continue for a maximum of 3 years to sustain this achievement. Maintenance level projects are then terminated unless new initiatives are developed that provide for rat control activities in new target areas that have severe rat infestations. In addition, contiguous blocks that have achieved and sustained maintenance for 12 or more months are expected to be dropped from the federally approved target areas and placed entirely under local surveillance. These blocks are referred to as "environmentally improved blocks (EIB)." Philadelphia will be reaching this point this fiscal year.

Mr. MICHEL. Of those communities who have received funding for 7 years—the entire length of the program—there is a great variation in the number of blocks which have reached the maintenance stage. For instance, in Philadelphia, 91 percent of the blocks have reeached that stage while in Newark the figure is just 24 percent. What accounts for this variation? Does it mean that one city is performing much better than the other?

ANSWER. Some cities have been more successful than others. Several factors account for this. For example, the magnitude of the problem varies from city to city. Also, some programs are more effectively managed than others and can better coordinate the diverse activities necessary for success. Another important factor is the amount of local support which can be generated for the program. The Philadelphia project has been able to obtain excellent local commitment. This has helped that program attain a comparatively high level of achievement.

Mr. MICHEL. Do you undertake any efforts to prod communities into performing better when the achievement rate is low?

ANSWER. Surveilliance of all projects is maintained on an ongoing basis through the review of quarterly statistical and narrative reports, and most projects are visited at least once yearly for program assessment purposes.

When the achievement rate is low or problems are otherwise identified, more frequent onsite assessment visits are conducted and technical assistance is provided. Written recommendations are made to the projects and a response from the project is required. Conditions can also be established on the notice of grant award that impacts upon improving program performance.

Mr. MICHEL. What about when you approve communities for refunding. Do you consider the progress made to date when you award funds? For instance, does it acrue to a community's financial advantage not to make much progress?

ANSWER. Continuation grants are made, in large part, on the basis of a project's progress toward achieving its stated objectives. Other factors which

are considered are the magnitude of the rat problem and contributing conditions, the effectiveness of the project's management, and local financial commitment to the project. Projects that do not demonstrate continuing progress and local commitment can lose their Federal grant support.

NATIONAL INFLUENZA IMMUNIZATION PROGRAM

Mr. MICHEL. I note by your statement that you are apparently sticking by the Center's recommendation last year that we undertake the Nationwide inoculation program for swine flu. In hindsight, and considering all the flak that arose, do you really think it was a necessary program?

ANSWER. Given the the same information again, there is no question that we would recommend a program which would afford the American people an opportunity to be protected. In 1968 the time between identification of a new strain and its appearance in epidemic form in the U.S. was too short to develop a program and make adequate supplies of vaccine available. In 1957, there was more lead time, but in my opinion, the Public Health Service moved too slowly and too cautiously. While the influenza virus behaves in unpredictable ways, we do know the ingredients of a pandemic—a new strain which can spread from person to person, and against which the bulk of the population has no natural immunity—and if we find these ingredients in the future in tme to produce and distribute a vaccine, we will come forward with a similar recommendation. We will have benefited from dealing with the problems which arose this past year, but we are not overly concerned about the flak.

Mr. MICHEL. Is there still any kind of an organized effort anywhere in this country to give swine flu shot, or has everything dropped by the wayside?

ANSWER. Most States are offering bivalent A/New Jersey (swine)—A/Victoria vaccine to the population through public and private channels, but no intensive community camapigns are being carried out. Our data indicate that very few people are being vaccinated.

Mr. MICHEL. How many people ended up receiving swine flu shots?

ANSWER. Since October 1, approximately 45.9 million people have reecived swine flu inoculations, in either its monovalent form or in combination with A/Victoria vaccine.

LEGIONNAIRE'S DISEASE

Mr. MICHEL. Can you eleborate a little more about what specifically your findings were regarding the Legionnaire's Disease?

ANSWER. As you are aware, last summer an outbreak of severe respiratory illness occurred in Pennsylvania, chiefly among those who had attended a State American Legion convention in Philadelphia, July 21–24, 1976. An estimated 180 cases occurred including 29 deaths. An organism has now been isolated in yolk sacs of embryonated hens' eggs that appears to be the etiologic agent. For the purpose of this report the yolk-sac isolate is being called a bacterium on the basis of its size and morphology.

The bacterium was first isolated from the lung tissues of 1 fatal case of Legionnaire's Disease and 1 fatal case of Broad Street pneumonia by inoculation of guinea pigs intraperitoneally. After a 1 to 2-day incubation period, the guinea pigs developed a febrile illness that was characterized in most animals by watery eyes and prostration. Spleen suspensions of febrile guinea pigs were inoculated into yolk sacs of embryonated eggs from antibiotic-free chicken flocks. The embryos died after 4–6 days, and stained smears of the yolk sacs were found by microscopic examination to contain many bacilli. The bacilli were gram-negative and moderately pleomorphic. Surviving guinea pigs were shown by indirect immunofluorescence to have developed antibody to the yolk sac isolates. Because most bacteria when inoculated into the yolk sac kill the eggs in 1–2 days, and rickettsia take longer, an unusual rickettsia was suspected. The organism is bigger than a rickettsia, however, and the convalescent guinea pig sera failed to react in serologic tests with known rickettsial antigens. Cross reaction would have been expected had it been a related organism. Cultivation on microbiological growth media has been attempted at each yolk sac passage. Frequently no growth has been observed but yolk sacs infected with one isolate have sometimes given many minute colonies after 2–3 days incubation. The slowness of growth has delayed bacteriological identification.

Evidence for the etiologic role of the yolk sac isolate in the epidemic has been obtained by indirect fluorescent antibody stains carried out by methods that are

very similar to those in regular use in the diagnosis of rickettsial diseases except that the microdrops fixed to the slide were prepared from yolk sacs infected with isolate 1 and isolate 2 of the Philadelphia agent. The results were obtained with sera from 33 patients who were selected because they were Legionnaire delegates who were hospitalized, survived, and had radiologic evidence of pneumonia and fevers of at least 102° F; they thus represented the most typical survivors.

Comments referring to sloppiness in the handling of specimens and the general manner in which the investigation of Legionnaire's Disease was conducted began to appear in the press when it became evident that this was not an ordinary agent and that the CDC would not be able to provide an immediate diagnosis. Critics maintained that the CDC had failed to collect specimens for toxicological examination until much later in the investigation, at which time such specimens allegedly were of little value. Although the specimen volumes which were originally collected and generously shared with the CDC by the Pennsylvania State Health Department laboratory, were inadequate for toxicological examinations, specimens obtained under CDC's supervision were collected according to a protocol which clearly specified amounts and types of material required for toxicology. Most critics also did not fully appreciate that the CDC was called into the investigation on the day of onset of the last case of Legionnaire's Disease, making collection of acute specimens impossible. Despite these difficulties, the specimens collected by the CDC in collaboration with investigtors from the state of Pennsylvania were of unusually high quality. That care was exercised in the collection of the proper clinical materials is borne out by the successful isolation of a previously unknown agent and the diagnosis of the disease in over 95 percent of the ill Legionnaires from whom specimens were available.

SEX EDUCATION

Mr. MICHEL. Can you tell us what this sex education program is going to involve?

ANSWER. The Center will initiate sex education project activities in several areas:

(1) Data gathering on current sex education activities and assessment of these programs in terms of their impact on specified health goals;

(2) Encouragement of training for leadership in sex education among such groups as parents, the clergy, primary health care personnel, youth group leaders, and young people themselves;

(3) Development and support of experimental community programs working with different kinds of local groups, and evaluation of such efforts in terms of health indices; and

(4) Assessment of existing educational materials currently available in this field, and consideration of appropriate ways to fill gaps in such materials.

Mr. MICHEL. It seems to me that many local school systems have moved ahead very effectively on their own in the sex education area, without any Federal stimulus. Why all of a sudden is the Federal Government being brought into the picture?

ANSWER. Unwanted pregnancies especially among adolescents constitutes an increasing health problem of national concern. The Center is aware of the good work of many school systems in delivering effective sex education programs, and it is this knowledge and experience that we hope to build upon. One important way will be to identify and document programs which have been particularly successful, so that other school systems may benefit from this experience. In addition, by supporting demonstration projects, the Center will serve as a useful catalyst in assisting not only school systems but other groups including parent organizations, youth groups and others to develop stronger sex education programs.

Mr. MICHEL. The Center for Disease Control in particular seems like a questionable place for such activity. Why you?

ANSWER. Given the Center's responsibility to serve as the Federal focal point for health education program activities within the Department of HEW, it is appropriate that a major categorical health education program activity such as sex education also fall within the mandated responsibility of the Center. In addition, other components of CDC such as the Family Planning Evaluation Division and Venereal Disease Control Division can contribute significantly to this effort.

OCCUPATIONAL SAFETY AND HEALTH

Mr. MICHEL. Where do we stand at present on the National Institute for Occupational Safety and Health site study? What is the status?

ANSWER. The site selection criteria were reviewed by both the House and Senate Appropriation Committees and their comments were incorporated into the final criteria. NIOSH interviewed four minority contractors and the contract was awarded to Bryant and Bryant, architects and planners, on February 18, 1977. The contract calls for completion of the study on April 15, 1977, with priority ranking of the top five cities to be submitted to Congress by May 1, 1977.

Mr. MICHEL. Has Perioria been evaluated as yet, and if so, can you tell me what the findings were?

ANSWER. The contractor is currently in the process of evaluating all cities as to their resources in accordance with established criteria. We will not know the findings in regard to Peoria until after April 15, 1977.

Mr. MICHEL. Your statement makes reference to the supporting of four or five occupational safety and health educational resource centers for personnel in certain specialized areas. Have these centers been determined as yet, and if so, where are they?

ANSWER. At present the 4 or 5 occupational safety and health educational centers have not been determined. However, announcements have been submitted to approximately 100 institutions. It is anticipated that approximately 20 applications for these funds will be received and it is further anticipated that about 10 to 15 will meet the basic criteria.

Mr. MICHEL. The funding of training centers implies a shortage of personnel. Can you describe for us what the shortages are?

ANSWER. The demand in both the private and public sector for occupational physicians, nurses, industrial hygienists, safety engineers, and other allied health professionals trained in occupational safety and health continues to increase. At present, many businesses covered by these standards either have no medical program or must rely on private physicians or nurses without special training in occupational health to maintain the required surveillance over the health of workers. It is conservatively estimated that an additional 1,000 certified occupational physician specialists and approximately 20,000 physicians with short-term occupational health training, serving primarily as part-time occupational health physicians, will be needed to meet physicians manpower requirements necessary for carrying out the purposes of the Occupational Safety and Health Act. Similarly, it is estimated there is currently a deficit of 4,000 industrial hygienists, 4,700 safety professionals, and over 25,000 nurses. Paradoxically, in the face of increasing demand for trained occupational health professionals, the number of training programs and trainees is decreasing. Currently, fewer than five schools of medicine or public health offer physicians formal residencies in occupational health and few medical schools include occupational health in their undergraduate programs.

Mr. MICHEL. With respect to occupational health, would you say the problem is growing more serious by the year, or is it lessening?

ANSWER. Due to the lack of a good, sensitive occupational illness reporting system, and due to what we believe is the frequent misdiagnosis of occupationally related diseases, it is impossible to say with certainty that the problem is growing or lessening. Certainly the health problems associated with the work environment are being identified at a growing rate. It can also be assumed that until there is widespread understanding and respect for the potential hazards involved with modern technologies, and until there is thorough testing and control of hazards inherent in new technologies, the problem will continue to grow.

CDC EMPLOYEE DEATHS

Mr. MICHEL. There were reports in the media yesterday about two of your lab employees dying, apparently from some disease they contracted. What can you tell us about this?

ANSWER. Center for Disease Control laboratory tests have confirmed that two CDC employees who died on February 27 and March 1, 1977, had infection with Rocky Mountain spotted fever. No other employees with this illness have been identified. There is no risk of secondary spread from an infected person to other contacts.

Both employees had access to the two laboratories that worked with the Rocky Mountain spotted fever agent. One employee was responsible for glassware distribution, and the other was a custodian. Extensive investigation in both laboratories working with the agent have not thus far identified the sources or routes of exposures. No laboratory accidents have been identified, and thorough evaluation of laboratory equipment and other facilities designed to contain infectious agents have revealed no malfunction.

The vast majority of Rocky Mountain spotted fever cases occur in spring and summer and are associated with tick exposures. The simultaneous occurrences and rapid progression to death of these employees suggest a common exposure. Disease acquisition was most likely related to their employment. Investigations to discover the sources of infection are continuing. If these illnesses were laboratory acquired, they represent the first two fatalities in CDC's 30-year history.

IMMUNIZATION

Mr. CONTE. To what do you attribute the increase in the incidence of measles between 1975 and 1976? What are you proposing to reverse this increase?

ANSWER. Although we do not have age specific data on measles cases, it is our impression that increased reported cases were due in part to increases in junior- and high-school-age children. Some of the increase in these age groups is probably due to three factors:

a. Unvaccinated children.

b. Children vaccinated prior to 12 months of age.

c. Children vaccinated with killed measles vaccine or live vaccine used with gamma globulin, practices which are no longer recommended.

With additional funding, States will be able to carry out much more intensive programs. More support will be provided to routine immunization activities, intensified programs to identify and provide services to those inadequately vaccinated will be undertaken, and outbreak control activities will be expanded.

Mr. CONTE. There have been recent reports that the level of immunization has been generally decreasing over the past several years—that people have become complacent about getting their children immunized. Is that true, and could you explain why this is happening? What can be done about it?

ANSWER. Immunization levels have been relatively stable for the past 5 years (U.S. Immunization Survey). However, these are lower than desirable, and efforts to increase these levels is made more difficult by the success of these programs. Many of our younger parents have no memory of polio and the iron lungs have all but disappeared. Many of our younger physicians have never seen a case of polio in a youngster. It is unfortunate but in the absence of disease some people do become complacent. We need to attempt to overcome the apathy by ensuring that services are available and that the medical providers and parents are constantly being reminded of the importance of immunization.

Mr. CONTE. Why would the largest increase in measles occur in junior and senior high school age children? Why not among younger children?

ANSWER. We are not sure that the largest increase is in children now in junior and senior high schools, but it is possible because some of these children were not vaccinated in infancy or in prior preschool vaccination efforts. Some were vaccinated when they were too young, and others were vaccinated with vaccine in combination with gamma globulin. Those who are not adequately protected have a greater risk because they are exposed to large numbers of people. The younger children are now being vaccinated with more effective vaccines and they generally do not have the same risk of exposure.

Mr. CONTE. Could you explain in more detail what your "new strategy" for dealing with measles incidence entails?

ANSWER. The key elements of this strategy 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 identificaion of pockets of high disease susceptibility. Effective ongoing immunization programs supported with intensive disease surveillance and outbreak control activites when disease does occur should be successful in preventing widespread epidemics.

Mr. CONTE. How much additional funding are you requesting for immunization in 1978?

ANSWER. $6 million.

Mr. CONTE. You are requesting an additional $6 million for immunization programs in 1978. In what specific programs will that money be used? How much additional immunization coverage can you provide for $6 million in terms of increasing the percentage of preschool age children protected by vaccine against various diseases?

ANSWER. The additional $6 million will be concentrated on raising immunization levels of preschool and school-age children among the urban and rural poor. The effective determination of immunization levels among these and other important sub-populations will be emphasized, as will the implementation of sensitive surveillance systems to detect outbreaks of vaccine preventable diseases. An effective mechanism will be developed to assure appropriate responses to threatened disease outbreaks and to the identification of inadequately immunized population groups. We would estimate that the $6 million increase will enable health departments to provide between 3 and 6 million additional immunizations.

Mr. CONTE. Why are there pockets of susceptibility to infectious diseases in cities and rural areas?

ANSWER. As with most other disease problems, residents of central cities and rural areas are faced with a maldistribution of private health care providers and seems to be less inclined to seek immunizations and other preventive health services. A disparity in immunity levels has been noted for several years and some of the factors which play a role in the lower protection levels are:

(1) Services which provide protection in the future seem to be of lesser concern compared to services which provide relief to immediate problems, such as pain, hunger, clothing, et cetera.

(2) Insufficient public awareness activities to impress upon individuals the needs and benefits of immunization.

(3) The lack of proper follow-up of services in the public sector.

(4) The frequency with which these population groups change residence.

VENEREAL DISEASE CONTROL

Mr. CONTE. What is the current course of treatment for penicillin-resistant gonorrhea? What is its cost compared to the ordinary penicillin treatment?

ANSWER. The present course of treatment for penicillin-resistant gonorrhea is 2 gm of spectinomycin hydrochloride, intramuscularly, in one injection.

The cost to treat a case of gonorrhea with aqueous procaine penicillin G (APPG) is approximately $1 while the cost to treat one case with spectinomycin hydrochloride is $4, or four times as much.

Mr. CONTE. Your justification says (page 135) that venereal disease screening and casefinding programs were curtailed in 1977. Why?

ANSWER. This curtailment in screening and casefinding programs is related to the availability of grant resources. In fiscal year 1976, Federal support for venereal disease control programs was reduced to $19.8 mililon from $28 million in 1975. The impact of this reduction was softened by the fact that the 1975 appropriation was available late in the fiscal year and supplemented the resources available in 1976. However, the full impact of this reduction is being felt now since the appropriation for 1977 was $18 million.

LEAD-BASED PAINT POISONING PROGRAMS

Mr. CONTE. We requested a report by February 1, 1977, on progress in screening and treatment of lead poisoning. Has that report been submitted? Could a copy of it be provided to me or to my office? If you haven't already done so, could you summarize that report for the record?

ANSWER. The report has been submitted and is in the record. In brief, the childhood lead poisoning prevention program has, since its inception, coordinated activities with the other Federal child health programs and sought the inclusion of services for lead poisoning prevention in their programs. This coordination has been intensified in the last year. Meetings between the staff of the child health programs on the national, regional, and local levels have occurred. Several of these programs have released or are preparing programmatic guidance on lead poisoning.

It has become readily apparent that the lead poisoning problem is not uniform throughout the country. Through fiscal year 1976, CDC has received laboratory results on approximately 452,000 tests for undue lead absorption by the other child health programs in 21 States. Approximately 7 percent were positive. In light of these results the other Federal programs have been encouraged to assess the magnitude of the problem in their patient population. The Center for Disease Control has assisted in conducting problem identification surveys for these other health programs when requested.

CDC, while providing consultative assistance has identified a lack of medical, laboratory, and environmental epidemiologic expertise in States and communities with a low incidence of undue lead absorption. The Center intends to provide this technical assistance.

Mr. CONTE. Your justification (page 138) says that in 1977, funds in the lead paint program were awarded to programs which continued to document a significant problem and which had developed productive programs. How would you define a "productive" program in that context?

ANSWER. A productive program is defined as one which meets all of the following criteria:

1. A significant number of children in the community continue to be identified with undue lead absorption,
2. A high percentage of these children receive appropriate medical followup, and
3. A high percentage of the lead hazard identified in these children's living environment are abated.

Mr. CONTE. What newly developed screening procedures have been implemented this year?

ANSWER. In the past, the childhood lead poisoning prevention program used a difficult direct analysis of lead in blood to detect excessive lead absorption in children. Most programs now use erythrocyte protoporphyrin analysis as an initial screening test since it is a more accurate indicator of lead induced illness.

An instrument developed by Bell Laboratories called a hematofluorometer is now available which provides an almost instantoneous and economical optical measurement of the erythrocyte protoporphyrin level in a child's blood.

Mr. CONTE. What sort of appropriate lead abatement activities are carried out under this program? Why does it only apply to 80 percent of the homes with lead paint hazards, rather than all of them?

ANSWER. Children with confirmed undue lead absorption must be separated from their source of lead if further damage is to be prevented. This is generally accomplished by removing or permanently shielding the lead-based paint hazards identified in the child's living environment.

Lead hazard abatement activities are the most difficult portion of the program. Generally, they are done by the owner of the property or at his expense in compliance with local housing codes. Most are voluntarily performed, but some require court action which in many instances is time consuming.

Our ultimate goal is to abate all hazards that are identified. This level has been increased from 39 percent in 1973 to 80 percent in 1976. We are striving to increase this percentage to the highest possible level. In many of the homes where lead abatement activities have not been carried out fully, the family with the child had been placed in temporary housing until the court actions can proceed.

NATIONAL INFLUENZA IMMUNIZATION PROGRAM

Mr. CONTE. Why didn't the epidemic strike—could you elaborate a little bit on why it is so difficult to predict such occurrences?

ANSWER. We have learned a great deal about the behavior of influenza viruses by studying them in both pandemic and nonpandemic years, and the science of virology has given us an understanding of part of the makeup of the virus itself. There is clearly much, however, that we do not understand and predictions about how they will behave are always risky. What happened and is happening with the swine flu virus is not known. It is possible that, in competition for survival the virus lost out after brief and localized appearances, and that the Fort Dix episode was one of those which we were able to detect. It is also possible that the vaccination program blunted outbreaks before they could take hold, although this is pure speculation and this would not be expected to occur with a truly pandemic strain. Pandemic influenza appears to be too explosive to be blunted by 45 million vaccinations in one country. However, our

investigation of the few cases which occurred since Fort Dix did uncover a large number of vaccinated persons among the social, work and family contacts of the index case. It is also possible that changes in the virus which produce pandemics begin several years in advance of the pandemic, and we were lucky enough to identify the change very early. There is no question that the world will yet be visited by influenza pandemics, and at this point in time we can't rule out the swine virus as a likely candidate.

Mr. CONTE. Is the flu season effectively over? Is there any possibility that there could still be an epidemic of swine flu?

ANSWER. Small outbreaks and isolated cases of A/Victoria and B/Hong Kong influenza continue to occur, and sizable outbreaks of influenza have been observed in the past as late as the end of March. While outbreaks, or even epidemics, of swine flu remain a possibility for this winter, it is becoming increasingly unlikely.

Mr. CONTE. How many people have actually contracted swine flu? How many people died from it?

ANSWER. Several hundred recruits at Fort Dix clearly contracted swine flu last winter, and one young man died. Intensive surveillance since that time has identified four confirmed cases of swine flu, three of which apparently resulted from contact with ill swine. In one of these four cases possible secondary transmission to two additional people was identified. There have been no known deaths associated with swine flu since Fort Dix.

LEGIONNAIRE'S DISEASE

Mr. CONTE. There have been a number of stories in the press about the conduct of the investigation of Legionnaire's disease, many of which seemed to say that there was tremendous sloppiness in the handling of specimens and the general manner in which the investigation was conducted. If there was such conduct, was it with the CDC personnel or with the local and state health officials?

ANSWER. Comments referring to sloppiness in the handling of specimens and the general manner in which the investigation of Legionnaire's disease was conducted began to appear in the press when it became evident that this was not an ordinary agent and that the CDC would not be able to provide an immediate diagnosis. Critics maintained that the CDC had failed to collect specimens for toxicological examination until much later in the investigation, at which time such specimens allegedly were of little value. Although the specimen volumes which were originally collected and generously shared with the CDC by the Pennsylvania State Health Department laboratory, were inadequate for toxicological examinations, specimens obtained under CDC's supervision were collected according to a protocol which clearly specified amounts and types of material required for toxicology. Most critics also did not fully appreciate that the CDC was called into the investigation on the day of onset of the last case of Legionnaire's disease making collection of acute specimens impossible. Despite these difficulties, the specimens collected by the CDC in collaboration with investigators from the State of Pennsylvania were of usually high quality. That care was exercised in the collection of the proper clinical materials is borne out by the successful isolation of a previously unknown agent and the diagnosis of the disease is over 95 percent of the ill Legionnaires from whom specimens were available.

Mr. CONTE. I know that you have isolated a bacterium which caused the Legionnaire's epidemic in Philadelphia. Have you determined how and why the bacterium happened to turn up at that particular place and time? Where is it usually found? And why haven't there been more outbreaks of this sort?

ANSWER. An agent resembling a small bacterium, but with unusual growth properties, has been identified as the cause of Legionnaires' disease. Further investigation has shown that this, or a closely related agent, has been associated with two previously unidentified outbreaks of respiratory disease in Michigan and Washington, D.C. Evidence has also accumulated which suggests sporadic cases have occurred in the eastern United States. The search for a natural reservoir of this agent is currently underway, but its fastidious nature and requirement for guinea pig isolation systems makes this a complex study which may not quickly provide answers.

SALMONELLOSIS

Mr. CONTE. What is being done to reduce the incidence of salmonellosis outbreaks caused by beef products? What is the Department of Agriculture doing about this? How do you coordinate your activities with the Department of Agriculture?

ANSWER. Over the past year and a half the Salmonella Surveillance System has triggered epidemiologic investigation of six outbreaks of salmonellosis associated with commercially prepared, precooked roast beef. In-depth investigation of the problem revealed that meat packing firms, in response to consumer preferences, cooked roast beef at a maximum temperature sufficiently low as to prevent the meat from becoming dry and overdone but not sufficiently high as to kill salmonellae that might have contaminated the meat. With this information, the Department of Agriculture has been investigating the industry's production methods to find how the meat becomes contaminated and then to implement necessary control measures. The CDC works quite closely with the Department of Agriculture, has in fact trained some of the personnel in epidemiologic methods, and keeps in close touch with several designated Department officials when problems within their jurisdiction are uncovered.

An example of how CDC has worked in the past with the Department of Agriculture on the overall problem of salmonellosis in the beef industry centers on the problem of salmonella-contaminated animal feed. Several years ago the CDS, after lengthy and painstaking epidemiologic investigation, was able to show how fish used for fish meal becomes contaminated by salmonella in polluted waters at an early stage in the animal feed production chain. The Department of Agriculture was able to take this information to make sweeping control measures in the production of animal feeds derived from fish meal and thereby close off this important avenue of contamination and eventual animal and human disease.

SEX EDUCATION

Mr. CONTE. You are requesting an additional $2 million for sex education. Can you tell me more specifically what will be done with this money? Are you just developing curriculum, or is this to actually provide sex education programs and services?

ANSWER. The Center will initiate sex education project activities in several areas:

(1) Data gathering on current sex education activities and assessment of these programs in terms of their impact on specified health goals;

(2) Encouragement of training for leadership in sex education among such groups as parents, the clergy, primary health care personnel, youth group leaders, and young people themselves;

(3) Development and support of experimental community programs working with different kinds of local groups, and evaluation of such efforts in terms of health indices;

(4) Assessment of existing educational material currently available in this field, and consideration of appropriate ways to fill gaps in such materials.

Mr. CONTE. As you know, there is often a great deal of local parental opposition to sex education programs. What can be done to overcome such opposition, and how do you propose to do it?

ANSWER. Unwanted pregnancies especially among adolescents constitutes an increasing health problem of national concern. The Center is aware of the good work of many school systems in delivering effective sex education programs, and it is this knowledge and experience that we hope to build upon. One important way will be to identify and document programs which have been particularly successful, so that other school systems may benefit from this experience. In addition, by supporting demonstration projects, the Center will serve as a useful catalyst in assisting not only school systems but other groups including parent organizations, youth groups and others to develop stronger sex education programs.

TERATOGENESIS

Mr. CONTE. What is Teratogenesis?

ANSWER. Literally, teratogenesis means the origin of terata, or monsters. More currently, teratogenesis deals with the causes and mechanisms of malformations. The causes include such environmental agents as drugs, viruses, and

irradiation or chromosomal abnormalities and genetic defects. Manifestations of teratogenesis may be evident in abortions, stillborn or liveborn infants, and may include gross or microscopic structural malformations. However, more recently the meaning of the term has been broadened to include functional abnormalities—mental retardation, learning disabilities, or behavioral disturbances—and low birth weight.

DISEASE INVESTIGATIONS, SURVEILLANCE, AND CONTROL

Mr. CONTE. Why are you requesting a $64 million decrease for disease investigations, surveillance and control? Is that amount exclusively from the swine flu program or are other activities being cut as well?

ANSWER. The net decrease of $64,059,000 includes increases of $1,707,000 for built-in increases such as annualization of new positions and within grade pay increases; and program decreases of $1,500,000 and 10 positions resulting from the one time funding in 1977 of the diabetes community control program. $700,000 resulting from the one time funding provided in 1977 to permit the Center to waive tuition fees for training personnel of Federal, State, and local governments when such training was in the public interest, and $63,566,000 resulting from the one time funding in 1976 and 1977 of the natinoal swine flu immunization program.

JOINT PROJECTS BETWEEN NIOSH AND NATIONAL CANCER INSTITUTE

Mr. CONTE. Can you tell me what sort of projects are carried out jointly between NIOSH and the National Cancer Institute?

ANSWER. In fiscal years 1976 and 1977 a variety of NIOSH projects have been supported by the National Cancer Institute. These all, of course, relate to cancer and are particularly concerned with occupationally related cancers. Many of the projects are mortality and industrial hygiene studies of particular groups and workers. NIOSH has had much experience in performing this type of study and also has access to data and established working relationships with unions and industry that the National Cancer Institute doesn't have. The results of all of the projects involved in the joint NIOSH-National Cancer Institute program will be of direct interest to both organizations in carrying out our respective missions. These projects include mortality and industrial hygiene study of gold-miners exposed to asbestiform minerals, mortality study of pesticide formulators, development of sampling and analytical methods for carcinogens, carcinogenicity/toxicity-inhaled 1,2 dibromoethane, occupational cancer surveillance, kepone registry, industrial hygiene and morbidity study of talc and other fibrous minerals, mortality, medical and industrial hygiene study of vinylidene chloride workers, mortality and industrial hygiene study of styene-butadiene rubber workers, mortality and industrial hygiene study of PCB, industrial hygiene study of azo dye workers, mortality and industrial hygiene study of trichloroethylene (TCE), mortality and industrial hygiene study of perchloroethylene (PCE), mortality, medical and industrial hygiene study of chlorinated hydrocarbons, study of beryllium workers, mortality and industrial hygiene study of nitrosamines/cutting oils, mortality and reproductive effects of chloroprene, mortality, medical and industrial hygiene study of the painting trades, mortality and industrial hygiene study of printing trades, mortality and industrial hygiene study of phosphate workers, occupational carcinogenesis reduction by behavioral methods, inhalation study of short asbestos fibers, perform subtrachial testing of copper and lead smelter dusts, determine the effects of combined exposure to smelter dusts and SO_2, and evaluation personal protective equipment.

CDC EMPLOYEE DEATHS

Mr. CONTE. A story in this morning's Washington Post said that two of your employees had died of an unknown disease, apparently work connected. Do you have any additional information?

ANSWER. Center for Disease Control laboratory tests have confirmed that two CDC employees who died on February 27 and March 1, 1977, had infection with Rocky Mountain spotted fever. No other employees with this illness have been identified. There is no risk of secondary spread from an infected person to other contacts.

Both employees had access to the two laboratories that worked with the Rocky Mountain spotted fever agent. One employee was responsible for glassware distribution, and the other was a custodian. Extensive investigation in both laboratories working with the agent have not thus far identified the sources or routes of exposures. No laboratory accidents have been identified, and thorough evaluation of laboratory equipment and other facilities designed to contain infectious agents have revealed no malfunction.

The vast majority of Rocky Mountain spotted fever cases occur in spring and summer and are associated with tick exposures. The simultaneous occurrences and rapid progression to death of these employees suggest a common exposure. Disease acquisition was most likely related to their employment. Investigations to discover the sources of infection are continuing. If their illnesses were laboratory acquired, they represent the first two fatalities in CDC's 30-year history.

CENTER FOR DISEASE CONTROL LOCATION

Mr. CONTE. You made reference to your location outside of the Washington, D.C., area and seemed to think that it was something of an advantage. Do you find it becomes more difficult to coordinate your work with the other Federal health agencies when you have a different location?

ANSWER. No, sir. The advantage we spoke of stems from the fact that we are relatively self-contained and manage for ourselves the supportive services necessary to respond rapidly to epidemics and emergency situations. This is in keeping with the original concepts that went into founding CDC in Atlanta. Modern transportation and communication obviate most of the difficulties in coordination created by distance.

FISCAL YEAR 1978 OMB REQUEST AND CHANGES

Mr. CONTE. Would you provide a listing of the amounts which you requested from OMB for each of your activities, along with a brief explanation of the justification given by OMB for the changes (if any) and any response to those changes?

ANSWER.

	Fiscal year 1978 OMB request	Fiscal year 1978 OMB allowance	Changes
Disease control:			
Project grants	$56,910,000	$58,500,000	+$1,590,000
Disease investigations, surveillance and control	65,559,000	53,607,000	−11,952,000
Laboratory improvement	28,677,000	15,490,000	−13,187,000
Health education	8,676,000	7,064,000	−1,612,000
Subtotal, disease control	159,822,000	134,661,000	−25,161,000
Occupational health:			
Grants	10,400,000	4,900,000	−5,500,000
Direct operations	52,722,000	44,277,000	−8,445,000
Subtotal, occupational health	63,122,000	49,177,000	−13,945,000
Buildings and facilities	51,250,000		−51,250,000
Program management	3,088,000	3,088,000	
Total	277,282,000	186,926,000	−90,356,000

Note: An increase of $7,590,000 in rat control project grants, and, $5,000,000 in lead-based paint poisoning prevention project grants was to maintain the 1977 level of funding for these programs. All other changes were dictated by the overall budget policy of spending restraint and a "hold the line" budget for 1978.

[NOTE.—The following report was submitted by HEW following the CDC hearings:]

Report on Progress in Raising
Immunization Levels in the United States

Introduction

In its report of June 8, 1976, the House Appropriations Committee requested "a report, prior to the hearings on the 1978 budget, from the Assistant Secretary for Health on his progress in raising the immunization levels of the population in general, and of the urban and rural poor in particular."

Discussion

Historically, when new vaccines have been introduced, Federal funds have been appropriated to assist the States in mounting intensive programs to immunize large numbers of the susceptible population in a short period of time. These efforts have typically resulted in the immunization of slightly more than half of susceptible children 1-4 years of age within three to four years after vaccine licensure. For example, an immunization level of 65.0 percent of that age group was attained within four years after the introduction of Salk polio vaccine. Reported cases of paralytic polio decreased from 13,850 in 1955 to 762 in 1962 following widespread use of Salk and Sabin vaccines. Four years after the licensure of measles vaccine, 56.4 percent of children 1-4 years old had received vaccine protection. In excess of 400,000 cases of measles were reported prior to licensure of measles vaccine. Within four years after the licensure reported measles cases had decreased to 62,705. Just two years after rubella vaccine was licensed, 51.2 percent of children 1-4 years of age had been vaccinated. Reported cases of rubella decreased from 57,686 in 1969 to 25,507 in 1972. Table 1 shows the extent of vaccine coverage among children 1-4 years of age during the early years following the licensure of polio, measles, and rubella vaccines. Table 2 indicates the number of reported cases of measles, rubella, poliomyelitis, diphtheria, tetanus, and pertussis for the years 1960 through 1976.

When a new vaccine becomes available, its introduction tends to affect the delivery of other vaccines as well. As indicated in Table 3, there is evidence that the coverage levels of other vaccines recommended for administration at the same point in a child's life as the new vaccine have been boosted by intensive programs initiated for the new vaccine. This phenomenon was observed with respect to DTP immunization levels in the first few years following the introduction of oral polio vaccine. Similarly, when intensive efforts were undertaken to vaccinate children against rubella, a parallel increase in measles immunization levels was observed between 1970 and 1974. However, the introduction of measles vaccine did not produce a corresponding increase in immunization levels with respect to polio vaccine, which is administered on a different schedule.

HEW, PHS, CDC

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As the childhood diseases become less prevalent following the initial introduction and widespread application of effective vaccines, immunization levels tend to decline. This is partly due to increasing public apathy in response to a perception that the threat to life and health posed by the disease has been greatly reduced or eliminated. Furthermore, changing priorities and reduced financial support in the face of declining disease morbidity have reinforced this tendency. For example, polio morbidity declined dramatically following the mass oral polio vaccination campaign, and a parallel decline in polio vaccine participation was observed. Similarly, by 1968 measles morbidity had decreased to its lowest level in history, and public interest and financial commitment to measles immunization dropped.

Within three or four years after a new vaccine is introduced, the trend in immunization rates can be expected to level off. For example, an essentially level trend line for measles immunizations and declining trends for DTP and polio immunizations were observed until 1973, as shown in Table 3. It is noted that in addition to those children with the full schedule of three or more doses of polio and DTP vaccine, a significant number of children in any given year have received one or more doses of those vaccines. Table 4 shows the percentage of children 1-4 years old with 3+ doses and 0 doses of polio and DTP vaccines for 1965 through 1976. In general, this pattern is observed for central cities, suburban communities, and rural areas, as shown in Table 5. Although these data have not been classified by "urban poor" and "rural poor," it is inferred that this trend holds for those specific groups as well.

Since 1973, immunization data for children 1-4 years of age have been collected specifically by "poor" and "non-poor" from the larger SMSA's (population of 250,000 or more). These data, as shown in Table 6, indicate that the disparity in immunization levels between the urban poor and the urban non-poor was reduced during the period 1973-1975, as program efforts were concentrated on those target populations with lower immunization levels. In 1976, the gap between the respective immunization levels of these two population groups widened. It is likely that at least part of the drop in immunization levels among the urban poor can be attributed to a procedural change in recording responses obtained in the annual U.S. Immunization Survey.

Data which identify the immunization status of rural populations described as "poor" and "non-poor" have only recently begun to be collected. The limited data presently available indicate a disparity between the immunization levels of these two groups of children living in rural areas. Because data for years prior to 1975 are not available, it can only be surmised that the size of the disparity has followed a pattern similar to that for urban populations.

Table 1

IMMUNIZATION STATUS OF 1-4 YEAR OLD CHILDREN DURING THE FIRST FEW YEARS FOLLOWING VACCINE LICENSURE UNITED STATES

	Salk Polio (IPV)		Sabin Polio (OPV)		Measles		Rubella	
	Year	Percent With 3+ Doses	Year	Percent With 3+ Doses	Year	Percent With Vaccine	Year	Percent With Vaccine
Licensure Year	1955	0	1961	0[1] 74.3[2]	1963	0[3]	1969	0[4]
First Year of Data Collection	1959	65.0	1961	74.3[2]	1965	33.2	1970	37.2
Subsequent Years	1960	72.2	1962	78.4[2]	1966	45.4	1971	51.2
			1963	84.1[2]	1967	56.4	1972	56.9

Source: U. S. Immunization Surveys

[1] OPV only

[2] 3+ OPV and/or 3+ IPV

[3] Prior to March 1963

[4] Prior to June 1969

Table 2

REPORTED MORBIDITY FOR

SELECTED DISEASES IN THE UNITED STATES

1960 - 1976

YEAR	POLIO Cases	MEASLES Cases	RUBELLA Cases	DIPHTHERIA Cases	TETANUS Cases	PERTUSSIS Cases
1960	3,190	441,703	na	918	368	14,809
1961	1,312	423,919	na	617	379	11,468
1962	910	481,530	na	444	322	17,749
1963	449	385,156	na	314	325	17,135
1964	122	458,083	na	293	289	13,005
1965	72	261,904	na	164	300	6,799
1966	113	204,136	46,975	209	235	7,717
1967	41	62,705	46,888	219	263	9,718
1968	53	22,231	49,371	260	178	4,810
1969	20	25,826	57,686	241	185	3,285
1970	33	47,351	56,552	435	148	4,249
1971	21	75,290	45,086	215	116	3,036
1972	31	32,275	25,507	152	128	3,287
1973	8	26,690	27,804	228	101	1,759
1974	7	22,094	11,917	272	101	2,402
1975	8	24,374	16,652	307	102	1,738
1976*	9	39,585	12,090	146	68	927

Source: MMWR Annual Supplements

* MMWR, Vol. 25, No. 52

na - not available

Table 3
IMMUNIZATION STATUS OF 1-4 YEAR OLD CHILDREN

FOR SELECTED PERIODS, UNITED STATES

YEAR	DTP (3+ Doses)	Polio (3+ Doses)	Measles	Rubella
1961	NA	74.3		
1962	67.8	78.4		
1963	72.9	84.1		
1965	73.9	73.9	33.2	
1966	84.5	70.2	45.4	
1967	77.9	70.9	56.4	
1970	76.1	65.9	57.2	37.2
1971	78.7	67.3	61.0	51.2
1972	75.6	62.9	62.2	56.9
1973	72.6	60.4	61.2	55.6
1974	73.9	63.1	64.5	59.8

Source: U.S. Immunization Survey

Table 4

PERCENT OF POPULATION 1-4 YEARS OF AGE WITH SPECIFIED DOSES OF POLIO AND DIPHTHERIA-TETANUS-PERTUSSIS VACCINES, UNITED STATES 1965-1976

YEAR	POPULATION (thousands)	PERCENT WITH POLIO 3+ Doses	POLIO No Doses	DTP 3+ Doses	DTP No Doses
1965	16,502	73.9	9.9	73.9	10.9
1966	16,091	70.2	11.3	74.5	10.8
1967	15,552	70.9	11.7	77.9	9.3
1968	14,994	68.3	10.5	76.5	8.6
1969	14,393	67.7	10.2	77.4	7.2
1970	14,123	65.9	10.8	76.1	7.0
1971	14,112	67.3	8.6	78.7	5.8
1972	13,905	62.9	10.7	75.6	6.9
1973	13,874	60.4	13.9	72.6	6.2
1974	13,210	63.1	11.7	73.9	5.2
1975	12,729	64.8	10.3	75.2	4.5
Data collected during 1976 are not directly comparable with data collected prior to 1976 because of a change in the questionnaire design.					
1976	12,276	61.6	9.5	71.4	3.7

Source: U. S. Immunization Surveys, 1965-1976

Table 5

PERCENT OF POPULATION 1-4 YEARS OF AGE WITH HISTORY OF SPECIFIED DOSES OF POLIO, DIPHTHERIA-TETANUS-PERTUSSIS (DTP), MEASLES, RUBELLA, AND MUMPS VACCINES BY STANDARD METROPOLITAN STATISTICAL AREA (SMSA) CENTRAL CITIES, REMAINING SMSA AND NON-SMSA, UNITED STATES 1970-1976

Vaccine	Year	SMSA Component Area		
		Central Cities	Remaining SMSA	Non-SMSA
Polio (3+ Doses)	1970	61.0	70.8	64.7
	1971	63.6	71.6	65.7
	1972	57.5	68.3	62.2
	1973	58.0	66.6	55.1
	1974	60.0	68.1	60.0
	1975	60.3	69.8	63.0
Data collected during 1976 are not directly comparable with data collected prior to 1976 because of a change in the questionnaire design.				
	1976	53.8	65.3	63.9
DTP (3+ Doses)	1970	68.9	80.7	77.1
	1971	71.9	82.9	79.8
	1972	68.5	81.7	75.7
	1973	67.4	79.5	69.2
	1974	69.5	77.9	73.2
	1975	68.8	79.3	76.1
Data collected during 1976 are not directly comparable with data collected prior to 1976 because of a change in the questionnaire design.				
	1976	64.1	75.7	72.9
Measles	1970	55.2	61.7	54.3
	1971	59.2	64.7	58.6
	1972	59.8	66.0	60.2
	1973	59.6	65.1	58.1
	1974	62.5	68.5	61.6
	1975	65.0	68.5	62.7
Data collected during 1976 are not directly comparable with data collected prior to 1976 because of a change in the questionnaire design.				
	1976	62.5	67.2	67.3
Rubella	1970	38.3	39.2	34.3
	1971	51.6	52.8	49.1
	1972	56.8	58.7	55.1
	1973	56.9	58.6	50.9
	1974	61.1	62.3	55.5
	1975	61.7	64.8	58.7
Data collected during 1976 are not directly comparable with data collected prior to 1976 because of a change in the questionnaire design.				
	1976	59.5	63.5	61.5
Mumps*	1973	33.4	38.7	31.2
	1974	37.9	43.9	35.4
	1975	43.6	49.1	40.0
Data collected during 1976 are not directly comparable with data collected prior to 1976 because of a change in the questionnaire design.				
	1976	45.6	50.7	47.9

* Mumps Vaccine was included in the questionnaire in 1973

Source: U. S. Immunization Surveys, 1970-1976

Table 6

PERCENT OF POOR AND NON-POOR CHILDREN AGES 1-4
IN CENTRAL CITIES OF SMSA'S WITH POPULATION ≥250,000
IMMUNIZED AGAINST SELECTED DISEASES - UNITED STATES, 1973-1976

Year	Status	Polio (3+)	DTP (3+)	Measles	Rubella
1973	Non-Poor	63.8	71.9	62.0	59.1
	Poor	38.3	53.0	48.4	51.8
	Disparity	25.5	18.9	13.6	7.3
1974	Non-Poor	62.5	73.9	66.3	63.9
	Poor	50.0	55.4	51.5	54.8
	Disparity	12.5	18.5	14.8	9.1
1975	Non-Poor	62.6	70.7	67.9	61.4
	Poor	50.8	60.9	56.3	59.7
	Disparity	11.8	9.8	11.6	1.7
Data collected during 1976 are not directly comparable with data collected prior to 1976 because of a change in the questionnaire design.					
1976	Non-Poor	58.7	71.0	66.6	61.7
	Poor	37.9	44.1	50.9	50.9
	Disparity	20.8	26.9	15.7	10.8

Source: U.S. Immunization Survey, 1973-1976

CENTER FOR DISEASE CONTROL

Preventive Health Services

To carry out [, to the extent not otherwise provided,] 1/ title III of the Public Health Service Act, title XVII of the Public Health Service Act, the Lead-Based Paint Poisoning Prevention Act, the Federal Coal Mine Health and Safety Act of 1969, and the Occupational Safety and Health Act of 1970; including insurance of official motor vehicles in foreign countries; and purchase, hire, maintenance, and operation of aircraft, [$175,228,000] *$186,926,000: Provided,* That training of employees of private agencies shall be made subject to reimbursement or advances to this appropriation for the full cost of such training. (*Department of Labor and Health, Education, and Welfare Appropriation Act, 1977.*)

Explanation of Language Changes

1/ This language is superfluous and therefore should be deleted.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Preventive Health Services

Amounts Available for Obligation /1

	1977	1978
Appropriation	$175,228,000	$186,926,000
Proposed supplemental	4,545,000	---
Subtotal, appropriations	179,773,000	$186,926,000
Unobligated balance, start of year	65,881,000	---
Unobligated balance, end of year	---	---
Total, obligations	245,654,000	$186,926,000

/1 Excludes the following amounts for reimbursable activities carried out by this account: 1977 - $18,000,000 and 150 positions; 1978 - $10,000,000 and 150 positions.

Summary of Changes

1977 Estimated Obligations	$245,654,000
1978 Estimated Obligations	186,926,000
Net change	-58,728,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. Annualization of new positions	189	$3,051,000	---	+$1,436,000
2. Within-grade increases.	---	---	---	+1,234,000
3. FICA increases	---	537,000	---	+56,000
4. Payment of GSA for rent	---	3,447,000	---	+288,000
5. Office of Federal Employees Health Benefits increase	---	1,096,000	---	+141,000
6. FTS and utility increases	---	1,742,000	---	+373,000
7. HEW working capital fund	---	378,000	---	+61,000
8. PHS service and supply fund	---	193,000	---	+5,000
Subtotal			---	+3,594,000
B. Program:				
1. Disease Control - project grants - immunization	---	13,000,000	---	+6,000,000
2. Health education - sex education, diabetes, and nutrition.	---	---	---	+2,488,000
3. Occupational safety and health - Direct operations - Occupational safety, women in the workplace, occupational respiratory diseases, and control technology	50	$4,000,000	---	+767,000

Summary of Changes - continued

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
B. Program (cont'd.)				
Maintenance services for the Robert A. Taft Laboratory ...	---	---	+15	+303,000
Subtotal			+15	+9,558,000
Total, increases			+15	+13,152,000
Decreases:				
A. Built-in:				
1. One less day of pay ...	---	201,000	---	-201,000
Subtotal.....			---	-201,000
B. Program:				
1. Disease investigations, surveillance, and control -				
Diabetes	10	1,500,000	-10	-1,500,000
National influenza immunization program	---	63,566,000	---	-63,566,000
Termination of fund-waiver	---	700,000	---	-700,000
2. Laboratory improvement - developmental assistance contracts to States in upgrading their intrastate laboratory improvement program	49	4,034,000	---	-998,000
3. Occupational safety and health -				
Research grants	---	3,000,000	---	-1,100 000
Training grants	---	4,500,000	---	-1,500,000
4. Buildings and facilities Repairs and improvements	---	2,315,000	---	-2,315,000
Subtotal			-10	-71,679,000
Total, decreases			-10	-71,880,000
Total, net change			+5	-58,728,000

Obligations by Activity

Page Ref.		1977 Estimate Pos.	1977 Estimate Amount	1978 Estimate Pos.	1978 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
	Disease Control:						
138	(a) Project grants	563	$52,500,000	563	$58,500,000	---	$6,000,000
144	(b) Disease investigations, surveillance, & control....	1,581	117,666,000	1,571	53,607,000	-10	-$64,059,000
	(Standard level user charge).....		(2,243,000)		(2,738,000)		(+495,000)
154	(c) Laboratory improvement..	558	15,803,000	558	15,490,000	---	-313,000
158	(d) Health education....	36	4,564,000	36	7,064,000	---	+2,500,000
	Occupational Safety and Health:						
160	(a) Grants	---	7,500,000	---	4,900,000	---	-2,600,000
161	(b) Direct operations...	889	42,269,000	904	44,277,000	+15	+2,008,000
	(Standard level user charge).....		(1,116,000)		(900,000)		(-216,000)
165	Buildings and Facilities.....	---	2,315,000	---	---	---	-2,315,000
166	Program Management..	129	3,037,000	129	3,088,000	---	+51,000
	(Standard level user charge).....		(88,000)	---	(97,000)		(+9,000)
	Total obligations	3,756	245,654,000	3,761	186,926,000	+5	-58,728,000

Obligations by Object

	1977 Estimate	1978 Estimate	Increase or Decrease
Total number of permanent positions	3,756	3,761	+5
Full-time equivalent of all other positions	300	325	+25
Average number of all employees	3,945	3,981	+36
Personnel compensation:			
Permanent positions	60,270,000	61,803,000	+1,533,000
Positions other than permanent	3,407,000	3,806,000	+399,000
Other personnel compensation	1,355,000	1,381,000	+26,000
Subtotal, personnel compensation	65,032,000	66,990,000	+1,958,000
Personnel benefits	9,779,000	10,021,000	+242,000
Travel and transportation of persons	4,604,000	4,604,000	---
Transportation of things	934,000	934,000	---
Rent, communications, and utilities	8,127,000	8,807,000	+680,000
Printing and reproduction	1,355,000	1,305,000	-50,000
Other services	9,078,000	6,112,000	-2,966,000
Project contracts	23,043,000	24,797,000	+1,754 000
Supplies and materials	68,983,000	5,367,000	-63,616,000
Equipment	3,270,000	3,140,000	-130,000
Grants, subsidies and contributions	51,451,000	54,851,000	+3,400,000
Subtotal	245,656,000	186,928,000	-58,728,000
Less quarters and subsistence	-2,000	-2,000	---
Total obligations by object	245,654,000	186,926,000	-58,728,000

Significant Items in House and Senate Appropriations Committee Reports

Item	Action taken or to be taken
1977 House Report	
Buildings and Facilities	
1. Committee directive that the Department conduct a study of possible location for construction of NIOSH facility (page 21).	1. Criteria have been developed and reviewed by appropriation subcommittees of each house, revised as recommended, and a contract will be let for the study to be carried out by a private organization. Results will be forwarded when the study is completed.
Lead-based Paint Poisoning Program	
2. The Committee expects a report by February 1, 1977 on progress in screening and treatment of lead poisoning (page 21).	2. The report is being prepared and will be submitted as directed.
Project grants - Immunization	
3. Committee expects a report on progress in raising immunization levels of the population in general, and of the urban and rural poor in particular (page 22).	3. The report will be submitted prior to FY 1978 budget hearings.
1977 Senate Report	
Health Education	
1. Committee directive that CDC submit a specific budget proposal and program recommendation for an accident prevention program during next year's hearings (page 38).	1. Budget proposed will be submitted as directed.

Significant Items in House and Senate
Appropriations Committee Reports - continued

Item	Action taken or to be taken
1977 Conference Report	
Buildings and Facilities	
1. Conferees agree that the Secretary shall study site selection for NIOSH facility and report results to Congress (page 11).	1. Criteria have been developed and reviewed by appropriation subcommittees of each house, revised as recommended, and a contract will be let for the study to be carried out by a private organization. Results will be forwarded when the study is completed.
2. Conference directive that the Secretary review and develop a plan for the construction and renovation of the Appalachian Laboratory for Occupational Safety and Health (page 12).	2. A report will be submitted to the Congress.

Authorizing Legislation

	Amount Authorized	1978 Budget Request
Preventive Health Services Activity:		
1. Disease control		
a. Project grants		
Section 317(g) (1) and (A) of the Public Health Service Act.	$23,000,000	$19,000,000
Section 318(d) (2) of the Public Health Service Act.	43,500,000	18,000,000
Lead-Based Paint Poisoning Prevention Act of 1973.	14,000,000	8,500,000
Section 317(g) (1) (B) of the Public Health Service Act.	14,500,000	13,000,000
b. Disease investigations surveillance, and control		
Sections 301, 307, 310, 311, 322(e), 325, 327, 328, 352, 353, and 361 thru 369 of the Public Health Service Act.	Indefinite	53,607,000
c. Laboratory improvement		
Sections 301, 311, 327, 328, 352, and 353 of the Public Health Service Act.	Indefinite	15,490,000
d. Health education		
Sections 301, 310, and 311 of the Public Health Service Act.	Indefinite	7,064,000
2. Occupational safety and health		
a. Grants		
Section 301 of the Public Health Service Act.	Indefinite	4,900,000

Authorizing Legislation

	Amount Authorized	1978 Budget Request
b. Direct operations Sections 301, 311, 327, and 328 of the Public Health Service Act; at the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.	Indefinite	44,277,000
3. Program management Title. III 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	3,088,000
Total 1978		186,926,000

Preventive Health Services

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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	124,714,000	134,910,000	140,443,000	152,345,000
1976	268,375,000	280,889,000	289,545,000	285,435,000
1977	143,293,000	121,728,000	189,928,000	175,228,000
Supplemental	4,545,000	---	---	---
1978	186,926,000			

Justification

Preventive Health Services

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Disease Control:						
(a) Project grants ..	563	$52,500,000	563	$58,500,000	---	+$6,000,000
(b) Disease investigations, surveillance, and control .	1581	117,666,000	1571	53,607,000	-10	-64,059,000
(c) Laboratory improvement	558	15,803,000	558	15,490,000	---	-313,000
(d) Health education	36	4,564,000	36	7,064,000	---	+2,500,000
Occupational Safety and Health:						
(a) Grants ...	---	7,500,000	---	4,900,000	---	-2,600,000
(b) Direct operations	889	42,269,000	904	44,277,000	+15	+2,008,000
Buildings and Facilities	---	2,315,000	---	---	---	-2,315,000
Program Management	129	3,037,000	129	3,088,000	---	+51,000
Total obligations .	3756	245,654,000	3761	186,926,000	+5	-58,728,000

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 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, protecting

against other diseases or conditions amenable to reduction, 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 prevention; (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 delegated certain national health responsibilities including the licensure of clinical laboratories engaged in interstate commerce and foreign quarantine activities aimed at preventing the introduction of disease into our Nation, and the development of scientific criteria for occupational health standards.

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Disease Control:						
Project grants:						
Venereal diseases ...	473	$18,000,000	473	$18,000,000	---	---
Immunization.	80	13,000,000	80	19,000,000	---	+$6,000,000
Rat control .	10	13,000,000	10	13,000,000	---	---
Lead-based paint poisoning in children ...	---	8,500,000	---	8,500,000	---	---
Disease investigations, surveillance, and control.	1581	117,666,000	1571	53,607,000	-10	-64,059,000
Laboratory improvement.	558	15,803,000	558	15,490,000	---	-313,000
Health education ..	36	4,564,000	36	7,064,000	---	+2,500,000
Total ...	2738	190,533,000	2728	134,661,000	-10	-55,872,000

Venereal Diseases

The incidence of syphilis and gonorrhea remains at unacceptable high levels, although there has been some decrease in incidence. 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, 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. Control program activities occurring in 1977 should continue in 1978. In 1977 screening and casefinding programs were curtailed.

During 1978, screening programs for gonorrhea will become more focused as nonproductive screening efforts are discontinued and as posttreatment and periodic rescreening of both male and female gonorrhea patients is expanded. Control efforts for penicillin-resistant gonorrhea organisms will emphasize the existence of this strain and the appropriate diagnostic, therapeutic and case management measures necessary to control its spread. Greater emphasis will be placed on concurrent treatment of steady sex partners, and 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 focus health department policies and control program activities on 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 1978 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 and men with asymptomatic gonorrhea, 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.

The trends in recently acquired syphilis declined during fiscal year 1976 as indicated below:

	1975	1976	Percent Change
Primary & Secondary (Total).	25,746	24,873	-3.4
Men	18,415	18,080	-1.8
Women	7,331	6,793	-7.3
Early Latent (Total)	26,166	26,164	-0.0

This national decrease in syphilis, a result of intensified case detection and prevention activities, has continued with early 1977 data showing an additional decline of 9.6 percent.

Gonorrhea continues to rank first among all reportable diseases. However, the annual percentage increase in the reported incidence of gonorrhea has slowed from 12.7 percent in 1973 to 6.5 percent in 1976, and preliminary 1977 data show a continuation of this trend. Gonorrhea continues to be reported most frequently from the 63 large cities with populations of 200,000 or more. These cities, comprising 27 percent of the nation's population, accounted for 54 percent of the reported cases during 1976. Age-specific case rates for gonorrhea show young adults (20-24 years of age) to be at greatest risk of acquiring disease with the second highest risk group being teenagers (15-19 years of age).

In screening programs for gonorrhea during 1976, 9,109,264 culture specimens were obtained from women. Of those cultured, 393,657 (4.3%) were positive for gonorrhea, and treatment was documented for 95 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.

Immunization

According to the 1975 Immunization Survey, approximately 62 percent of all preschool age children were protected by vaccine against rubella, 65 percent against polio, 66 percent against measles, and 75 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. Among preschool age children of poor central city families, vaccine protection against rubella is 60 percent, against polio is 51 percent, against measles is 56 percent, and against diphtheria, tetanus and whooping cough is 61 percent.

Grants will continue to be provided to assist States and localities in carrying out immunization programs against measles, rubella, poliomyelitis, mumps, diphtheria, pertussis, and tetanus. Project grant funds will be used: (1) to focus special attention on developing the capability of States to rapidly identify and contain outbreaks of diseases and on refining their overall assessment activities in order to determine pockets of high disease susceptibility before outbreaks of disease occur, and (2) to carry out targeted immunization programs to improve the level of protection against vaccine preventable diseases among preschool and school children, particularly in central city and rural areas. The $6.0 million increase requested for 1978 will enable the health departments to concentrate additional resources on increased immunization levels for all childhood vaccine preventable diseases among the urban and rural poor.

It is anticipated that the measles containment programs being implemented will prove effective in substantially curtailing the spread of disease among susceptible children, and will be particularly effective in helping health departments to identify pockets of susceptibles which exist in central city and rural areas. The key elements of this strategy, which are similar to those employed successfully in the world-wide 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. This approach permits health departments to target their resources on interrupting transmission of measles, and at the same time it facilitates the identification of pockets of high disease susceptibility.

During calendar year 1976, reported cases of rubella, diphtheria, and mumps declined from their 1975 levels; however, reported cases of measles increased about 60 percent over 1975. Increased grant funding in fiscal year 1977, supplementing State and local resources, permitted the targeting of control measures for vaccine preventable diseases and the extension of efforts to improve immunity levels, particularly in the preschool age group.

Rat Control

During 1977, 38 project grants to 67 program communities are currently providing services for 5,200,000 people. By the end of 1977, it is expected that 16,000 of the total 43,300 target blocks will significantly 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.

These project grant funds provide employment for 1,900 individuals, of whom 1,300 are target area residents.

In addition, the goal of environmentally improved blocks* will have been achieved in 11,500 blocks. These blocks will no longer require intensive rat reduction activities and will be removed from the target areas and totally supported with local resources. An estimated 4,800,000 people will be residing in communities which have become essentially rat free. Program direction, in some projects, is also being expanded to include surveillance, detection, and reduction activities for interior infestations.

During 1978, 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

*Environmentally improved blocks (locally sustained blocks which have been in maintenance status for a period of 12 months or more).

State or local financial support. The new initiative directed at the control of interior rat infestation will be continued and expanded. The Federal share of most 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 63 community programs through 36 project grants. Employment will continue to be provided for 1,900 individuals, 1,300 of whom are target area residents.

Responsibility for the support of maintenance activities in many areas will be turned over completely to State and local governments. These areas will then be classified as locally sustained environmentally improved blocks. The cumulative population residing in the maintenance and environmentally improved blocks which are essentially rat free will reach 5,750,000. The increased local commitment will pave the way for full termination of Federal support to approximately five of the previously supported communities in 1978 and for gradually reduced Federal support to most of the remaining community programs. Support will continue to 36 grants serving 63 community programs. This includes grant funds for rat control programs in five new communities with a documented problem.

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.

Laboratory proficiency testing continues to be provided by the Center for Disease Control to 38 centralized State and 70 public health and commercial laboratories to assure accuracy of results for blood lead and erythrocyte protoporphyrin in specimen submitted by lead-based paint screening programs. No laboratories are directly funded during the current fiscal year.

Funds available in 1977 were awarded only to those programs which continued to document a significant problem and which had developed productive programs. Fifty-five projects were funded. It is estimated that 400,000 children will be screened by these projects, and an estimated 34,000 children will be found with undue lead absorption. An additional 300,000 children will be screened by Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs, Bureau of Community Health Services programs, including Maternal and Child Health (MCH) of

the Public Health Service, and Women, Infants, and Children programs of the Department of Agriculture.

For the fiscal year ending on June 30, 1976, 71 projects screened 400,000 children for undue lead absorption. Thirty-eight thousand children were placed under pediatric management for undue lead absorption with 4,000 children requiring chelation therapy. Appropriate lead abatement action was carried out in 80 percent of those houses found with a lead hazard.

The 1978 appropriations will be used to continue support to approximately 55 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 newly developed screening procedure, 1978 funds will enable these programs to screen approximately 400,000 children during 1978 and to identify 36,000 children with undue lead absorption. Appropriate lead abatement activities will be carried out in 80 percent of those homes found with a lead hazard. Efforts will be intensified to coordinate activities with other Federal child health programs.

Some communities have significantly reduced the lead-based paint hazard or have generated local funds to continue without Federal support. Federal funds presently supporting activities in these communities will be transferred to other communities with a documented problem.

Summary

An increase of $6,000,000 in immunization project grants will enable the health departments to concentrate on increased immunization levels for all childhood vaccine preventable diseases among the urban and rural poor.

Disease investigations, surveillance, and control

The scientific and technical competence and facilities which are devoted to this budget activity support a wide variety of public health functions aimed at a multitude of diseases and conditions. These activities represent the major aspect of the preventive health activities and represent a valuable national health resource.

Investigations

Clinical and epidemiological investigations of selected diseases of public health significance are carried out both in the laboratory and in the field.

Viral diseases - As a result of a major epidemic of St. Louis encephalitis in the summer of 1975, national weekly surveillance of this disease was initiated in early summer 1976; no significant outbreaks were detected. Nationwide influenza surveillance from various reporting levels encompassing 400 institutions in 138 cities was expanded in 1976. Morbidity data from approximately 100 reporting areas (including cities and some States), mortality statistics from 121 cities, and laboratory reports from selected laboratories throughout the United States all remain components of ongoing influenza surveillance. Clinical studies in enteric viral diseases initiated in 1976 and continuing in 1977 constitute a relatively new area in viral disease work.

Nationwide surveillance of viral hepatitis will continue in 1977 and 1978 with an expansion of efforts in certain hospital and community settings, notably with respect to kidney dialysis centers. Also, efforts to identify hepatitis A cases related to day care centers will be intensified in hopes of controlling possible epidemics in such centers, an increasingly important community problem. A major focus of the epidemiologic study of hepatitis B continues to be the identification of high risk groups in need of hepatitis B immune globulin.

Bacterial diseases - Investigation of an outbreak of salmonellosis in Colorado showed that commercially prepared cheddar cheese can serve as a vehicle of transmission for salmonellosis. Investigation of 2 cases of botulism in Oklahoma found that the source was commercially canned cherry peppers served in a motel on a major transcontinental highway, and that at least 5 other cases not previously diagnosed had occurred in 2 other States.

A review of salmonella serotypes associated with reptiles revealed that the reported incidence of salmonellosis in man caused by these serotypes has decreased since the interstate shipment of turtles was banned. A review of outbreaks of salmonellosis found that the percent caused by poultry has been decreasing while the percent of outbreaks caused by beef products is increasing; this has important implications for the U. S. Department of Agriculture.

Since June 1975, small outbreaks of serogroup A meningococcal disease have occurred in the skid-row communities of Seattle, Washington; Portland, Oregon; and Anchorage, Alaska. This disease has been rare in the United States since the major epidemic in 1945. Investigation of the outbreaks in Portland and Seattle in May 1976 led to the first use of serogroup A meningococcal polysaccharide vaccine for disease control in the United States.

Botulism - The development and application of improved laboratory technology in the diagnosis of botulism has made it possible to increase the percentage of cases of botulism diagnosed from 33 percent, when only the suspected patient's serum was tested to 87 percent, when feces and suspected foods were tested in addition. Examination of feces by these new methods has made it possible to diagnose botulism in infants under 4 months of age. Twelve such cases were diagnosed in 1976, uncovering a new and important manifestation of botulism. Because of the finding that the botulism bacillus may persist for prolonged intervals in the intestines of infants, and perhaps adults, studies are planned to investigate the conditions which favor this colonization and the elaboration of botulinal toxin without producing the serious illness and high mortality that is customarily associated with botulism. Investigations will also be carried out to determine the characteristics of the botulism bacillus which favor such colonization and how to correct this condition.

Parasitic diseases - The Center's diagnostic parasitic serology program constitutes a national and international resource for the diagnosis of parasitic infections. This program routinely processes 20,000 to 25,000 serologic specimens per year for 23 parasitic infections. In an effort to improve diagnostic methodology, developmental research on an enzyme-linked immunosorbent assay (ELISA) technique has been in progress. The ELISA technique is most promising and constitutes an important breakthrough in the diagnosis of this infection. Tests are being evaluated for the detection of organisms that cause fatal meningoencephalitis . Tests for the detection of a cause of severe diarrhea in travelers to foreign countries and within the United States, are being developed. This past year, seven new cases of babesiosis, a very rare disease, have been found on Nantucket Island, bringing the total number of cases reported to 24 for 1976. Final evaluation of an international reference Chagas antigen has been initiated. Studies on the development of a vaccine for schistosomiasis which is a disease that has infected about 200 million people worldwide, are in progress.

A pilot surveillance program for toxoplasmosis was developed in 1976 and is expected to be implemented in 1977, leading to national surveillance of toxoplasmosis in 1978 or later if an analysis of the data warrants extension of the pilot program. Surveillance of intestinal parasitism was also initiated in 1976. Field studies, including serological evaluations, of visceral larvae migrant (VLM) are currently under way and are expected to extend into 1978. Investigations of

outbreaks of giardiasis among travelers continue to require investigation by CDC epidemiologists. In 1977, a study will be conducted of giardiasis in a community water system, an increasingly significant problem in this relatively rare disease area. A combined parasitic-bacteriologic study of diarrhea in day care centers is under way and will continue into 1977.

Fungal diseases - The various diseases caused by pathogenic molds and yeasts comprise an important public health problem with respect to the mortality and morbidity that they cause. In addition, they pose a diagnostic and therapeutic challenge to both the attending physician and diagnostic laboratory. In recent years, there has been a significant increase in infections caused by fungi. This has resulted primarily from the vulnerability of elderly persons to mycotic infections and by the susceptibility of patients suffering from chronic diseases or being treated, for example, with broad spectrum antibiotics, immunosuppressive drugs, and cobalt irradiation to opportunistic fungi. Deaths directly attributed to pathogenic fungi totaled 580 in the latest available report. This number is significantly higher than the 441 average reported over the decade 1965-1974. Since many hospital laboratories and health departments lack competency in the diagnosis of fungal diseases, the Center provides a national mycotic diseases diagnostic service. Physicians are aided in the selection of proper and effective chemotherapeutic agents and dosages by the Center's initiation in 1975 of tests designed to determine the sensitivity of fungal isolates to various antifungal drugs.

In 1978, efforts will be directed to development and evaluation of new serological procedures for the rapid and specific identification of pathogenic fungus isolates. Efforts will be made to develop blood tests to aid in the diagnosis of the opportunistic fungus diseases that have been increasing so rapidly in recent years and for which no tests currently exist.

Chronic diseases - A major emphasis of environmental exposure centers around the problem of polybrominated biphenyls (PBBs) contamination of animal feed in a 1973 incident in the State of Michigan. The CDC, in conjunction with the NCI and NIERS, is conducting a study with the State of Michigan to monitor the long term effects of human PBB exposure. Special epidemiologic investigations have dealt with the possible associations between selected birth defects and maternal exposures to vinyl chloride, drugs, and fluoridated water supplies.

An important new development in the area of congenital abnormalities is the start in metropolitan Atlanta area of a community-based program for prenatal diagnosis of Down's Syndrome among pregnant women age 40 and above. The pilot project has been in operation for one year and has occasioned a 2- to 3-fold increase of over 40 expectant mothers seeking prenatal screening through amniocentesis.

Surveillance and epidemiologic studies of other abnormalities through the monitoring program have continued in 1976 and are slated to continue at current levels through 1978. The monitoring program is based on the screening of approximately one million births a year reported through the Professional Activity Study data system of the Commission on Professional and Hospital Activities.

Surveillance

The Center for Disease Control develops and maintains surveillance systems to identify and characterize important disease problems occurring in this country or presenting a threat of introduction from other nations.

The Epidemic Intelligence Service (EIS), the corps of primarily physician epidemiologists (the EIS includes several veterinarians, statisticians, and nurses) that is responsible for maintaining the various Bureau surveillance systems and for providing epidemic assistance to CDC's constituents, employed 39 new EIS officers in 1976, making a current total of 88 EIS officers. The EIS responded to requests for investigation of 1,600 disease outbreaks in 1976; it is expected that 1,700 investigations will be carried out in both 1977 and 1978. EIS officers also are responsible for the maintenance of the various surveillance systems and publication of periodic reports, of which 19 were published in 1976, plus 12 in the TQ. It is expected that 31 surveillance reports will be published each year during 1977 and 1978 with a total annual circulation of 110,000. In addition, a Morbidity and Mortality Weekly Report is published to report cases of notifiable diseases nationwide.

The investigations noted above encompass the full range of diseases and public health problems under the purview of the CDC. A number of epidemics of acute bacterial, viral, and parasitic diseases were investigated, such as shigellosis in a day care center, several outbreaks of hepatitis, and a localized outbreak of babesiosis. Outbreaks of diseases broadly categorized as chronic diseases were increasingly prevalent. The Center, and the EIS in particular, were heavily involved in the nationally publicized epidemic of "Legionnaire's Disease," and are expected to continue to be involved in analysis of the substantial volume of data collected in the epidemic investigation in 1977.

In 1977, the Center processed 150,000 of the most difficult reference diagnostic specimens from throughout the Nation. Approximately 1.9 million different determinations were made on these specimens. For 1978, a slight increase in the number of specimens received and processed is expected.

Nosocomial infections - Based on limited data, it is broadly estimated that infections developed during hospitalization constitute a serious public health problem, adding seven days to the average hospital stay,

and increasing the cost of health care in this country by more than $1 billion. In 1974, CDC initiated the Study on the Efficacy of Nosocomial Infection Control (SENIC) to determine to what extent infection surveillance and control programs in hospitals reduce the occurrence of hospital-acquired (nosocomial) infections. In 1975 and 1976, the "study" methods were designed and validated in pilot studies, and the main hospital survey was begun in a statistical sample of U. S. hospitals. Data collection will continue through 1977, and the final analysis of the study should be completed by the middle of 1978. The risks associated with monitoring arterial blood pressures were evaluated in 1976, and bacteremia acquired from disposable transducers has been documented for the first time. Nosocomial infections with bacteria resistant to clinically useful antimicrobial agents have been a major problem and several outbreaks caused by such organisms have been investigated. Increasing numbers of cardiac surgery procedures are being performed. In this fiscal year, 2 outbreaks of atypical mycobacteria wound infections were investigated; epidemics with this microorganism have not previously been seen in this population.

Influenza - In February 1976 a new strain of influenza virus, designated as influenza A/New Jersey/76 and similar to a virus which causes influenza in swine, was isolated from an outbreak of disease among recruits at Fort Dix, New Jersey and person to person transmission was confirmed. This virus was distinctively different from other recently circulating influenza A viruses indicating a major antigenic "shift." Such shifts in the past have been inevitably associated with Influenza A pandemics. In turn, pandemics of Influenza A have inevitably been assaulted with excess mortality.

Serologic surveys among the United States population and past experience indicated that virtually the total population of this country was vulnerable to infection from this virus.

Based on these considerations, the Congress appropriated $135,064,000 to enable the Department to initiate a comprehensive, nationwide influenza immunization program.

These funds were available to support the development, licensing and monitoring, purchase of vaccine; and epidemiologic and laboratory surveillance; as well as to provide financial aid to assist States in carrying out Statewide influenza vaccination programs.

With project grant assistance, and using the immunization program framework already in place, State and local health agencies were called upon to serve as catalysts, organizers, and coordinators of the vaccination effort. Project grants were awarded in May and June to all States and Territories, and to selected cities.

As grants were awarded, States and communities began immediately to plan and organize their respective programs. Additional health

department personnel were hired and large numbers of volunteers were recruited to assist in conducting mass vaccination clinics. This prompt response by States was geared to the original timetable, which called for the immunization of high risk populations to begin in July, with the initiation of vaccination activities for the general population in September.

Delays in availability of vaccine, caused by a number of factors delayed the initiation of the program until October 1, 1976. During the period October 1, 1976 to December 16 over 42 million persons were vaccinated.

On December 16, the influenza program was suspended because of an apparent association between the vaccine and a neurological complication known as Guillain-Barre Syndrome. An intensive investigation of this apparent relationship is in progress. Preliminary data from the investigation indicate that between October 1 and January 4, 496 cases, including 19 deaths, of this poorly understood syndrome were reported; 246 of these individuals had received influenza vaccine, of whom 11 died.

Smallpox - The major objective of the CDC in smallpox is to continue to maintain the smallpox-free status of the United States, which is best accomplished by assisting in the worldwide eradication of this disease.

The geographic area affected by endemic smallpox is now confirmed to parts of Somalia where the only cases were occurring in December 1976. The original target of "a smallpox-free world in 10 years" established by the World Health Organization in 1966 may still be achieved within that time period. 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.

Control

The CDC 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 the State 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 1977 were directed toward strengthening syphilis control methodologies, refining control strategies and techniques for gonorrhea (including the recently discovered penicillinase-producing Neisseria gonorrhoeae (PPNG),

and developing initiatives to measure the magnitude of the problem of other sexually transmitted diseases (STD). Technical assistance included reviewing progress in control methods and new strategies and developing awareness and surveillance activities for both PPNG and the problem of STD other than syphilis and gonorrhea.

These efforts will continue in 1978. Emphasis will be placed on (a) developing alternative VD casefinding approaches among identifiable high risk groups, including male homosexuals; (b) national monitoring to assess increasing resistance of gonorrhea strains to antibiotics to control the spread of PPNG; (c) developing standards for medical care delivery and control methodologies; (d) defining additional risk factors, diagnostic techniques, and treatment modalities for pelvic inflammatory disease; and (e) developing control measures for other STD.

During 1977, the sudden and unexpected discovery of gonococci capable of producing an enzyme that rapidly inactivated penicillin required immediate investigation. Efforts are now being directed toward more intensive monitoring of gonococcal resistance to penicillin and to test strains of gonococci from all possible sources against a large number of newer antimicrobial agents to find one or more effective alternative therapeutic agents.

Center staff have also developed and standardized a small animal model for studying gonococcal immunity without the costly and time consuming use of chimpanzees. A high level of immunity has been developed in these animals; however, it is dependent on matching the type of gonococcus responsible for the infection to the type needed to produce immunity. In addition, specific protective antigens have been isolated from penicillin sensitive and penicillin resistant strains of gonococci. These antigens will be evaluated in the animal model to determine their effectiveness against a variety of gonococcal strains. This information will form a basis for the ultimate development of a polyvalent vaccine for immunizing the experimental animals. This research has also yielded information which is now being studied as a means of typing gonococci for epidemiological investigations. Research on Non-gonococcal Urethritis (NGU) has centered on isolation and identification of the various agents responsible for this venereal disease entity of increasing importance. An immunofluorescent test has been developed to specifically demonstrate chlamydia, one of the agents in urethral material. This test facilitates a presumptive diagnosis and paves the way for the development of a simpler but more sensitive procedure to cultivate these agents. It has also strengthened our capability to detect and isolate genital mycoplasmas, a second agent and to better assess their role in this disease.

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Major research emphasis in syphilis has focused on the need to improve existing serologic tests which will enhance the capabilities of all laboratories to diagnose syphilis. An extensive evaluation has determined that the hemagglutination test for syphilis, a simpler and less cumbersome test than the Fluorescent Treponemal Antibody Test (FTA), compares favorably with the FTA. This evaluation vastly increases the capability of virtually all laboratories to perform a confirmatory serologic test for syphilis. An extensive evaluation of the FTA in testing spinal fluid in patients suspected of having neurosyphilis has been initiated but findings to date indicate that it cannot be recommended for this purpose because it yields too many false positive reactions. Since the FTA test remains the test of choice for the serological confirmation of syphilis, considerable effort has been directed toward the improvement of the reagents used in this test resulting in the development of technology for more specific reagents.

Tuberculosis - The reported tuberculosis incidence in the United States for calendar year 1975 was 33,989 cases, an increase of 12.8 percent from calendar year 1974 which was anticipated because of a change in reporting criteria as of January 1, 1975. Preliminary figures for calendar year 1976 show a predicted resumption of the downward trend in tuberculosis morbidity which was evident prior to 1975. A major activity in 1977 to be continued in 1978 will be analysis of data from areas showing deviations from the national tuberculosis morbidity trend to determine causes and to assess that changes in control program activities might account for or might be indicated to combat the deviations.

Continued activity with the Primary Drug Resistance Surveillance Program has yielded interesting and unexpected results. The data show that there is an overall resistance of 12.6 percent to one or more of the drugs used to treat patients who have primary tuberculosis. The range of new cases of TB with drug resistance is 3 to 22 percent with areas of high resistance in California, Illinois, Mississippi, and Texas. This primary drug resistance is less prevalent in South Carolina, Oklahoma, Ohio, and Maryland. These findings have prompted an expansion of this ongoing study to include additional geographic areas which will allow the study of a larger population and better assessment of emergence of drug resistant TB bacilli throughout the various demographic groups within the United States. Emphasis will also be placed on the laboratory testing of the TB bacilli to several of the more promising newer antituberculosis drugs.

During 1978, the Center will continue its efforts to assist health care providers to improve surveillance and realign programs and reallocate resources so that a more effective tuberculosis control program can be accomplished. Assistance will be provided to areas which request review and analysis of selected activities or of their total program and will be offered to areas when program information suggests a need for improvement or redirection. Operational research activities

during 1978 will continue the effort to develop more rapid, specific and effective methods for diagnosis, treatment and prevention of tuberculosis.

Immunization - Major efforts during 1977 were directed toward assessing status of immunity of pre-school and early school age children, surveillance of disease patterns and trends, and refining disease containment strategies. Additionally, an intensive motivational-educational campaign, coordinated by the Center to attempt to reduce declining trends in immunization levels, was continued. Technical assistance has been devoted to assessing progress of these strategies and methods, providing leadership in creating an awareness of needs, problems, and appropriate actions, and increasing surveillance, investigations, and containment methodologies.

In 1978, emphasis will be given to (1) national monitoring of childhood disease patterns and trends; (2) refinement and expansion of containment strategies; (3) instituting appropriate actions to insure a reduction in morbidity and increased vaccine protection levels against polio, measles, rubella, diphtheria, pertussis, tetanus, and mumps; and (4) providing leadership in determining the appropriate use of vaccines.

Environmental Health - During 1977, the technical assistance program in Environmental Health was expanded according to the needs identified in the comprehensive survey of 9 State environmental health programs. Resource materials and expertise in a broad variety of environmental health areas were used to meet State and local agency needs. In addition to providing grant funds, communities were assisted in identifying areas where lead-based paint poisoning and urban rat problems exist, and technical assistance was provided to develop programs to solve these problems.

The Center completed a comprehensive technical assistance program for State agency personnel in developing and improving their youth camp safety programs. This program includes suggested State statutes and regulations for all types of youth camps including camps for handicapped campers and safety and health guidelines for 13 high risk camping activities. A complete analysis of existing youth camp safety legislation was also completed. In addition, a field tested surveillance system for injuries and illnesses occurring in camps was made available to States along with advice and consultation to assist in the expansion of State youth camp safety programs.

The Center provided assistance to the Bureau of Health Planning and Resource Allocation, HRA, in developing environmental health planning guidelines for health service agencies. In addition, the Center provided guidance to State agencies in developing their environmental health plans.

In 1978, the technical assistance program in youth camp safety and health will be continued with new materials and resources developed as needed. In particular, the Center plans to offer additional assistance to States to improve the skills of local youth camp consultants in the area of safety inspections.

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.

Special provisions being promulgated for 1977 and 1978 deal with radio reporting of illness in advance of arrival, updating requirements for deratting of ships, visa medical examination procedures and practices, and disinsectization of aircraft.

Training - The Center supported the attendance of an estimated 1,500 State and local public health workers to training courses presented by the Center. Eighty-seven courses presented in 1977, dealing with various preventive health subject matters, were attended by these workers.

The net decrease of $64,059,000 and 10 positions includes built-in increases of $1,707,000 for annualization of new positions; within grade pay increases; SLUC, FICA, FTS, OFEC, and utility increases; HEW working capital fund, and PHS service and supply fund increases; offset by one less day of pay; and program decreases of $1,500,000 and 10 positions resulting from the one time funding in 1977 of the diabetes community control program, $63,566,000 resulting from non-recurring funding in 1976 and 1977 of the National Swine Flu Immunization Program, and $700,000 resulting from the one time funding provided in 1977 to permit the Center to waive tuition fees for training personnel of Federal, State, and local governments when such training was in the public interest.

Laboratory Improvement

The CDC, by administering the Clinical Laboratories Improvement Act of 1967 (CLIA '67), continues to be the lead Federal agency concerned with upgrading the Nation's clinical and public health laboratories. Recent agreements with other Federal agencies concerned with clinical laboratory performance - the Social Security Administration's (SSA) Bureau of Health Insurance (BHI) and the Health Services Administration's (HSA) Bureau of Quality Assurance (BQA) - when implemented will support this leadership role in the development of standards. These agreements also recognize the Center's logical role in monitoring the effectiveness of the application of standards, regardless of which agency applies them. The Center continues to assist and cooperate with all State health agencies and private professional associations in achieving the broadest possible application of high, uniform standards designed to assure accurate diagnostic laboratory test results. Emphasis continues on the development of laboratory technology in three major areas: (1) analytical methods, (2) calibration and control materials of high quality, and (3) procedures for quality assessment and control. Additionally, extensive effort continues to be directed to the transfer of technology to laboratorians responsible for providing accurate results for use by physicians in managing patients. Since the passage of CLIA '67, and since the development of regulations governing the reimbursement of hospitals and independent laboratories under Medicare, CDC has directed efforts to achieve non-duplicative application of uniform standards.

In 1975, CDC entered into an agreement with the SSA/BHI and HSA/BQA providing for integration of functions related to the Federal responsibilities for clinical laboratory services. This agreement has been translated into a formal instrument of redelegation which is before the Secretary, HEW.

The agreement with SSA and HSA assigns new responsibilities to CDC for review and evaluation of the effectiveness of the application of clinical laboratory standards by State agencies, by the Joint Commission on the Accreditation of Hospitals, the corresponding program of the American Osteopathic Association, and by national accreditation bodies such as the College of American Pathologists Inspection and Accreditation program. CDC will continue to provide proficiency testing for laboratories in interstate commerce. CDC also will initiate new or amended scientific or technical standards to be embodied in new regulations. Several of these are in various stages of revision and extension to hospital laboratories in the areas of personnel, quality control, and proficiency testing. CDC will serve as the backup for evaluation of laboratories for CLIA '67 or for Medicare in the event that a State agency is determined to be unable or unwilling to assume these functions. CDC will assist such States in upgrading their programs to an acceptable level.

The number of laboratory technical training courses presented by CDC will increase from 180 by 1977 to 200 by 1978. Students trained will increase from 3,600 to 4,000. Training will emphasize the transfer of newly developed technology, as well as improvement in deficiencies identified through laboratory evaluation programs. Laboratory supervisors and others responsible for further multiplying the application of sound technical methodology will be given priority to attend Center courses.

Additionally, much emphasis will be placed on technical assistance to States to increase their capacity for providing training intrastate. Assistance will consist of course design, logistics planning, pre- and post-course student evaluation, and training materials development.

An important effort will also be made to train the SSA Medicare regional office and State agency personnel to improve the quality of laboratory inspections. It is extremely important that all inspection personnel apply the standards for clinical laboratories uniformly thoughout the country. This will become more important if legislation is passed to extend coverage to all laboratories in the United States.

The CDC began work on standards for in vitro diagnostic reagents in the 1940's with standardization of and criteria for reagents used in the serological diagnosis of syphilis. For non-syphilis reagents, the work became more sharply focused in the 1960's, and today the Center has published specifications for approximately 2,100 serological reagents used in microbiology.

Currently along with developing new specifications, CDC is operating a Premarket Evaluation Program in which manufacturers may voluntarily submit samples of each lot of selected microbiological reagents for evaluation prior to marketing. If the samples meet CDC specifications, the manufacturer may use a statement that the product has been tested by CDC and found to meet CDC specifications. A report of all products found to meet CDC specification during the previous 30 days is published and distributed nationwide.

For the 5 years prior to March 1977, media marketed for the isolation of Neisseria gonorrhoeae (GC) were voluntarily submitted by manufacturers for evaluation. During this time, the quality of media was improved. Currently, we are monitoring products in the market place by (1) direct purchase from manufacturers, (2) random sampling of products purchased by consumer laboratories, and (3)review of consumer laboratory quality control data. The specifications are constantly updated to keep pace with the state of the art; whether the improvement be in production methodology, clinical usefulness, or sharpening the tools of performance evaluation.

The biggest job ahead is development of specifications and evaluation systems for microbiological media. The Center is currently developing specifications and evaluation systems for blood culture media. Emphasis will continue in this area during 1978.

The Food and Drug Administration has the responsibility for developing regulations for control of commercially produced in vitro diagnostic products (Medical Device Amendment, May 28, 1976). The CDC is serving as a scientific advisor to the FDA in microbiology, clinical chemistry, hematology, toxicology, and immunology. Scientific data and professional scientific recommendations to support the need for regulations and the development of regulations has been supplied.

The National Committee for Clinical Standards is developing consensus standards for in vitro diagnostic methods and materials. The CDC scientists serve on several NCCLS committees and laboratory support is provided to generate supportive data for the standards.

In 1971, the CDC conducted a nationwide census of clinical and public health laboratories. This census attempted to identify all health laboratory resources in the United States and establish baseline data to assist in future laboratory improvement efforts. During 1977, the data is being updated through a mailed survey based on a statistical sample from a list of laboratories identified in 1971 and updated by contacts with State and professional agencies. Current plans are to have the basic data available by May 1977. These data will be used by Federal, State, and local governments as well as professional associations and industry in continuing efforts to improve laboratory services. The census update will provide the most comprehensive data base available on laboratories in the United States. Our success in achieving at least 80 percent response from each of the 51 reporting jurisdictions assures us that the data will have a 95 percent confidence level nationally.

During 1978, the Center for Disease Control will have implemented a program of developmental assistance for improving the clinical laboratory certification and improvement programs in several of the States demonstrating an interest and capability in carrying out such programs on an intrastate basis. In 1978, States will be awarded contracts which, along with the extensive technical assistance available from the Center, will establish them as the primary agencies responsible for improvement of clinical laboratory performance within their borders.

State activities supported by these contracts will include, but not be limited to, laboratory certification including standards development, on-site inspection and evaluation, and proficiency testing. It also is intended that remedial training, management, and technical consultative activities be supported by these funds. Specifically, the funds can pay for personnel, supplies, equipment, technical services,

and possibly facilities modification. As the name implies, the money will be time-limited and the States will be expected to provide operating funds after the expiration of the program.

The decrease of $313,000 includes built-in increases of $685,000 for annualization of new positions, within grade increases, and FICA increases, offset by one less day of pay, and a program decrease of $998,000 in the developmental assistance contracts to States in upgrading their intrastate laboratory improvement programs.

Health Education

In carrying out its health education mission, the Center's strategy stresses the systematic identification and documentation of successful approaches and development of evaluation methodologies to assess elements associated with success.

Liaison and consultation services were provided in 1977 to the major components of DHEW involved in carrying out health education activities, other Federal agencies, State and local health agencies, international health agencies, and professional, voluntary, and civic groups and individuals. A system was initiated for maintaining current information on health education activities being supported and conducted by HEW programs. An HEW work group completed an analysis and recommended HEW strategies for mass media health education projects to be initiated in 1978. State agencies and HEW regional offices were given assistance in the development of plans for incorporating health education in implementing the National Health Planning and Resources Act. Regional offices of HEW were given assistance in the review of selected projects and proposals for health education content. At the invitation of the World Health Organization, the Center's National Clearinghouse for Smoking and Health was established as a WHO Collaborating Center for Smoking and Health.

In 1977 the Center for Disease Control continued to develop and disseminate information to diverse audiences of health professionals. Over 170,000 copies of technical smoking and health, and health education publications were distributed. Several thousand technical requests for publications, photocopy services, literature searches, bibliographic and reference services, primarily in the areas of smoking and health were filled. Almost a half million brochures on smoking and health were distributed to interested groups and individuals. A project advertising the Automated Search and Retrieval System for Smoking and Health Information was initiated which increased the number of demand searches for smoking information to over 700. In 1978, on-line access to this unique data file will be explored.

In 1977, the Center supported innovative demonstration projects in health education, directed toward target population groups in special need, and conducted and supported studies to assist in identifying population groups who may be at risk to health hazards because of a lack of specific health education services.

Beginning in 1977 and continuing into 1978, special emphasis is being given to strengthening the capability of official agencies at State and local levels in the delivery of health education services to the public. In 1977 new educational programs were developed around the health problems of nutrition and diabetes. The Center initiated a research program to identify and develop improved measures of

health-related knowledge, attitudes and behavior, to be used in evaluating health education programs related to these and other health problems. The information generated in these studies will serve as the basis for pilot projects in 1978 to test specific approaches to problems of defined target populations.

Of the proposed increase of $2,500,000 for 1978, $488,000 will be used to continue and augment selected initiatives undertaken in 1977 in nutrition education, diabetes education and strengthening of health education and consumer information programs of official State and local agencies. The remaining $2,000,000 will be used to initiate a major new program designed to address the educational aspects of the rapidly growing problem of unwanted pregnancies, especially among adolescents. Studies will be supported to assess current and past educational activities for youth related to reproduction and contraception, and to identify successful approaches and societal obstacles involved in such activities. Based on this assessment, model programs in sex education will be developed, using such channels as health agencies, schools youth organizations, parenting, and other community resources.

Nationwide comprehensive surveys of health behavior are being conducted among teenagers, adults, health professionals and consumers. A new teenage smoking prevalence survey was conducted in 1977 and other smoking prevalence surveys will be conducted in 1978. Surveys of health education activities at the State and local level, consumer education activities related to health insurance, patient education activities and worker health education activities are being conducted in 1977 and will be continued in 1978.

A special project was initiated in 1977 to develop prototype consumer information/education materials package, including a decision model designed to provide adequate information and knowledge for the consumer to make rational decisions in purchasing and using health insurance. This project will be continued in 1978 with implementation of pilot projects with official State agencies.

The increase of $2,500,000 includes $12,000 for built-in increases for within grade increases, offset by one less day of pay, and a program increase of $2,488,000. The program increase of $2,488,000 includes $488,000 to continue and augment selected initiatives undertaken in 1977 in nutrition education and consumer information and $2,000,000 to initiate a new sex education program.

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Occupational Safety and Health:						
Grants.....	---	$7,500,000	---	$4,900,000	---	-$2,600,000
Direct Operations	889	42,269,000	904	44,277,000	+15	+2,008,000
Total.....	889	49,769,000	904	49,177,000	+15	-592,000

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 behavorial factors research. It is expected that 30 research grants in the amount of $3,000,000 will be awarded in 1977. No new research grants will be awarded in 1978, and all continuation grants will be reduced 15 to 20 percent.

Training grants are used to support (at educational institutions) programs and curricula development designed to prepare qualified researchers, administrators, teachers, professionals, 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 1977, it is expected that 34 training grants in the amount of $4,500,000 will be awarded to continue active grant supported training programs and initiate new grants. This includes approximately four or five Education Resource Center Grants. No new training grants will be awarded in 1978, and all continuation grants will be reduced 15 to 20 percent.

The decrease of $2,600,000 results from the reduction of $1,500,000 of the training grant program and a reduction of $1,100,000 of the research grant program to the 1976 level.

Direct Operations

The National Institute for Occupational Safety and Health (NIOSH) 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 various 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 health hazard evaluations, to publish an annual list of toxic substances, to conduct industry-wide epidemiological studies, to stimulate occupational health and safety programs in State and local governments and in industry, and to provide translation of research findings into programs of technical assistance and training with a goal toward preventing exposure to hazardous agents and conditions.

During 1977 the Institute will:

1. Complete development of 24 criteria for occupational safety and health standards including: anesthetic gases, fibrous glass, polychlorinated biphenyls, nickel and its inorganic compound, coal tar products, and fluorocarbons;

2. Test approximately 400 protective devices and industrial hygiene monitoring devices;

3. Publish the seventh 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 41 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 procedures as required by the Toxic Substances Control Act are badly 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. Provide the necessary engineering control design technology for closed systems, ventilation equipment, etc., for the various work sites where carcinogenic substances are employed.

12. Provide the necessary development, review, and certification of respirators and protective clothing for workers employed in areas using or producing carcinogenic substances.

13. 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.

14. Stimulate occupational health and safety programs in State and local governments, and in industries.

15. Undertake safety research that will result in validating and/or providing new information to undergird the safety standards that are presently being enforced by the Occupational Safety and Health Administration.

16. Embark on a program that will highlight the special problems of women in the workplace, especially those of the childbearing age.

17. Strengthen the Institute's respiratory disease research program in the non-coal area.

18. Develop a control technology program initiating studies to redesign high risk industrial processes so that new plants could be built which would virtually eliminate problems

of workplace chemical and physical exposures; develop more sophisticated measurement and monitoring techniques to warn workers of unduly high chemical exposures; and provide research for the development of more effective and usable protective equipment.

The efforts supported by this activity will be continued at the same level in 1978. An increase of $767,000 will support the following four (4) new programs initiated in 1977.

(1) Safety - A program designed to develop and analyze data which would be the basis for future research activities in occupational safety; to conduct safety research which will result in valid, scientifically-based Occupational Safety and Health Administration (OSHA) standards; and to provide fundamental information for educational and technical assistance efforts for use in improving safety of the worker.

(2) Women in the Workplace - This initiative would incorporate into the Institute's ongoing research program expanded studies of occupational hazards which may be especially harmful to women, particularly pregnant women and the fetus, with a special emphasis on carcinogenesis, mutagenesis and teratogenesis; and to include in future criteria documents and to update existing criteria documents any information which may implicate an agent as a potential human mutagen, teratogen, or transplacental carcinogen.

(3) Occupational Respiratory Disease - This program increases NIOSH's ability to identify, quantify, and provide reasonable and well documented recommendations for the reduction and prevention of occupational respiratory diseases. It allows for re-evaluation and strengthening of proposed standards such as those for coal dust, asbestos, cotton dust and other agricultural respiratory hazards. It stimulates distribution of information and early recognition of these diseases.

(4) Control Technology - The purposes of this program are (a) technology assessment including initiation of studies to redesign high-risk industrial processes so that new plants may be built which can virtually eliminate recognized problems of workplace chemical and physical exposures; (b) development of more sophisticated measurement and monitoring techniques to warn workers of unduly high chemical exposures; and (c) research and development of personal protective equipment to serve as a short-term solution until new controls or processes are developed.

Maintenance services of the Robert A. Taft Laboratory in Cincinnati, Ohio have been performed by the Environmental Protection Agency (EPA) personnel in the past but in anticipation of the transfer of the Robert A. Taft Laboratory to NIOSH, the services will not be available.

The increase of $2,008,000 and 15 positions in 1978 includes $938,000 for built-in increases such as within-grades, FTS charges, PHS Service and Supply Fund, FICA increases and Federal Employees Compensation; and program increases of $767,000 to expand the four new programs initiated in 1977, and $303,000 to support 15 positions requested for maintenance of the Taft Center.

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Buildings and facilities ...	---	$2,315,000	---	---	---	-$2,315,000

In this activity funds 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.

In 1977, these funds will be used for general repairs required to protect government facilities from deterioration and provide for their most efficient use. These repairs include reroofing of buildings, painting, replacing parts in power plant, air conditioning and heating systems, facilities for the handicapped, modern fire alarm systems, and resurfacing roads and parking lots.

No new budget authority is requested in 1978. The $2,315,000 available in 1977 will be obligated during the year, resulting in a decrease of $2,315,000 in obligations in 1978.

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program Management	129	$3,037,000	129	$3,088,000	---	+$51,000

The Center for Disease Control is the Nation's primary federal focus for an interrelated group of program activities directed at preventing diseases and their consequences. The activities of the Center being both national and international in scope make it imperative that quality staff support be provided.

In 1977, the Center provided the executive direction and resource management staff necessary for the planning, direction, and evaluation of all preventive health program activities. With this staff the Center fulfilled its responsibility for proper stewardship of resources and for management of centerwide operations.

In 1978, the Center for Disease Control will continue to provide the management and support services to assure the desired direction and development of the Preventive Health Services program's goals and objectives.

The increase of $51,000 is for built-in increases such as within grade increases, FICA, and GSA rent.

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CENTER FOR DISEASE CONTROL

Preventive Health Services

Program Purpose and Accomplishments

Activity: Disease Control

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
2,738	$190,533,000	Indefinite	2,728	$134,661,000

Purpose: Title III of the Public Health Service Act. Preventing illness and maintaining scientific surveillance of diseases.

Explanation: This activity is funded through project grants and a direct operations program to accomplish various functions important to the prevention and suppression of disease and illness. Project grants are awarded to State and local health departments for prevention and control of venereal and other infectious diseases, control of rats in urban areas, and prevention of lead poisoning in children. The direct operations program provides for: disease surveillance; protection against the importation or spread of communicable diseases; epidemic aid to States and communities; surveillance of the immunization status of the population; development of new or improved standards and methods for the diagnosis, treatment, prevention, or control of diseases or preventable conditions; upgrading the Nation's clinical and public health laboratories; and coordination of various Federal health education programs.

Accomplishments in 1977: Intensified case detection and prevention activities has resulted in a continued national decline in syphilis with early 1977 data showing an additional decline of 9.6 percent. Preliminary 1977 data for gonorrhea indicates a continued slow down in the annual percentage increase (12.7 percent in 1973 to 6.5 percent in 1976 and continuing downward in 1977). During 1976 reported cases of rubella, diphtheria, and mumps declined from the 1975 level, but reported measles cases increased. By the end of 1977, it is expected that 16,000 of the total 43,300 target blocks will reduce rat infestations to the routine maintenance levels. Approximately 400,000 children were screened in 1977 for lead-based paint poisoning and 34,000 children had undue lead absorption. Approximately 1,700 separate disease outbreaks were investigated in 1977 by the Epidemic Intelligence Service and 31 surveillance reports were published. During 1977, 150,000 of

the most difficult reference diagnostic specimens from throughout the Nation were processed. Approximately 1.9 million different determinations were made on these specimens.

Objectives for 1978: During 1978, syphilis epidemiologic case management efforts will be strengthened to maximize the impact of contact referral and epidemiologic treatment on case prevention. Screening programs for gonorrhea will become more focused and control efforts will emphasize the existence of penicillin resistant gonorrhea strain and appropriate diagnostic, therapeutic and case management measures necessary to control its spread. It is anticipated that immunization project grants will focus special attention on developing the capability of States to rapidly identify and contain outbreaks of diseases. 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. In 1978, funds will be used to continue support to approximately 55 projects which are faced with the most severe lead poisoning problems and which have developed effective programs. Approximately 1,700 separate disease outbreaks will be investigated in 1978. Additional immunization project grant funds will support concentrated efforts to increase immunization levels for all childhood vaccine preventable diseases. Also, additional funds in the area of health education will be used to continue and augment the nutrition and diabetes education, and to initiate a new sex education program.

CENTER FOR DISEASE CONTROL

Preventive Health Services

Program Purpose and Accomplishments

Activity: Occupational Safety and Health

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
889	$49,769,000	Indefinite	904	$49,177,000

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, to develop criteria for standards necessary for the successful implementation of a safe and healthful work place, and participate in support for the ten regional offices.

Accomplishments in 1977: (1) Completed development of 24 criteria for occupational safety and health standards; (2) Tested approximately 400 protective devices and industrial hygiene monitoring devices; (3) Published the seventh annual "Registry of Toxic Effects of Chemical Substances"; (4) Completed approximately 41 industry-wide studies; (5) Conducted safety research which validates and/or provides new information to undergird safety standards presently being enforced by the Occupational Safety and Health Administration; (6) Initiated a program that will highlight the special problems of women in the workplace, especially those of childbearing age; (7) Strengthened the Institute's respiratory disease research program in the non-coal area; and, (8) Developed analytical methods and provided research for the development of more effective and usable protective equipment.

Objectives for 1978: (1) Complete criteria of 24 hazardous substances or harmful physical agents; (2) Publish the eighth annual "Registry of Toxic Effects of Chemical Substances"; (3) Test approximately 400 protective devices and industrial hygiene monitoring devices; (4) Complete approximately 85 health hazard evaluations; (5) 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, (6) Expand research efforts on the four new programs initiated in 1977 (i.e. Safety, Women in the Workplace, Occupational Respiratory Disease, and Control Technology).

CENTER FOR DISEASE CONTROL

Preventive Health Services

Program Purpose and Accomplishments

Activity: Buildings and Facilities

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$2,315,000	Indefinite	---	---

Purpose: Title III of 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 1977: Reroofing of buildings, painting, replacing parts in power plant, air conditioning and heating system, sewer or water lines, resurfacing roads and parking lots, facilities for the handicapped, modern fire alarm systems, and other general repairs and improvements required by the aging of the facilities were provided.

CENTER FOR DISEASE CONTROL

Preventive Health Services

Program Purpose and Accomplishments

Activity: Program Management

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
129	$3,037,000	Indefinite	129	$3,088,000

Purpose: Title III of Public Health Service Act. Provide leadership for the development of the Nation's Preventive Health Services programs' goals and objectives, and management capability for the proper stewardship of the resources assigned those programs.

Explanation: National coordinated preventive health programs require: sophisticated planning and analysis in terms of mission accomplishment; liaison with other governmental agencies and outside groups; adequate building space; and coordination and assessment of administrative management activities.

Accomplishments in 1977: The necessary staff was provided to assure policy and program leadership and evaluate progress in achieving program goals and objectives. Effective adminstrative management of the Center's resources were provided.

Objectives for 1978: To continue providing the effective and efficient program direction, administrative management, and liaison and advisory capabilities required for the Center's national coordinated Preventive Health Services programs.

New Positions Requested

	1978		
	Grade	Number	Annual Salary
Occupational Safety and Health			
Ungraded		15	$233,129
Total new positions, all activities		15	233,129

THURSDAY, MARCH 3, 1977.

HEALTH SERVICES ADMINISTRATION

WITNESSES

JOHN H. KELSO, DEPUTY ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION
DR. EDWARD D. MARTIN, DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES
DR. MICHAEL J. GORAN, DIRECTOR, BUREAU OF QUALITY ASSURANCE
DR. JAMES H. ERICKSON, DIRECTOR, BUREAU OF MEDICAL SERVICES
W. HARELL LITTLE, DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT, HEALTH SERVICES ADMINISTRATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
DR. FRANK H. SEUBOLD, DIRECTOR, DIVISION OF HEALTH MAINTENANCE ORGANIZATIONS, BUREAU OF MEDICAL SERVICES
DR. WILLIAM B. MUNIER, DIRECTOR, OFFICE OF QUALITY STANDARDS/PHS
DR. FAYE G. ABDELLAH, DIRECTOR, OFFICE OF LONG TERM CARE/PHS

Mr. FLOOD. The committee will come to order.

Now we will hear from the Health Services' Administrator. This presentation will be made by John H. Kelso, Deputy Administrator for the Health Services Administration.

Now we have a biographical sketch of Mr. Kelso which we will place in the record at this point.

[The biographical sketch follows:]

BIOGRAPHICAL SKETCH

Name: John H. Kelso.

Position: Deputy Administrator, Health Serivces Administration, U.S. Public Health Service, Department of Health, Education, and Welfare.

Birthplace and Date: Iowa City, Iowa, June 16, 1925.

Education: B.A.—1949 and M.A.—1950, State University of Iowa.

Experience:

June 1976–to present: Deputy Administrator, Health Services Administration, PHS, DHEW.

1973–76: Director, Office of Regional Operations, Office of the Assistant Secretary for Health, DHEW.

1971–73: Associate Administrator for Management, Health Services and Mental Health Administration, DHEW.

1968–71: Assistant Administrator for Management, Health Services and Mental Health Administration, DHEW.

1966–68: Executive Officer, Public Health Service, DHEW.

1962–66: Assistant Executive Officer, BSS/Environmental Health, PHS, DHEW.

1960–62: Chief, Management Advisory Branch, BSS/EH, PHS, DHEW.

1957–60: Management Analyst, PHS, DHEW.

1955–56: Management Analyst, Department of Agriculture.

1951–55: Occupational Research Analyst, Department of the Navy.

Association Memberships: American Society for Public Administration, American Academy of Health Administration.

Awards: DHEW Superior Service Award—1969, DHEW Distinguished Service Award—1972.

Mr. FLOOD. Do you have some people that you would like us to meet?

Mr. KELSO. Yes, Mr. Chairman.

On my far left is Dr. James Erickson, Director of the Bureau of Medical Services. Next to him is Dr. Ed Martin, Director of the Bureau of Community Health Services, and Mr. Harell Little, the Agency Budget Officer. On my right is Dr. Michael Goran of the Bureau of Quality Assurance, and on his right is Mr. Charles Miller.

PREPARED STATEMENT

Mr. FLOOD. You have a prepared statement. I gather you will insert that in the record, and we will proceed with the questions?

Mr. KELSO. Yes.

[The statement follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Statement by the Deputy Administrator, Health Services Administration

Mr. Chairman and Members of the Committee:

I am pleased to have this opportunity to discuss with you the Health Services Administration budget request for fiscal year 1978.

The programs of the Health Services Administration deal with the accessibility, delivery and quality of health care available to the American people. In pursuit of these goals, the Health Services Administration has organized its program efforts around five strategic roles. These are: (1) to build primary care capacity by placing appropriate health personnel and related services in underserved areas; (2) to maintain such capacity especially under those special circumstances in which it cannot be self-sustained; (3) to improve the organization and efficiency of health care delivery; (4) to provide the direct delivery of health care to Federal beneficiaries and (5) to assure the quality of Federally financed health services.

In 1978 the Bureau of Community Health Services will continue its efforts to build capacity to deliver primary health care through its several programs, with a special emphasis given to improvements of child health care. Particular concern will be given to fostering State-based child health systems, and in all activities the special problems of adolescents will receive priority attention. I would now like to discuss some of our major programs.

The Community Health Center program is responsible for the development of health services delivery capacity in medically underserved areas. The 1978 budget request of $229.1 million will provide support to 164 on-going Community Health Centers and 348 Primary Health Care Centers providing a wide range of preventive, curative, and rehabilitative ambulatory services to 4.2 million people. This request includes an increase of $14 million for an expansion of activities related to family-oriented health services, including family planning, counseling, pre- and postnatal care for approximately 136,000 people. Special attention will be directed to adolescents, especially regarding the problems of teenage pregnancy.

The 1978 budget request of $315 million for maternal and child health grants to States seeks to improve the availability, accessibility, quality and effectiveness of

the health care provided to mothers and children through the development of State-based child health care systems. Activities principally will be devoted to 5 major service areas: family planning, prenatal care, perinatal care, child health care, and adolescent health, especially teenage pregnancy. We anticipate having Statewide systems in all 57 States and jurisdictions by 1982.

Our 1978 budget request for the Family Planning program is $123.6 million an increase of $10 million over the 1977 level. The 1978 level of funding will provide services to almost 3.3 million low-income and high risk individuals, and the expansion of delivery sites to unserved and underserved areas. This request includes a $10 million increase to expand family planning and related services to 278,000 high risk persons, especially adolescents.

The National Health Service Corps directs its resources to the development of viable health services capacity in critical health manpower shortage areas. The Corps' fundamental goals are to assist communities to develop the capacity to plan, build, and maintain independent health care practices, and to encourage health professionals, once placed, to remain in their communities on a non-Federal basis. The 1978 budget request of $37.6 million will enable us to staff 547 ~~453~~ sites with 975 field assignees and provide

health services to an estimated 932,000 persons, an increase of 262,000 people over 1977.

Bureau of Community Health Services management will continue to make program coordination and integration at the State and local level, its area of highest priority concern. The 1978 budget request for all the programs in the Bureau of Community Health Services is $894.7 million, an increase of $37.2 million over the 1977 level. This level will support our roles of building new primary care capacity and maintaining existing capacity in circumstances in which it cannot otherwise be self-sustained.

In addition to these grant programs, we are requesting $135.5 million to maintain services capacity through the direct provision of health care to certain statutory beneficiaries in the eight Public Health Service general hospitals, the National Leprosarium, and 26 outpatient clinics. This budget request will allow for the maintenance of the research and training programs in addition to the Federal beneficiary programs.

During 1978, we will continue our development of two programs intended to foster improvement in the organization of health services. First, the Health Maintenance

Organizations encourage the delivery of comprehensive and cost-effective health services, emphasizing prevention and ambulatory medical care. During fiscal year 1978 we plan to fund 23 initial development grants. Also, approximately 36 loans for initial operations totaling $90 million will be made. These grants and loans will provide the nucleus for approximately 57 HMOs with a potential for eventually serving 1,710,000 enrollees. Second, the Emergency Medical Services program provides assistance in establishing systems for the delivery of emergency medical services that enhance patient survival and care from an initial incident through definitive care. Our budget request of $33.6 million will provide support to 87 regional EMS systems. In addition, on a cumulative basis, funding will have been provided to support 155 operational emergency medical services systems in some form of operation, serving areas with populations of about 108 million people.

Another major role of the Health Services Administration is that of quality assurance. We have the responsibility for assuring the quality of care in the Medicaid, Medicare and Maternal and Child Health programs through a nationwide network of Professional Standards Review Organizations. The PSROs carry out their responsibilities of assuring the necessity, appropriateness, and quality of medical care by applying the concept of peer review through a system of

local physician organizations. 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. Early but limited data from PSROs indicate that PSRO review not only reduces average lengths of stay and results in overall dollar savings, but also the quality of care is being maintained.

Considerable progress is being made in the implementation of this program. Physician acceptance has grown considerably. Over 120,000 physicians are now members of PSROs representing over 50 percent of the eligible physicians in PSRO areas. The PSRO budget request of $72.2 million, an increase of $11.1 million over 1977, will support conditional PSROs in all 203 PSRO areas nationwide. These PSROs will review an estimated 6.3 million Medicare and Medicaid admissions -- about 57 percent of the total Medicare and Medicaid annual admissions. In addition this budget request also provides funds for long term care review and ambulatory care demonstration projects.

In summary, Mr. Chairman, I have discussed with you five major roles which we are performing through our health care activities. To continue and expand these efforts we are

requesting $1.2 billion in budget authority and trust funds, an increase of $55.7 million over the 1977 level.

Mr. Chairman, I will be pleased to answer any questions the Committee may have.

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COMMUNITY HEALTH CENTERS

Mr. FLOOD. Now in this budget request you have $14 million in here for the community health centers program. I believe that is part of the Department's alternatives to abortion strategy.

Well, can you give us some specific examples of how you are going to use that money?

Mr. KELSO. Yes, sir, Mr. Chairman.

This money will be used in the community health centers to expand family planning activities currently going on to provide better education and counseling to people who come to the community health centers, primarily teenagers.

Mr. FLOOD. Will these funds be awarded to the existing community health centers or are you planning to send this money to make grants and create new centers or what?

Mr. KELSO. This $14 million will be spent through the existing community health centers.

Mr. LITTLE. By that we mean the existing community health centers as well as the primary health care centers.

Mr. FLOOD. Yes.

Now there are several agencies within HEW that are involved in this—alternatives to abortion strategy. How are all of these activities being coordinated so that you are going to achieve maximum utilization of this investment you are going to make?

Mr. KELSO. There is also another $10 million in our budget. It is in the family planning program. Both of those are in the Bureau of Community Health Services.

Mr. FLOOD. Aren't there several agencies?

Mr. KELSO. Yes, we will be working closely with NIH. We will also be working with the Deputy Assistant Secretary for Population Affairs in the Office of the Assistant Secretary for Health.

Mr. FLOOD. Is that the extent of that?

Dr. MARTIN. There is an established committee, the Child Health Executive Committee, which consists of representatives of all the major agencies, and which is chaired by Dr. Charles Lowe, who is the Special Assistant for Child Health Affairs.

This working group developed the initial adolescent strategy for the alternatives to the abortion initiative.

In the past 6 months it has worked very effectively to provide integration and coordination of our activities. We anticipate that that committee will be a good mechanism to carry this out.

IMPROVEMENT OF PROJECT MANAGEMENT

Mr. FLOOD. In this material that you submitted to the committee you state you intend to improve project management and you are going to do that through the application of what you call uniform performance criteria.

Well, what happens to a community health center or any other project for that matter that doesn't meet the performance criteria? Do you simply cut off the funds?

Mr. KELSO. Not necessarily; technical assistance could be given to them so that they can make necessary improvements to meet the performance indicators. But failing that, there is the possibility that funds might be terminated.

Mr. FLOOD. What evaluation activities, if any, are you supporting to determine if these various programs of the Health Service Administration are actually serving the people that they are supposed to serve and if they are delivering the services in a cost-effective manner?

Mr. KELSO. Mr. Chairman, are you referring to community health centers?

Mr. FLOOD. Yes.

Mr. KELSO. I think Dr. Martin can speak to that.

Mr. FLOOD. These are the various programs in the Health Services Administration.

Dr. MARTIN. Yes, sir, within the ambulatory projects, which include the community health centers, the migrant health projects, and the National Health Service Corps, there are criteria that have been developed for assessment of physician productivty. There are also certain quality indicators that we attempt to use. The projects are aware of these, and we carefully review them both in the site visits and during the grant reviews.

In addition, we have a common reporting system which allows us to begin to compare the data on projects, and we also conduct audits on the projects. We evaluate exactly whether the project is meeting the standards and whether it is impacting on the target population. The combined effects of these activities has resulted over the last couple of years in a very significant improvement of the programs' performance.

For example, in just the 2 fiscal years from 1974 to 1976, the number of patients actually being served has increased by 70 percent with a constant budget level. The physician productivity increased by 30 percent. The cost of the actual encounters has decreased by 5 percent during that period of time for medical encounters while for the rest of the country the cost went up by about 30 percent.

So the system is a total one, and works very well at the local and the regional level to make those assessments and continue to improve management effectiveness in the projects. They have done a superior job at the project level of making these projects work much better.

PRIMARY HEALTH CARE INITIATIVE

Mr. FLOOD. In the budget, Doctor, you refer to a primary health initiative. Will you explain to the committee what that is?

Mr. KELSO. Briefly, Mr. Chairman, this is an attempt to take some of the categorical programs of the Bureau of Community Health Services in certain specific locations and to put them together to meet the community's needs. Some of the programs, such as community health centers, family planning, migrant health, the National Health Service Corps, and the Appalachia programs, provide better impact for the area, coordinate activities and use resources in a more effective manner.

Mr. FLOOD. But how does what you call primary health care initiative, differ from the community health center activity?

Mr. KELSO. Well, the 164 community health centers are the community health centers the Public Health Service has had since the middle sixties. They are the ongoing community health centers. The primary health care centers are the ones where we attempt to take existing categorical programs, such as family planning and some of the others, and package them in such a way that we can bring greater service to a particular community.

Did you want to add something to that?

Dr. MARTIN. Actually, the basic 330 legislation, the community health center legislation, is met by all of the grantees. The distinction between the 164 and the additional 348 projects is actually becoming very dim because as we assign National eHalth Service Corps professionals to existing community health centers, they effectively become part of the primary initiative.

So, the basic point is that they are all community health centers which provide the scope of services required by law.

What we talked about was the initiative. Instead of using separate programs in the same area with different project requirements, we tie all of these efforts together. For example, the Daniel Flood Clinic is really part of the primary health care initiative. It includes community health center money and Family Planning money. It is not just a section 330 project.

Mr. FLOOD. In fiscal 1977 do you plan to support 130 new community health centers?

Dr. MARTIN. We are proposing 100 in rural areas and 20 in urban areas, sir.

Mr. FLOOD. Do you have enough money in fiscal year 1978 to support the continuation of these projects?

Dr. MARTIN. The 1978 budget includes money not only for the continuation of the existing projects but in addition includes money to start 90 new community health centers that will be part of the primary care initiative.

Mr. FLOOD. Is there money available in this 1978 budget to initiate new community health centers?

Dr. MARTIN. Yes, sir; 90 new centers.

LINKAGES OF FEDERAL, STATE, AND LOCAL HEALTH PROGRAMS

Mr. FLOOD. In the budget justifications there you state that you will focus efforts on the development of integrated systems of health care. You make quite a thing out of that, by linking these community health centers with all the other Federal, State, and local health programs.

Dr. MARTIN. Yes, sir.

Mr. FLOOD. I guess I can safely say this committee certainly approves of that approach. Can you give us some idea of what specific goals now are in this area, what you have in mind and how long it will take to achieve these goals?

Dr. MARTIN. The attempt at that activity resulted last year, for example, in well over half of the new centers having formal relationships with community mental health centers. About a third of the National Health Service Corps new assignees went into these new

primary care activities. In addition to that, almost all of the centers are now being qualified as providers of family planning services.

We now have been working on these efforts for 1 year. At the end of 3 years, we anticipate that all of our community health centers will have linkages to community mental health, be official providers of family planning services, be appropriate for assignment of National Health Service Corps professionals, and all will have official relationships with local hospitals for provision of secondary services.

Where there are area health education centers, our projects also will be linked to those. That is the 3-year plan.

We are well past accomplishing more than one-third of these goals in the first year of our capacity building strategy.

THIRD PARTY REIMBURSEMENTS

Mr. FLOOD. I see you expect these community health centers to collect up to 35 percent of their operating costs from third-party reimbursements. That is a considerable increase from a few years ago when you told us that the maximum third-party reimbursement would be 20 percent.

What has happened to achieve an increase like that?

Mr. KELSO. Yes, sir. It has gone up from 31 percent in 1977 to 36 percent in 1978. It has gone up every year.

Dr. MARTIN. I think the largest reason for that increase has been significantly improved management at the project level. There has been a greatly increased focus upon providing technical assistance to these projects.

In addition, there has been an expansion of the centers' efforts to include the broader populations and to include people who are eligible for some kind of third-party reimbursement. When we look at the population we are serving in these areas, we do think that although our original projections of maximum third-party collections were fairly conservative, it will start to level off at somewhere between 36 and 40 percent.

Mr. FLOOD. Do you think you can go beyond this 35 percent from the third-party reimbursement, and if so, what needs to be done and what do you have to do to improve this rate of reimbursement? We certainly would encourage that, you know, anything we can do to encourage you to collect from third-party reimbursements.

Dr. MARTIN. Yes, sir. The management system that you were asking about before plays a major role in this. We will continue to aggressively and actively push the centers to maximize their third-party reimbursements.

I think that the very dramatic increases between 1973 and 1977 are beginning to slope off. It basically has to do with the question of what percentage of people in certain areas are eligible for third parties. We are starting to reach the point where most of the eligible people being served in an area are being billed for those services.

There is a significant number of people in these areas who are just not eligible for third parties.

Mr. FLOOD. Mr. Michel?

[The information follows:]

ACTIVITIES AND RESPONSIBILITIES OF CHC'S, PHCC'S, AND CMHC'S

Breakout of activities and responsibilities between the community health center program, the maternal and child health program, and the community mental health center program:

The community health centers program develops health service delivery capacity in medically underserved areas and provides family-based primary health care and arranges for specialty and inpatient care where health resources are scarce or nonexistent.

The maternal and child health title V program promotes the health of mothers and children and emphasizes preventive services, crippled children's rehabilitative services, and highly specialized obstetric and pediatric care which are not primary care.

The community mental health centers program provides community-based mental health services such as diagnosis, treatment, control, and prevention of mental illness; a distinct activity from community health centers.

The Bureau of Community Health Services has as a major goal the integration of categorical community-based health programs at the Federal, State, and local levels in order to better serve the entire family. Some of the programs are community health centers, maternal and child health, crippled children's programs, community mental health centers, drug abuse programs, family planning programs, early and periodic screening, diagnosis and treatment programs.

Mr. MICHEL. Thank you.

Mr. Kelso or Dr. Martin, would you provide us in general today and more specifically for the record what the precise breakdown of the activities and responsibilities is between the community health center programs, the maternal and child health program, and the community mental health centers programs?

I get the general feeling that there is not a great deal of difference between them and thus a lot of overlapping. How do you distinguish?

Mr. KELSO. As we indicated, the term "Community Health Center" has been around the Public Health Service for quite a while. As Dr. Martin had indicated before you came in, the primary health care centers we have in the budget are very similar in terms of the service delivered.

Mr. MICHEL. So it is the same thing?

Mr. KELSO. No.

Mr. MICHEL. That is the point. You get these fine semantical differences here, but it all makes a different line item in the budget. I am thinking that all we are doing is piling one on top of the other. Clean it up for me so I understand what the difference is.

Dr. MARTIN. There is a clear difference between the responsibilities. There is an important distinction between community mental health centers, community health centers, and maternal and child health programs. Community mental health centers provide community-based mental health services as a separate activity. Our community health centers provide primary care to the patient. The title V program for maternal and child health include services for crippled children, rehabilitative services and highly specialized obstetric and pediatric care activities which are really not part of primary care.

As major programmatic activities there are identifiable and clear differences between the three. Our attempt of course, is to decrease any duplication and, more importantly, to create effectively the working relationships between those different kinds of programs.

Mr. MICHEL. Could you tell me, for example, how many communities have both the community health or primary health care center and a community mental health center?

Dr. MARTIN. We could provide that for the record.

Mr. MICHEL. All right

[The information follows:]

Number of communities having both community health centers and community mental health centers

At the beginning of fiscal year 1977 there were 82 community mental health center projects with linkages to community health centers which are funded as part of the Primary health care initiative.

STUDIES OF IMPROVED HEALTH OF POPULATION SERVED

Mr. MICHEL. Do you have any figures that show the extent to which the community health center program and the maternal and child health care have actually improved the health of the population they are serving?

Dr. MARTIN. There have been a number of studies conducted, both of isolated project activities and comparative studies, analyzing the aggressive efforts in particular areas as contrasted to others. We can provide for the committee specific studies that have been done in that regard.

Partly it is difficult to identify a single reason for improvements in infant mortality because that indicator of health status is affected by socio-economics, population, relationships and other factors over which our health service programs have no control.

Understanding that, we can show that there are some studies that have been conducted which indicate that when you correct for all the broader social and economic considerations, the provision of preventive care by those programs clearly makes a difference in the morbidity and mortality.

Mr. MICHEL. Feel free to expand in the record and if you can, maybe a comparison between a good one and a bad one. Maybe sometime somebody will read the record and take some advice from the better ones.

[The information follows:]

Morris, N.M. et al. "Shifting Age-Parity Distribution of Births and Decrease in Infant Mortality," American Journal of Public Health. 65 (April, 1975): 359-362.

> "Data supporting the impact of Maternity and Infant Care (MIC) services on infant mortality are equivocal. Wholey and Silver estimated in 1966 that MIC Projects could reduce infant mortality in high risk patients to a level closer to the national average, or from about 41 per 1,000 live births to about 24 to 29. This estimate is apparently supported by some data such as that from Chicago's MIC Project, in which neonatal mortality (which usually constitutes approximately 90 percent of infant mortality) for project patients 15 years old or younger was 19 per 1,000 live births, while for non-project it was 37. ...In discussing only pregnant women and their babies, we are not giving credit for high risk births averted by the family planning services offered in MIC projects."

Gordis, L. "Effectiveness of Comprehensive-Care Programs in Preventing Rheumatic Fever," New England Journal of Medicine. 289 (August 16, 1973): 331-335.

> "The result of this study indicates that a sharp drop in the incidence of rheumatic fever has taken place in census tracts served by four comprehensive-care programs (C & Y's) in Baltimore as compared with several comparison populations. The incidence rate in census tracts adjacent to those served by these programs but not eligible for care by the projects were intermediate between those of the comprehensive-care tracts and those of the other two comparison groups: the findings are consistent with observations that the populations of those tracts (tracts adjacent to areas with C & Y projects) do in fact benefit to a limited extent from the services of the comprehensive-care programs. They therefore suggest that the differences observed may reflect the impact of comprehensive-care programs in preventing rheumatic fever and are consistent with evidence that in these programs, cultures from children with acute pharyngitis are frequent."

Pearse, W.H. "The Maternity and Infant Care Program," Obstetrics and Gynecology. 35 (January, 1970): 114-119.

> "In the Omaha project our initial objectives were to reduce the number of patients receiving no prenatal care, the rate of the prematurity, and perinatal mortality. The first and third objectives were achieved. Prior to the project, about 16% of our patients were unregistered. This number declined to 10.5% in 1965, 8.1% in 1966, 6.3% in 1967 and 6.2% in 1968. ...Perinatal mortality has declined.... Prematurity rates remain essentially unchanged....

Zackler, J. "The Young Adolescent as an Obstetric Risk," American Journal of Obstetrics and Gynecology. 103 (February, 1969): 305-312.

> "This study was conducted to determine whether the care provided by the Chicago Board of Health through Maternity

Infant Care Project No. 502 was effective in meeting the medical care needs of the increasing number of pregnant girls under 16 years of age living in low socioeconomic areas....

"Because not all of the patients in the Project and non-Project groups were ethnically or socioeconomically alike, the Negro patients in each group were compared, since most of them were from similar low socioeconomic areas. In comparing the hebdomadal and neonatal mortality rates and the premature rates of Negro Project patients and the non-Project patients, the rates were significantly higher in patients not receiving care at the Board of Health; the hebdomadal mortality rate was 125 percent higher, the neonatal rate 136 percent higher and the prematurity rate 5.8 percent higher."

Morehead , M.A. et al. "Comparison Between OEO Neighborhood Health Centers and Other Health Care Providers of Ratings of the Quality of Health Care," American Journal of Public Health. 61 (September, 1971):

"Among the health care providers whose performance was measured by these baseline standards, the care provided by the Children's Bureau Children and Youth Projects and Maternal and Infant Care Programs received the highest ratings. These highly organized programs, generally with full-time professional staff, are amply funded and have a broad range of paraprofessional resources. In addition they are dealing with programs whose standards of care have had professional acceptance and patient understanding for some years.

"...The M & I programs did not succeed in reaching their populations earlier in pregnancy than the other providers serving the disadvantaged (the group practice plans did better in this regard); but quite obviously, once a patient became part of the program, education about the need for ongoing care and implementation of follow-up procedures were successful in having patients adhere to the programs' goals."

Kessner, D.M. et al. Infant Death: An Analysis by Maternal Risk and Health Care. Institute of Medicine, National Academy of Sciences, Washington, D.C. 1973.

"In general, the projects (M & I's) are credited with accelerating the organization of comprehensive health care for mothers and infants in their target areas and with serving as models for delivering maternal and infant health services in low-socioeconomic areas. They have also been credited with promoting the team-care concept among physicians and other health professionals. Most of the projects have used new types of health personnel, especially health aides."

Studies and examples showing impact of Community Health Center programs upon the health status of the people

The use of Community Health Center program grant funds to provide ambulatory health care services which emphasize prevention results in lower utilization of higher cost inpatient services and represents an efficient mechanism for delivering services. A study completed October 31, 1973 on the hospital utilization experience of persons using five health centers shows a marked decrease in in-patient hospital utilization, as compared with the national experience. For the five centers participating in the study, the average hospitalization experience was 762 hospital days per 1,000 patients. The national average for 1971 was 1,160 hospital days per 1,000 patients.[1/]

Four inner-city comprehensive-care programs in Baltimore were evaluated by studying their effect on the incidence of rheumatic fever. It was found that rheumatic fever decreased by 60 percent in those areas having the comprehensive-care programs but remained unchanged in the rest of the city. Base data were collected in 1960-64 and compared with 1968-70 data.[2/] (The New England Journal of Medicine, in an accompanying editorial statement, pointed out that the reduction in costs to the community for the acute hospital care alone could be calculated to be at least $100,000, assuming a three-week hospital stay)

In a study of admission patterns of children to Rochester, New York hospitals, made in order to assess the effect of a community health center upon hospitalization, it was found that hospital days for community health center clientele dropped by approximately half, in the first two years of operation of the center.[3/]

1/ Duggar, Benjamin, et al. Hospitalization and OPD Experience Study Final Report of a Study Conducted for DHEW, Contract No., OEO B2C-5405 October 31, 1973)

2/ Gordis, Leon. Effectiveness of Comprehensive-Care Programs in Preventing Rheumatic Fever. New England of Medicine 289:331-335 August 16, 1973)

3/ Klein, Michael, Roughmann, Klaus; Woodward, Kenneth; and Charnacy, Evan. The impact of the Rochester Neighborhood Health Center on Hospitalization of Children, 1968 to 1970. Pediatrics 51:833 (May 1973)

Mr. MICHEL. You know it is difficult for us when we are trying to settle on a dollar figure. We have to rely on your telling us that, yes, this is good and that is good and so many dollars put together make this an effective program here and then multiply it by the number of communities we can serve.

I know it may be very difficult in a sense to get a precise dollar and cent figure on what accomplishments there are. But I think we have to ask the question to really justify how you put together those building blocks of so many dollars here, here, and here, and end up with this total package you have been testifying for.

Now every year for the last several years we have asked for a list of HEW programs which provide funds for family planning, including medicaid, et cetera. I wonder if you would do that again simply for the record, listing the estimated expenditures for both fiscal years 1977 and 1978.

Now briefly off the top of your head, can you tell us at this time what the total projected figures are for both years in family planning?

Mr. KELSO. In the budget justification, Mr. Michel, we have an estimate of $243 million. This is available from various sources.

Mr. MICHEL. That is for 1977?

Mr. KELSO. That is for 1978. It is $232.5 million in 1977. This is from various programs in HEW.

Mr. MICHEL. And then you fill it out for the record.

Mr. KELSO. Yes, sir.

[The information follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
POPULATION RESEARCH AND FAMILY PLANNING ACTIVITIES

Obligations, 1977 - 1978

Agency and Program	1977 (Est.)	1978 (Est.)
Total, Department of Health, Education and Welfare	$378,808,000	$412,003,000
PUBLIC HEALTH SERVICE		
Office of the Assistant Secretary for Health		
Office of International Health		
Scientific Activities, Overseas (Special Foreign Currency Program, P.L. 480)1/	52,000	88,000
National Institutes of Health		
National Institute of Child Health and Human Development	59,481,000	63,444,000
Health Services Administration		
Bureau of Community Health Services (BCHS)		
Community Health Centers2/	---	14,000,000
Maternal and Child Health		
Formula grants to States	$25,000,000	$25,000,000
Project grants for maternity and infant care	---	---
Research	---	---
Family Planning	113,615,000	123,615,000
Subtotal, BCHS	$138,615,000	$162,615,000

1/ Not included in the PHS or DHEW total. All obligations are in U.S.-owned excess foreign currencies.
2/ These funds have been identified in 1978 as part of a special initiative to increase family planning services to high risk populations, especially teenagers. Family planning services also are provided to all patients as part of the comprehensive plan of care at Community Health Centers; however, we are unable at this time to give an estimate of the cost for total family planning services provided.

Obligations, 1977 - 1978

Agency and Program	1977 (Est.)	1978 (Est.)
Indian Health Service	$1,476,000	$1,476,000
Bureau of Medical Services	200,000	210,000
Subtotal, Health Services Administration	140,291,000	164,301,000
Center for Disease Control	615,000	615,000
Health Resources Administration		
National Center for Health Statistics	810,000	4,074,000
Total, Public Health Service	$201,197,000	$232 434,000
SOCIAL AND REHABILITATION SERVICE		
Social Services	88,000,000	76,000,000
Medical Assistance	87,933,000	101,471,000
Total, Social and Rehabilitation Service	$175,933,000	$177,471,000
EDUCATION DIVISION		
Office of Education		
Elementary and Secondary Education		
Grants for Disadvantaged (ESEA I)	3/	3/
Support and Innovation Services	455,000	488,000

3/ Funds expended for family-related activities which are components of larger projects cannot be separately identified. Allocations are made to the States on a formula basis, and States are not required to report the use of funds according to subject area.

Obligations, 1977 - 1978

Agency and Program	1977 (est.)	1978 (Est.)
Occupational, Vocational, and Adult Education		
Vocational Home Economics Education	4/	4/
Adult Education	$973,000 5/	$1,610,000 5/
Higher Education		
Grants to States for Community Service and Continuing Education	250,000	---
Total, Education Division	$1,678,000	$2,098,000

4/ Funds expended for family-related activities which are components of larger projects cannot be separately identified. Allocations are made to the States on a formula basis, and States are not required to report the use of funds according to subject area.

5/ Beginning with FY 1976, estimates are only for family planning rather than for all family-related activities. Family planning activities constitute approximately one to two percent of all family-related activities.

Mr. MICHEL. Now according to your statement there is family planning activity under the community health centers and the maternal and child health as well as the regular family planning program. Now is there any difference in the nature of how this thing is administered in those three programs?

Dr. MARTIN. With regard to the actual standards for the care and the mechanism by which family planning services are delivered, we have now standardized those in the three program activities. The use of one of the different authorities or the other to support family planning services depends largely on the availability of services in an area.

Our preference is that where we have a comprehensive family based community health center, we will deliver family planning services in the context of family care. If there is not that kind of comprehensive capability, then it is possible to use title X or title V in an area to provide the services. Obviously we are attempting to move them together. Our goal here is, wherever possible, to provide all the family health care needs, including those for family planning services, at a single point.

Presently about 43 percent of the family planning visits being provided are through the States and local health agencies. So at the State and local level there is increasing coordination.

We have become very aggressive about not having multiple providers in the same area. What we attempt to do is pick the best family planning providers in an area and to funnel the funds from all three sources into that one provider.

Mr. MICHEL. Do each of these programs serve the same type of population or would you gear one program to one population group; or is it a mix across the board?

Dr. MARTIN. The community health center program is limited in its scope in that its responsibility is for a broad set of services to specific communities of which there are now about 300.

We have 300 communities, counties, or areas that are receiving care. About 9 percent of the total number of people in underserved areas are the recipients. The title X family planning projects provide just family planning services in many other places where we have not created this comprehensive facility, and work in conjunction with title V activities.

Between title V and title X you have services essentially available in every county across the country where you don't have a comprehensive center. Where you get a comprehensive center, then title V and title X activities go into that center rather than operate a separate center.

The largest number of people being served is through this broad but carefully planned system of care which covers the entire Nation through the State and county health departments.

Mr. MICHEL. According to your justifications, regular family planning funds are funding 4,410 clinics?

Dr. MARTIN. Yes, sir.

Mr. MICHEL. Where are these centers generally located in a community? Is there any set pattern?

Dr. MARTIN. There are some general estimates. About 40 percent of those clinics are linked in with county health departments. That is largely a rural phenomena where you don't otherwise have the capability. About 19 percent of the clinics are tied in with hospital out-patient departments, large group practices, community health centers and migrant health centers. About 25 percent of the clinics are free-standing family planning activities within a community.

In communities where it is not possible to do any of those three, we often develop a contract with local providers to deliver those services. As a general statement, those are the characteristics.

Mr. MICHEL. I note there is a $10-million increase in here for family planning, but no increase in the number of clinics funded. Does that just mean it is a beefing up of the current ones we have onboard?

Dr. MARTIN. As Mr. Kelso indicated before, as part of this integrated activity focusing on adolescents, the intent there is to take the present clinic activities we have and expand the quality of their ability to deal with teenagers, especially with regard to outreach services. The intent is to reach the high-risk adolescents, and to increase our effectiveness in getting these young people into the ssytem. As with all our family planning services, the priority will be placed on using these funds to provide care in the comprehensive centers.

FUNDING FAMILY PLANNING ACTIVITIES BY STATES AND LOCALITIES

Mr. MICHEL. Are the States and localities contributing any funds for family planning activities?

Dr. MARTIN. Yes, sir.

Mr. MICHEL. Could we have that spelled out in the record as to how much? Does it vary between States?

Dr. MARTIN. Yes, sir; and between localities.

Mr. MICHEL. Can you give us some feel for that by expanding it on the record?

Dr. MARTIN. Yes, sir.

[The information follows:]

STATE AND LOCAL FUNDS IN FAMILY PLANNING CLINICS

In 1976, the estimated non-Federal funding in organized family planning service programs was $42,910,000 or 20 percent of the total funding. Of the 20 percent, it is estimated that 57 percent of the non-Federal funds were provided by State and local governments. It should be noted that a major portion of this amount was matching funds.

Mr. MICHEL. Thank you.

GAO REPORT

Mr. FLOOD. Mr. Natcher?

Mr. NATCHER. Mr. Kelso, I have had an opportunity to glance at the GAO report which states that improvements are needed in recording and reporting appropriations for your agency.

Now you are acquainted with this report, aren't you?

Mr. KELSO. Yes, sir; we are.

Mr. NATCHER. They identified some of the problems such as illegal transfer of funds between appropriation acts. What have you done now to correct this matter?

Mr. KELSO. We just received the final report in the middle of February. We are analyzing it.

Mr. LITTLE. We are currently developing a response to the GAO report. Based on the original draft submitted to us by GAO in May 1975, we initiated action to improve our accounting system. We have completed a reconciliation of accounts receivable, and implemented additional accounting procedures in the regional offices to require monthly reconciliation.

As we indicated in our response to the GAO findings, we do not have sufficient staff in our accounting office. As a result, management has initiated efforts to increase the staff.

One part of the GAO report referred to $18 million for which a reconciliation needed to be accomplished. $6 million of that $18 million has been reconciled.

The GAO report also identified $190 million in 1975 which need to be reviewed; 90 percent of that task has been accomplished.

MATERNAL AND CHILD CARE

Mr. NATCHER. All right.

Now in your opening statement, Mr. Kelso, you say that in fiscal year 1978 special emphasis will be given to improvements of child health care. However, you are not requesting additional funds for the maternal or child health program.

What do you have in mind and how do you intend to do this, Mr. Kelso?

Mr. KELSO. During fiscal 1978 we will move into what we refer to as the State-based child health care system. Basically this is the development of systems or management methodologies whereby we can develop, monitor, and coordinate child health activities in a better fashion better than we have before.

Mr. NATCHER. What do you mean now by State-based child health systems?

Dr. MARTIN. The attempt being made with those activities is to begin to focus strengthened planning and implementation activities within a title V agency in the State health department. We have given them additional funds to begin to work closely with the existing activities that we fund within the State.

For example, a plan needs to be developed within a particular State so that over a 5-year period specific steps can be taken to decrease the infant mortality rate below the national mean. We have chosen the five or six worse States in regard to infant mortality as the first ones where we will begin these efforts. Part of this activity is to use MCH in coordination with programs like title X family planning services and community health centers.

Mr. NATCHER. How much will it cost to establish such a system?

Dr. MARTIN. For the initial developmental activity the estimated grant award for each of the States we have done so far is about $375,000. The determination of the total cost of supporting such systems over a 5-year period is part of what the States must do in the first year. We would be happy to provide the committee that information.

The projections in the State of Mississippi and the State of Alabama are just now being made. The question as to what it would take to make sure these people receive adequate high quality care is part of what we are determining in this procedure.

Mr. NATCHER. Are all of the States now providing the required five types of services under the maternal and child health program?

Dr. MARTIN. Yes, sir. All States are in compliance with the program of projects.

Mr. NATCHER. Tell me, Doctor, how does the maternal and child health program coordinate its immunization activities with other programs at the local level, such as Head Start, for instance?

Dr. MARTIN. In most States there is a specific State relationship between the immunization activities for the Center for Disease Control conducted in the States and the local county health departments. In some States it is a fully coordinated activity undertaken by the title V agencies. In other States there are informal relationships.

Part of what the President and Secretary are proposing as a high priority is to take a close look at the effectiveness and scope of these activities over the next 2 to 3 months. That particular study and critical evaluation is being undertaken at this time.

RURAL HEALTH

Mr. NATCHER. In addition to the programs identified in this appropriation, you are responsible, I believe, for the administration of the health underserved rural areas program. That is correct, isn't it?

Dr. MARTIN. Yes, sir.

Mr. NATCHER. How much money is available to you for the program in 1977?

Dr. MARTIN. This fiscal year it is $15 million for this fiscal year, sir.

Mr. NATCHER. Is this a matter of transfer of money as far as the $15 million is concerned?

Mr. LITTLE. It is a matter of accomplishing a reimbursable financial agreement with the Social and Rehabilitation Services. The basic agreement was reached last year by the Assistant Secretary for Health and the Administrator of the Social and Rehabilitation Service.

Mr. NATCHER. How do you plan on spending this money?

Dr. MARTIN. There are three kinds of program activities. The first involves the development of existing resources in rural areas building on the private practices, group practices, health departments, to develop an integrated system of care, to decrease duplication and improve the ability to reach the whole population.

A second major set of activities coordinates health care services with the title XIX activities.

A third set of the grant activities links the title V agencies with the title XIX activities in demonstration projects.

All of this shows that you can pull these activities within the State together in a functional way to serve more people.

Mr. NATCHER. In the health underserved rural areas program, how much is needed for the fiscal year 1978 to continue the projects and the program as you have it underway?

Dr. MARTIN. I think the Department's proposal is for continuation at the present level.

Mr. NATCHER. $15 million?

Mr. LITTLE. $15 million is the continuation costs in the budget.

Mr. NATCHER. Is this on a one-year basis of funding or how do you handle this?

Dr. MARTIN. It is a 1-year appropriation. It is a year-by-year activity.

Mr. KELSO. But I think he is asking how long the projects are.

Dr. MARTIN. The average projects have planned to complete their activities between 3 and 5 years. It normally takes some time to pull all these pieces together.

Mr. NATCHER. What have you learned from the various demonstration projects funded under the health underserved rural areas program?

Dr. MARTIN. I think some of the important things we have learned have to do with the best ways to attract physicians into these areas and with how to improve the working relationships between federally funded programs and private physicians in those areas.

In addition to that, it has demonstrated very clearly some good ways to get title V and title XIX projects to work together. We use what we are learning in the HURA activity across all of our programs.

Another very important thing has to do with the telecommunications area where there has been a lot of talk about what is the most effective way to communicate with health care providers in rural areas. Some have suggested satellites or TV. Some of the studies have demonstrated that the simple technology, telephones, and things like that, turn out to be the most efficient, as well as the most effective.

We are doing a considerable amount of work with nurse practitioners and physician's assistants through the program. The impact of that activity affects, of course, the vast numbers of programs in the rural areas.

We would be able to provide some specific, tangible examples of this research and how it has been applied.

Mr. NATCHER. Mr. Chairman, with your permission we would like to have pertinent parts of this material inserted in the record.

Mr. FLOOD. Without objection.

[The information follows:]

STATUS REPORT OF
HEALTH UNDERSERVED RURAL AREAS PROGRAM
JANUARY 1, 1977

Since the Health Underserved Rural Areas (HURA) Program is new, the projects funded by HURA have been in existence only a short time. In fact, of the 53 funded projects, only 17 have reached the stage of full operation, another 17 are partially operational and the balance are in the planning and organizational stage. Observations of these demonstration projects are preliminary and research relating to the Program is in the early stages.

While all HURA projects are research and demonstration projects, a subgroup of 15 has been selected for intensive study. The selection was based on the particular approach to health delivery and on the capacity of the projects to produce data required for the purposes of this study. A major objective of the research is to determine the effectiveness of various modes of practice and their applicability to similar rural settings in other areas. The findings of the study will be applied by the Public Health Service in the future development and operation of all rural primary health care projects.

The projects approved were selected on the basis of several considerations, such as: (1) the relative need for health services in the applicant's proposed service area; (2) the apparent ability of the applicant to organize, manage, and ultimately to independently finance the project; and (3) the type of delivery system proposed and what it would demonstrate as a prototype to be applied in similar rural situations as the Program develops.

The goal of the HURA Program is much broader than the development of a facility and staff to provide primary health care services. It envisages the organization and coordination of health services from a number of sources into a comprehensive health system. The focal point normally would be a primary care practice, with a complement of two or more physicians and support staff, a group practice where feasible. That practice, in turn, would develop satellite sites to extend services into remote areas, arrange for secondary care with local community hospitals, and with large urban hospitals where needed for highly specialized care. It would arrange, also, for care by specialists in the area. Included in the network would be nursing home care and home health care. There are many variations in the structure of HURA projects and it is not feasible to describe each project in detail in this report.

The most practical approach to bringing comprehensive health services to underserved rural areas is to utilize, to the extent possible, the health services now available in the area. The Program is working toward supplementing existing services and filling in missing elements of health care by linking them to others on a multiple community or regional basis, rather than by replacing or duplicating those already available. This is being done experimentally by the HURA Program by building its research and demonstration projects on the foundations of existing, self-supporting primary care providers, enabling existing providers to expand into areas not presently served. This policy permits maximum utilization of Program funds. Also, by building on successful models of existing health services delivery, HURA accomplishes a part of its goal of developing a comprehensive system utilizing the range of health services providers available in the area and expanding the capability of the most popular models in the private sector, such as group practices and hospitals to deliver health services. A side benefit resulting from this approach is that it is more acceptable to local physicians, who may well be a part of the Program, than a new free-standing health facility that might be considered competitive. It has the further benefit of making it easier to recruit physicians from outside the area since the concern about peer acceptance is removed.

While the majority of these projects have been operational for less than one year, some information is now available on efforts by the HURA Program to develop linkages and build systems of health care. We have found through the provision of technical assistance and general guidance, projects have been able to move toward the development of coordinated activities with other health care providers in the area. As a result of the activities that have been undertaken, 365 linkages with the 53 projects have been developed, including arrangements with 47 hospitals, 31 nursing homes, 30 home health agencies, 31 maternal and child health programs, 39 programs of Early and Periodic Screening, Diagnosis and Treatment, 26 cancer programs, 34 mental health programs, 29 alcoholism programs, 27 drug programs, 49 specialists, and 22 others. These arrangements enable the building of health care systems which we believe will bring better health care to the residents of rural communities and will better be able to attract and retain physicians and other health care providers in the area.

The National Health Service Corps is a key component of the Rural Health Initiative (RHI) and the HURA Program. A study of the NHSC shows that from an early retention rate of only 3 percent in 1973, the retention rate has increased to 38 percent in 1976 and is projected to increase to 43 percent in 1977 and 50 percent in 1980. While we recognize that a number of factors enter into this increased retention rate, it is our belief that the development of the health care system which provides peer contact and continuing education opportunities is among one of the major factors resulting in the ability to recruit and retain health care personnel in rural areas.

An area of research in which the HURA program is actively involved is the field of biomedical communications technology. Research previously conducted by the National Center for Health Services Research has indicated that the most practical and most cost effective system of telecommunications is that based on telephone-based technology to link a non-physician health care provider in a satellite clinic to a central source of medical expertise. See attachment for a listing of the projects utilizing telecommunications systems and the types being used.

BCHS staff and the staff from the National Center for Health Services Research are working together in a joint effort that will attempt to address some of the problems of isolated and sparsely populated areas.

A detailed analysis of nine HURA and seven RHI projects has been initiated. Each of the sites proposes to make use of one or more of the following: telecommunications (telephone, radio and television), transportation, and/or computer technology to support the delivery of health services and thereby improve health care access for residents of isolated and low density communities. A framework is being developed to compare costs of the various technologies, to assess the impact of improving access to care, and to determine the quality of services. Upon completion of the analysis, a summary of innovations and models that have potential for replication in other areas will be compiled.

In a related research effort, $100,000 in HURA funds have been awarded to two research grantees, the Rhode Island Health Department and the Lane County Health District. These funds will be used to develop a telehealth laboratory and to purchase and test various telephone end instruments that are commercially available and appear capable of being used in rural areas. These instruments include stethophone, electrocardiograph, facsimile, slow-scan television, and patient viewing microscope. Tests results will be analyzed and published and will serve to update portions of the National Center for Health Services Research Telehealth Handbook. Arrangements have been made for the National Center for Health Services Research to distribute copies of the Telehealth Handbook and subsequent test result findings to HURA grantees, other Public Health Service primary care sites, and to Regional Office Public Health Service staff.

SUMMARY OF INNOVATIONS IN TENTATIVELY SELECTED PROJECTS

	Mobile unit	New health practitioner	Telecommunications	Computers
REGION I				
1. Grand Isle (RHI)	X	X	X	
2. Rhode Island (HURA)	X		X	
REGION IV				
3. East Alabama (HURA)	X	X	X	X
4. Gateway (HURA)			X	
5. Hampton County (RHI)				X
REGION V				
6. London Mills (RHI)	X			
REGION VI				
7. Tucumcari (HURA)	X	X	X	
REGION VII				
8. Decatur County (HURA)	X	X	X	
9. Sandhills (RHI)			X	
REGION VIII				
10. Dove Creek (RHI)		X		
11. Mountain Plains out-reach program (HURA)			X	X
12. Unitah basin (HURA)		X		X
REGION IX				
13. Southern Arizona (RHI)	X			X
REGION X				
14. Lane County (HURA)		X	X	
15. Rural Healthmobile, Olympia (HURA)	X			
16. Tricounty (RHI)		X	X	
Total	8	8	10	5

Mr. FLOOD. Mr. Patten?

HMO

Mr. PATTEN. Who will speak up for the HMO's? They have been around a while. I have one in my area now. Have you lost any of the enthusiasm? Are they going to be as good as we thought?

[Discussion off the record?]

Mr. PATTEN. Some of my doctors are writing letters, kicking the HMO's around.

Mr. KELSO. As you know, the HMO is a demonstration program. We have been in the business for about 3 years or more. Although we have a level budget in fiscal year 1978, we are going to move ahead and fund 23 projects. We think the HMO concept has geat value and will be an alternative way to reduce costs and provide medical care.

Dr. ERICKSON. I would just add that this will fund the last 23 of 83 projects. We feel that it is a going program.

Mr. PATTEN. Has the opposition quieted down?

Mr. KELSO. I don't know about opposition.

Mr. PATTEN. It is only 4 years ago. Remember Mr. Casey sat here and Houston was up in arms against the program. He didn't want any money for HMO's, if I remember right.

Mr. KELSO. I think the HMO program has achieved considerable acceptance. We have some success stories which we could place in the record if you would like.

Mr. PATTEN. Everybody here is concerned about the little girls getting pregnant. What is new?

Mr. KELSO. I think the concern is that the problem is increasing.

Mr. PATTEN. I doubt it. Maybe it was just my area. I was mayor of a city in 1934. I had 200 born out of wedlock to some of the grammar school kids, 13, 14, and 15. There were 200. It used to be a problem trying to find a place to put them, the Salvation Army or a place the Catholics had up on the hill. But it was a problem. I couldn't get someone else.

We didn't have social workers like you have today. The mayor had to be the psychiatrist and HMO. I used to have to get into these things.

In the interest of economy, I have no further questions, Mr. Chairman.

CHC'S PHYSICIAN ENCOUNTER RATE

Mr. FLOOD. All right.

Doctor, last year if you will recall, we talked about improvements in productivity at the community health centers that we were talking about a few minutes ago. I think you told us the physician encounter rate was 2.7 encounters per hour.

Now what are you doing to bring that closer to the national average of 3.2 encounters an hour? By encounters I mean patients treated.

Mr. MARTIN. Mr. Chairman, since the original GAO report that indicated 1.7 encounters, we have gone from 1.7 to a level of a little above 2.7 over the last 3 years. We anticipate it will continue to increase to about 3.

I think one will also see concurrently with that increase that the private sector number will start to come down because of the nature of the new kinds of physicians. As the average visit time increases, I think they will come together.

If you look at annual physician productivity with comparably trained physicians, right now we are very close to that with community health centers.

FAMILY HEALTH CENTERS

Mr. FLOOD. You will recall a few years ago the committee provided funds to support family health centers. These were the prepaid health care programs. They emphasized primary and ambulatory care in the urban and rural underserved areas. Well, what has happened to these centers? We don't see any mention of it at all in this budget justification.

Dr. MARTIN. We now include the family health centers in the community health centers program. With the changes under section 330, which clarified the distinctions between the projects, they all have had to meet the same statutory requirement for the community health centers.

Those family health centers have become full-fledged community health centers and their performance level is very positive.

Mr. FLOOD. What have we learned from the experiments?

Dr. MARTIN. I think we learned that we needed a law for Health Maintenance Organizations. That was one of the results of that demonstration. We found prepaid systems a very effective way to deliver care to these populations.

Mr. FLOOD. Should we be spending more on family health centers? Are they a better mechanism than the community health centers?

Dr. MARTIN. I think that, with the changes in the laws and the direction of Congress as we perceive it, the support of that kind of activity is intended to be conducted through the HMO authority. And the intent for section 330, community health center funding is that it be used just for community health centers.

Mr. FLOOD. I think we had better have a report in more detail for the record which evaluates the effectiveness of the family health center program.

Dr. MARTIN. Yes, sir.

[The information follows:]

EFFECTIVENESS OF FAMILY HEALTH CENTERS

In 1971, attention was focused on the need to complement the services being provided by neighborhood health centers, primarily to low-income families in urban communities, with comparable services for the country's medically underserved rural population. The family health center (FHC) concept was developed as a potential means of meeting these needs. These centers were designed to provide a prescribed package of ambulatory health care benefits on a prepaid basis to an enrolled population residing in a defined area of medical underservice.

Funding for these centers under section 314(e) of the Public Health Service Act (PHS) first became available in fiscal year 1972. The Nurse Training and Health Revenue Sharing and Health Services Act of 1975 (P.L. 94–63) repealed section 314(e) of the PHS Act and added a new section 330 of title III, part C of that act, to provide Federal assistance for community health centers. The Congress used the term "community health center" purposely in lieu of neighborhood health center to make clear the intent of the Congress to include in this legislation (P.L. 94–63) family health centers and other similar entities funded previously under section 314(e) of the UHS Act. The authorizing legislation defines a community health center as a public or private nonprofit entity which provides (1) primary health services; (2) supplemental health services which are necessary for the adequate support of primary health services and appropriate to the particular center; (3) referral to providers of supplemental health services and payment, therefore, as appropriate and feasible for the center; (4) environmental health services, as may be appropriate to a particular center; and (5) information on the availability and proper use of health services to all residents of its catchment area.

A brief description of the status of former family health centers which are now included in the 512 community health centers to be supported by the Bureau of Community Health Services in 1978 are as follows:

THE STATUS OF FHC PROGRAM

	1973	1974	1975	1976
Number of projects	41	[1] 39	[2] 30	[2] 24
Accomplishments in terms of number of people served	NA	35,000	105,000	219,001

[1] 2 projects defunded in 1973.
[2] 9 projects in 1975 and 6 projects in 1976 were converted to NHC or merged with other community health center projects in the community.

ENROLLEES BY GROUP AND SOURCE OF PREMIUM PAYMENT AND NONENROLLEES AS OF SEPT. 30, 1976

	Total enrollees non-enrollees	Enrollees groups and source of premium						
		Total enrollees	Group I			Group II, paid by enrollee	Group III, paid on sliding scale by low-income enrollees	Non-enrollees
			Paid by medicare	Paid by medicaid	Paid by other 3d party			
Number	219,001	[1] 120,614	1,268	9,218	65,019	13,265	30,362	98,387
Percentage distribution	100	55.1	1.1	7.6	53.9	11.0	25.2	44.9

[1] Source of premium not reported in its entirety, consequently regional and U.S. totals do not check arithmetically

(D) Number of encounters by type for fiscal year 1976 including transition quarter, 1976:

Total encounters	764,786
Types of encounters:	
Medical	691,595
Dental	20,469
All other	52,722

INFANT MORTALITY RATES

Mr. FLOOD. Doctor, whenever you decide to initiate a new community health center or a new National Health Service Corps, whenever you select a site, do you give any top priority to those areas with a high infant mortality rate?

Mr. KELSO. Yes, sir.

Mr. FLOOD. Do you have any data you could give us on the impact that these programs have on the infant mortality rate in any community?

Dr. MARTIN. Yes, sir. Most of the new activities we are discussing have been initiated in the last 12 to 18 months.

However, we can provide information on some studies which have been done to look at infant mortality changes.

Mr. FLOOD. We would like to have that in the future. You can see why.

[The information follows:]

Studies on Infant Mortality Changes

Chabot, M.R. and Pratt, Margaret W. Improvements in Infant Mortality in the United States, 1965-1971. Maternal and Child Health Program of the University of California School of Public Health, Berkeley. Unpublished Manuscript, 1976.

"From 1965 to 1971 the infant mortality rate decreased at a rate of 4 percent per year in contrast to the 1 percent annual rate of decrease during 1950-1964. In 1965 the United States infant mortality rate was 24.7, and by 1971 had decreased to 19.1. The decline has been continuing, and provisional data for 1974 shows an infant mortality rate of 16.5, the lowest rate ever recorded in the United States. Thus, while between 1950-1964 infant mortality had decreased by 15.1 percent, it decreased by 22.7 percent between 1965-1971, and an additional 10.8 percent between 1972-1974. Similar rates of declines have occurred in both the neonatal and postneonatal components of mortality rates."

Kleinmen, J.D. et al. "Geographic Variations in Infant Mortality," Public Health Reports. 91 (September, 1976):423-432.

"A decrease in the infant mortality rate has taken place in the U.S. between periods 1961-65 and 1969-73. The decrease has not resulted in a homogenization of areal rates. Geographic variation in the period 1969-73 was as great as the period 1961-65 for the overall infant mortality rate. There was a decrease in variation for the postneonatal and fetal death rates and an increase for the neonatal.

Although the U.S. infant mortality rate has always been lower for white infants than for others, the gap has been narrowing in recent years. The differences, however, are still great as evidenced by the fact that the highest white infant mortality rates are still below the lowest nonwhite rates."

Brooks, Charles "Path Analysis of Socioeconomic Correlates of County Infant Mortality Rates," International Journal of Health Services. 5 (1975):499-514.

"Data examined clearly indicated that socioeconomic factors appreciably determine variations in county infant mortality, neonatal mortality, and post-neonatal mortality rates. Two variables in particular which significantly affect rates of infant loss in a county are percentage of blacks and of persons who have completed fewer than five years of school."

Dott, Andrew and Fort, Arthur T. "The Effect of Maternal Demographic Factors on Infant Mortality Rates: Summary of Findings of the Louisiana Infant Mortality Study, Part I, "American Journal of Obstetrics and Gynecology. 123 (1975): 847-853.

"From all recorded birth and infant death certificates for 1972 (69,556 birth and 1,541 death certificates) infant, neonatal and postneonatal mortality rates were computed for maternal demographic (intrinsic patient physical and life-style characteristics) factors including age, race, parity by age cohort, education, and legitimacy. Excessive infant deaths were found among illegitimate offspring, except in mothers less than 15 years of age or nonwhites over 35 years of age; the less educated; those having too many children too soon; and whites relying on charity hospitals. An increased mortality rate was seen with nonwhite and with younger and older mothers."

Dott, Andrew and Fort, Arthur T "The Effect of Availability and Utilization of Prenatal Care and Hospital Services on Infant Mortality Rates: Summary of Findings of the Louisiana Infant Mortality Study, Part II," American Journal of Obstetrics and Gynecology. 123 (1975): 854-860.

"... mortality rates were twice as great for infants born outside of hospital. With no prenatal care, the infant mortality rates were between four and ten fold greater than the rates of women receiving more than nine visits even when race, poverty, geography and birth weight were considered. Infant mortality rates were twice as high in the neonatal period and three times greater in the postneonatal period among the poor who utilized charity hospitals."

Pakter, Jean and Nelson, Freida "Factors in the Unprecedented Decline in Infant Mortality in New York City," Bulletin of New York Academy of Medicine. 50 (1974): 839-868.

"Infant mortality in New York City declined from 27.3 per 1,000 in 1962 to 20. 1 per 1,000 in 1972, a 26.3% decline with the most significant drop beginning in the second period and growing more marked in the third period to date.

... analysis revealed that favorable changes in birth patterns began in the second period and became accentuated in the third period. Among those changes recognized as favorable for viable births are:

1. A reduction in fertility rates in all ethnic groups;
2. A reduction in births to the very young and relatively older women;
3. A reduction in births to women of high parity;
4. A reduction in low-birth-weight births, especially the very small (1,500 grams or less);
5. A reduction in births to women of low socioeconomic groups and those on ADC rolls.

These changes have been coupled with noteworthy declines in mortality for all groups of babies, including those at high risk. Significant improvement in the mortality rates was evident for:

1. Low-birth-weight infants as well as normal-weight infants;
2. Infants born to very young or older and high parity mothers;
3. Babies born out of wedlock.

Despite these improvements in specific mortality rates, a disparity still exists in relative rates of mortality by ethnic groups, marital status, and weight categories. For example, the infant-mortality rate for out-of-wedlock births was still twice as high as for in-wedlock births."

TEENAGE PREGNANCY

Mr. FLOOD. Now you also propose here an increase of $10 million for the family planning program and you say specifically to intensify efforts to reduce the teenage pregnancies.

Mr. KELSO. Yes, sir.

Mr. FLOOD. All right.

Specifically how do you plan to carry out that effort?

Dr. MARTIN. The effort will be undertaken by a number of different components of the Department. I think we need to find out much more clearly what are the changes in behavior among young people and in their attitudes toward sexual activity and pregnancy.

There have been increases, significant increases in sexual activity by young women between 13 and 14 years old. There are increases in the actual birth rates for those two age groups.

There is a significant relationship between those young people having children and the incidence of children born with crippling and disabling diseases. Those have increased over the last 10 years.

The intent of the $14 million in community health centers and the $10 million in family planning is to increase the accessible services to this high-risk population so that they will be fully informed and better able to make informed decisions.

Mr. FLOOD. Will you be initiating new family planning projects or expanding the existing programs?

Dr. MARTIN. Both. We will be initiating some new activities in areas with large numbers of high-risk teenagers.

Mr. FLOOD. How are you going to go about identifying those areas of the country where you are going to have the greatest need for this additional family planning money?

Mr. MARTIN. The National Center for Health Statistics has done a careful study.

Mr. FLOOD. I don't think this problem of teenage pregnancy is evenly distributed. Of course, it might be.

Dr. MARTIN. No, sir, it is not. There are parts of the country with teenage fertility rate for 13 and 14 year olds that are two to three times the national average. The District of Columbia has an abortion rate of well over 86 per 1,000 teenagers.

With the data we get from birth certificates and with the information we have on abortion, we can make a good assessment of the location of the greatest problems.

Mr. FLOOD. That is the way you identify the area?

Dr. MARTIN. Yes, sir. We have identified the areas. We will be focusing on those areas.

Mr. PATTEN. I understand there is a big drop in the D.C. figures.

Dr. MARTIN. No, it has not dropped. It is continuing to rise.

FAMILY PLANNING

Mr. FLOOD. Last year you will recall we requested the Department to provide us with a table to show the amount spent by family planning by all the other agencies in HEW. Now if you take a look, that table appears on page 83 of our hearings.

When I compare that table with the one you have included in this year's budget justification, we notice there a considerable decrease in the amount of money being spent by the maternal and child health program for family planning.

Why is that? Are you deemphasizing the family planning services?

Dr. MARTIN. I think it is a combination of two factors. Where we use the title V family planning activity is in areas where we don't have more comprehensive capability. As we develop the comprehensive capability, those centers pick up the responsibility, and the categorical family planning centers are not needed.

I think probably even a better reason for that is that as our data improves, we learn that the original numbers might very well have been an error in the estimate. The number of people actually being served through title V has increased.

So if the dollars have decreased, it is because we are more cost effective.

Mr. FLOOD. If you take a look at page 83 of the hearings, there you see you have been consistent there, 94.5 and then maternal and child health, 43,600. You have been pretty consistent with that. Then all of a sudden there is this dramatic drop.

Why is that? That is why I am asking you. Are you deemphasizing family planning? What happened?

Mr. LITTLE. I think we ought to provide this for the record. I do know that we worked with the Office of Population Affairs in developing these estimates.

Mr. FLOOD. You can provide that for the record, but that stands out like a sore thumb.

Mr. LITTLE. I know about 1977. $28 million is identified because we were reducing our budget in 1977 below 1976.

Mr. FLOOD. Are you deemphasizing the family planning services?

Mr. KELSO. Clearly, no.

NATIONAL HEALTH SERVICE CORPS

Mr. FLOOD. You are asking for 975 field positions for the National Health Service Corps. We very seldom say anything like this around here. If this committee wanted to increase the number of field assignees, would you be able to recruit beyond 975?

Mr. KELSO. Yes, sir.

Mr. FLOOD. What evidence do you have to support anything like that?

Mr. KELSO. We believe that we could recruit more because of the recruitment plan that the Bureau of Community Health Services has developed. With the scholarship people graduating and with the projected retention rate, we believe that we can recruit beyond the 975 level.

Mr. FLOOD. For those reasons?

Mr. KELSO. Yes, sir.

Mr. FLOOD. Do you want to add to that?

Dr. MARTIN. In specific numbers, we anticipate 300 to 350 scholarship recipients coming on next year. The extension rate for professionals already assigned has risen to 40 percent. We anticipate that by

this August we shall have about 900 field assignees so that in 1978 we would be moving from a 900 base upward.

Mr. FLOOD. That budget justification you have in front of you there shows that you could use 4,250 National Health Service Corps assignees for the designated areas. How did you arrive at that number?

Dr. MARTIN. We took the number of areas that were designated as qualified for the National Health Service Corps and we made an estimate as to the number of people required to bring those communities to a reasonable level of care. That estimate is the present number of Corps assignees we project as being required.

Mr. FLOOD. Do this for the record. Show us the makeup of that 4,250 assignees, that is the number of people doctors, nurses, and so on.

[The information follows:]

NUMBER OF NHSC ASSIGNEES BY TYPE

Public Law 94-484 specifies the following distribution of health manpower scholarship awards beginning in fiscal year 1978: 81 percent medical or osteopathic, 9 percent dental and 10 percent nursing and other health professions students. Applying these percentages to the estimated 4,250 assignees required to man the 1,700 critical health manpower shortage areas identified in 1978 produces the following staffing ratio:

Type of assignee	*Number*
Medical or osteopathic	3,442
Dental	383
Nursing and other	425
Total	4,250

MIGRANT HEALTH

Mr. FLOOD. On migrant health you have a statement in your justification that you intend to implement programs to improve environmental sanitation for the migrant workers. Would you elaborate for us on what you plan to do in that area and tell us how much you intend to spend.

Dr. MARTIN. Yes, sir.

As a part of section 319 we have already negotiated contracts to work with four States to intensify environmental health activities. We have a cooperative agreement with the Environmental Protection Agency and we have trained 125 people in pesticides. We also have a contract concerning the quality of housing which will be awarded, and which will take a close look at environmental health. We further have supported environmental health activities by the health centers in their target areas. We are far more aggressive now in working with the States and Environmental Protection Agency to identify the needs than we have been in the past.

Mr. FLOOD. Here again we think you have a program that will contribute to your goal of improving child care. However, there is no budget increase proposed for this migrant program. Why is that?

Dr. MARTIN. Basically, it is a question of assessing the priorities and the availability of funds.

Mr. FLOOD. Do you have money in this budget to meet the continuation costs of the ongoing migrant programs?

Do you in this budget?

Dr. MARTIN. No.

Mr. FLOOD. Could some increase be possible at all due to this unionization process of the migrant workers resulting in health insurance coverage?

Dr. MARTIN. Yes, sir.

Part of the instructions for this budget request were prepared under the limitation that inflationary increases could not be included; however, the unionization of migrants and the increased hospital coverage could have an impact on the migrant and community health center budgets.

Mr. FLOOD. Doctor, you are requesting $5,862,000 for equipment. That is an increase of $789,000 over 1977. Why do you need this kind of increase?

Mr. KELSO. Is this in migrant health?

Mr. FLOOD. No, this is equipment.

Mr. LITTLE. We have a 274-position increase proposed for the National Health Service Corps. This money will largely be used to purchase the equipment for the National Health Service Corps assignees.

Mr. FLOOD. While we are on this subject of equipment, you requested about $5 million in the last 3 years. How did you use that money in 1978—$5 million for 3 years?

Dr. MARTIN. Each time we assign a new physician to an area there is some requirement for equipment.

Mr. FLOOD. If anyone takes a look at this budget one gets the impression after a record like that that you buy equipment, that you use it for a year and throw it away or you have it someplace to fall over.

Mr. LITTLE. Mr. Chairman, a large percentage of our equipment requirements are to keep the hospitals, the eight general Public Health Service hospitals and the 26 operating outpatient clinics, up to date. As you know, these hospitals have been around a long time. Basically the equipment requirements that we have in our budget are for those PHS hospitals and clinics: to update the equipment and to replace that which is worn out. In addition, we have equipment requirements in conjunction with placing these National Health Service Corps assignees in the field.

COMMUNITY HEALTH CENTERS

Mr. FLOOD. Mr. Obey.

Mr. OBEY. Thank you, Mr. Chairman.

First of all let me congratulate the administration for the support they have shown for these programs. I only have basically two questions because the questions I intended to ask, the chairman I understand has already asked. Frankly because I am skeptical about the responses to at least one of them, let me ask this again.

It is my understanding that before I came into the room you responded to the chairman that you felt that the budget level is sufficient to both provide for the 90 additional operations you are talking about plus meet inflationary costs for existing centers in the community health centers program; is that correct?

Dr. MARTIN. We testified that one of the budget assumptions is that there was no increase for inflation reflected in these requests. To the degree that there was inflation, we were to make it up with program efficiency improvements.

Mr. OBEY. You have not taken into account or added money to take care of any inflationary effect in those existing centers; is that correct?

Dr. MARTIN. No, sir.

Mr. OBEY. It is not correct?

Dr. MARTIN. You are correct.

Mr. LITTLE. Mr. Obey, as part of our initial development of the budget we were not allowed mandatory increases for cost inflation in any of our health service grant programs.

Mr. MILLER. Off the record.

[Discussion off the record.]

Dr. MARTIN. We can continue the centers.

Mr. OBEY. But you were not able to factor in any additional increment for existing centers for inflation?

Dr. MARTIN. No, sir.

Mr. OBEY. What is the approximate inflation rate for the kinds of materials and services provided and financed by the Feds under that program, do you know.

Dr. MARTIN. The national indicator for this set of services is between 10 and 11½ percent. For these actual centers because of continuing improvements in management, increased third party reimbursements in the aggregate, we actually experience a 5½ to 6 percent increase effectively each year.

Mr. OBEY. So you are saying you can make up about half the strain with your budget?

Dr. MARTIN. Yes, sir.

Mr. OBEY. If that is the case there should be about a 5-percent net reduction in actual services deliverable.

Mr. LITTLE. This budget does not project a reduction in services, Mr. Obey.

Mr. OBEY. How does that answer squares with his response?

Mr. LITTLE. Our budget includes an increase in the number of people who will be served. The degree to which——

Mr. OBEY. I am talking about present centers' present programs.

Mr. LITTLE. We are projecting the same number of people to be served in those centers——

Mr. OBEY. I must not be clicking very well this morning. If he said that the inflationary rate was 10 or 11 percent——

Mr. MICHEL. If you will yield—we are at a 4½ percent rate of inflation.

Mr. OBEY. You know that the inflationary area in this sector of the economy for these kinds of services is higher. That is what I am talking about. I am not talking about a national inflation rate because it is irrelevant in terms of specific programs.

I don't understand the disparity between your two responses, frankly.

Dr. MARTIN. The numbers of patients actually being seen are not going to be cut back.

Mr. OBEY. Forget the numbers. I don't care what measuring stick you are using. What you said earlier—correct me if I am wrong—was that the inflationary factor in this area of the economy was between 10 and 11 percent.

Dr. MARTIN. Yes, sir.

Mr. OBEY. And you thought that increased efficiency, management capability, productivity, you label it, would absorb half of that cost.

Dr. MARTIN. Yes, sir.

Mr. OBEY. Didn't you?

Dr. MARTIN. Yes, sir.

Mr. OBEY. If I understand what you are saying, you are saying, in fact, it is going to be half absorbed somewhere else?

Dr. MARTIN. Yes, sir.

Mr. OBEY. Let me just ask one other question: What is the budgeted amount which you would need to take care of that extra 5 percent?

Dr. MARTIN. We could do it within the present budget, but it would require decreasing the number of new starts from 90 to 15.

Mr. OBEY. I am saying if you want to keep your 90 programs and you wanted to make up that missing 5 percent—about what kind of dollars are we talking about?

Dr. MARTIN. We are talking about approximately $11 million.

Mr. OBEY. Just one other question.

Mr. MILLER. Could I then ask if you put the $11 million into covering the additional costs of your centers that are now in existance? How many new centers could you open?

Dr. MARTIN. About 25.

Mr. MILLER. Twenty-five new centers.

Dr. MARTIN. We could drop the projection of 90 new centers to 25.

Mr. MILLER. My question is: If you use the funds requested in the budget to cover all of the inflationary costs of your existing centers, how many new centers could you own? And the answer is 25?

Mr. OBEY. I am not arguing about the creation of the new. I am simply trying to figure out—I think it is fair to level with people and let them understand that you are expecting to eat some additional costs beyond the inflationary factor. I think that is going to be pretty tough because I am pretty impressed with the way some of these programs run.

You indicated that you expected to increase your third-party reimbursement by what?

Mr. KELSO. Thirty-one percent in 1977 to 36 percent in 1978.

Mr. OBEY. What did you increase it by this year?

Mr. LITTLE. From 29 percent in 1976 to 31 percent in 1977.

Mr. OBEY. What was your expectation in your budget presentation of last year's budget?

Mr. LITTLE. Significantly less than that.

Mr. OBEY. So you exceeded your expectations?

Mr. LITTLE. Yes sir.

I can give you the number if you would like.

Mr. OBEY. I would like it for the record.

[The information follows:]

In the 1977 budget for community health centers, third party reimbursements were projected at a level of 22 percent of total operating costs for 1976. In actuality, third party reimbursements were 29 percent of total operating costs in 1976. This increase was due primarily to improved project management.

The following table indicates the estimated total operating costs, and third party, State/local contributions and grant funds for community health centers:

	1976 estimate	1976 actual	1977 estimate	1978 estimate
A. Total 3rd-party reimbursements (ongoing CHC's)	$65, 428, 000	$93, 685, 000	$114, 509, 050	$156, 364, 207
Percent	(22)	(29)	(31)	(36)
B. Estimated support from other sources (State/local)	32, 000, 000	36, 949, 000	41, 759, 165	48, 760, 899
C. Grant funds	196, 648, 000	196, 648, 000	215, 148, 000	229, 148, 000
Total operating costs	294, 076, 000	327, 282, 000	371, 416, 215	434, 273, 106

Mr. OBEY. Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Michel.

IMPROVED PRODUCTIVITY IN COMMUNITY HEALTH CENTERS

Mr. MICHEL. On that last point there, you talked of increased productivity. Is there a tradeoff there, an offset?

Mr. Obey is concerned about the 10-percent rate of inflation and we are only cranking up 5. I don't buy the proposition that there is no possible way you are going to get increased productivity. We have to have it.

Dr. MARTIN. Last year, for example, there was no request for inflation and the entire impact was absorbed by improved management and increased productivity and third party reimbursements. The amount required for total center operations increased, but we cut the amount used for administrative costs during that period of time.

We anticipate that the centers will absorb the equivalent of $11 million or $12 million of the inflationary cost by making additional management improvements, therefore, using a 10-percent inflation factor, about $11 million of the $22 million total is required to be provided through additional funding to the centers. We are clearly anticipating that the remaining inflationary impact can be absorbed.

FAMILY PLANNING

Mr. MICHEL. Let me come back to family planning. Are you able to put together any estimates as to the number of pregnancies that do not take place because women have received family planning services?

Dr. MARTIN. Yes, sir. We can provide a careful look at this if one makes projections based upon the previous birth rates that occurred before there was substantial funding for family planning services and compares them with the actual rates over time. It is very important to point out that the use of contraceptives in family planning is a complex social, psychological, and cultural kind of concern. In a simplistic way there is a way to evaluate the change in the number of births, over the last 10 years.

[The information follows:]

LIVE BIRTHS, BIRTH RATES, AND FERTILITY RATES:

UNITED STATES, 1950, 1955, 1960, AND 1965-75[1/] [2/]

(Birth rates per 1,000 population in specified group. Fertility rates per 1,000 women aged 15-44 years in specified group)

Year	Live Births	Birth rate	Fertility rate
REGISTERED BIRTHS[3/]			
1975	3,144,198	14.8	66.7
1974	3,159,958	14.9	68.4
1973	3,136,965	14.9	69.2
1972	3,258,411	15.6	73.4
1971	3,555,970	17.2	81.8
1970	3,731,386	18.4	87.9
1969	3,600,206	17.8	86.5
1968	3,501,564	17.5	85.7
1967	3,520,959	17.8	87.6
1966	3,606,274	18.4	91.3
1965	3,760,358	19.4	96.6
1960	4,257,850	23.7	118.0
BIRTHS ADJUSTED FOR UNDER-REGISTRATION			
1955	4,097,000	25.0	118.3
1950	3,632,000	24.1	106.2

1/ Source: Advance Report Final Natality Statistics, 1975. From the National Center for Health Statistics (HRA) 77-1120, Vol. 25 No. 10, Supplement, December 30, 1976.

2/ Based on 50 percent sample of births 1960-1966 and 1968-1971, 20 to 50 percent sample of births in 1967, and 100 percent of births in selected States and 50 percent sample of births in all other States 1972-1975.

3/ Beginning 1970, excludes births to nonresidents of the United States.

Kelly, W. J. *A Cost-Effectiveness Study of Clinical Methods of Birth Control: With Special Reference to Puerto Rico.* Praeger Publishers. New York, Washington, London. 1972.

The author, an economist, derives an effectiveness measure for family planning programs based on the "success criterion" of number of birth prevented. Using actual data obtained at two clinics funded through the Puerto Rico Health Department Family Planning program, the author calculates the number of births prevented for patients receiving services at each clinic (3,769 and 3,570). Total program costs for one year are estimated to be $231,385.72. Using a value of $3,600 per birth (accepting calculation that each prevented is worth approximately 2.6 times per capita output, and applying that to the population and GNP data for Puerto Rico in the year of the study) net benefits are estimated to be $13.34 million and $12.62 million.

Thus, the cost/benefit ratio for the total program 1:112.

Of interest also are the findings that the costs per birth prevented, where abortion is the method used, are higher than where contraceptives are used.

Dr. MARTIN [continuing]. Whether family planning per se was the sole reason for that change is easily debated.

Mr. MICHEL. I appreciate that each of us would take a little different assessment probably of the impact, but give us several standards of what you consider the measurement there. We all know we have a declining birth rate and we have to attribute it to something.

Mr. MICHEL. Is there any way of estimating how many Federal dollars are being saved through reduced welfare and medicaid payments due to the family planning services provided?

Mr. LITTLE. There have been some studies made.

Mr. MICHEL. In other words, a reduction in the traditional welfare area and how that reflects itself in dollars and cents. Provide that, if you can.

[The information follows:]

Short-Term Costs and Benefits of United States Family Planning Programs

FREDERICK S. JAFFE

This paper presents a method for estimating the short-term costs and benefits of public family planning programs in the United States. The analysis proceeds from an attempt to estimate the number of births averted through the efforts of organized family planning programs in the United States between 1966 and 1971 to an assessment of the short-term government expenditures that would have been associated with these births. These savings are then compared to federal expenditures in the relevant years and benefit/cost ratios computed.

Organized family planning programs, supported in large part by government funds, assist low-income persons in the United States to secure the most effective medical methods of contraception and thus to improve their ability to avoid births they do not want. In addition to important health, social, and demographic benefits, the prevention of an unwanted birth has two major economic benefits: It avoids the cost of providing for an additional child in the family and it avoids the loss of income by the woman while she is pregnant and while she is rearing the child (or it may enable a woman to take a job to add to the family's income). These benefits accrue to both the individual and to society, and the corollary costs when a birth is not prevented are borne in part by the individual and in part by society in the form of government expenditures.

Long-Term versus Short-Term Benefit/Cost Analyses

Benefit/cost analyses have attempted to calculate the long-term benefits of family planning programs by estimating the number of births averted by the program, its costs, and the total expenditures necessary to raise a child until adulthood. These analyses yield a range of long-term benefit/cost ratios, depending on the assumptions employed by the particular investigator. Enke, for example, who focused primarily on family planning in developing countries, estimated a rate of return of about 100:1 (Enke, 1966). In 1967 Campbell (1968) calculated a benefit/cost ratio of 26:1 for a US family planning program serving low-income persons. In a recent study in Great Britain, Laing (1972) used a somewhat different approach and estimated benefit/cost ratios for the prevention of specific types of unwanted births: he calculated a ratio of 128:1 for an illegitimate child, 20:1 for a fourth child, and 22:1 for a fifth child.

Some economists have questioned long-term benefit/cost analyses that do not address the issue of the extent to which a child, during his productive years, pays back the cost of his birth and upbringing (Leibenstein, 1969). To evaluate this issue involves assessment of factors that are difficult to predict, such as the future impact of education and technological change on economic growth in general and, in the context of the US family planning program, on the economic prospects of individuals born today to low-income families.

One of the principal uses of benefit/cost analyses is to assist government officials in making decisions on resource allocation. From their vantage point, the issues surrounding long-term benefit/cost studies are not necessarily salient, however significant they may be from a scientific or philosophic point of view. Government decision-makers typically function in a limited time-frame bound, on the one side, by the length of terms of office, and on the other, by a planning process and methodology in which five years is considered the distant future. Under such conditions, it is difficult for decision-makers to give appropriate weight to the potential claims on public resources, or returns to public resources, that will result two decades in the future from government action or inaction now. Faced with more claims than can be met with the resources at his disposal, the typical official usually evaluates budgetary decisions in terms of their likely impact on government expenditures in the years immediately ahead.

The present analysis, therefore, seeks to answer more limited questions than are posed in long-term benefit/cost studies: Are there savings in government expenditures in Year 2 that can be attributed to federal family planning expenditures in Year 1? If there are savings, what is their likely range? The analysis concentrates on the short-term costs to government of unwanted births to women with low or marginal incomes, since 90 percent of those served by organized family planning programs in the United States are drawn from these socioeconomic groups (Jaffe, Dryfoos, and Corey, 1973). With available data it is possible to estimate the following costs:

- *Medical care* associated with pregnancy and birth (prenatal care, delivery, and postpartum care for the mother, and care of the infant for the first year of life). For low-income women, a significant part of these costs is currently borne by federal, state, and local government through Medicaid, special health projects, and tax-supported hospitals and health centers.
- *Public assistance* for children born to women already on public assistance.
- *Opportunity costs* of income lost to the mother due to the need to give up employment during pregnancy and the early child rearing period. These costs are reflected in reduced family income and may in turn generate increased government expenditures for additional social, health, and housing services.

These categories do not exhaust even the short-term costs associated with births; for example, they do not include the public assistance costs for women who would become assistance recipients as a result of the birth, or the costs for their children. Nor do they include such medium- and long-term costs as education, further dependency, housing, health, care of the mentally retarded, police, and other public services. Only some of the specified short-term costs, and the proportion of births with which each is associated, can be quantified

TABLE 1 Changes in average annual fertility rates by poverty status and race, 1960–1965 to 1966–1971

Poverty status group	Average annual fertility rates*						Change: 1966–1971 from 1960–1965					
	1960–1965			1966–1971			Total		White		Nonwhite	
	Total	White	Nonwhite	Total	White	Nonwhite	Number	Percent	Number	Percent	Number	Percent
Below 125 percent of poverty†	152.5	140.7	180.4	119.3	112.1	134.8	−33.2	−21.8	−28.6	−20.3	−45.6	−25.3
Above 125 percent of poverty†	98.1	97.2	108.5	79.5	77.6	98.6	−18.6	−19.0	−19.6	−20.2	− 9.9	− 9.1

*Births per thousand women aged 15–44.
†The federal poverty index is a schedule of income and family size thresholds, which are now adjusted annually in accordance with changes in the Consumer Price Index, below which individuals and families are classified as poor. (Bureau of the Census, 1969; Orshansky, 1965). In 1971, for example, the cutoff defining 125 percent of poverty for a nonfarm family of four was $5,141.
SOURCES: Data for 1960–1965 are from Campbell, 1968. Campbell's methodology was replicated for 1966–1970 in Jaffe, 1972. The present paper adds unpublished *Current Population Survey* data for 1971 to calculate average annual fertility rates for each poverty group from 1966 to 1971.

directly on the basis of available data; for others, data are presently unavailable and they will be omitted from the analysis. Because of these omissions, the overall estimate of short-term savings in government expenditures is believed to be understated.

Births Averted by US Family Planning Programs

There have been no systematic studies of the number of births that have been averted as a result of the rapid expansion of organized family planning programs serving low-income persons in the United States since the mid-1960s. In the absence of such studies, the probable number can be suggested by assembling data from other sources. The results, it should be emphasized, are intended to be illustrative and should not be regarded as definitive.

US fertility declined substantially during the last half of the 1960s. Analysis of data from the annual *Current Population Surveys* conducted by the Bureau of the Census shows that during this period, fertility declined more rapidly among poor and near-poor women than among those with incomes above the near-poverty level. From 1960–1965, women of childbearing age below the near-poverty level had an average of 153 births per thousand per year; from 1966 through 1971, they had an annual average of 119 births, a decline of more than 33 births per thousand, or 22 percent. Women above the near-poverty level had a decline of 19 births per thousand, or 19 percent (Table 1).

Fertility declines can be caused by changes in family size preferences and patterns of family formation, improved control of fertility, or some combination of these factors. It is difficult to evaluate the effects of each of these factors independent of the others. For the whole US population, a significant part of the decline in fertility during the last half of the 1960s has been attributed to the "modernization of contraceptive practice" marked by increased use of the most effective available methods—pills, intrauterine devices, and sterilization (Westoff, 1972).

The greater fertility decline among low-income women from 1966 to 1971 was accompanied by a substantial increase in the number of low-income persons served by organized family planning programs. The estimated number of new and continuing clients served by organized programs operated by government and private health agencies increased from about 450,000 in fiscal year 1965 to 2,612,000 in fiscal year 1972

TABLE 2 Estimated number of new and continuing clients in organized US family planning programs, FY 1965–FY 1972

Fiscal year	Estimated number (thousands)
1965	450
1966	540
1967	690
1968	863
1969	1,070
1970	1,410
1971	1,915
1972	2,612

SOURCE: For FY 1968–1972, see Jaffe, Dryfoos, and Corey, 1973; for FY 1965–1967, unpublished estimates.

(Table 2).[1] Of all persons served by these programs over the three years for which records are available (1969–1971), seven out of ten had incomes below the near-poverty level.

The increase in numbers of persons served is largely attributable to increased federal funding as a result of the 1967 amendments to the Social Security Act and the Economic Opportunity Act, and the adoption in 1970 of the Family Planning Services and Population Research Act. Between fiscal year (FY) 1965 and FY 1972, federal outlays for family planning services grew from less than $5 million to an estimated $147.7 million.

The main functions of these programs are to introduce effective contraception to low-income persons who previously practiced no form of family planning and to upgrade the practices of others by assisting them to substitute more effective contraceptive methods for the less effective methods they previously used. In 1971, 78 percent of all patients in organized programs chose pills and 13 percent chose IUDs (Jaffe, Dryfoos, and Corey, 1973). These are, of course, the two most effective nonpermanent contraceptive methods currently available, as the findings of the 1970 National Fertility Study on the use-effectiveness of different methods clearly show (Ryder, 1973).

It seems reasonable, therefore, to attribute at least part of the fertility decline in the group below the near-poverty level to the efforts of organized programs in extending effective contraception to low-income families. This fertility decline is a

[1] In the US government, fiscal years are from July 1 to June 30.

result both of the services the programs render directly and of their role in legitimizing the provision of medical contraception by other providers and the use of medical methods by low-income women. There is no way to determine precisely how much of this decline can be attributed to the impact of organized programs and how much to other factors.

An approximate assessment is possible, however, if we employ various ratios from other studies of woman-years of contraception per birth averted. Campbell (1968) suggested a conservative ratio of 10:1 for a US program serving low-income women. Laing (1972) noted that the range is between two woman-years of contraception (as reported in a small follow-up study) and 15 years for each birth prevented, and he decided to use a ratio of 7:1 in his study relating to Great Britain. In this analysis, we will use both ratios—10:1 and 7:1—to approximate the number of births averted as a result of the family planning program. The number of new and continuing clients reported by US family planning programs is not the exact equivalent of woman-years of contraception. It is, however, the only time-series data presently available and is close enough to the woman-years concept to be used for this analysis. Under these assumptions, the number of births averted during the 1966–1971 period ranges from 614,000 to 874,000.

Most of these averted births were concentrated in the last few years of the period, since the programs registered very sizable growth only after 1969, reaching an annual rate of increase of 38 percent in 1972. Statistics on persons served by organized programs are reported as of the end of each fiscal year (June 30). Because of the nine-month period of gestation, there is a time lag before the effect of the programs' services is reflected in terms of births. Assuming that clients are served at a uniform rate during the year, three-quarters of the births averted by women served by these programs during a fiscal year will be averted during the same calendar year and the balance during the next. Table 3 uses this assumption to distribute the estimates of births averted in calendar years 1966–1971 in accordance with the actual growth in number of persons served by the program. The number of births averted was small at the beginning of this period but reached an estimated 179,000–255,000 during 1971.

It is important to point out that the above estimates may understate the impact of organized family planning programs in the United States on the fertility of low-income women. Although some low-income persons secure effective family planning services from private physicians, there is considerable research showing the limited extent to which they are able to secure preventive health services of any kind in the private sector (Yerby, 1965). The establishment of organized programs designed to remedy this deficit in regard to family planning care is one of the principal changes during the period under study in the immediate conditions influencing fertility among low-income persons. It is quite possible, therefore, that the program has assisted low-income women to avoid more births than the estimates indicate.

TABLE 3 Two estimates of number of births averted by organized US family planning programs, 1966–1971 (thousands)

Calendar year	*One birth averted per 10 woman-years*	*One birth averted per 7 woman-years*
1966	52	74
1967	66	93
1968	82	117
1969	102	146
1970	133	189
1971	179	255
Total	614	874

Short-Term Costs Saved by Averting Unwanted Births

Medical Costs

The medical services directly associated with childbirth are those related to maternity and to care of the newborn during the first year; in addition to normal pregnancies and the sick- and well-baby care of normal infants, the services required include the care of complications associated with pregnancy, of fetal loss, and of premature infants and those with congenital abnormalities. Estimates of the proportion of births that are premature or have other complications and of the current costs of maternity and pediatric care are derived from the most recent national data reported by the National Center for Health Statistics, the American Hospital Association, the American Medical Association, the American College of Obstetricians and Gynecologists, Blue Cross, and the Commission on Professional and Hospital Activities, complemented by local data obtained in an intensive study of a large metropolitan area in the South.[†] The available data are not ideal for purposes of this analysis for several reasons. They cover different reporting periods and they do not clearly delineate costs to government as distinguished from third-party payors or the individuals themselves. Despite these limitations, however, the resulting figures are believed to represent approximately the cost of delivery and infant care in 1970–1972.

Since nearly 99 percent of US babies are born in hospitals (US Bureau of the Census, 1972), the small percentage of deliveries occurring outside of hospitals are ignored in the estimate and the costs are computed based on the average length of stay for mother and child reported by various sources. Two-thirds of births to low-income mothers are assumed to occur in city or county hospitals, and the cost factors appropriate to these hospitals are applied. The remaining one-third are assumed to occur in voluntary hospitals, based on the Department of Health, Education and Welfare's estimate (1970, p. 10) that Medicaid covered service for about one-third of low-income persons in 1969. For each normal delivery, the estimate includes charges for hospitalization of both mother and infant, services of the attending physician or resident, and anesthesia. Additional charges are estimated for the 5 percent of births delivered by Caesarean section, for complications of

[†] For the basic methodology employed, see Muller and Jaffe, 1972; additional national cost information was obtained by Dr. Muller during 1972 as part of a continuing research project supported by the Ford and Rockefeller Foundations Program In Support of Social Science and Legal Research on Population Policy. Comparable local cost information is from Muller et al., 1973. The cost data presented in this paper are revisions of the first estimates, based on later and more complete information secured during 1972 from these sources and on the relationship between medical prices in Jacksonville and in the United States. The prematurity rate is derived from National Center for Health Statistics, 1972. The rates of hospital admissions of infants for acute illness and for abnormalities are derived from special tabulations of the NCHS Hospital Discharge Survey. The rate for Caesarean births is derived from the American College of Obstetricians and Gynecologists, 1971.

TABLE 4 Estimated medical costs of maternity care for low-income women and pediatric care during infant's first year, 1970–1971

Component of care	City and county hospitals (⅔ total)		Voluntary hospitals financed by Medicaid (⅓ total)	
	Cost	Per birth	Cost	Per birth
I. Maternity				
A. Normal delivery				
1. Hospital (including nursery charge)	$451		$451	
2. Physician	96		320	
3. Anesthesia	9		27	
Total	556	$556.00	798	$798.00
B. Increment for Caesarean section (5% of births)				
1. Hospital (6 days)	418		418	
2. Physician	32		106	
3. Anesthesia	28		93	
4. Attending pediatrician	21		53	
Total	499	24.95	670	33.50
C. Increment for complications (17 days @ $80 per 100 deliveries), hospital		14.47		14.47
Maternity total per birth		595.42		845.97
II. Pediatric care				
A. Ambulatory care	149		149	
1. Less deduction for sub-standard care	75		75	
Total	74	74.00	74	74.00
B. Prematurity (8.9% of births)				
1. Hospital (16 days)	645		689	
2. Physician	40		101	
Total	685	60.97	790	70.31
C. Admissions for acute illness (15% of births)*				
1. Hospital	734		539	
2. Physician	43		106	
Total	777	116.55	645	96.75
D. Congenital anomalies (1% of births)				
1. Hospital (5 days)	205		249	
2. Physician	255		638	
3. Anesthesia	47		117	
Total	507	5.07	1,004	10.04
Pediatric total per birth		256.59		251.10
III. Fetal losses (17.4% of births)	213	37.06	213	37.06
Grand total per birth		889.07		1,134.13
Weighted average total cost per birth	$970.76			

*Figures for acute illness costs are based on experience in public and private hospitals in Jacksonville, Florida. Public hospital charges exceeded those in private hospitals as a result of the greater severity of illness in admitted cases. The physician charge is estimated on the basis of an 8-day stay for all cases.

delivery, and for medical care of miscarriage and fetal loss.[3] Pediatric care for normal infants is first estimated on the basis of a standard nine well-child visits, plus immunizations, during the infant's first year, and then reduced by one-half on the assumption that the care of low-income infants does not typically meet this standard. In addition to the care of normal infants, estimates are computed for the proportion of births that are premature (based on the finding that 8.9 percent of births to women with family incomes below $5,000 were premature in 1964–66), for the 1 percent that have congenital abnormalities, and for the 15 percent of infants who suffer acute illness during the first year and require hospitalization.[4]

Each of the component costs, based on recent institutional charges, fees, and average length of hospitalization, is set forth in Table 4. The weighted average total cost for maternity and pediatric care of a child born to a low-income woman in 1970–1971 is estimated at $971.

Not all of these costs are borne by government; some are paid by the individuals themselves or through health insurance. There is only fragmentary information available on the share of these costs that is borne by government. From data published by the Social Security Administration for 1970–1971, it is possible to isolate those government expenditures for hospital care that may be applicable to maternity and pediatric care (Rice and Cooper, 1972, Table 3). Of the total of $14.8 billion spent by government in 1970–1971 for hospital care, $8.2 billion was allocated through programs that do not generally include maternity and pediatric care (such as Medicare, Veterans Administration, vocational rehabilitation, and workmen's compensation). The remaining programs—public assistance vendor payments, general hospital and medical care, and maternal and child health—spent $6.6 billion, which

[3] Fetal loss is estimated at 17.4 percent of births, based on Shapiro et al., 1971, p. 55.

[4] The estimate omits the medical costs for institutional and home care of mentally retarded infants. The estimate of 1 percent with congenital abnormalities is a national proportion for births in all socioeconomic groups. A greater proportion of low-income births have congenital abnormalities. Use of the overall national proportion will tend to understate the costs of this component of care—and the savings as a result of births averted.

TABLE 5 Approximation of government's share of hospital maternity and pediatric costs, 1970–1971

Item	*Cost ($ millions)*
1. Total public expenditures for hospital care	$14,756.8
a. Less: Programs not applicable to maternity care and pediatric care (e.g., Medicare, Workmen's Compensation, VA vocational rehabilitation, etc.)	8,212.9
b. Remainder: Programs applicable to maternity and pediatric care (public assistance vendor payments, general hospital and medical care, maternal and child health)	6,543.9
2. Maternity admissions as percent of all hospital admissions	11.6%
3. Estimated cost to government of maternity admissions (lb × 2)	759.1
4. Estimated total cost of hospital maternity and pediatric care for low-income births (weighted average cost of $701.66 per birth computed from Table 4 for 1,735,000 births to women of low or marginal income)	1,217.4
5. Government's share of total hospital cost (3 ÷ 4)	62.3%

SOURCES: 1. Derived from Rice and Cooper, 1972, Table 3, p. 9. 2. American Hospital Association, 1972.

constituted the maximum total government expenditure that could be applicable to maternity and pediatric care. American Hospital Association statistics show that maternity admissions constitute 11.6 percent of all hospital admissions. Applying this proportion to the total of $6.6 billion yields a gross approximation of $759 million as the amount that federal, state, and local government could have expended for maternity services in 1970–1971. Women in families with incomes below twice the poverty level (who include, most, if not all, potential recipients of subsidized care) had about 1,735,000 births a year during this period with a weighted average hospital cost of about $702 per birth; the total expended was thus approximately $1,217.4 million. Crudely estimated, the government's share is about 62 percent (Table 5).

The data available with which to estimate the government's share of the costs of physicians' services for maternity and pediatric care are even less satisfactory. Of the total of $14.2 billion expended in the United States on all physicians' services in 1970–1971, $3.5 billion, or 25 percent, was expended by government (Rice and Cooper, 1972, Table 2). The weighted average cost per birth of physicians' services for maternity and pediatric care shown in Table 4 is $268; if the government's share of these costs follows the overall national pattern, 25 percent, or $67 per birth, would be public expenditure.

A conservative estimate of the average government expenditure for medical care associated with a low-income birth, then, would consist of 62 percent of the average hospital cost per birth ($437) plus 25 percent of the average physicians' cost ($67). The total estimated government expenditure of $504 constitutes about one-half of the total average cost of $971.

Public Assistance Costs

The estimated average national cost of cash assistance, social services, food stamps, and administrative costs per public assistance recipient is $798.77 per year (Table 6). Of all patients enrolled in organized family planning programs in 1971, 16 percent were recipients of public assistance (Jaffe, Dryfoos, and Corey, 1973). It seems reasonable to assume, therefore, that at least 16 percent of the births averted by organized family planning programs would have been to recipients of public assistance. This undoubtedly underestimates the total public assistance costs associated with births averted through such programs since it ignores those births that would have resulted in their families becoming assistance recipients and the ensuing costs to government for both mother and child in these families.

If at least 16 percent of the unwanted births averted would have been public assistance recipients, the minimum costs of public assistance per 100 births averted would have been $12,780 per year (16 × $798.77), or an average of $127.80 per year per birth averted.

Opportunity Costs

In addition to the costs of medical care and public assistance, there are short-term costs associated with the mother's loss of earnings as a result of the pregnancy. Data on the age composition of persons served by family planning programs permit these opportunity costs to be estimated, based on *Current Population Survey* findings on the labor force participation rates and earnings of women in different age groups. The calculation is presented in Table 7, which shows that nearly one-half of the clients of organized family planning programs are likely to be employed. Since 90 percent of clients have low or marginal incomes, it is assumed that they work in the lower-paying jobs—clerical, sales, private household service, and other service positions—and the calculation employs the applicable mean earnings and rates of full-time and part-time employment for each job classification. Based on these assumptions, it appears that each birth represents an opportunity cost in the year of the pregnancy alone of about $1,044 in lost earnings.

There are no data available to determine how much of these opportunity costs are borne by government in the form of increased expenditures for public assistance, day care, social, health, and housing services, and how much are borne by the individual and her family. If only one-half were a charge to government it would add more than $500 to the savings attributable to each averted birth.

Since we do not have data with which to make an estimate of the cost to government, the opportunity cost represented by lost earnings will be excluded from this analysis. This

TABLE 6 Estimated annual public assistance costs per AFDC recipient

Item	*Cost*
Average annual payment per AFDC recipient[a]	$625.92
Average expenditure for social services per recipient[b]	18.65
Average administrative cost per recipient[c]	63.00
Total per recipient	707.57
Average cost of food stamps per recipient[d]	91.20
Total average annual cost per recipient	$798.77

SOURCES: [a]Department of Health, Education and Welfare, 1972, Table 7; [b] derived from Senate Committee on Finance, 1970, p. 107; [c] derived from House Committee on Appropriations, 1972, p. 315; [d] derived from Department of Agriculture, 1971, p. 1.

TABLE 7 Estimate of opportunity costs to women per 100,000 births averted by organized US family planning programs, 1971

I. Employment status of family planning program clients by age group

Age	Total number enrolled[a]	Percent employed[b]	Number employed
19 and under	27,000	39.3	10,611
20–24	38,000	56.1	21,318
25–34	27,100	45.8	12,411
35–44	7,900	51.5	4,069
Total	100,000		48,409

II. Earnings[c]

Type of job	Full-time workers[b]			Part-time workers[b]		
	Number employed	Number	Earnings ($ thousands)	Number	Earnings ($ thousands)	Total earnings ($ thousands)
Clerical	12,102	8,096	$41,605	4,006	$9,226	$50,831
Sales	12,102	6,208	31,903	5,894	13,574	45,477
Private household service	12,102	5,228	7,633	6,874	3,822	11,455
Other service	12,102	6,099	21,493	6,003	9,977	31,470
Total	48,408	25,631	$102,634	22,777	$36,599	$139,233

III. Earnings loss

$$\text{Full year loss} = \frac{\$139,233,000}{2} = \$69,616,500$$

$$\text{Half year loss} = \frac{\$69,616,500}{2} = \$34,808,250$$

Total earnings loss per 100,000 births = $104,424,750

Earnings loss per birth = $ 1,044

SOURCES: [a]Based on age composition reported in National Center for Health Statistics, Department of Health, Education and Welfare, National Family Planning Reporting System, 1971; [b]derived from Bureau of the Census, *Current Population Survey*, March 1971, unpublished data; [c]assuming one-half would lose earnings full year and one-half for six months and employed clients are distributed equally between clerical, sales, private household service, and other service jobs.

exclusion, like the earlier ones, understates the short-term savings to government as a result of births averted through the federal family planning program.

Summary of Savings, 1966–1971

For purposes of this analysis, then, the minimum short-term savings in government expenditures will be calculated to include only $504 per birth averted for costs of medical maternity and pediatric care and $128 per birth averted in public assistance, with no savings attributed to loss of earnings during pregnancy and the early child rearing period.

The total saving of $632 per birth, which represents costs during 1970 and 1971, is reduced for the years 1966 through 1969 in accordance with changes in the Consumer Price Index for those years. The order of magnitude of the short-term savings in government expenditures as a result of the organized family planning program can be estimated by applying these savings to the estimated number of births averted (Table 8).

Federal Expenditures for Family Planning Services and Benefit/Cost Ratios

To estimate the benefit/cost ratios for these short-term savings, it is necessary to determine the level of federal expenditures applicable to each year's savings. Federal funds for family planning service projects have typically been awarded in the last quarter of one fiscal year to be used in the following fiscal year. The time lag between a grant award, delivery of family planning services, and a birth averted is therefore at least nine months. Funds awarded at the end of FY 1970 (May–June 1970), for example, were used for services between July 1970 and June 1971; their impact in terms of births averted began to be reflected only in March 1971 and continued throughout calendar year 1971 and into the first quarter of calendar year 1972. The appropriate relationship, therefore, is between FY 1970 grants and calendar year 1971 births averted. The benefit/cost ratios for federal family planning expenditures, based on this time lag, are shown in Table 9.

For the four-year period from FY 1967 through FY 1970, the federal government estimated that it spent $174 million for family planning services. The aggregate savings to government in medical care and public assistance costs in each single year following these expenditures are estimated to range from $368 to $524 million, for an overall short-term benefit/cost ratio between 1.8:1 and 2.5:1.[5]

[5] These benefit/cost ratios apply to the federal investment in organized family planning services, not to total public and private expenditures for these services. Federal outlays since 1967 have both financed the cost of services directly and stimulated investment of other funds in family planning by state and local government, private philanthropy, and in some cases, partial fees paid by patients. Systematic data are unavailable on the extent of financing through these nonfederal sources; a reasonable guess would be that nonfederal funds amounted to 20–25 percent of the federal investment. The addition of these nonfederal funds on the cost side would reduce somewhat the ratios of return presented here.

TABLE 8 Two estimates of savings in short-term government expenditures for medical care and public assistance as a result of births averted by US organized family planning programs, 1966–1971

Calendar year	*Births averted using ratio of 10:1 (thousands)*	*Estimated savings ($ thousands)*	*Births averted using ratio of 7:1 (thousands)*	*Estimated savings ($ thousands)*
1966	52	$27,474	74	$39,098
1967	66	35,872	93	50,547
1968	82	46,434	117	66,254
1969	102	60,854	146	87,105
1970	133	84,056	189	119,448
1971	179	113,128	255	161,160
Total	614	$367,818	874	$523,612

NOTE: The computation assumes that savings are proportional to births in the absence of any information on economies or diseconomies of scale or of utilization of a fixed capacity for services. The savings per birth averted is estimated at $632 for 1970 and 1971; for 1966 through 1969, this estimate has been reduced in accordance with changes in the Consumer Price Index for those years (*Statistical Abstract of the United States*, 1971, p. 339).

TABLE 9 Short-term benefit/cost ratios of federal family planning expenditures, FY 1967–1970

Fiscal year of expenditure	*Estimated expenditure for family planning ($ millions)**	*Calendar year when births were averted*	*Benefit/cost ratio based on*	
			One birth averted per 10 woman-years	*One birth averted per 7 woman-years*
1967	$18.1	1968	2.6:1	3.7:1
1968	25.2	1969	2.4:1	3.5:1
1969	60.6	1970	1.4:1	2.0:1
1970	70.0	1971	1.6:1	2.3:1
Total	$173.9		1.8:1	2.5:1

*Derived from *Special Analyses, Budget of the United States* for FY 1969 and 1972.

Conclusion

A method of calculating the short-term savings in government expenditures as a result of the funding of US family planning programs has been presented. There are a number of reasons to believe that the benefit/cost ratios derived understate the actual savings in government expenditures. In addition to the possible underestimate of births averted already noted, the analysis may understate the true situation because:

- It does not include as savings the short-term costs to government that result from lost earnings to women who have to give up their jobs during pregnancy and the early child rearing period.
- It does not attempt to estimate the number of families who become public assistance recipients as a result of the birth of a child and the ensuing short-term costs to government.
- It exludes entirely the medium- and long-term costs to government of raising a child—the cumulative costs of education, housing, health services, care of the mentally retarded, public assistance, and other public services after the child is two years old.

Even in this limited framework, however, it is clear that the short-term benefits of family planning to public funds alone are high, without taking into consideration the economic, social, and personal benefits to the individuals and families themselves. There are few public programs in the United States—and possibly none—that have the potential of saving a minimum of two dollars in government expenditures in Year 2 for every dollar expended in Year 1. It is noteworthy that the bulk of these savings derive from the costs of medical care associated with pregnancy; only about one-fifth derive from the cost of public assistance.

These savings are in addition to the long-term savings, and the health, social, and demographic benefits to government and individuals, from the prevention of unwanted births. The government resources saved as a result of family planning programs would in principle be freed to finance other urgent health and social needs in the year following the program expenditure.

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Mr. MICHEL. What mechanism is there to insure that those family services go principally or solely, which I would prefer, to the poor as distinguished from being spread across the economic spectrum?

My view is as we get better educated and know what causes this thing, for those who are able to pay, this should be necessary cost, and the real money ought to go to the indigent who just can't afford it, period. What assurance do we have that we are really targeting in on that?

Dr. MARTIN. The assurance is in the way we allocate the money and make the awards based on the number of women in need below 150 percent of poverty whom the projects have to report on the number of women in the category can show they serve. Therefore, both at the regional and at the central office level, the size of a grant isn't based just on what they got the year before; it is based on overall performance, including the number of people being served from the high risk population. Presently we are projecting for 1977 that at least 79 percent of the women being served are below 150 percent of poverty and that 86 percent are below 200 percent of poverty.

Further, the system by which the dollars are distributed clearly uses only high risk persons in determining who get the funds. We care a lot less about how many total users we have in a family planing center than about the number of them who are at or below 150 percent of poverty. We get a lot of inquiries from Congress on that because the law speaks clearly to the priority.

INFANT MORTALITY

Mr. MICHEL. I am going to submit some questions for the record, but one more here if I might. On our infant mortality rate, what are the causes of death for infant mortality?

How many children would be normal children if they lived? Is it because of malnutrition, drugs, deformity? How does that break down?

Dr. MARTIN. We would be pleased to provide a careful look at that. Basically, if one looks at our mortality rate in this country somewhere between 9 to 10 per 100,000 are the congenital deaths; a considerable number of anomalies are in infants who wouldn't survive under any circumstances. The remainder are potentially preventable deaths, most of whom could survive. The problem with infant mortality in this country is not so much the overall rate of 16.7 for the Nation as it is that there are huge disparities between different parts of the country, In some areas, we have rates of 34 to 35. By definition, 16 of those are preventable by simply good prenatal care and care of newborn infants. The important question on infant mortality is not how to get the Nation from 16 to 12, but how to get particular sections from 32 down to 14.

Mr. MICHEL. Feel free to expand in the record.

Dr. MARTIN. We will be pleased to provide that.

[The information follows:]

Deaths under 1 year—1975 [1]

Rank order and cause of death:	Number
1—Certain causes of mortality in early infancy	26,585
2—Congenital anomalies	8,582
3—Symptoms and ill defined conditions	5,121
4—Immaturity, unqualified	4,398
5—Asphyxia of newborn, unspecified	4,051
6—Hyaline membrane disease	3,920
7—Respiratory distress syndrome	3,878
8—All other complications of pregnancy and childbirth	3,096
9—Congenital anomalies of heart	3,011
10—Influenza and pneumonia	2,201

[1] Data extracted from "Advance Report—Final Morality Statistics, 1975" from NCHS—Feb. 11, 1977.

Mr. MICHEL. We will recess until 2.

AFTERNOON SESSION

PHS HOSPITALS AND CLINICS

Mr. FLOOD. We will continue with the Health Services Administration.

Doctor, this budget increase is $4,369,000 for the Public Health Service hospitals and clinics. Why do you need this big increase?

Mr. KELSO. Mr. Chairman, we need that money to keep the hospitals operating at a level consistent with the level of services on January 1, 1973, which is required by law.

Mr. FLOOD. You propose a certain level. Will this level that you propose in the budget continue operations of a hospital system now as you indicate in accordance with the mandate—and it is a mandate—of section 818 of Public Law 93–155?

Mr. KELSO. Yes, sir, it will keep operations going in accordance with that mandate in 1978.

Mr. FLOOD. We have heard from a number of sources that additional funds are needed to comply with Public Law 93–155. I want to be sure that I understand you correctly. What you are telling us is the budget of $135.5 million is sufficient for you to provide the same patient services now in 1978 that you provided on January 1, 1973?

Mr. KELSO. Yes, sir, that is the purpose of this budget.

Mr. FLOOD. And the law requires it to be maintained at that level?

Mr. KELSO. Yes, sir.

SERVICES PROVIDED TO THE COAST GUARD

Mr. FLOOD. How closely do you work with the Coast Guard in all of this? That is one of the primary users of your hospital service.

Mr. KELSO. Very closely.

Dr. ERICKSON. We work very closely with the Coast Guard and they continue to be one of our primary beneficiary groups. As you know, we have officers detailed to the Coast Guard to operate in-house Coast Guard service as well.

Mr. FLOOD. They tell us that they intend to reduce their use of your hospitals and that they are asking for additional funds from the

Transportation Subcommittee in order to shift to VA and to the DOD hospitals. If that is so, did you take that into consideration?

Dr. ERICKSON. I am not aware of this.

Mr. LITTLE. Mr. Chairman, this budget includes funds within the $135 million that we are requesting to provide care to Coast Guard personnel in our hospitals and clinics. In addition, we have a reimbursement agreement with the Coast Guard to staff outpatient facilities at their shore stations. However, there are no funds requested in our budget to provide care for Coast Guard personnel at DOD, VA, or other non-PHS facilities. These funds are requested in the Department of Transportation budget.

Mr. FLOOD. I know that. But if the Coast Guard is not going to use you, you have this question of reimbursement.

Mr. LITTLE. We have projected that they will use us.

Dr. ERICKSON. We do not have any knowledge that they are not going to use us as they have.

Mr. FLOOD. You don't know about the impact this is going to have on your hospital?

Mr. KELSO. No, sir.

Mr. LITTLE. Our projection included in the budget is that in 1977 we will provide an average daily patient load to the Coast Guard of 91 compared to 88 in 1976.

Mr. FLOOD. I know about that. I am asking you, do you know?

Mr. MILLER. We should extend the record.

Mr. FLOOD. For the record you better find out and clarify and extend.

Mr. KELSO. We shall.

[The information follows:]

COAST GUARD MEDICAL SERVICES

After further review with the Office of the Chief Medical Officer of the Coast Guard, we find that the Coast Guard is requesting $700,000 to cover in-patient costs for Coast Guard personnel located in the midsection of the United States where the Public Health Service has no hospitals.

The Coast Guard has estimated an average daily patient load of 11 from this area to be admitted into Department of Defense hospitals, (e.g., U.S. Naval Hospital, Great Lakes, Ill.; and the U.S. Air Force Hospital, Scott Air Force Base, Ill.) An additional $200,000 is being requested by the Coast Guard for Alaska-based personnel, where again, the Public Health Service has no hospital.

It is not expected that the Coast Guard request will have any impact on the Public Health Service hospital system or budget. We will continue to admit Coast Guard personnel as necessary from coastal and near-coastal areas, as we have been doing in the past.

PHS HOSPITALS—MODERNIZATION AND RENOVATION

Mr. FLOOD. At the request of this committee HEW prepared a master plan for modernization and renovation of the hospitals. I think the estimated cost was $120 million. That being so, why isn't there a budget request for this $120 million or even part of it?

Mr. KELSO. Mr. Chairman, the reason for that is because we will operate the hospitals at the 1973 level through 1978. Prior to fiscal 1979 however, the Department will be reexamining the PHS hospital program.

Mr. FLOOD. Who will resume this issue?

Mr. KELSO. HEW. There was reluctance to launch a facilities program until a final decision had been on the future of the hospitals.

Mr. FLOOD. Have any of your hospitals lost accreditation due to the condition of facilities?

Mr. KELSO. Technically, no.

Dr. ERICKSON. There is no loss of accreditation to date. We have not lost any as of today.

Mr. FLOOD. What about tomorrow?

Dr. ERICKSON. The only hospital where we feel there is a possibility of losing accreditation is the Galveston hospital situation.

Mr. FLOOD. That is what I thought you would say. Is that in jeopardy?

Dr. ERICKSON. Yes; I would have to say it is in jeopardy on an environmental basis.

HEMOPHILIA

Mr. FLOOD. Last year, Doctor, this committee agreed to reprogram $500,000 of hemophilia money to support a study of the various aspects of the blood supply, blood distribution, demand, and so on. What is the status of that study? Do you have anything to report on that?

Dr. MARTIN. The study was a joint one with the National Institutes of Health. The due date for the study to be forwarded to the Department is the 15th of April. It is a fairly careful and thoughtful report. We have seen drafts of it.

Mr. FLOOD. The committee would like a copy of that.

Dr. MARTIN. Yes, sir.

[CLERK'S NOTE.—Report not completed at time of printing.]

Mr. FLOOD. With reference to hemophilia, we have heard criticism about the hemophilia program. Specifically, we are being told from time to time that the program as administered by your agency is not designed to help bring down the cost of treatment to the hemophilia patient. What are you doing, if anything, to reduce this high cost of treatment?

Dr. MARTIN. The statutory authority, sir, for this particular program is to support specific centers to enable them to develop the capacity to provide comprehensive care to patients. For the 2,300 patients who are being served in the centers funded under this program, some of their additional care is being supported through this $3 million activity. However, the full cost that the patient incurs is higher than the amount for which this program can pay, and, therefore, needs to be carried by third parties and private carriers. This is partly because of the high cost of hemophilia treatment.

We could only pay for a smaller number of people if we were to use that particular authority just for treatment. It was designed more to develop systems than for patient care.

Mr. FLOOD. We have heard other cases that in the hemophilia program too much emphasis is being placed on behavioral science instead of meeting the more immediate need of the patient, the availability of plasma at a reasonable price.

Have you heard about that? Is that correct?

Dr. MARTIN. Part of the study that we will provide to the committee will give some good in-depth analysis of that point. In regard to the different assessments of the priorities, I think where people stand on that depends a lot on their professional backgrounds. From the viewpoint of our patients, these services are indispensable. It might be that the people who provide the plasma might not be as happy because indeed we are not spending it for the equipment; we are spending it for the children to help them with the myriad of special problems encountered by hemophiliacs.

Many of the problems with hemophilic children and many of the services required to help them adapt to school are exactly the kinds of things which we are making a priority in this program. These activities help to rehabilitate them to a functioning life.

Mr. FLOOD. What are you emphasizing with that $3 million?

Dr. MARTIN. We are emphasizing the ability to give the interdisciplinary team care to the family and the children and rehabilitate the children so that they may function effectively in school and society.

HOME HEALTH SERVICES

Mr. FLOOD. Your budget on home health agencies shows one-third of that money is supporting new agencies and two-thirds of it is to expand existing agencies. How are you making that kind of distribution?

Dr. MARTIN. Mr. Chairman, the intent there is to provide services in unserved areas by expanding available capacity in existing home health agencies that are located adjacent to the unserved areas.

Mr. FLOOD. Is that the best way to get this home health service to those who need it?

Dr. MARTIN. Yes, sir. We have a clear priority process for identifying counties with the greatest need. We have estimated that about two-thirds of those areas without service are adjacent to areas that have services, and we are attempting to build on those existing systems. In some other places such expansion is not possible so we have to begin an entirely new agency.

Mr. FLOOD. Mr. Michel.

EMERGENCY MEDICAL SERVICES

Mr. MICHEL. In the justifications for EMS you are not projecting any funding for research in 1978?

Mr. KELSO. That is correct.

Mr. MICHEL. Why is that?

Mr. KELSO. Basically budget priorities. We feel that it would be more productive to put the money into systems than into research.

Mr. MICHEL. Does that suggest in any way we have learned all we need to learn about the EMS?

Mr. KELSO. No, I wouldn't say that, but it does suggest that we feel this money could be used better in systems development than in research. In addition, we feel EMS research probably should compete with other research that is in the National Center Health Services Research and Development.

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Mr. MICHEL. Even though your overall EMS budget remains the same as the current year, the fact you won't be spending $3.9 million for research I guess must mean you will be increasing other categories. Where will that be?

Mr. LITTLE. Principally, Mr. Michel, it will be in the area of section 1203, that is the establishment and initial operations area, which is our priority area. We are trying to move all of those projects that we can that have already completed their feasibility funding into that initial operation funding.

Mr. MICHEL. How many specific ones would fall within that category?

Mr. LITTLE. I believe it is 32 new ones.

Mr. MICHEL. Are they spread evenly across the country geographically or would there be a high density someplace?

Mr. KELSO. They will be spread evenly.

Mr. MICHEL. You are projecting a total of 12 EMS systems this year and 36 next, which will have completed their Federal funding. Which ones in Illinois fall into that category?

Dr. ERICKSON. The EMS regions that have completed their eligiblity: Chicago has and that is the only one in Illinois that has completed it under title 12. There would be others that would come in for grants, we would assume.

Mr. MICHEL. Are all these systems which have or will complete their Federal funding making it on their own?

Dr. ERICKSON. Yes, sir, to my knowledge we have had no failures.

Mr. MICHEL. Of the 48 areas and regions which by the end of fiscal 1978 will not yet have received emergency medical service funding, has the interest subsided in those areas? Is it still as keen? Are they just waiting in line for funds? How do we characterize those areas?

Mr. LITTLE. I have a figure, I think, in 1976, Mr. Michel, which indicated that at that time we had 65 that were not funded. In 1976, 35 of those organizations did apply for funds.

Mr. MICHEL. Would you say those 35 would be ready for initial funding in 1978 if the money were available?

Mr. LITTLE. Certainly those 35. Of course, we may fund some of those 35 within our 1977 request, but some number of that 48 would be seeking funds.

Dr. ERICKSON. There is still good interest.

Mr. MICHEL. Why don't you for the sake of having a complete and valid record make that distinction between those that would get the funds in 1977 and those in 1978?

[The information follows:]

PLANNED FUNDING FOR EMERGENCY MEDICAL SERVICES SYSTEMS FISCAL YEAR 1977-78

	1977 estimate	1978 estimate
Feasibility and planning:		
Number of systems funded	8	9
Amount	$800,000	$900,000
Initial operations:		
Number of systems funded	33	45
Amount	$17,200,000	$20,600,000
Improvement:		
Number of systems funded	35	33
Amount	$11,700,000	$12,125,000
Subtotal:		
Number	76	87
Amount	$29,700,000	$33,625,000
Research:		
Number of grants awarded	28	0
Amount	$3,925,000	0
Total amount	$33,625,000	$33,625,000
Number of EMS systems which have completed funding under the EMSS Act	12	36
Identified regions which have received no EMS funding under this title	57	48

Mr. MICHEL. Does anybody want to volunteer on characterizing the quality of that emergency medical system we have out in Illinois? Is it good, bad, or indifferent?

Dr. ERICKSON. Your system in Illinois is one of the prototypes of what a good system will do.

Mr. MICHEL. I didn't lead you on in that question.

Mr. KELSO. No. I think if we had Dr. Boyd here he would say the same thing.

Dr. ERICKSON. I happened to live in Illinois at that time and the saying was if you had to have an accident, that was one of the better places to have one because you get good care there.

Mr. MICHEL. Last year you provided examples of accomplishments of emergency medical systems programs in terms of reduced fatalities and so forth. I wonder if you would update that. Some of them were strikingly good evidence of what can be accomplished.

[The information follows:]

The following examples, are a cross section of the types of activities reported by many of the EMS systems.

In Massachusetts 3/4 of the State has active EMS committees including hospital administrators, physicians, and nurses; over 1/2 of the State is implementing Basic Life Support; over 200 physicians are regularly involved in medical supervision and policy development. Further, 63% of all ambulance runs fully staffed by two or more EMT's; decrease of over 50% in number of deaths on route to hospital.

In the Western New York Region 75% of all ambulance runs include care by an EMT, 82% of all ambulance runs include advanced notification to the hospital, and medical supervision over BLS services is provided for 70% of all ambulance runs by individual hospital emergency departments.

In the Norfolk, Virginia Region the EMS system has established a fully operational basic EMS communication system with compatible mobile radios and all hospitals with similar emergency department base stations closely linked on the Region's EMS frequency. (This involves ten (10) counties and cities.)

In the Charlottesville, Virginia Region the EMS system physicians have adopted protocols on burns and spinal cord injuries to be utilized by all hospitals within the EMS Region and also by many outside of the Region.

The EMS Region in Fairmont, West Virginia has established medical communications (staffed by five surgical third year residents) at the University Hospital. These positions were created by the chancellor and are specifically for med-communications which will ultimately handle the entire northern half of the State.

The South Carolina Hospital Association made two studies of acute myocardial infarction with complications, comparing the period July-December 1975 with January-March 1976, that revealed in the Appalachia Region an 8% improvement (79%-71%) and in Midlands Region a 4% improvement (84%-80%). This improvement in critical patient care is directly related to advanced training of Emergency Medical Technicians.

The citizens of Lucas County in Northwest Ohio (population 500,000) passed on .8 mill tax levy to establish an advanced life support County EMS System composed of nine life squad units supported by volunteer and paid rescue units and commercial ambulance companies. Utilization of all EMS resources in the county will yield an expected save of ninety (90) persons per year and reduce the suffering of thousands more.

In the Amarillo, Texas Region a Communications Center has been completed in a 25 county rural region. The central communications center connects hospitals, ambulances and physicians.

The Kansas City EMS Region reports a reduction in the incidence of death and disability, with approximately 250 clinical saves in the EMS system. They have also established a central communications system with central dispatch for the 9-county metro-area, giving easy and immediate citizen access to emergency medical services through use of 471-1111 single emergency number with 24-hour coverage for 95% of the Kansas City metro-population.

In Montana the State EMS program has moved from a public safety program to a regionalized emergency medical care system that has the direct and active involvement of the Montana Medical Association.

In San Diego County, the San Diego Poison Information Center in 1976 responded to 26,000 calls and prevented 15,500 persons from having to receive treatment in hospital emergency departments. Further, 2,653 persons received advanced life support services from paramedics from May to December 1976.

In the Sierra-Sacramento Valley Region of California, the EMS Paramedic program successfully defibrillated and saved the life of a 72 year old lady in rural county. After release from hospital she went ahead with her plans for marriage.

EMS-STATE AND LOCAL FUNDS

Mr. MICHEL. Will you also update the figures provided last year on State and local funds that were funneled into the emergency medical system.

[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		State	Local
Alabama	$128,285	$18,000,000	New Hampshire	$12,000	---
Alaska	2,854,925	2,041,963	New Jersey	375,000	$3,500,000
Arizona	300,000	1,558,000	New Mexico*	66,795	---
Arkansas*	73,408	1,462,804	New York	390,000	2,557,350
California	295,000	33,506,108	No. Carolina*	2,381,235	---
Colorado	260,000	182,000	No. Dakota	65,000	125,000
Connecticut	310,232	---	Ohio	50,000	6,100,962
Delaware	67,976	1,357,450	Oklahoma*	71,229	---
District of Columbia	2,000,000	---	Oregon	134,000	737,000
Florida	925,000	4,498,500	Pennsylvania	2,400,000	430,000
Georgia	300,000	25,250,000	Rhode Island*	53,000	---
Hawaii	1,276,000	1,600,000	So. Carolina	317,202	17,500,000
Idaho	292,000	945,000	So. Dakota	77,600	164,000
Illinois	510,000	---	Tennessee*	390,000	15,000,000
Indiana	430,000	---	Texas*	700,000	12,000,000
Iowa	107,180	300,000	Utah	68,327	2,138,968
Kansas	58,000	3,800,000	Vermont	---	---
Kentucky	845,000	14,100,000	Virginia	125,845	750,000
Louisiana*	410,018	---	Washington	367,000	3,505,000
Maine	130,000	---	W. Virginia	110,000	1,763,000
Maryland	6,194,000	12,500,000	Wisconsin	643,200	---
Massachusetts	130,000	---	Wyoming	13,000	51,400
Michigan	478,000	---	Puerto Rico	831,700	680,300
Minnesota	281,440	---	Total	29,902,517	200,389,021
Mississippi	80,000	10,300,000			
Missouri	595,615	245,000			
Montana	142,000	50,000			
Nebraska	645,512	1,430,716			
Nevada	140,793	258,500			

*Provided in most recent fiscal year (1976).

Does anybody have any idea roughly how much that is today?

Mr. LITTLE. $230 million from State and local funds in 1976.

Mr. MICHEL. How did that compare roughly with the year before? Is it an increase?

Dr. ERICKSON. It was an increase.

Mr. MICHEL. Significant?

Dr. ERICKSON. Yes.

INTERAGENCY COMMITTEE ON EMS

Mr. MICHEL. Will you tell us how the interagency committee on EMS, which coordinates those programs of 23 different Federal Agencies, operates?

Dr. ERICKSON. The interagency committee is composed of folks from various different Government agencies and the idea is to coordinate what they may be doing, such as the Department of Transportation and HEW, for example. One example of how this committee has coordinated duplication of effort is in the recently soon-to-be-published guidelines for training EMT paramedics. This was a joint thing from the Department of Labor, Department of HEW, and Department of Transportation. The meetings are held throughout the year. I think there is a good interchange of information and trying to coordinate so there is not duplication.

Mr. MICHEL. How much, if anything, in this whole emergency medical system would be earmarked or detailed for the training of doctors specifically to handle emergency medical situations? Would that fall within your bailiwick?

Dr. ERICKSON. That falls, sir, within the Health Resources Administration bailiwick. They cover the old section 776.

Mr. MICHEL. Sometimes I can't see the forest for the trees. I really never thought of that as being such a specialty area.

Dr. ERICKSON. It is a brand new one.

Mr. MICHEL. When the proposition was put to me, my response was, what are they teaching in medical schools these days if one isn't prepared to handle or cope with that kind of situation? But then, when I go through the steps, initially the first doctor you meet in the emergency room isn't a longstanding pro in many cases, but one just out of school, then it made some sense to me that if we have these kinds of facilities and resources, if we man those emergency rooms with longstanding pros, we would fare that much better.

Dr. ERICKSON. This has been happening over the last few years. Emergency rooms are starting to be manned by physicians who like that activity and get continuing education in that area rather than what was done in years past by the intern and resident doing it solely on their own.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Mr. MICHEL. Regarding the PSRO's, an effort is apparently being undertaken to determine the effect of the PSRO's on health care. When are we going to get some real results from that study?

Mr. KELSO. We have an evaluation study under way.

Dr. GORAN. There are already some preliminary results about individual PSRO's. You have some of them, I think, in the budget material. The best study that has been done to date was conducted by another arm of the Department, the Social Security Administration, which looked at the Sacramento PSRO. They found there that approximately $2 to $3 are being saved for every dollar of operating costs in that PSRO, primarily by reducing unnecessary use of the hospital, either by cutting unnecessary admissions or cutting unnecessary days being spent in the hospital.

Today we only have isolated studies of a handful of PSRO's. There is underway in the Health Services Administration a national evaluation of the program which is scheduled to have its results ready by September of 1977, which will be the first time we begin to try to project whether these isolated studies can be generalized to the entire program, which we are confident they will be.

Mr. MICHEL. Why don't you expand for the record on that. I would be interested, too, in knowing whether or not those findings can be considered to be valid for the Nation even though it is isolated, and then what effect it would have on the quality of care.

[The information follows:]

The national evaluation empasizes: (1) the impact of PSRO-conducted concurrent review upon the utilization of short-term hospitals and associated medicare and medicaid expenditures, and (2) the incremental costs of the PSRO program relative to other utilization review activities.

The evaluation plan calls for the analysis of data from several sources and on hospitals in many PSRO areas. Data sources being included in the evaluation plan include: (1) the Social Security Administration sponsored MEDPAR file (i.e., 20 percent sample of all medicare claims); (2) a large, selective sample of hospitals from several hospital discharge abstract services: (3) special cost surveys of a sample of hospitals, and (4) special intensive studies of a number of mature PSRO programs.

The data acquired from these sources will include cost and utilization from an extensive number of PSRO review areas, as well as areas in which PSRO review has not been initiated; the latter will serve as comparison areas in the evaluation study.

We are also conducting additional special studies on the extent to which concurrent review is affecting hospital utilization, and their attendant costs. Three hospital utilization measures will be analyzed: (1) total days of care, (2) numbers of discharges, and (3) average lengths of hospital stay. In relation to these utilization measures, we are examining the differential changes according to such "independent variables" as age, sex, ethnicity, surgical and nonsurgical stays, and selected diagnostic categories. With the anticipated reductions in hospital utilization, we will estimate the corresponding reductions in health care expenditure. Hence, the special studies being conducted will analyze both the reduction in inappropriate hospital utilization, and the savings in health care, due to the PSRO concurrent review system.

Mr. MICHEL. Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Natcher.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. NATCHER. The budget proposal before the committee concerning HMO carries the program at the 1977 level; is that correct?

Mr. KELSO. Yes, sir.

Mr. NATCHER. Do you do that as a result of coming to the conclusion that the program is not working?

Mr. KELSO. No, sir.

Mr. NATCHER. Why do you carry it to 1977 level?

Mr. KELSO. Here again we feel that within the budget constraints we can move into 1978 with 23 grant awards and continue to conduct the HMO demonstration program.

Mr. NATCHER. Have any of the HMO's initiated with Federal funds reached the breakeven point as far as becoming self-supporting?

Mr. LITTLE. No, sir. The HMO act is designed to provide Federal support for 3 to 8 years before the breakeven point is reached. The grant funding program includes a 3-year funding period from the point of conducting a feasibility study to completing the initial HMO development. At that point, the organization may for a period of 3 to 5 years to offset initial operating deficits. In summary, we don't have any organizations that have received loans for a long enough time to actually reach a breakeven point.

Mr. NATCHER. Have any of the HMO's gone out of business during the present year?

Mr. LITTLE. None that received a loan.

Mr. KELSO. There might have been some with grants.

Mr. NATCHER. Will you give me some idea as to how many with grants?

Dr. ERICKSON. To answer that question, there was a total of some $5-plus million which had been invested in 59 feasibility studies which are to decide whether it will go or not, 7 planning projects, and 5 development projects which have been terminated and won't become HMO's. There are various factors to those. If you look at that feasibility planning that is precisely what feasibility is to do, to see whether it ought to go or not, so you are investing some amount of money so you won't have to invest more down the pike in a program which may or may not survive due to market potential or whatever.

These factors which cause the outcome have been identified and evaluated and they formed the basis for improved guidelines and technical assistance to future projects.

QUALIFIED HMO'S

Mr. NATCHER. How many HMO's have qualified under the act?

Dr. ERICKSON. Twenty-eight.

Mr. NATCHER. Do you have a backlog or a list of those that are seeking to be placed in the category of qualifying?

Do you have any applications pending?

Mr. KELSO. Yes. The qualifications activity is not in our agency. It is in the Office of the Assistant Secretary for Health. Dr. Munier may want to respond to that.

Dr. MUNIER. Following amendments in October of last year, the Office was transferred from HSA to Assistant Secretary of Health, into my immediate office, so I will be happy to supply that answer. We currently have 42 applications in the backlog.

Mr. NATCHER. In your budget justification you state that the selection of projects to be funded will be based on the highest probability for success.

How do you determine this as far as success is concerned? You say probability of success. What is the criteria that you use?

Dr. ERICKSON. Some of the criteria are the number of enrollees, market, the ability for cost containment, decrease of number of hospital days, for example, as has been shown in the HMO program. You can decrease hospital utilization by increasing preventive and ambulatory care service.

HMO LOAN FUND

Mr. NATCHER. How many loans have you made to date for HMO's approximately? Can you give me some idea as to the number?

Mr. LITTLE. We made 15 in fiscal year 1976 and 6 in the first quarter of this fiscal year.

Mr. NATCHER. Any defaults?

Mr. LITTLE. No, sir.

Mr. NATCHER. What happens to an operating HMO which receives a loan based on certain assumptions for growth but maybe later it turns out it doesn't meet its enrollment projections or something comes up? What happens? Do you continue funding as far as the loan is concerned or do you take some action?

Mr. LITTLE. In one of the instances we talked about the other day, one of the organizations got to the point where it received the loan and then in the early stages of that particular grant decided that it should not continue in the initial development of HMO, that it couldn't make it. It returned the money to the Federal Government and it was available for us to reaward to another organization.

Mr. NATCHER. I believe the basic law permits you to go up to $2.5 million?

Mr. LITTLE. For the loan, yes, sir.

Mr. NATCHER. For the loan. How closely do you monitor HMO's to find out whether or not they are operating properly?

Dr. ERICKSON. They are monitored routinely through the regional office HMO staff as well as the central office.

Mr. NATCHER. Down my way you are having some problems, aren't you?

Dr. SEUBOLD. Mr. Natcher, we have one qualified HMO in Louisville. They are falling behind on their projection for enrollment. The procedure which we invoke in these instances is to first of all consult with the project to identfy as closely as we can the areas in which they are having difficulties to supply them with technical assistance to help them in their marketing aspects and also to give them some guidance where they can trim their overhead costs because really what we are looking at is the margin between costs and revenues. If their enrollment slips there are frequently ways in which administrative overhead can be reduced so that the amount of debt is minimized.

Under this plan the problem is identified. A technical assistance plan is developed which is consistent with the overall compliance plan which is developed on each qualified HMO. A period of time is then given to determine if this get-well program actually can be affected early enough in the action. We have yet to see a case in which this get-well plan will not be effective. Should it not prove effective then the organization would be deemed out of compliance and its qualification as an HMO that meets all the aspects of the Federal program would be withdrawn.

Mr. NATCHER. Thank you.

Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Early.

Mr. EARLY. I commend you. If I got the right impression, you are going to implement all the studies we have now that we are spending our money for.

Mr. KELSO. We are spending money in the development and implementation of systems; yes, sir.

Mr. EARLY. You may be the one Federal agency that we have which isn't studying their studies. You might set a precedent and we might really start going in the right direction and start getting some results. I really commend you for that. I don't want to block research, but we study and then we have to implement to find out whether it was right or wrong.

I think you are going in the right direction.

NATIONAL HEALTH SERVICE CORPS

On page 3 of your statement, with regard to National Health Service Corps, you request $37.6 million to enable you to staff 549 sites, et cetera. In the next paragraph you say you are working with the States and at the local level. Will you give us a runthrough of how you are working with the States and with the local authorities in the States?

Dr. MARTIN. I think the important point about the relationship of the local government and State has partly to do with the requirements of the law. Our law requires there be active consultation with local government. One of the clear things that the program now is expected to do with its new authorities is to work with whatever State authorities in manpower area health education, service programs. This is designed to assure that the National Health Service Corps assignee is not just put into an area independent of everything else, and that where State resources are available, a memorandum of agreement or integration of activities would be developed with the assignee and the relevant organization.

Mr. EARLY. I just hope when you say you are abiding by the law you are not telling the States what you are doing but rather working with them, telling them what you are going to do and assisting them to follow through.

Dr. MARTIN. Our law requires that local governments agree to the assignment of National Health Service Corps personnel.

Mr. EARLY. But it is Federal funding so local governments always agree with that. When they don't have to put anything in, they will buy it.

Dr. MARTIN. About a third of the people who request the Corps assignees are local government. They are fairly aggressive about pursuing it. Our relationship with local medical societies are quite good. Our relationships with State governments in the context of planning is quite good. We have never run into a situation where we have had serious difficulties with a State or local government.

Mr. EARLY. You say it is good with regard to planning. How about implementation?

Dr. MARTIN. I also would say implementation. The only problem has been with a few dental societies.

Mr. EARLY. Is that difficulty with the local dental societies in not providing service but replacing them?

Dr. MARTIN. Obviously there are concerns by some local dentists that assignees might cause them difficulties. In every case, the States and the local governments have supported the assignment of the Corps professionals.

Mr. EARLY. These requested personnel for these 549 sites, how will they be implemented in the State? What would happen in Massachusetts, for example, with these additional people?

Dr. MARTIN. The basic assignment of National Health Service Corps personnel begins with the process of designating critical health manpower shortage areas. After the designation, a sponsor of a public or nonprofit group requests that a corpsman be assigned. After that assignment, the corpsman is put into the community. Part of that process for the approval of the application involves the determination by the local and State government that these individuals are needed. After the corpsmen are there, a portion of the receipts from third parties is collected and sent back to the Federal Government. These funds are from the actual receipts of income generated by the corpsmen themselves.

PSRO IMPACT

Mr. EARLY. With regard to the PSRO program, in your statement you say early but limited data from this program indicate that the review not only reduces average length of stay but results in overall savings.

Can you give us some idea of the reduction in the length of stay and the dollars saved?

Dr. GORAN. In the few PSRO's that have been studied we have reductions in length of stay that usually range in the neighborhood of a half to a day of the entire hospital stay being reduced as a result of review.

As I indicated in my earlier response, the best study we have was done in Sacramento. Translated into cost savings there, about an estimated $1 million was saved in the medicare program as a result of PSRO review. The review itself cost about $280,000, so about $2 or $3 were saved for every dollar spent on review.

Mr. EARLY. Don't all those review teams suggest they save money and reduce the length of stay? Aren't you in competition with one another?

Dr. GORAN. In Massachusetts, where we now have five PSRO's, PSRO review replaces the other systems that were there before. CHAMP was a system that preexisted PSRO. PSRO replaces it.

Mr. EARLY. It is still going on, isn't it?

Dr. GORAN. Only in those areas that are not doing PSRO review.

Mr. EARLY. Can you give me an example in Massachusetts where a PSRO has come in with a report that has reduced the savings and, overall, reduced the dollar amount, while at the same time assuring the recipient at least the same health service?

Dr. GORAN. In Massachusetts there is one called the Charles River PSRO, which is in the metropolitan Boston area. By its own assess-

ment, which has not been verified yet, it indicates they have saved some money to the State medicaid program and the national medicare program while assuring quality of care to the recipients. They are estimating dollar savings over the year.

Mr. EARLY. We are talking principal PSRO's and HMO's and Massachusetts probably has a surplus of beds and you are still building hospitals. I don't see any statistics or any results coming in from these groups that suggest we don't need them.

Dr. GORAN. One of the things PSRO's are responsible for is trying to identify in which hospitals there is an excess.

LOW-OCCUPANCY RATES IN MASSACHUSETTS

Mr. EARLY. Let me say this to you. We have a medical school that the Federal Government just built for $120 million. We have probably $300 million invested in it, a 400-bed hospital, the most plush hospital complex in the country, and we don't have any patients. We have 85 patients and the Government is going to cut off funding it. We don't seem to be going anywhere.

Dr. GORAN. I do think we have some of the ingredients that will deal with it. The PSRO helps to identify whether there are in fact unnecessary beds.

Mr. EARLY. We don't need it for that. I can tell you that. Adjacent to that is a hospital that has 1,500.

Mr. KELSO. Mr. Early, if there are no patients obviously it is not being used and PSRO is a program that looks at utilization of the hospital. The Health Resource Administration, which administers the new Health Resources and Planning Act, will be testifying and I am sure they can respond to you.

Mr. EARLY. My own problem is they come up and they justify their own existence. All the agencies do that. President Carter's promised less Federal Government, more service. That is only if we reduce the bureaucracy. That is the intent of the PSRO's and similar type things. But no one identifies what we don't need. Now there is talk of building a new hospital in Boston for $124 million.

Dr. GORAN. There is a certificate of need law in the State.

Mr. EARLY. I am very familiar with it. It is not working.

I have no further questions.

EMS ACCOMPLISHMENTS

Mr. FLOOD. Mr. O'Brien.

Mr. O'BRIEN. Dr. Erickson, I was just interested in those activities mentioned during your exchange with Mr. Michel. You were referring to some of the accomplishments that come as a result of the EMS. Was that a baby of your creation?

Dr. ERICKSON. It wasn't a baby of our creation. It was started before the EMR was passed and it was one of the original local affairs which started that enabled us to go on more with the impetus of the act, but that is one of the prototypes that we would like to look to.

PSRO—HMO RELATIONSHIP

Mr. O'Brien. Mr. Kelso, speaking from my area, we had the first PSRO, I think, in the State of Illinois. It is doing a self-assessment now. As near as I can determine from their appraisal—and I don't have the statistics—I think the utilization is improving and I think attention to quality is down the road. We get one before the other. The general feeling in my neighborhood is PSRO is working well and it is a good idea.

I wonder if PSRO's can't really have some impact and maybe perform the function the HMO's might be designed to do? I believe we have one qualified HMO. I think the people who participated got burned because that was not a complete HMO. They had to go out for highly specialized orthopedic treatment, for psychiatric treatment, and so forth. It just seems to me that is a weakness that you are going to have a hard time dealing with, and if I had to spend the Federal dollar I would go the PSRO route before I would go the HMO. I don't know your views on that.

Mr. Kelso. The HMO program is a demonstration program dealing with prepaid group practice, with a large component of preventive treatment in it. PSRO is basically peer review of medical activities in the hospital, including long-term care activities. One is a demonstration on how to deliver care and the other is a look at the effectiveness of care being delivered.

HMO IMPACT

Mr. O'Brien. With reference to the Tennessee Valley group, in your support papers you talk about a rather dramatic comparison of inpatient utilization, 302 days per thousand, against 673 per thousand.

Mr. Kelso. Right.

Mr. O'Brien. Isn't it fair to state that comparison may not be quite as good as it would appear? Don't you get many young families in that particular grouping as opposed to maybe Blue Cross people dealing with the older, more susceptible to injury and illness?

Dr. Erickson. I think we can still show that the HMO demonstration has had an impact if you look at some broader figures than just that. There has been a conservative estimate that HMO saved on the average $70 per enrollee per year by virtue of their ambulatory services, preventive service and in-patient utilization. As of September, qualified HMO's had accumulated over 108,000 enrollee years corresponding to a savings of $7.5 million. Of course, an essential feature is the control of in-patient utilization consistent with real medical necessity. The average for all qualified HMO's as of last September was 415 days per thousand enrollees per year, compared with the national average for persons under 65, so here we are comparing apples with apples, 985 days per thousand persons per year, so that is about half.

Mr. O'Brien. I think that is a pretty wide comparison when you say under 65.

Dr. Erickson. Yes. So that takes out of the problem, as you mentioned, the possibility of younger families rather than the elderly.

Mr. O'BRIEN. What I am saying, if you are under 65, leaves quite a bit of room. In my judgment it is possible you have a lot under 40 rather than the older ones. Isn't it true that an HMO has provided full service and really meets a large population?

Mr. KELSO. Yes.

Mr. O'BRIEN. So I must be a little parochial about it. In my district it is half rural. I really don't think my taxpayers selfishly and justifiably care one whit about their money going to an HMO, but I doubt I have any flak from them about money going to PSRO even though there is some difference. That is all, Mr. Chairman.

Thank you.

HYPERTENSION

Mr. FLOOD. You are asking for $9 million for formula grants to States again. This is for the hypertension screening detection, et cetera. How many people are actually going to be screened in 1977 and in 1978 under this program?

Dr. MARTIN. The best we have now are some projections. Most of the first year's funds were expended to build the capability within the State health departments. Part of the data we anticipate getting over the next 6 months will give us a lot better numbers.

Mr. FLOOD. How many would you say in 1977 and 1978 you have screened? You must have some idea under this program.

Dr. MARTIN. I would prefer if I could, Mr. Chairman, to provide a solid answer for the record.

Mr. FLOOD. All right.

[The information follows:]

HYPERTENSION

NUMBER OF PERSONS SCREENED, 1977–78

We cannot make a reliable estimate of the number of people screened in the hypertension program. This is a new program so we have no data reported or past trends to use for estimates. The first grant awards were made in September 1976 to the State health agencies. These grant funds are being used in a variety of ways, such as for massive public education programs, professional education efforts, and screening. The lateness in which the State health agencies received their funds, and the diversified ways the funds are being used preclude a reliable program estimate at this time. Data from the National Center for Health Statistics indicate that one in five persons 17 years of age and over has been informed by a doctor that he has hypertension.

Mr. LITTLE. I think the awards from the first money we had available for this program were made just last September.

Mr. FLOOD. Are these screening units freestanding things or are they part of the community mental health center or some health care program?

Dr. MARTIN. Under section 314(d) the majority of the projects being supported are conducted by county health departments. They use both the staff of the State and county department of health. In addition, many States have activities which include large numbers of volunteers.

In addition, there is a large-scale screening activity within all the centers that we support, and, of course, the Naitonal Heart and Lung Institute's activities in that area include a vast array of other kinds of screening.

Mr. FLOOD. How does this particular hypertension program work with the Office of Hypertension Control that is over at the National Heart and Lung Institute? Do you talk to each other?

Dr. MARTIN. We not only talk with each other, we also work with each other. We have jointly sponsored a conference with the State health officers, we are coproject officers on their contracts, and they consult on our guidelines and discussions with the State. It happens to be a close working relationship.

Mr. FLOOD. That Office of Hypertension Control is responsible for the whole statewide demonstration project?

Dr. MARTIN. Yes, sir.

Mr. FLOOD. You can do this for the record: How much money will be spent throughout 1977, throughout 1978, on hypertension screening and treatment?

[The information follows:]

DHEW ESTIMATED OBLIGATIONS FOR HYPERTENSION CONTROL, 1977 AND 1978

	1977	1978
NIH: National Heart and Lung Institute	$56,059,000	$57,045,000
HSA: Bureau of Community Health Services	9,000,000	9,000,000
Total	65,059,000	66,045,000

ESRD

Mr. FLOOD. How much money is the Social Security Administration paying for renal dialysis?

Dr. GORAN. We estimate this year there will be about 32,000 beneficiaries.

Mr. FLOOD. No. How much money?

Dr. GORAN. It is $600 million in service benefits; $600 million is the current estimate.

Mr. FLOOD. You indicate in your plan to curtail the end stage renal medical information system. What kind of data do you collect under this system?

Dr. GORAN. This system primarily collects clinical data about all the beneficiaries of this program, about the medical history and the treatment they have received. It will be used by the medical review boards in assessing the quality of care received by these beneficiaries.

Mr. FLOOD. How will the curtailment of this system impact on the Social Security Administration's ability to administer the renal dialysis program?

Dr. GORAN. It should not adversely affect the Social Security Administration's ablity to administer the program. It will limit the information available to medical review boards to assess the quality of care.

Mr. FLOOD. Let me ask you this, then. What role do the end stage renal disease network coordinating council and the medical review boards play in the administration of the renal dialysis program?

Dr. GORAN. The network coordinating councils, of which there will be 32, are primarily interested in planning for additional resources

and making sure that all of the facilities, some 900 facilities that provide service, work together. The review boards are primarily interested in making sure patients are receiving the right treatment and the right quality treatment whether they should have transplants, for instance, or be treated in a hospital setting, or be on home dialysis.

Mr. FLOOD. How much do they cost the medicare trust fund?

Dr. GORAN. We estimate that the support of the network coordinating councils and review boards will cost the trust fund in the neighborhood of $3 million a year.

Mr. FLOOD. Did you say three?

Dr. GORAN. About $3 million.

MCS—DRUG PROGRAM

Mr. FLOOD. Doctor, you are asking for funds to support the maximum allowable cost of the drug program. What is the current status of that program and when are we going to see some substantial savings in that?

Mr. KELSO. That program is in the Office of the Assistant Secretary for Health and Dr. Munier can respond to that.

Dr. MUNIER. I will be happy to respond. We are just beginning to get the MAC in the operational phase. We have been considering setting our first maximum allowable cost on two drugs, two different capsules of ampicillin, and we will probably have a final MAC on that within the next month or two.

Mr. FLOOD. When are we going to see some substantial savings in the program?

Dr. MUNIER. We don't have any savings yet because we have not established our first MAC. We estimate when the program is fully implemented the savings may be in the order of $37 million a year to the medicare and medicaid programs.

Once we have the program operational, a total of about 80 drugs will be put on the MAC lists.

Mr. FLOOD. How much is in the budget for the program?

Dr. MUNIER. $1½ million.

Mr. FLOOD. What is it costing altogether to administer the program?

Dr. MUNIER. It is hard to say. There are program staff in a number of agencies within the Department which, of course, are paid for out of the regular salaries of the Department. The additional cost above and beyond the individuals working in HEW is $1½ million for 1978.

PSRO'S—NEW POSITIONS

Mr. FLOOD. Now we touched on the PSRO's, but for the PSRO program you are asking for 40 new jobs. Now with these 40 new jobs you are talking about you have a total of 270 positions.

Why do you need an additional 40 people in the program? Why 40 more?

Dr. GORAN. The primary reason for requesting an additional 40 positions in this program is to provide an additional staff support as the program expands. We intend in 1978 to complete implementa-

tion of the program and add 83 new reviewing organizations.

So the principal reason for the new staff is to provide support for the new organizations.

Mr. FLOOD. What kind of people are you talking about?

Dr. GORAN. Primarily professional people to help PSRO's put together review plans.

Mr. FLOOD. What do you mean?

Dr. GORAN. Health specialists, medical care organization specialists, public health advisors, program analysts.

Mr. FLOOD. Including any paramedics of any kind?

Dr. GORAN. We do have some nonphysicians that help the PSRO's in establishing their nonphysician review organization activities.

Mr. FLOOD. What are you doing to coordinate all these PSRO activities with this utilization review program, the program we have under medicaid?

Dr. GORAN. PSRO replaces utilization review under medicaid. Once PSRO is fully implemented in 1978 there will be no more utilization review in hospitals.

PSRO REVIEW

Mr. FLOOD. In the budget material you indicate that PSRO's will review about 60 percent of the hospital admissions. When do you expect to reach 100 percent of the hospital admissions?

Dr. GORAN. In 1979 we hope.

Mr. FLOOD. How much will this program cost at that point in time?

Dr. GORAN. We are not sure, but our estimates of what the cost of this program would be when it is fully implemented, and we guess this would be some time around 1981 which is when PSRO's will be reviewing all hospital care and all care in long-term care institutions, would be in the neighborhood of $300 million annually.

PSRO IMPACT

Mr. FLOOD. Now you also make a point there, you identify the impact of the PSRO's on the improvements of quality care. How do you go about assessing the improvement of quality care? How do you do that?

Dr. GORAN. Each PSRO essentially looks at two kinds of things. necessity of services which directly relates to cost, and quality of care. They primarily look at improving quality by doing medical care evaluation studies, also known as patient care audits. These are done in every hospital around the country.

There are projected to be 203 PSRO's in 1978. Each of those will be running audits in all their hospitals. It is from these audits that they will attempt to improve quality of care.

For instance, in some of the ones that have been reported to date, PSRO has improved the use of blood by cutting back on unnecessary use of single transfusions by doing such studies.

Another PSRO has improved the use of medications by studying the way doctors prescribe drugs, and through the findings has influenced doctors to change their behavior and improve quality of care.

So it is all these studies in aggregate that result in quality improvements to the patient population.

PHYSICIAN'S ACCEPTANCE OF PSRO

Mr. FLOOD. What has been the change, if any, of the physician's acceptance of this program during the past year?

Dr. GORAN. It has been much better. We now are in the process of trying to complete implementation of the program. Remember, it is still a voluntary program. We anticipate that there will only be a few areas in the entire country where physicians won't voluntarily come forward to set up a PSRO.

There are currently 120,000 physicians who belong to PSRO's. We project that that will go to about 175,000 over the course of the year.

PSRO FUNDING

Mr. FLOOD. Why shouldn't we fund the entire cost of the PSRO program from the medicare trust fund? In your budget proposal you have $34.9 million from the trust fund and you have $37 million from direct appropriations.

Dr. GORAN. That is because PSRO reviews both medicare and medicaid. The $37 million is primarily used for the payment for the medicaid review and the $34 million for the medicare.

Mr. FLOOD. You can't fund the entire cost of the PSRO's from the medicare trust fund?

Mr. LITTLE. You can, but it seems an incorrect use of the medicare trust fund.

Mr. MILLER. I don't think it would be legal. You can only use trust fund money for medicare programs. Medicaid is not a trust fund program.

PSRO LONG-TERM CARE REVIEW

Mr. FLOOD. When will the PSRO's begin to review the long-term care services? We understand at the present time there are about 1 million people in nursing homes. So, when?

Dr. GORAN. Fifteen are already doing it in a long-term care demonstration program. We asked for authority in the 1978 budget to increase the number to 40. We are in the process now of trying to identify these 40 PSRO's that would do long-term care review.

Mr. PATTEN. Mr. Chairman, may I ask, when you are referring to those who performed the long-term care review, you speak of them as 10 conditional PSRO's. Why do you use the word "conditional"?

Dr. GORAN. The word comes from the PSRO law which said that during the first 24 months that a PSRO is doing review, it will be on a conditional status so that its performance can be assessed to determine whether it is performing satisfactorily.

Mr. FLOOD. Mr. Early?

Mr. EARLY. My questions deal with nursing homes.

First of all, the group in Massachusetts that more or less inspects and maintains the nursing homes has suggested to me that the Federal Government is going to phase them out as of midyear. Is that true?

Dr. ABDELLAH. Massachusetts has a record of outstanding leadership in looking at a new way of surveying nursing homes. Working with our regional office of long term care standards enforcement,

which identifies all the deficiencies but reduces the effort of repeating all the positive things. This approach saves a great deal of time. The poor facilities will gradually have to phase out but we hope that the State can work with these to make sure that quality of care is provided.

Mr. EARLY. If they phase it out and think the State is going to pick it up, they are fooling themselves. The State is not going to police our nursing homes anymore.

Our attorney general was down last week to see the Speaker requesting a Federal prosecutor to prosecute nursing homes in Massachusetts.

What do our PSRO's tell us about our nursing home in Massachusetts?

Dr. GORAN. In Massachusetts currently PSRO's are not doing review of long-term care facilities. That is a responsibility that remains with the State medicare agency.

So review is being conducted by the State itself. It is not yet a PSRO responsibility there.

Dr. ABDELLAH. I would like to speak to what we are doing in the Department directly in terms of nursing homes in Massachusetts.

Mr. EARLY. I would like to hear that.

Dr. ABDELLAH. We have as part of our long-term care improvement campaign developed an instrument which we call patient appraisal and care evaluation which is a direct assessment of care in long-term and intermediate care facilities.

In Massachusetts there are nine facilities participating in this effort. We hope by October to increase and include almost all facilities in that State. What this does, it involves regional and State personnel and training them and doing a more direct assessment of the patients and residents and their needs. All of this is a part of reducing the bureaucracy of getting away from a 68-page form, revising that entirely and moving much more toward a direct assessment.

Mr. EARLY. You told me last year. I want to wait until you can show me how this 68-page form has really been reduced.

Dr. ABDELLAH. By June we will have a large evaluation of that effort.

Mr. EARLY. How many pages is that evaluation?

Dr. ABDELLAH. At the moment it is 18 pages.

Mr. EARLY. Well, it is down from 68.

Dr. ABDELLAH. We hope by June that we can get down to five or six. But the important thing about that is that it focuses directly on the quality of patient care and services provided.

Mr. EARLY. My only concern is the quality of care. I once again see us taking the nursing homes in Massachusetts and going after the one or two fly-by-night operations rather than giving credit to the ones who are doing it the right way.

Will you be back?

Dr. ABDELLAH. I will be glad to.

HMO IMPACT

Mr. EARLY. You referred to the HMO's saving $70 per patient per year. How much is it costing us in paperwork to administer HMO's per patient per year?

Dr. ERICKSON. I will enter it for the record. I don't have it.

Mr. EARLY. We are saving $70. Is it costing us more than $70?

Mr. LITTLE. I think not.

Mr. EARLY. Will you supply for the record what you estimate as the cost per patient per year?

Mr. KELSO. Yes, sir.

[The information follows:]

Those who receive services from an HMO will, of course, pay for those services directly or through their employers or through a Government agency such as the medicaid or medicare programs. HMO premiums vary according to the general level of health care costs in the area. Nationally, family premiums vary from about $65 per month to about $115 per month.

Administration of the program for operational HMO's is carried out by the Office of HMO Qualification and Compliance. The operating budget for that unit is about $800,000 for fiscal year 1978. On a per-member, per-year basis, this administration costs about $4 at present HMO enrollment levels and is estimated to be about 30 cents when these HMO's reach maturity at about 2,500,000 members.

In terms of grant investment to bring these HMO's into operation, the present estimate of $77 million in grants corresponds to about $50 per member at maturity enrollment. The estimated savings of $70 per member per year would continue to accrue each year.

Mr. FLOOD. Gentlemen, thank you very much.

[The following questions were submitted by members of the subcommittee with the request that they be answered for the record.:]

MR. FLOOD

Mr. FLOOD. What is the National Health Service Corps (NHSC) doing to support staffing needs in community mental health centers (CMHC)?

ANSWER. The Bureau of Community Health Services (BCHS) has as a major goal the integration of categorical community-based health programs at the Federal, State, and local levels in order to better serve the entire family. The BCHS and the National Institute of Mental Health (NIMH) have negotiated an interagency agreement to work together to define the need for NHSC assignees in CMHC's. To date the NHSC has placed 18 assignees in CMHC's with an additional 52 scheduled for placement. We expect substantial increments in the number of psychiatric assignees at community mental health centers over the next 3 to 4 years. Additionally, to help assure that this goal is achieved, the National Health Service Corps scholarship program will give priority to persons who want to defer service obligations in order to complete psychiatric residency training.

In addition, at the beginning of fiscal year 1977, there were 82 CMHC projects with linkages to community health centers which are funded as part of the primary health care initiative.

MR. CONTE

HEALTH MAINTENANCE ORGANIZATIONS

Mr. CONTE. Why are you requesting no funds in 1978 for feasibility or planning activities? Do you have any applications pending for such surveys?

ANSWER. Since all fiscal year 1977 funds were needed to support on-going projects, no feasibility projects were started which would have led to planning projects for funding in fiscal year 1978. In other words, the pipeline could not be filled.

There is a demand for participation in the program now that the amendments have been passed. In a survey carried out by our regional office in January, we have identified 57 organizations which intend to apply for feasibility grants, 12 for planning, and 1 for initial development if funds are available.

Mr. CONTE. You indicate that you intend to fund 23 initial development grants. Why is the projected average cost for those 23 lower than the average cost for the 21 initial development grants being funded in 1977?

ANSWER. The average funding levels are planning estimates. If the average need is found to be less than expected, we will fund more projects; if it is more, we will fund fewer. In no event, however, would a project be funded unless it met our established criteria.

Mr. CONTE. What success has there been in setting up rural health maintenance organizations?

ANSWER. There have been some outstanding successes in setting up HMOs in nonmetropolitan areas, in spite of the difficulties known to exist in such settings.

As two examples, Choice Care Health Services of Fort Collins, Colo., and the Marion Health Foundation of Marion, Ohio, were recently qualified and both are exceeding their marketing projections. Three projects now in the development stage are doing well and are expected to be ready for qualification in the next 6–9 months: Valley Health Plan of Amherst, Mass.; San Luis Valley HMO or Alamosa, Colo., and Los Padres Group Health Plan of San Luis Obispo, Calif. An additional eight projects are moving strongly in the planning phase and are expected to progress into development within a year.

Mr. CONTE. Do you see any additional initiatives in this area coming along?

ANSWER. Some of the programs being developed under the Department's rural health initiative may well mature to the point at which they may evolve into health maintenance organizations which meet the requirements of the HMO Act.

Mr. CONTE. Have any of the HMO's reached the break-even point yet?

ANSWER. No, not among the qualified HMOs which "graduated" from the grant program. The Genesee Valley Group Health Association of Rochester, New York, will reach its breakeven point with some 31,000 enrollees within the next month or so. That will be the first one.

Mr. CONTE. What is your present backlog of applications that could be funded?

ANSWER. We have received firm indications of intent to apply for funding from some 70 organizations, asking for a total of about $7 million. We have not requested applications because funds to start new projects were not available.

Mr. CONTE. Has any work been done in terms of staffing health maintenance organizations with physician extenders that you have been aware of? Could this be one way of controlling operating expenses—by using physician extenders in addition to practicing physicians?

ANSWER. The HMO movement is making important and valuable contributions to the use of physician extenders as meaningful and cost effective providers in the HMO health and medical care delivery system.

In the HMO movement, physician extenders are generally nurses in expanded roles, nurse midwives, physician assistants, and mental health professionals who work with or in the primary care setting. The nurse in the expanded role may be called a nurse clinician or even health associate depending on advance training, practice, custom, and State professional practice laws.

One of the most innovative uses of allied health professionals in the primary care team is underway in the community health care plan of New Haven. Most successful is the Pediatric Service which has been the historical evolution of MD extenders with its opportunity for provision of well-baby care, counseling, the time-limited diseases of childhood. CHCP has nevertheless, effectively expanded into the various medical teams of the health center.

Every two primary care providers have as other team members a physician associate, nurse practitioner, and an appropriate mental health worker who works almost exclusively with patients and other team providers either through consultation to the providers, joint work with patients or when necessary with the patient alone. As a result of this arrangement, physician associates and nurse practitioners were able to treat 72 percent of emotional problems of child patients alone or with consultation, and only 28 percent had to be seen by the mental health workers.

In response to the cost and service significance of these developments, the DHMO has staff assigned to stimulate and encourage thorough research, consultation, publications, meetings, the maximum and most cost effective use of allied health professionals in HMOs. Two national meetings with HMO medical directors have been held during past years, and sessions on common interests and concerns as well as special meetings of these new health practitioners are being scheduled in conjunction with the Medical Directors Meeting in June and October of 1977.

Mr. CONTE. Your justification uses the example of the Genesee Valley Group Health Association in Rochester, New York, and indicates that over $2 million is saved through utilization of the HMO. Is this an unusual case?

ANSWER. This is not an unusual case although, as mentioned before, GVGHA will be the first of our grant-supported HMOs to reach the breakeven point.

Mr. CONTE. Have any other HMOs had this kind of success?

ANSWER. All the qualified HMOs are reporting inpatient utilization well below the national average. The average for all of them is running a bit above 400 days per 1,000 enrollees per year. That is less than half the national average for persons under 65. It equates to a savings of about $70 per enrollee per year at today's hospital prices. On this basis, the currently planned grant investment in HMO development will be paid off in terms of national health care cost savings when a total of 1,100,000 member-years has been reached. As of September 30, 1976, 10 percent of that goal had been achieved. We estimate the overall goal will have been met by 1980.

Mr. CONTE. How many members are necessary for an HMO to be successful? Are there variations in that number?

ANSWER. The number of enrollees needed for an HMO to break even can vary from perhaps 5,000 or 6,000 up to 30,000 depending on the type of HMO. The centralized, strongly integrated, staff-type urban HMO is a capital-intensive operation. This form is highly efficient, but requires a substantial enrollment, perhaps 30,000 or more, to generate breakeven. An individual practice association type of HMO, with physicians serving in their own offices, requires little capital and can break even at well under 10,000 members.

Mr. CONTE. What seems to be the most important characteristics of a successful HMO?

ANSWER. The key to HMO success is knowledgable and effective business and medical management, backed by full commitment to make the HMO work. The health care resources and the market must, of course, be present, but the HMO must be soundly managed to be successful.

Mr. CONTE. How long do you project it will take for the average HMO to become self-supporting—that is, at the breakeven point?

ANSWER. Just as the number of HMO enrollees required for break even can vary, so will the time to get those members on board. The average time is probably about 3 to 4 years.

Mr. CONTE. And can an HMO borrow from the loan and loan guarantee fund indefinitely? What restrictions are placed upon borrowing from the fund?

ANSWER. No. The maximum amount which may be borrowed by an HMO is set by statute at $2.5 million. The HMO may use no more than $1 million per year. These funds can be used during a 5-year period.

Mr. CONTE. What are the payback and interest provisions of those loans?

ANSWER. The borrower pays interest only during the period of use of the loan funds. Payment on principal begins at that time. The entire period for repayment of the loan is 20 years. The interest rate is set at 1 percent above the prime rate on the date the loan is committed.

Mr. CONTE. If HMO's can have such tremendous cost saving potential, and I know that the Administration is vitally concerned about controlling health care costs, then why don't you propose to put more money into HMO development, and fund additional projects?

ANSWER. As you know, Mr. Conte, this program was framed in the legislation as a demonstration. To date, the demonstration has indeed brought additional HMO's into being which are performing up to the standards of the prototype organizations that stimulated the HMO Act. It has also generated definitive information on the characteristics of organizations which have not succeeded in developing into operational HMO's, information that will be of real value in future program decisions.

MR. CONTE

NEXT STEP FOR PSRO PROGRAM

Mr. CONTE. I am pleased to hear that you will have conditional PSRO's in all 203 PSRO areas nationwide by the end of the year. That is a significant accomplishment. Once those PSRO's are in place, what is the next step for the program? In other words, where does the program go from here?

ANSWER. Once PSRO's have been designated in all 203 PSRO areas, we will work toward full implementation of PSRO review in all hospitals nationwide. In addition, we will continue to assist the PSRO's in assuring the effectiveness and efficiency of their review systems. Our next priority will be long-term care

review. This is a statutory requirement and as such, we are beginning to implement PSRO review of long-term care. By the end of fiscal year 1978, we plan to have 40 PSRO's conducting long-term care review; and all 203 PSRO's will be doing such review within the next few years. The review of ambulatory care is our next priority. In this context we have funded five PSRO's to demonstrate different approaches to developing and maintaining an ambulatory quality assurance system in an areawide PSRO framework. In addition, we have been working with PSRO's to enhance their efforts regarding PSRO review of ancillary services as part of their hospital review system.

STATEWIDE COUNCILS

Mr. CONTE. Will you be supporting additional statewide councils this year? How about future years?

ANSWER. Six statewide councils are currently being supported. They are: Massachusetts, Connecticut, New York, Pennsylvania, Maryland, and California. Three other statewide councils—Ohio, New Jersey, and Missouri will be added to this list as soon as appointments are made. Appointment of the Ohio Council is expected within the next few weeks and the other two councils within the next 2 to 3 months.

Since statewide councils can be established only when a State has three or more conditional PSRO's, further statewide council development depends on additional conditional PSRO's in seven other states. Those states are: Florida, Michigan, Illinois, Indiana, North Carolina, Virginia, and Louisiana. We hope to establish councils in all of these states during the fiscal year 1978. Establishment of a statewide council in Texas and Minnesota is unclear pending area redesignation action.

REQUIREMENT FOR PSRO TO BECOME OPERATIONAL

Mr. CONTE. What is required for a PSRO to move from conditional to operational status? What criteria have to be met?

ANSWER. Section 1154(b) of the Social Security Act indicates that a conditional PSRO may be considered a fully qualified organization only if it is found to be "substantially carrying out in a satisfactoy manner" the activities and functions of a PSRO. We are now developing the criteria associated with these requirements. They are likely to include, for example, significant implementation of hospital review and evidence of the effectiveness of such review. We hope that these criteria will be completed in the next several months.

IMPACT OF PSRO REVIEW

Mr. CONTE. I understand your initial indications are that PSRO implementation has led to reductions in lengths of stay for medicare and medicaid patients as compared to non-PSRO operations. Presumably that means that patients are leaving the hospital more quickly than their doctors would ordinarily have recommended. Are there any indications that the quality of care has been permitted to slide, or are these figures simply indicative of the fact that doctors are more careful when someone is checking up on them?

ANSWER. There is no evidence that reductions in hospital lengths of stay have been accompanied by reductions in the quality of care received by medicare and medicaid patients. On the contrary: Avoiding unnecessary days of stay in the hospital is an improvement in the quality of care. The PSRO review system is not concerned only with utilization, but also with quality of care. In general, through concurrent review, PSRO attempts to assure appropriate utilization; through medical care evaluation studies, it attempts to assure quality of care. Because of this dual approach to review, there is every expectation that quality of care should improve.

PSRO EVALUATION ACTIVITIES

Mr. CONTE. Would you tell me about your evaluation activities in the area of determining the impact of PSRO activities on health care expenditures?

ANSWER. The national evaluation emphasizes: (1) The impact of PSRO-conducted concurrent review upon the utilization of short term hospitals and associated medicare and medicaid expenditures, and (2) the incremental costs of the PSRO program relative to other utilization review activities.

The evaluation plan calls for the analysis of data from several sources and on hospitals in many PSRO areas. Data sources being included in the evaluation plan include: (1) The Social Security Administration sponsored MEDPAR (i.e., 20 percent sample of all medicare claims): (2) a large, selective sample of hospitals from several hospital discharge abstract services; (3) special cost surveys of a sample of hospitals, and (4) special intensive studies of a number of mature PSRO programs.

The data acquired from these sources will include cost and utilization from an extensive number of PSRO review areas, as well as areas in which PSRO review has not been initiated; the latter will serve as comparison areas in the evaluation study.

We are also conducting additional special studies on the extent to which concurrent review is affecting hospital utilization, and their attendant costs. Three hospital utilization measures will be analyzed: (1) Total days of care, (2) numbers of discharges, and (3) average lengths of hospital stay. In relation to these utilization measures, we are examining the differential changes according to such "independent variables" as age, sex, ethnicity, surgical and nonsurgical stays, and selected diagnostic categories. With the anticipated reductions in hospital utilization, we will estimate the corresponding reductions in health care expenditure. Hence, the special studies being conducted will analyze both the reduction in inappropriate hospital utilization, and the savings in health care, due to the PSRO concurrent review system.

PSRO NEW POSITIONS

Mr. CONTE. You are requesting 40 additional positions. Where will those positions be located? What will those people be doing?

ANSWER. The 40 new positions requested for the program in fiscal year 1978 will be distributed between the central office and regional offices of the Bureau of Quality Assurance. The primary reason for requesting an increase of 40 positions in this program is to provide the additional staff needed to support an expanding program. In fiscal year 1978 we intend to complete implementation of the program in all 203 designated PSRO areas throughout the country. This will require the addition of 83 new reviewing organizations. The primary reason for additional staff is to provide the technical support and project monitoring capability to effectively manage these additional PSRO's.

PSRO REVIEW ACTIVITIES

Mr. CONTE. Your justification (p. 51) mentions that PSRO's may review additional types of health care with the Secretary's approval. Can you tell me what other types various PSRO's are reviewing, and how prevalent a practice this is?

ANSWER. The additional type of health care referred to is ambulatory care. Several PSRO's are now conducting ambulatory care review. The New Mexico and Utah PSRO's have contracts with their respective States to do ambulatory review of medicaid claims. The New Mexico PSRO is using State funds and Federal funds to perform ambulatory care review.

In addition, five PSRO's have been selected to conduct ambulatory care review demonstrations for a 2-year period. These demonstrations will assess a variety of review methods and assist in defining the elements of a plan for the conduct of ambulatory care review.

The demonstrations were initiated September 1976 by the following PSRO:

Bronx
South Central Pennsylvania
New Mexico
Multnomah (Portland, Oreg.)
Central Massachusetts

Mr. CONTE. You also mentioned the integration of PSRO activities with certain health care review activities required by the Social Security Act. Could you summarize the activities required by the act? When will duplication between PSRO and Social Security Act review activities be eliminated? Does that require additional legislaton, or can it be done under existing authority?

ANSWER. The PSRO program is authorized to review the services and items for which payment may be made under the Social Security Act for the purpose of

determining the medical necessity, appropriateness, or quality of those services. Under existing authority, PSRO review replaces the utilization review requirements imposed by the medicare and medicaid statutes to the extent that PSRO's have assumed review responsibilities. These utilization review activities are required by title XVIII of the act for inpatient health care institutions participating in the medicare program and by title XIX of the act which places requirements on the Single State agency for medicaid to assure that appropriate mechanisms exist under the State medicaid plan to review and thereby control utilization of all health services provided to medicaid recipients under such plan.

UNNECESSARY USE OF SERVICES

Mr. CONTE. Page 52 of your justification says that there is evidence that PSRO review helps control the unnecessary use of services. One reason that is often given for such overuse is that it is necessary in order to reduce the risk of malpractice prosecution. Is there any evidence to suggest that PSRO review could have a beneficial effect on the incidence of malpractice claims and recoveries?

ANSWER. Although there are no hard data which suggest that PSRO review reduces the practice of "defensive medicine," the potential for such reduction does exist. Since one cause of defensive medicine is the uncertainty of the standard of care to which a physician may be held in court, reduction in the practice of defensive medicine is possible as physicians become more aware of what their peers believe to be reasonable practice. PSRO offers a mechanism, through the setting of review standards and criteria and through the review process, by which physicians can become more certain of reasonable practice. Their tendency to overutilize services merely because of defensive medicine should, therefore, be diminished.

PHS HOSPITALS

Mr. CONTE. This health care program was initially established for merchant seamen. How many seamen use the hospital facilities at present, and how many of those who use these facilities are additionally covered under regular employee benefits?

ANSWER. During fiscal year 1976, American seamen accounted for 475,398 PHS hospital and clinic visits and 11,652 hospital admissions. There were 41,364 first clinic visits by American seamen, which gives an estimate of the actual numbers of individuals served during the year. There are approximately 201,870 American seamen beneficiaries eligible for care in the system.

There are no definitive studies as to the total number of merchant seamen who have some form of employee health insurance. Most of the large union contracts contain provisions for "second pay" for the seamen and regular "first pay" for the dependents and for the seamen after their retirement. A few companies may have regular employee health insurance that does not require utilization of the Public Health Service if it is available. Our best estimates are that a very small percentage of all merchant seamen have such coverage.

Mr. CONTE. What specific functions that these hospitals and clinics provide could not be better handled by the National Institutes of Health and why?

ANSWER. There are four separate major functions of the Division of Hospitals and Clinics, first, to provide continuing comprehensive medical care for Federal beneficiaries; second, to integrate participation in the communities' response to high priority local health care needs; third, to provide education and training for current and future Federal and community health forces; and lastly to perform both health services research and traditional clinical research. A network of eight general hospitals, the National Leprosarium at Carville, 30 outpatient clinics, and over 300 contract physicians is utilized to perform these functions.

The National Institutes of Health (NIH), located in Bethesda, Md., administer extramural research programs through grant and contract mechanisms and intramural research by in-house staff scientists.

By virtue of the single location of NIH, its purely research-based patient selection and professional staff interest, and the specific orientation and emphasis of its mission, there is little realistic potential for substituting NIH to satisfy the fundamental division of hospitals and clinics responsibilities. A single possible exception may be in the area of medical research which, in toto, comprises approximately 3 percent of the DHC budget. Even here, the

patient and service mix at the PHS general hospitals provide the basis for health services research that does not exist on the NIH campus. Further, a large portion of this PHS hospital expenditure is devoted to research on leprosy at Carville, where existing facilities are unexcelled.

Although the remaining research endeavor might be considered for transfer to NIH, some opportunity to pursue investigative interests is needed to attract high calibre professional staff and to maintain professional training programs.

Mr. CONTE. A recent OMB publication states that if these PHS hospitals were phased out of the Federal budget the increased demand on other community health care facilities would not adversely affect access to care for other citizens. Do you agree with this statement? If so, how can you justify further Federal funding of these hospitals?

ANSWER. In 1976, issues relating to the local community impact of PHS hospital closure were addressed by those individual State and local areawide comprehensive health planning agencies representing the hospital locations. This was in response to a solicitation from the Assistant Secretary for Health regarding proposed closure or transfer of the hospitals. On the basis of their findings, none of them agreed with the proposal. It seems reasonable to conclude that these agencies, who are most conversant with local issues, would not agree with the view expressed in your question.

Under these circumstances, it is difficult to respond to your second question. However, given the view mentioned, the need for Federal funding of this nucleus of PHS hospitals and clinics would, in my view, remain justified. These hospitals have demonstrated their ability to provide continuing comprehensive health care at a total cost that is substantially below that currently available on the open market. Clearly, they offer something that, at the very least, deserves examination rather than termination.

Mr. CONTE. This publication states that at least five of these hospitals are in areas with an excess of hospital beds. The operation of the PHS hospitals tend to push up local hospital costs. Will you comment on this statement?

ANSWER. The issues relating to excess hospital beds and the overall impact on local hospital costs are not constant at the various localities of PHS hospitals, and are evaluated by the representative State and areawide community health planning agencies. After studying the 1976 proposal to close or transfer the hospitals, none of these agencies agreed with the proposal. The simple comparison of a net statistical observation does not adequately permit consideration of the relevant problems and needs that are recognized at the local level.

Mr. CONTE. OMB projected a 69-percent utilization of capacity in 1977. What percent of the hospital capacity will be utilized during 1978, and how accurate is OMB's estimate?

ANSWER. In fiscal year 1976, the occupancy rate in the PHS hospitals was 69.5 percent. Estimated occupancy rates for fiscal years 1977 and 1978 are 71 and 73 percent, respectively.

Mr. CONTE. What kind of maintenance investment do you foresee in years to come?

ANSWER. The full expenditures required to modernize and upgrade this system amount to $91.4 million for the general hospitals—including acquisition and transfer costs for relocating the Galveston Hospital—2.1 million for the clinics, and 26.6 million for the National Leprosarium at Carville. After modernization, it would cost 3.3 million per annum for continuing maintenance and repairs to the entire system.

Mr. CONTE. What are the training and research projects that you sponsor in the hospitals that are not being done privately or by other Governmental health agencies?

ANSWER. The Public Health Service hospitals and clinics are engaged in a series of training and research projects, some of which are not being done in private or other governmental hospitals. Four examples of unique training programs are,

First, the only Federal health record administrator, formerly the medical record administrator, program in the country is operated at the PHS Hospital, Baltimore.

Second, the physician assistant training program at the Staten Island Public Health Service Hospital is unique in that it originated as a purser/pharmacist-mate training program and expanded into a fully accredited physician assistant

program, training individuals to work in Federal and private facilities with special emphasis on shipboard independent duty.

Third, the Seattle PHS Hospital is in the process of developing two primary care residencies in conjunction with the University of Washington. One will be a family practice model and the other will be an internal medicine model. It is planned to compare utilization, costs and quality measures, including outcome measures and patient satisfaction, to see if there are differences between these two categories of physicians.

Fourth, in several of the communities the hospitals are providing clinical experiences for health professions students such as nurses (associate in arts and baccalaureate level programs), physical therapy assistants, occupational therapy assistants health technicians, and others. In many of these communities similar opportunities for clinical training are unavailable. Four examples of unique research programs are:

First, cooperative drug studies. Over the past 15 years the Division has been engaged in a series of cooperative drug studies involving patients with hypertension and urinary tract infection. These studies have involved identical protocols being implanted in seven or more sites with identical methods of examining and treating the patients being studied. The success of these studies can be measured by the publication of results and the renewal of grant applications. Very few other Federal systems exist for these studies and none exist in the private sector.

Second, evaluation of alternative review systems: This is an intramural research project of the National Center for Health Services research in collaboration with the Division of Hospitals and Clinics. Its purpose is to evaluate concurrent and retrospective review alone or in combination, using as a baseline standard implicit review techniques, to see if there are differences in utilization of resources, cost of care, outcome measures, patient satisfaction, or other quality indicators. This is a unique study and possible because of the common system of management in the hospitals and clinics and identical personnel systems. This is being duplicated nowhere else in the country.

Third, the Seattle Public Health Service Hospital is engaged in performing evaluation of physician assistant productivity and has a unique capability to perform the studies. These studies are being undertaken under contract from the Department of Defense. No other group in the country has the identical capability for these studies.

And lastly, a series of studies concerning hospital information systems and medical information systems are being conducted at the Baltimore and Seattle Public Health Service hospitals. Identical studies could not be completed in any system that does not have a full time staff such as ours, nor would the studies be as useful unless the other system operated independent clinics as well as hospitals.

Mr. CONTE. What is your annual budget for research and training?

ANSWER. In fiscal year 1976 the total annual expenditures on research were $5,448,000 including direct funding, reimbursements, grants and cooperative projects. Expenditures on training were $3,662,954 including interns, residents, upward mobility and allied health personnel.

Mr. CONTE. How much more costly per patient is it for contract care than for PHS hospital care?

ANSWER. The actual per diem cost for hospitalization, including depreciation cost, physician cost, drug cost, etc., was $118.21 per day in fiscal year 1976. If, in addition, the presently proposed $91.4 million hospital modernization costs are depreciated and prorated, the cost of hospitalization in PHS hospitals is increased by $2.62 per patient day, giving an adjusted per diem cost of $120.83 for the PHS hospitals. The cost of providing equivalent services in community facilities is estimated at $230 per day.

A study performed by GEOMET, Inc., in 1974, revealed that the cost per case admitted to a sample of PHS hospitals ranged from 33 to 49 percent below the cost of comparable cases admitted to a matched sample of private voluntary hospitals, in spite of an average shorter stay in the latter facilities.

EMERGENCY MEDICAL SERVICES

Mr. CONTE. You are requesting $33.6 million, the amount included in the continuing resolution. Are you aware that we provided for a 1977 level of $40.1 million in the supplemental bill we marked up on Monday? Does that make any difference for your request?

ANSWER. We are aware that the House Appropriations Subcommittee has proposed an increase in the fiscal year 1977 appropriation for the program. This proposed change does not make a difference in our proposed fiscal year 1978 request at this time. In the event there is a fiscal year 1977 appropriation greater than the requested $33.625 million, we will evaluate the section by section distribution of the fiscal year 1978 request.

Mr. CONTE. Your justification indicated that some 65 EMS regions have not as yet received financial assistance under title XII. How many of those regions would receive funding this year under the budget which you are proposing? If less than all 65, how much additional funding would be required to fund all 65?

ANSWER. In fiscal year 1977 the President's budget proposes funding for an additional eight EMS planning grants. This would reduce the number of regions that have not prepared plans under section 1202 from 65 to 57. The President's budget, in fiscal year 1978, allows funding for approximately nine planning grants. This would further reduce the number to 48 unfunded regions. These regions would require an additional $2,160,000 based on present estimates of $45,000 per planning project. However, since the revised statute provides that we spend at least 2½ percent but not more than 5 percent of the EMS appropriation for planning grants under section 1202, the total fiscal year 1978 EMS appropriation for sections 1202 through 1204 would have to be $61.2 million which is $6.2 million above the legislative authorization.

Mr. CONTE. This year you are proposing no grants or funding for EMS research. Would you explain why not?

ANSWER. We are not requesting funds under the EMS Act for research in fiscal year 1978, however we are specifically requesting EMS research funds in the Health Resources Administration under its general health services research authority. As you know, the research previously funded under the EMS Act has been conducted by the Health Resources Administration.

Mr. CONTE. Apparently EMS funds have been used to assist 49 of the 50 States. What is the remaining State, why isn't it included?

ANSWER. The only State that has not received operational or planning funds under title XII is New Mexico. The reasons New Mexico has not received funds are that they did not apply for funds in fiscal years 1974–75, and that they were not eligible for funds in 1976 due to a statutory limitation.

Mr. CONTE. What has been your experience with regard to the ability of emergency medical services to continue after Federal funding has been completed?

ANSWER. At the completion of grants awarded in fiscal year 1977, 12 regional systems will have completed their eligibility for funding under the emergency medical service systems act. Based upon our knowledge of those 12 systems in their current operation, we know of no failures. Since the completion of funding, adjustments have been made to these Emergency Medical Service systems so that they would be more responsive to the needs of the people and the ability of people to pay for the system, but all of the systems are still operational.

Mr. CONTE. What are the inflation rates associated with emergency medical services? In other words, how much would last year's funding level have to increase in order to actually provide for a constant program level?

ANSWER. We have made no formal study of the inflationary impact which would manifest itself in EMS grant requests. However, from our knowledge of the individual requests for personnel and the cost of equipment, it would be fair to say that EMS has not escaped the inflation of the past 3 years. This year in a revision of our proposed regulations, we are increasing the limit on planning grants from $45,000 to $60,000, representing an increase of approximately 10 percent a year to take care of the increased salary cost of planners and people associated with the development of EMS plans. We have seen similar increases in the 1203 and 1204 applications for salaries of people, instructors, and cost of equipment.

Mr. CONTE. Can you give me some examples of successful EMS operations which have been effective in reducing mortality figures from trauma and burn injuries?

ANSWER. Yes; we have several examples of this type of very impressive and favorable outcome. In Massachusetts, there has been a decrease by 50 percent of deaths en route to the hospital as a result of the fact that ambulances are staffed by two or more emergency medical technicians. In Charlottesville, a detailed study of heart attack has shown that the EMS system has resulted in a 28-percent reduction of deaths due to heart attack. In South Carolina, two studies were made of acute myocardial infarctions with complications, comparing the

period of July through December 1975 with January through March 1976. The Appalachian region showed an 8-percent improvement and the Midland region showed a 4-percent improvement. This improvement in critical patient care is directly related to the advanced training of emergency medical technicians.

Mr. CONTE. Would you explain how the EMS program atually works? Does the program work on a categorical or formula basis? How are funds distributed to areas and communities?

ANSWER. The program distributes its funds on a categorical basis, not on a formula basis. Our planning estimate is based on the assumption that the Federal share in the development of the typical or average national emergency medical services region is approximately $1.75 million. This is matched under sections 1203 and 1204 by grantee dollars.

Three hundred emergency medical service regions have been identified by the States. There are no specific guidelines with regard to population and square mileage to define an EMS region. Their designation is dependent upon the understanding and acknowledgement of current patient flow patterns for emergency purposes.

Also, we have EMS regions at different stages of planning and development throughout the Nation.

This distribution tends to be rather evenly divided nationwide even though there are different numbers of EMS regions in each of the 10 DHEW regions. When the appropriation has been enacted by the Congress and signed by the President, funds are distributed to each of the DHEW regional offices on the basis of the current status of regional EMS system development within each of the DHEW regions, trying to provide as much consistency of funding within each DHEW region and among these same regions. We also try to provide national guidance for the DHEW regions with regard to priorities of funding within their jurisdiction. For example, this year a priority will go to the reduction in the number of the planning grants that have been completed and are awaiting operational funding. This must balance with the need for providing continuation funding for all of those grantees that are doing a successful job and are requesting continuation of operational funding. The final decision on grant awards is made after competitive examination of their applications and needs. The final award decisions are made by the regional offices.

Mr. CONTE. I understand that there have been some problems at the local and State levels with fairly high administrative costs associated with the EMS program. Do you have any information on your administrative costs, and how they compare to other health service programs?

ANSWER. We are unaware of any problems beyond the normal inflationary problems of high administrative costs at the local level. It is true that places where there had not been an EMS system or EMS capability and there is now an emerging EMS system, costs have gone from zero to something higher than zero. Also, during the developmental phase there are initial operational costs for procurement, training, and administration. These costs are, in great part, picked up by the DHEW grant and they will be reduced or eliminated after the developmental process.

HEMOPHILIA

Mr. CONTE. How many hemophiliacs are there in the United States? What percent of these are reached by your program?

ANSWER. It has been estimated that there are 100,000 to 140,000 persons in the United States who suffer from hemophilia. However, we are in the process of analyzing new data and a preliminary check would indicate this estimate is too high. With the available resources we project we will reach approximately 2,300 persons.

Mr. CONTE. What kind of treatment is given through your service, and what are the costs per person for this treatment program?

ANSWER. The centers funded through the BCHS hemophilia program are providing a long range of services, depending on the need of the patient, and establishing a relationship with private physicians and other providers. The funds provided by this program have been used to augment services and expand capabilities of existing centers. Our contribution to the centers is not the total cost of treating the estimated 2,300 patients.

Mr. CONTE. Does your budget request adequately reflect the extent of the need for hemophilia centers? How much of an increase, if any, would be sufficient to assure the necessary services to hemophiliacs who cannot afford private services?

ANSWER. The extent of the need for hemophilia centers has not been defined. Because of the developmental nature of the BCHS program, we feel that $3 million is an appropriate level of funding to adequately accomplish our emphasis to increase capacity in existing centers and to serve as a resource for health care providers who serve hemophiliacs.

Mr. CONTE. Are there any other agencies which would provide hemophiliacs with services similiar to those of the hemophilia treatment center program? Does this result in an overlap of resources, and if so how can this be avoided in the future?

ANSWER. The National Hemophilia Foundation estimates there are 67 clinics in the United States, of which many do not have sufficient resources to provide the broad range of the needs of hemophiliacs' required services.

We are attempting to avoid overlap of resources by planning and coordinating all efforts to determine that treatment centers are located in areas where no comprehensive services are now available.

Mr. CONTE. How many of the Nation's hemophiliacs can afford the necessary treatment?

ANSWER. Given the estimated annual cost of $3,400 for a mild case to $40,000 for a severe case, it seems unlikely that many can afford the necessary treatment. This disease requires continuous treatment throughout the patient's lifetime.

Mr. CONTE. What can be done about decreasing the costs of treatment, and would Federal subsidy with State, local, and third party matching funds have more impact than the present operation of your program?

ANSWER. This program is basically to increase capacity to improve patient care, and facilities as well as to increase the capability to deal with the special medical, psychological, and social problems of hemophiliacs on the part of the general public, health providers, families, and schools. It is essential that this component of the program be continued regardless as to who provides the funds to pay for treatment.

Mr. CONTE. How much of your allocated resources go toward administrative costs which could be more effectively used for treatment costs? Could the funds be more effectively used by reimbursement of pharmacists and doctors in private practice rather than setting up treatment centers which increase the cost of treatment?

ANSWER. We do not use any of the allocated resources for administrative costs.

In 1976, $1.5 million was allocated for the diagnostic and treatment centers; and $500,000 was used for a blood separation center study. In 1977 and 1978 the full appropriation will be used to support diagnostic and treatment centers. The capacity building activities for which the appropriated funds are being used are essential to assure that hemophiliacs are provided a medical program of health maintenance and supervision on a continuous basis. Too often, only emergency care, primarily injections of blood derivatives, are provided for acute conditions; patients are not provided the continuing medical care and information they need to help avoid the recurrence of such acute problems. The purpose of our capacity building effort is to assure that those treating hemophiliacs are better able to provide the continuous medical supervision that is required.

MIGRANT HEALTH

Mr. CONTE. Explain the specific needs of migrant health programs and why other agencies cannot provide these services?

ANSWER. The migrant farmworkers and their dependents, who are the primary beneficiaries of the migrant health program, are usually a low-income population who move from area to area seeking employment. The areas where migrants live and work are usually rural areas, and have a limited capacity to provide health-care services. With a limited income, the migrant usually is not able to pay for needed medical care in the private sector; as temporary residents in the community, migrants often are ineligible for publicly financed medical care programs. In addition to these financial barriers to health care, the migrant faces a number of access barriers. The migrant's inability or reluctance to take time off from work, which reduces his earnings, and to seek needed health care in facilities that are open regular business hours also limits his access to health care. Since many migrants are Spanish speaking, cultural and language barriers also have an adverse impact upon their ability to get needed care.

Current legislation specifically addresses some of the barriers which migrants have to services. For example, when English is not the major language of a substantial portion of the population served, then a staff member who is fluent in both the predominant language of the particular migrant group and in English must be utilized to bridge linguistic and cultural differences. Other agencies do not have such migrant specific requirements. In addition, we believe that all community health centers to which migrants have access should be involved in addressing these special needs. Therefore, a goal of the Bureau of Community Health Services is to develop active outreach programs in such centers to enable them to identify and serve migrants.

Mr. CONTE. How are the funds and services delivered to the individual migrant worker? Do doctors work for the agency or does the agency provide funds for reimbursement of services, similar to Medicaid?

ANSWER. Funds are not provided to the individual migrant worker. Grants are made to public and private nonprofit agencies which develop centers or projects offering a full range of primary care services including preventive services and referral to specialty care. The delivery method depends on the size of the project and the organizational structure. Many larger projects and centers hire primary-care staff physicians and contract with private practitioners for specialty care. Some projects contract with local physicians for clinic session during the evening hours while in some smaller projects patients are referred to local physicians who will accept migrants and the project reimburses the physician on an agreed-upon basis.

Mr. CONTE. What other health service programs and Federal programs serving migrants does you agency have linkages with? How does this relationship work, and what measures are taken to prevent an overlap in the services provided?

ANSWER. The migrant health program has linkages with the community health center program, the National Health Service Corps, family planning and Appalachian health. These programs integrate their resources through the capacity building initiative by providing linkages of primary health-care services with secondary and tertiary care into a total health-care delivery system and serve populations of all these programs. In addition the Office of Education, Division of Education for the Disadvantaged, and the migrant health program is presently developing guidelines designed to bring about more coordination of services provided and eliminate potential overlap.

Coordination efforts with the Department of Agriculture to develop guidelines which would improve the utilization of women, infant and children services by migrant family members are ongoing within the Bureau of Community Health Services. The Office of Child Development, which provides day care services for migrant children, is also cooperating in this effort and will be included as a participating agency.

Mr. CONTE. How many migrant workers who could qualify for these benefits do not apply? Does the outreach service get information to these workers, and what impact has it had in a quantitative change in the migrants being served?

ANSWER. We have identified 193 areas covering 367 counties which have a migrant population of more than 1,000 migrants for more than 2 months each year. The target population in these areas is estimated to be 931,000 migrants and 1,000,000 seasonal farmworkers. Utilization data from the projects in these areas indicate that approximately 80 percent of the target population remains unserved.

Outreach services are an integral part of every migrant health project to provide information to patients on the availability of services. While it would be most difficult to break out that portion of increased utilization of services which is a direct result of outreach activities from past experience, project reports clearly identify the need for these services and it can be safely assumed that the continued increase in utilization of services in projects is in part due to outreach.

Mr. CONTE. In light of inflation, your fiscal year 1978 requests are actually a decrease in resources, even though the figure is constant. Should I take this to mean that the program's goals have been achieved in providing all eligible migrant workers with the services available to them under law? What kind of change, if any, would you like to see made in the budget?

ANSWER. The present funding level is serving approximately 20 percent of the identified target population. Even though inflation has been a factor in the delivery of services to migrants, it has not required a reduction in services or

employment. There has been approximately a 9½ percent increase which amounts to $2.8 million of total resources.

The migrant health program goals have not been achieved. There is a continued need for services as well as the need to integrate resources with other programs through the capacity building initiative by providing linkages of primary health-care services with secondary and tertiary care into a total health-care delivery system. Through this initiative, we will serve 99,000 migrants and seasonal farmworkers in fiscal years 1977 and 1978.

Mr. CONTE. Is it true that migrant health funds only provide for primary care?

ANSWER. Migrant health funds may be used to provide the broad array of medical and outreach services defined in the program regulations as primary care and may be used as well to provide supplemental services and environmental health services. The migrant health program also provides funds through a hospitalization program which covers 11 projects serving approximately 3,000 patients annually.

Mr. CONTE. What resources are available to these workers if treatment for their ailment goes beyond the primary care?

ANSWER. with the exception of those projects which are participating in the hospitalization program, there are few resources available to migrants who require hospitalization or extensive supplemental health services. Projects in a few areas have been able to arrange for assistance through community resources such as hospitals and mental health centers. However, the migrant program is a component of the capacity building initiative which integrates the resources of several programs linking primary health-care services with secondary and tertiary care into a total health-care delivery system.

Mr. CONTE. In your justifications you state that improvement of management and efficiency is one of your goals. How can this be done without shifting personnel or resources and ultimately leaving part of the program short?

ANSWER. The improvement of management and efficiency is primarily brought about by implementation of performance indicators which allow for the self-assessment by the project and regional office evaluation of project management. Norms for staff performance, unit cost for medical encounters, and cost of project administration have been established based on efficient management practices and are intended to guide project managers in the most efficient use of personnel or resources without reducing the program's output. Participation in the Bureau Common Reporting Requirements (BCRR) will also improve management of the projects and provide for improved accountability.

Mr. CONTE. What are the reasons for a migrant labor housing study and the cooperative EPA/BCHS pesticide study intended for 1978?

ANSWER. The cooperative EPA/BCHS pesticide study is a continuation of activities supported with 1976 and TQ program resources. The purpose of the study is twofold: (1) to establish capability of clinic staff for the diagnosis, treatment, prevention, and reporting of pesticide episodes, and (2) to amass a broader base of morbidity and mortality statistics related to pesticide poisonings. These statistics will be used by EPA in determining restricted use criteria and classification of hazardous pesticides, BCHS projects will serve as a primary national network for reporting pesticide episodes to EPA.

Mr. CONTE. You state in your justifications in the chart on page 39 that there will be no money funded for these studies. Where then will the funds come from?

ANSWER. The migrant labor housing study and the cooperative EPA/BCHS pesticide study will not require additional funding for 1978. These are "one-time" activities initiated in 1976 and carried over into 1977 and funded from 1976 and TQ resources.

The migrant labor housing study was mandated in the current migrant health legislation, Public Law 94-63, title IV. The purposes of the study are to determine the quality of temporary housing which is available to migratory agricultural workers: determine the effect on the health of migrants of deficiencies in their housing conditions; and determine the status of existing Federal, State, and local standards respecting housing conditions and the adequacy of enforcement of such standards. A report of the findings of the study and the recommendations of the Secretary, Department of Health, Education, and Welfare shall be submitted to the House Committee on Interstate and Foreign Commerce and to the Senate Committee on Labor and Public Welfare.

Mr. CONTE. As you know, hospital costs rise every year in large increments. What result will the budget have on your ability to serve the hospitalization needs of your constituency?

ANSWER. With hospital costs rising and utilization increasing in the participating projects, the same amount of money will inevitably serve fewer people; therefore, we have projected fewer people served in fiscal year 1978.

Mr. CONTE. The figures for third-party collection have also remained constant in your fiscal year 1977–78 estimates. In a cost-efficient manner, couldn't you increase these contributions through public awareness measures?

ANSWER. Experience has shown that third-party collections for health-care services provided to migrant farmworkers persist at a low and constant rate due to several factors such as mobility of the migrants through the various political jurisdictions in the country—communities, counties, States; eligibility requirements, intend to reside, income data, etc., impede certification for third-party benefits; and administrative impediments encountered by migrant health projects to obtain certification as providers under titles XVIII and XIX. It is not envisioned that promotion of public awareness measures can increase third-party collection to any meaningful degree.

HOME HEALTH

Mr. CONTE. How will it be possible to expend existing projects and also increase the number of new projects at the same funding level as 1977?

ANSWER. The 1978 budget proposes to make new grant awards to 40 projects. One-half of these will go to new agencies to support startup costs; the other half will be awarded to home health agencies that already are operational, and will be used to allow them to expand their service capacity. The 20 expansion awards will be available to any existing agency that meets the statutory and regulatory requirements and wants to expand its service program. This includes those agencies which previously received grants for startup costs under the program.

Mr. CONTE. How many projects are funded independent of Federal money at the present time?

ANSWER. It is not known how many home health agencies are funded independent of Federal dollars. However, in 1970 the number of medicare certified home health agencies reached a total of 2,346 and by June of 1976 there were 2,361 excluding the 16 new projects funded by the Home Health Services program in PHS. Very few home health agencies are funded independent of Federal startup moneys. Taking into account that the potentially eligible population 65 and older increased from 20.1 million in 1969 to 24.9 million in 1975—an increase of approximately 24 percent, the assumed capacity of home health agencies has not increased proportionately to meet that need.

Mr. CONTE. How long does it usually take to set up an efficient independent project, and what is the average cost?

ANSWER. Since home health projects in BCHS were funded for the first time in fiscal year 1976 and have had only 6 months of project development, data are not available at this time to determine how long it will take to set up an efficient independent project. However, each applicant for a home health agency is required to submit a detailed financial plan specifically structured on how it will achieve financial self-sufficiency. This plan includes such items as quarterly cash flow projections, identification of revenue sources and marketing plans. We believe that this requirement plus a seventeen month project period for new starts, allows adequate time in which a project can develop a positive cash flow so that it can become financially self-sufficient. This requirement does not, however, rule out the possibility of an agency applying for additional funding to expand further home health services over and above those activities funded in prior years. The estimated average cost of a new developmental project is $50,000 and the average cost of a new expansion project is $100,000.

Mr. CONTE. Are the States and counties usually willing to maintain the same level of services as the Federal Government after Federal involvement has ended?

ANSWER. The Home Health Services program provides for the making of project grants to improve the delivery of home health services. The intent is to provide initial funding with the view to projects becoming independent of Federal project support. Continuation support is expected to be received from State and

local governments; third party payors for services provided; and direct user payments.

Mr. CONTE. At your present rate of funding how long will it take the agency to provide services for the 788 counties which are presently without services of a medicare certified home health agency?

ANSWER. While the 788 counties which are without the services of a medicare certified home health agency are a priority of the Department, projections cannot be made as to how long at the present rate of funding it would take to develop home health agencies in each of these counties. However, Congress, within the authorizing legislation, directed the Secretary in making grants to consider the relative needs of States and give preference to areas within a State where such services are not otherwise available and where a high percentage of the population to be served is composed of individuals who are elderly, medically indigent or both. The home health regulations define the benchmarks and procedures for determining a preference area.

Mr. CONTE. Would an increased budget allow for a greater number of certified agencies and hence, a greater number of people eligible for your services? If so, how much additional funding would be necessary?

ANSWER. Yes; an increased budget would allow for a greater number of medicare certified agencies, thereby providing services to a greater number of people who are eligible for services to receive them. However, it is difficult at this time to estimate how much would be required, at present there are approximately 788 counties with a total population of 12 million persons without the service of a medicare certified home health agency. It is estimated that the cost of a new development project is $50,000 and a new expansion project is $100,000. With the $3 million appropriated in fiscal year 1976 we were able to fund 56 projects which served approximately 15,000 persons.

Mr. CONTE. In light of the tremendous rise, annually, for hospital costs what effect has this had on your resources? Although your budget request is the same as it was in 1977 what do you estimate to be the actual loss in total resources?

ANSWER. The rise in hospital costs will not effect the resources of the Home Health Service program. Home health agencies provide health services within the home rather than in hospitals.

FAMILY PLANNING

Mr. CONTE. In categorizing target groups you refer to "never married teenagers" who face obstacles other than financial and have difficulty receiving services from private physicians. What are these obstacles?

ANSWER. One of the major obstacles is the unmarried teenager herself. Unmarried teenagers are the least willing to seek contraceptive services from their family physicians because of embarrassment and fear of disclosure to their parents.

Access is another obstacle since few private physicians maintain evening or Saturday hours.

Mr. CONTE. It seems that very little of your effort is directed to the dissemination of family planning information; but rather the main function of the family planning program is to hand out birth control devices. What have you done to inform the people in your target areas about what is available to them?

ANSWER. While the provision of the method of contraception to an individual wishing to practice family planning is an important element of the program, public awareness, community education, and patient education are equally as important to a successful family planning program. To inform people in these areas, we have developed the tools, techniques, and materials which grantees, providers, and communities can use to carry out these functions, and have required grantees to develop and conduct programs tailored to the needs and uniqueness of their geographic area.

Mr. CONTE. Are there any provisions in title X of the Public Health Service Act to allow for matching funds requirements? If Federal funds of 50 percent or even 75 percent to State and local money raised were imposed would the 1978 request of $117,500,000 be met?

ANSWER. Yes, there is a matching provision in title X. The provision provides that no grants for new projects after June 30, 1975, may be less than 90 percent of its costs. Grants for projects funded prior to June 30, 1975, may be made for a percentage not less than the percentage of its costs for which the 1985 grant

was made. Overall, there seems to be no particular problem since the total Federal contribution exceeds the 50 percent to 75 percent contribution suggested. On a State-by-State basis, our estimates indicate that 49 percent of the States have 75 percent or over in Federal contributions, 46 percent are in the range of over 50 percent and under 75 percent with the remaining 5 percent of the States showing less than 50 percent Federal contributions.

Mr. CONTE. What is meant by "family planning medical visits at clinics"? How much of the title X money is used for this function?

ANSWER. Family planning medical visits at clinics include a medical history, a physical examination, screening tests for cancer (pap smear, and breast examination with patient receiving instruction on self-examination), diabetes, high blood pressure, and venereal disease, contraceptive supplies and continuing supervision. Additional procedures are provided when medically indicated, such as genetic screening, pregnancy testing, a skin test for tuberculosis, infertility services, and referral to other medical facilities for followup therapy.

Approximately 60 percent of the title X appropriation for family planning services supports direct medical care. The remaining funds support services such as community education, patient counselling, social services including transporting patients to the clinic when necessary and providing child care, and general administration.

Mr. CONTE. Better than 100,000 teenage girls are forced into marriage because of pregnancy. These forced marriages usually break up. What can be done to increase awareness about family planning centers, and through the centers offer alternatives to unhappy or destructive marriages caused by unwanted pregnancy?

ANSWER. As part of the Department's activities in fiscal years 1977 and 1978 to address the problem of teenage pregnancy and childbearing which may result in early marriage, a campaign will be undertaken to increase awareness among teenagers, parents, the community and health professionals of the problem of teenage pregnancy and the health, social and economic consequences of too early pregnancy and parenthood. In addition, 60 percent of the increase in funds appropriated for title X family planning services are being channeled into areas with greatest need for services to teenagers. With these funds grantees will increase the availability and awareness of informational, educational, and contraceptive medical services to sexually active teenagers and assist individuals to avoid the many undesirable consequences of an unwanted teenage pregnancy.

Mr. CONTE. Of the 540,000 pregnancies each year to unmarried 15–19 year olds, only 10 percent are intended. What successes have you had in cutting the growth of unwanted teenage pregnancies?

ANSWER. Family planning is a preventive alternative to unwanted teenage pregnancy and abortion. Organized family planning programs are providing services to about 4.2 million teenagers and low-income individuals of which 3 million are seen in the 4,400 clinics supported by title X, Public Health Service Act. Residents in all counties in the United States will have access to services by the end of 1977.

General public, community, and patient education is as important a component of the program as the actual provision of family planning medical services. Increased emphasis has been placed on creating awareness among the general public of the problem of teenage pregnancy and the health, social and economic consequences of too early and unwanted pregnancies.

In 1976, 65 percent of the sexually active never married teenage females reported using contraception the last time they had intercourse, compared with 45 percent in 1971, and 30 percent reported consistent usage of contraception compared to 18 percent in 1971. A recent study has shown that some 2 million tenagers at risk of unintended pregnancies are now using effective birth control methods.

In 1974, the last year for which data are available, there were about 300,000 teenage pregnancies terminated by induced abortion and an additional 140,000 resulted in miscarriages. Assuming that 1 in 6 teenagers at risk actually do get pregnant every year and that 27 percent of the pregnancies are terminated by abortion, the 2 million teenagers now using effective methods of contraception have avoided 330,000 unwanted pregnancies.

Mr. CONTE. What specific group do you see as being the agency's main target for educational information?

ANSWER. The main target group for educational information is the general public. It is our intent to increase their awareness of the problem of teenage pregnancy and its consequences, of the alternatives available to reduce the numbers and the adverse consequences of teenage pregnancies, and of the resources and assistance available to communities wanting to address this issue.

Mr. CONTE. Every year approximately 10 percent of the Nation's teenage girls become pregnant with 6 percent having their children. This would lead one to believe that about 4 percent are aborted. How have you approached the problem of abortion and what have your successes been in decreasing its occurrence?

ANSWER. Our approach to abortion is basically the same as our approach to unwanted teenage pregnancies, which I have discussed before. We are using family planning as a preventive alternative to abortion. The Bureau of Community Health Services has increased efforts to provide services and access of these services to teenagers and high risk persons in unserved and underserved areas. Further, we have increased emphasis on the education component of the family planning program to create an awareness among the general public of the problems and consequences of too early and unwanted pregnancies. As I previously stated, in 1976, 65 percent of the sexually active never married teenage females reported using contraception the last time they had intercourse, compared with 45 percent in 1971, and 30 percent reported consistent usage of contraception compared to 18 percent in 1971. A recent study has shown that some 2 million teenagers at risk of unintended pregnancies are now using effective birth control methods.

Mr. CONTE. The number of unwanted pregnancies and its side effects are overwhelming. If family planning centers are the answer to the problem is your present budget request adequate to fulfill the intended purposes of the program?

ANSWER. The family planning program received a $13 million increase in 1977, which will enable access to services to be provided to residents of every county, territory and trust of the United States; to expand services in some areas that previously had only minimal access and to increase services for teenagers in areas of greatest need. The $10 million increase proposed for 1978 will enable us to provide more services to an increased number of teenagers and low-income high risk individuals in need of services. Although these increases will not enable the program to reach the total population at risk, they will increase by 18 percent the number of individuals seen in organized programs by the end of 1978.

HYPERTENSION

Mr. CONTE. How are these hypertension grants distributed, and where is the greatest need for these funds?

ANSWER. The hypertension grant funds are distributed on a formula which provides a base amount of $10,000 to each State and the financial need weighted by the extent of the hypertension problem in that State.

The greatest need for funds appears to be in the rural, black South where hypertension rates are at their highest. Other populations greatly affected include those with inadequate diets.

Mr. CONTE. How is hypertension detected in its early stages? Is this something people have to be made aware of or are the symptoms usually not obvious enough to be detected by an individual or those around him?

ANSWER. By the simple procedure of taking blood pressure—a procedure which usually is, or should be, done routinely during a health examination. Hypertension in its early stages is more often than not asymptomatic. Patients, and others around them, are unaware of having this condition and become aware only after blood pressure has been taken for some other reason.

Mr. CONTE. What are some of the causes and effects of hypertension?

ANSWER. Although hypertension may be secondary to renal disease or certain glandular tumors, the cause of most hypertension is unknown. It is often called primary hypertension or essential hypertension. Much research has been done to eliminate the cause, or causes, but despite many theories it as yet remains a disease of unknown etiology. Heredity, salt intake, overweight, psychological stress, and other factors seem to be associated with hypertension along with complicated interplay of chemical substances from the kidneys and adrenal glands. Some feel that primary hypertension is not a simple disease but a grouping of general diseases.

It is an accepted fact that elevated blood pressure is associated with premature disability and death. Primary hypertension may progress to a form called malignant hypertension which is a serious disease of the small arteries which affects many of the body organ systems. Heart failure, myocardial infarction, and strokes occur at a higher frequency in hypertensives. Insurance companies have long known that people, even with mild high blood pressure, are at increased risk of premature disability and death.

Mr. CONTE. How many people suffer from hypertension, and do you feel that this budget of $9 million will enable you to follow through with the intended impact of the program?

ANSWER. It is estimated that some 20–25 million Americans have elevated blood pressures. In 1978, the administration proposes to extend the legislation of this program. We feel that $9 million is appropriate for this type of program. We will continue with patient screening, evaluation of patient's needs, referral of existing health providers for care, and followup to see that the patient is continuing with treatment and using prescribed medication.

We are cooperating with the NIH in spreading information and technical information on hypertension control. We recently jointly sponsored with NIH a workshop with State health officials on hypertension control and the use of 314(b) funds. The general indicator at the meeting is that States are receptive to the linkage of the 314(d) program and other programs.

We are stressing the need for States to establish intrastate coordinative mechanisms to plan and implement control programs. The problem is too large to expect any one agency to assume total responsibility.

We cannot afford to duplicate effort. Voluntary agencies, hospitals, and professional societies must approach the problem on a cooperative basis with official State health agencies, and other agencies.

Mr. CONTE. In spreading information and technical assistance are you utilizing already existing community and State groups or are you setting up offices with your own people?

ANSWER. The plan is to use existing Federal, States, and local groups and official and voluntary groups in the informational and technical assistance areas in every way possible. However, it is too early in the life of the program to be able to identify specific needs for staffing within BCHS.

Mr. CONTE. What changes will be made in the program in 1978, and how will this shift the direction of funds from one area of the program to another?

ANSWER. Under the present legislation we do not anticipate any changes in the hypertension program in 1978. However, the current legislation does not provide for treatment of hypertension; current authorization may be used to support only detection, diagnosis, prevention, and referral.

NATIONAL HEALTH SERVICE CORPS

Mr. CONTE. What success have you had in encouraging health professionals to remain in their communities once their National Health Service Corps obligation has been fulfilled?

ANSWER. The National Health Service Corps (NHSC) projects an increase in the retention rate of NHSC assignees from 43 percent in 1977 to 48 percent in 1978. The increase is a projection based upon prior years experience. In 1978, 70 percent of Corps physicians will be board eligible, an increase of 5 percent over the 1977 rate of 65 percent. The NHSC has deliberately recruited more board eligible M.D.'s who have completed their postgraduate training and are, therefore, more likely to continue at a site after completing their service obligation. This concentration on board eligible M.D.'s accounts primarily for the steady increase in the retention rate.

Other factors which impact favorably on the retention rate are a steady increase in the number of multiprovider sites, a good match of doctor and community initially and, provision of preoperational and operational technical assistance to assignees.

Mr. CONTE. How many designated medically underserved areas are there in the United States How many people live in those areas? How many of them should be covered by National Health Service Corps personnel by the end of this year?

ANSWER. The geographic areas required to be served by the NHSC are critical health manpower shortage areas (CHMSA's). There are two kinds of CHMSA's—medical and dental. A medical CHMSA's is a rational area (census tract, portion of a county, or one or more counties) where the ratio of population to full-time equivalent primary care physicians is greater than 4,000 to 1. A dental CHMSA is such an area, except that the ratio of population to full-time dentists is greater than 5,000 to 1. A total of 354 areas are both a medical and dental CHMSA.

As of January 13, 1977, 1,412 medical or dental CHMSA's with a population of 27,608,000 had been identified. We estimate that 1,700 CHMSA's will be identified by 1978.

A CHMSA is a described geographical area within which the NHSC may staff one or more sites. In 1978, 549 NHSC sites located in approximately 527 CHMSA's with an estimated population of 10,277,000 persons will have a NHSC site with at least one assignee. This represents 31 percent of the CHMSA's presently identified. The impact of these assignees on the total population of a given CHMSA is substantial in terms of lessening the workload of physicians already in practice and in the development of linkages with secondary and tertiary sources of health care.

Mr. CONTE. Will you be able to adequately staff all of those communities with approved applications?

ANSWER. In 1978 the Corps estimates that 775 communities will have approved applications and that 549 sites will be funded.

Mr. CONTE. What is the nature of the National Health Service Corps participation in the primary health care initiative program? How does the Corps coordinate that effort with the community health centers program?

ANSWER. The NHSC provides staff for some of the projects funded under the primary health care initiative. During 1978 the NHSC plans to have approximately 170 new assignees working in projects identified as community health centers (CHC's) providing primary health care. This is an increase of 50 over the 120 personnel assigned in 1977 to CHC's.

Through the primary heal care initiative, components of the community health centers, migrant health, Appalachian health, and National Health Service Corps programs integrate resources to serve populations of all these programs. The centers supported with these resources are rural (including centers originally funded as part of the rural health initiative) and urban ambulatory health service projects designed to establish health delivery capacity in areas of extreme need and medical underservice. The centers provide primary health services and develop linkages with existing secondary (specialist and inpatient) and tertiary (medical center) care resources. Continuity of care, quality of care and comprehensiveness of care, especially prevention, are emphasized. The primary health care centers established as a part of this initiative are expected to play a crucial role in assuring our ability to deliver services authorized by health care financing programs. This will be especially crucial for areas which currently lack sufficient health care providers and facilities even when adequate financing is available.

Mr. CONTE. The cost per encounter appears to be increasing every year, although at a relatively slow rate. Will this trend continue? How have you been able to keep the cost increase down?

ANSWER. Given the Corps mandate to provide high-quality comprehensive care in isolated rural areas, we can expect the increase in cost per encounter to continue. However, in order to control this cost, the National Health Service Corps (NHSC) has emphasized certain management practices in all of its sites. The first management practice is to keep site operating expenses within the budget limits set for each provider. As part of this process, the Corps has identified the potential of each provider that cannot be exceeded without risking increased cost.

Another factor helpful in controlling cost is effective administrative practices which include provision of both preoperational and operational technical assistance; improved access to regional staff for assistance in improving administrative practices; assignment of NHSC staff who already are board-eligible; matching of assignee and community needs in determining where individual health practitioners will be assigned; establishment of multiprovider sites to reduce professional isolation; and improving linkages to secondary and tertiary sources of care.

Mr. CONTE. Can you tell me exactly how the application and assignment process works? How are medical personnel matched up with communities in need of such personnel?

ANSWER. Any community entity that is or becomes a nonprofit corporation which is located within a critical health manpower shortage area which has been approved for Corps assistance may apply for placement of Corps personnel. The application, which contains detailed staffing and utilization plans, is reviewed and approved in the regional office which serves the area where the site is located. To the extent possible, the Corps attempts to match an assignee to the region and location of his choice. An opportunity is provided for each assignee to visit a prospective site and matches are made, taking into consideration the preferences of the assignees, as well as the applicant community. In addition, the Corps conducts recruitment seminars where potential assignees are brought together with applicant community groups.

Mr. CONTE. What form of technical assistance is given to communities who participate in this program? Is such assistance given on a contract or in-house basis?

ANSWER. The NHSC provides technical assistance to the area requesting designation or guidance in developing an application for Corps placement. Once an application is approved, the Corps continues to provide technical assistance in the preoperational phase of developing a primary care practice. Specifically, the Corps provides assistance in the areas of medical practice policies, facility design, equipment and supplies, personnel, office management, medical records, financial management, accounting and reporting, and public relations.

Once a Corps practice becomes operational, a planned followup program of technical assistance is provided in all phases of medical practice management throughout the life of the Corps practice. This assistance is provided through both contract, and central office or regional office staff.

COMMUNITY HEALTH CENTERS

Mr. CONTE. In looking at your budget request, it appears that you intend to accomplish three major objectives at a projected level of funding only $14 million above last year's budget. Especially when you say you are requesting $14 million for the adolescent care program alone. Realistically, how much money would be required to fund 90 new primary care initiative projects? How much money would be required to provide an increase in the basis for ongoing projects to meet increased costs?

ANSWER. In the 1978 budget request we are proposing to fund 90 new community health centers at a cost of $15,250,000, which is an adequate amount to meet the first year requirements. These projects would be established in rural and urban areas where there is an extreme need of medical underservice.

To meet the increased costs of inflation in community health centers in fiscal year 1978, a net increase of approximately $11 million would be required. In past years, such increases could be absorbed through third-party reimbursements and increased productivity in projects. However, in 1978 the increased factors will not be significant enough to permit the centers to offset all inflationary costs.

Mr. CONTE. In last year's bill, we increased funding for community health centers by $18.4 million above the previous year's level, or about a 10-percent increase. Could you evplain then why the targeted allocation of these funds for New England (region I) is being cut by $900,000 (nearly 10 percent)?

ANSWER. The Bureau of Community Health Services has developed a methodology for allocating available grant funds to its regions in an equitable manner. The method for computing target allocation has two components—the "base component" and the "performance component," the sum of which equals the target allocation. The base component is simply 60 percent of a region's fiscal 1976 base, and the performance component for a region is based on the regional percentage of the total national service level. Generally, one-half of the performance component is based on data covering the 6 months ending June 30, 1976. The other one-half of their performance component is based on data covering the 6 months ending December 31, 1976.

Based on the targeted regional office allocation formula and the Regional Health Administrator's funding plans, region I received $7,489,000 for fiscal year 1977 which represents 4.3 percent of the total fiscal year regional allocation

of grant funds. Region I also has 4.3 percent of the national total number of users and encounters for community health centers.

Mr. CONTE. Since 1975 of the new primary health care centers in the rural and urban health initiatives program have been funded. But only six of these centers were funded in the New England Region. Why?

ANSWER. At present, there are 1,500 counties, 1,509 minor civil divisions and census county divisions, and 5,215 census tracts nationally which have been designated as medically underserved areas (MUA) having a shortage of personal health services. The total number of people residing in these areas is estimated to be approximately 44,900,000. Region I has only 1.66 percent of the total MUA population. However, in 1976, based on an objective review, six RHI's in the region received $878,000. This is 4 percent of the grants awarded and 5 percent of the total funds, $16.2 million, awarded in that year. To date there have been no urban health initiative grants.

Mr. CONTE. What does the Bureau of Community Health Services intend to do about the over 130 medically underserved areas in the New England region.

ANSWER. The Bureau of Community Health Services has developed a methodology for allocating available grant funds to its regions in an equitable manner. The method for computing target allocation has two components—the "base component" and the "performance component," whose sum equals the target allocation. The base component is simply 60 percent of a region's corrected fiscal 1976 base, and the performance component for a region is based on the regional percentage of the total national service level. Generally, one-half of the performance component is based on data covering the 6 six months ending June 30, 1976. The other one-half of their performance component is based on data covering the 6 months ending December 31, 1976.

The Bureau has identified over 1,500 counties, 1,509 minor civil divisions and census county divisions, and 5,215 census tracts which have been designated as medically underserved areas (MUA) having a shortage of personal health services. The total number of people residing in these areas is estimated to be approximately 44,900,000. While there are 130 MUA's in the New England region, the total population in these areas represents 1.66 percent of the total medically underserved population of this Nation.

BCHS in fiscal year 1976 funded 6 rural health initiatives in region I, projects which are designed to meet the medically underserved needs of residents in non-SMSA's. In 1977, 10 of the projected 100 RHI's will be funded in region I.

In the urban or SMSA areas the Bureau has identified a need for BCHS funded projects but because of limited funds will only be able to fund 20 projects nationwide in fiscal year 1977. Region I will therefore have to compete for these funds against the medically underserved needs of the population of the rest of the Nation.

Mr. CONTE. How many of the new "urban health initiatives" do you plan to fund this fiscal year—and how many of those will likely be in region I (New England)? What about rural initiatives?

ANSWER. In 1977, there will be 20 new RHI's receiving $6.5 million. These will be continued at the same service level in 1978, and another 10 will be funded for $3.3 million. Regional staff are presently working with potential grantees. At this time at least five applications are being considered in region I. Final funding will be based on an objective review which will occur by June 1977.

On the rural health initiative, 100 new projects will be funded at a level of $15 million. Region I has submitted 10 applications which we expect to fund in 1977 and continue to fund in 1978. In addition, any new applications from region I received in 1978 will be reviewed along with applications from other regions on a competitive basis.

Mr. CONTE. I understand that your regional allocation formula is in part based upon the number of patients served by your programs and the dollar allocation to the region for the previous year. If this is the case, and if the New England region has traditionally been neglected in funding and project levels, then doesn't the formula perpetuate this situation? What can be done to see that New England receives its fair share of this program's resources?

ANSWER. New England already is getting more than its fair share. Based on the targeted regional allocation formula and the Regional Health Administrator's funding plans, region I received $7,489,000 for fiscal year 1977 which represents 4.3 percent of the total fiscal year 1977 regional allocation of grant funds. Region I also has 4.3 percent of the national total number of users and encounters for community health centers. Also, region I has 1.66 percent of the

total MUA population, and in 1976, six rural health initiatives in the region received $878,000; this represents 4 percent of the grants awarded and 5 percent of the total funds, $16.2 million, awarded.

Mr. CONTE. Your budget projects support for 164 on-going community health centers and 348 primary health care centers. How do these numbers compare to previous years? If your projections are correct, how many people will have access to such community health facilities by the end of fiscal year 1978? How will this compare to present levels of service and access?

ANSWER. In 1976, the Bureau supported 164 on-going community health centers and 138 primary health care initiative projects. A total of 6,565,000 people had access to services in these projects. In fiscal year 1977 an estimated 7,765,000 people will have access to 258 primary health care initiative projects in urban and rural areas, and 164 on-going CHC's.

Bureau estimates for fiscal year 1978 indicate that 8,665,000 people will have access to 164 on-going CHC's, and 348 primary health care initiative projects, providing access to health care services for 2,100,000 more people in fiscal year 1978 than we did in fiscal year 1976.

Mr. CONTE. What basis do you have for anticipating that third party reimbursements will increase from 31 percent in 1977 to 36 percent of the total project operating costs in 1978?

ANSWER. The new community health center regulations require that charges established in fee schedules be reasonably related to actual project costs. The Bureau of Community Health Services has performed an analysis of accounts receivable for community health centers for the period July 1, 1975 to September 30, 1976. This analysis indicated that community health centers have billed for 43 percent of their total costs, collected 31 percent of their total costs, and written off as bad debts and uncollectible 10 percent of their total charges. By implementing more realistic fee schedules, by increasing collections from titles XVIII, XIX, and XX and from patients charged on sliding fee schedules, and by decreasing the percentage of bad debts and writeoffs to 7 percent, community health centers should be able to increase the amount of third-party reimbursements collected to 36 percent of total project operating costs in 1978.

Mr. CONTE. Why does your budget project a decrease in first-year funding for primary health care centers from $21.5 million last year to $15.2 million this year?

ANSWER. In 1977 we funded 100 first year rural projects at a cost of $150,000 each and began 20 new urban projects at a cost of $625,000 each, a total of $21.5 million. In 1978 we are proposing to fund 10 new urban projects—10 less than 1977, and 80 new rural projects—20 fewer than 1977, thereby reducing the costs of first year funding of new community health centers from $21.5 million in 1977 to $15.2 million in 1978. The decrease in new projects is due primarily to the cost of continuing the projects started in prior years.

Mr. CONTE. To what do you attribute the decrease in cost per person from $129 in 1976 to a projected $104 in 1978?

ANSWER. The Bureau of Community Health Services has established program indicators and funding criteria that stress the need for project efficiency. As a result, primary practitioner encounters per hour increased from 2.5 in 1976 to 2.7 in 1977, total ambulatory costs that are direct ambulatory care costs increased to 64 percent in 1976 from 59 percent in 1975, and the cost per person served decreased from $129 in 1976 to a projected $104 in 1978.

MR. ROYBAL

Mr. ROYBAL. I was pleased to learn of your interest in developing links among our federally funded health services programs. What steps are being taken to establish linkages for instance between community health centers and maternal and child health programs in the State of California? In the Los Angeles area?

ANSWER. As you know, the effort to develop linkages have been of great concern to us. In fiscal year 1977, the community health centers program, through its primary health care initiative, identified 111 high priority areas for consideration in the development of integrated health care delivery projects. In region IX, the two areas identified are located in Los Angeles and in San Diego.

Community health centers funded through this effort will attempt to integrate all health resources available within communities, with particular emphasis on community health centers funds and National Health Service Corps health professionals and where appropriate family planning and maternal and child health

funds. Seven community health centers in region IX have been designated as access points for family planning services. This means that these seven community health centers can receive funds from title V, Social Security Act, and title X, Public Health Service Act, for family planning services.

In addition to this new initiative, regional staffs are working with existing community health centers and staffs of maternal and child health projects in the integration of certain aspects of their programs. For example, in Los Angeles, community health centers project staff and maternal and child health staff are working together in the development of nutrition plans.

Mr. ROYBAL. Do you intend to have health service plans of action developed for each State as I earlier recommended in supplemental views to the 1977 Labor-HEW appropriations bill?

ANSWER. Yes; we are beginning to work with the States to develop health service plans. By that I mean we are assessing what resources they already have, the problems in further developing these resources to meet the needs and working with them to develop mechanisms for coordinating such resources.

For example, a child health strategy has been developed to correct specific problems and deficiencies in the health care system for mothers and children. We intend to develop organized, integrated, State-based child health care systems which focus on leadership and emphasize effective linkage of State and local resources. The general objectives are to reduce the incidence of low birth weight and mentally retarded babies, to reduce the numbers of adolescent pregnancies, and to increase the number of children immunized, screened, and referred for diagnosis and treatment.

Mr. ROYBAL. How would your linkage approach develop close working ties among the various community-based health organizations, public health departments, schools, and providers?

ANSWER. BCHS programs are striving toward coordination and integration which will enhance maximum utilization of resources while eliminating fragmentation and/or duplication of health care services. It is anticipated that these efforts will establish closer ties between the public and private sectors of health care delivery at the local and State levels and therefore establish a firm base for health care delivery systems. They also insure continuity of care for the patient and a supportive and stimulating environment for health professionals.

The trend of randomly developing health projects and initiating new programs with fragile or no linkage with a more comprehensive delivery system finally is being reversed. It is now a condition of funding for Bureau programs that coordination or linkage must be made with other Federal, State, and local agencies and programs, private groups, and private sector practicing physicians. Some of the programs are: maternal and child health programs; crippled children's programs; community mental health centers; alcohol abuse and alcoholism programs; family planning programs; cancer screening programs of the National Cancer Institute; drug abuse programs; early and periodic screening, diagnosis, and treatment programs; emergency medical services programs; area health education centers; home health programs; family medicine residency programs; hemophilia comprehensive diagnostic and treatment centers; sickle cell screening and education clinics; health delivery or health-care oriented programs of Federal agencies other than the Public Health Service; State and local health departments; local schools; voluntary health agencies, i.e., heart, cancer, lung, et cetera; Farmers Home Administration and Food and Nutrition Services of the Department of Agriculture; State cooperative extension services; local labor union groups; local industry; biomedical communications/National Library of Medicine; providers of secondary care, including hospitals; providers of tertiary care; and long-term care providers/facilities.

A good example of the result of these linkages is the rural health initiative—RHI—program through which 191 primary care projects now provide services to over 726,000 people. These projects resulted from the integration of such Bureau-supported programs as the community health centers, migrant health, and assignees from the National Health Service Corps. The RHI has resulted in the development of linkages, referral and consultation relationships with other PHS agencies such as community mental health centers in 82 projects, alcoholism programs in 51 projects, and linkages with Health Resources Administration's area health education centers, the drug abuse program, the cervical cytology clinics, and breast cancer detection supported by the National Institutes of Health. In addition, linkages also have been developed with such other Federal agencies as the supplemental food program of the Department of Agriculture.

Concurrent with this effort to successfully integrate categorical activities at the local level, we are developing working relationships among all providers of health care services to help foster the delivery of family-based care, with emphasis on the mother and child. This is being accomplished through the development of statewide child health systems in each State.

Mr. ROYBAL. What specific steps will be taken to insure community and family involvement in health care delivery, planning, and assessment.

ANSWER. As the Bureau continues to provide leadership in increasing primary health care capacity in medically unserved and underserved areas, a key element of concern is directed toward assuring family involvement in health care delivery, planning, and assessment.

Program regulations require that projects have a governing board or advisory body which includes in its composition family members who are served by the project. This board may participate in the design of the program, establish policy for the conduct of the project, monitor and evaluate project activities, and assure that the project operates in compliance with the law and regulations.

In addition to having a decisionmaking entity which is composed of members of the family, BCHS programs provide services which are oriented toward the family as a unit. Bureau projects provide primary health care and develop linkages with existing secondary—specialists and inpatient—and tertiary—medical center—care resources. Among the services provided are family planning, health education, counseling, outreach, and transportation. Through the latter two, projects can identify family members who are in need of services and, if necessary, arrange transportation to make the services more accessible. By having linkages with other health, educational, and social service agencies the projects can further arrange for needs of the family to be met beyond their health problems.

Mr. ROYAL. What kind of affirmative plans have been developed to fully use all of the Federal health services programs to significantly improve health care and environmental health protection for migrants and their families?

ANSWER. It is the goal of the Bureau of Community Health Services to provide increased access to health care for as many migrants and seasonal farmworkers as the Bureau's resources will permit. To accomplish this goal, the Bureau has developed a capacity building strategy which provides for the integration of the Bureau's program services and funding resources. Bureau components which are directly participating in the effort include community health centers, migrant health, Appalachia health, National Health Service Corps, health underserved rural areas, maternal and child health, and family planning.

Beyond Bureau participation, efforts have been made to effect coordination of services with other Federal health service programs, including the migrant activities within the Division of Education for the Disadvantaged, Bureau of Elementary and Secondary Education, women, infants and children program, Office of Child Development, et cetera, for the purpose of accomplishing the most effective utilization of resources of all Federal health services programs.

In addition to the capacity building initiative, a child health strategy has been designed to correct specific problems and deficiencies in the health care system for mothers and children. The intent is to develop organized, integrated, State-based child health care systems which focus on leadership and emphasize effective linkage of State and local resources. Migrant mothers and children are a part of the targeted population of this strategy.

Mr. ROYBAL. What projects will be developed to improve housing and sanitation conditions for migrants?

ANSWER. The Bureau has initiated a number of activities for improvement of the housing and sanitation conditions of migrants. Under authority contained in the current migrant health program legislation, contracts have been negotiated with four States—Ohio, Texas, Florida, and California—to assist them in intensifying their migrant labor camp inspections and legal enforcement of applicable housing and sanitation standards. It is planned to extend this assistance effort to additional States in future years as funding resources become available.

During 1976, a major initiative was undertaken for the alleviation of excessive pesticide exposures to which the migrants are subjected. Through a cooperative program with the Environmental Protection Agency—EPA—training seminars were conducted for migrant health project clinical personnel to increase the capabilities of the projects to recognize, diagnose, treat, and prevent pesticide poisonings. The program also intends to gather a broader base of

morbidity and mortality statistics related to pesticide poisonings which EPA will use for determining restricted use criteria and classification of hazardous pesticides.

Also, under authority contained in the migrant health program legislation, a contract proposal has been initiated for the study of the quality of housing available to migrants. In addition to documenting the quality of migrant labor housing, the study is intended to establish the relationship and effects of existing housing conditions on the health status of migrant farmworkers. Study findings will be summarized and recommendations proposed for the alleviation of the detrimental housing and sanitary conditions documented in the study.

Mr. ROYBAL. What work has been done to eliminate cultural and language barriers to health care?

ANSWER. In several Bureau programs legislation and/or regulations require that projects have the services of outreach workers and other personnel who are fluent in the language spoken by the population served. For example, when English is not the major language of a substantial portion of the population served then a staff member who is fluent in both the predominant language of the population and in English must be utilized to bridge linguistic and cultural differences. With respect to the National Health Service Corps, the characteristics of assignees are matched with those of communities. A satisfactory match reduces the possibility of cultural and language differences and also increases the probability that the assignee will continue practicing in the area after the Federal commitment has been completed.

Mr. ROYBAL. What evaluations and measurements have been developed to show the impact of our health services programs in improving the health care of our underserved communities and among children, adolescents and mothers?

ANSWER. The Bureau Common Reporting Requirements—BCRR—is one of the means being used by the Bureau of Community Health Services to evaluate and measure capacity building and the impact of improving total health care to beneficiaries, most of whom are from low-income families in unserved and underserved areas. In addition, we are involved in an effort to develop statewide child health care systems, one objective of which is to help States evaluate the kinds of services available for mothers, adolescents and children in underserved communities.

A major initiative is the implementation of the BCRR. The BCRR provides for the collection of data on numbers of people served, cost of services, financial status of patients served, and clinic staffing and productivity. The BCRR is used in Bureau funded projects as a tool to collect data on how Federal funds are being managed, and provides a means of determining the level of efficiency and productivity, as well as those where additional improvements are needed. This information is considered in determining future grant awards. The National Reporting System for Family Planning Service has been modified to provide more reliable statistical data on contraceptive trends, patient characteristics, and the extent of medical services for all organized family planning projects.

MR. MICHEL

PHYSICIAN ACCEPTANCE OF PSRO PROGRAM

Mr. MICHEL. Is the medical profession fully cooperating with the PSRO program?

ANSWER. Initially the PSRO program was opposed by a significant number of physicians. However, the program has been very successful in turning this opposition into support. Now, nationwide, over 120,000 physicians are PSRO members. The initial opposition caused some delay in implementing the program but is no longer a significant factor, although there remain a few PSRO areas without sufficient physician support to establish a PSRO yet. We hope that the physician in these areas will soon come forward to establish a PSRO.

MEANING OF CONDITIONAL PSRO'S

Mr. MICHEL. You mention that all 203 PSRO areas in the nation will have conditional PSRO's in fiscal year 1978. What does "conditional" mean in this context? It has a temporary ring to it.

ANSWER. The conditional period is that time when the PSRO gradually assumes its review responsibilities. These include the implementation of hospital

review throughout the area and the implementation of long-term care review. Once these activities are underway, the Secretary will examine the PSRO's progress to assure the PSRO is "substantially carrying out in a satisfactory manner" the activities and functions of a PSRO and the Secretary may then convert the PSRO to fully designated status.

PHS HOSPITALS

Mr. MICHEL. What is the average occupancy rate at the Public Health Service Hospitals?

ANSWER. In fiscal year 1976, the occupancy rate in the Public Health Service hospitals was 69.5 percent. Estimated occupancy rates for fiscal years 1977 and 1978 are 71 percent and 73 percent respectively, based upon adequate budgetary support.

HEALTH MAINTENANCE ORGANIZATIONS

Mr. MICHEL. Last September, you asked us to approve a reprogramming of $3.1 million to the health maintenance organization program because of increasing demand in that program. That request was turned down, but there has been no increase in your budget for HMO's. If the demand has been that significant, why haven't increased funds been requested in the Budget?

ANSWER. With the passage of the amendments, an increased demand for participation in the program has developed. In a recent survey done in the regions, 70 organizations indicated an intent to apply for grant funds should they become available. However, the program was conceived as a demonstration program. As it has developed to date, approximately 80 operational HMO's will be generated, a number considered to be adequate to fulfill the demonstration aspects of the effectiveness of HMO health care under the terms of the HMO act.

ANSWER. The HMOs new in existence have performed effectively in exercising responsible control of health care services utilization. This is particularly significant in the area of inpatient utilization. The current average level for inpatient care is about 400 days per 1,000 enrollees per year, compared to a national average of 985 days per 1,000 persons per year for the population under age 65. This corresponds to a savings of about $70 per enrollee per year. An in depth evaluation to determine savings more precisely through identification of all payments, including out-of-pocket expenses, is now in the planning phase prior to implementation.

HEMOPHILIA

Mr. MICHEL. Where are most of the 17 hemophilia centers located? Are they part of some other health facility?

ANSWER. Most of the centers are part of some other health facility. A majority are in university medical centers and the balance are affiliated with teaching hospitals and State health departments. Three Centers are located in California, three in New York, two in Texas and one each in District of Columbia, Florida, Iowa, Massachusetts, Minnesota, North Carolina, Oregon, Pennsylvania and Wisconsin.

Mr. MICHEL. Do the patients served by these centers pay for that service, or do they receive it free?

ANSWER. When possible, funds are collected from State and local governments, nonpublic agencies, third-party entitlements and patients who can afford to pay.

FAMILY PLANNING

Mr. MICHEL. What is my State of Illinois receiving in Federal family planning funds, and how much are the State and localities contributing? Do you have any figures in this regard?

ANSWER. In 1976, our records show that the State of Illinois received around $3 million or 3 percent of the total title X appropriations. In addition, Illinois received funds amounting to approximately $1,200,000 under title V of the Social Security Act and title XIX and title IV–A of the Social Security Act. Our available data show only non-Federal contributions with no breakout of State and local funds. The total non-Federal contribution is estimated to be 29 percent of approximately $1,700,000 of the total funds. This includes State and local funds and funds from the private sector.

Mr. MICHEL. What is the National Health Service Corps (NHSC) doing to support staffing needs in Community Mental Health Centers (CMHC)?

ANSWER. The Bureau of Community Health Services (BCHS) has as a major goal the integration of categorical community-based health programs at the Federal, State and local levels in order to better serve the entire family. The BCHS and the National Institute of Mental Health (NIMH) have negotiated an interagency agreement to work together to define the need for NHSC assignees in CMHC's. To date the NHSC has placed 18 assignees in CMHC's with an additional 52 scheduled for placement. We expect substantial increments in the number of psychiatric assignees at community mental health centers over the next 3 to 4 years. Additionally, to help assure that this goal is achieved, the National Health Service Corps Scholarship program will give priority to persons who want to defer service obligations in order to complete psychiatric residency training.

In addition, at the beginning of fiscal year 1977, there were 82 CMHC projects with linkages to community health centers which are funded as part of the primary health care Initiative.

NATIONAL HEALTH SERVICE CORPS

Mr. MICHEL. Regarding the National Health Service Corps, last year you told us that 91 practices had become entirely independent of Federal support. What is the figure this year?

ANSWER. There had been, by the end of 1976, 98 site terminations where the sites were projected to continue, staffed by ex-NHSC practitioners, and operating without direct Federal funds. The number of assignees terminating their Federal service in order to continue independent practices has increased steadily. There were 98 independent sites in 1976, 149 in 1977 and we estimate there will be 188 in 1978.

Mr. MICHEL. We are talking about increasing funding for this program at quite a rapid pace over what it was in fiscal year 1976. Is the demand on the part of the communities sufficient enough to warrant such an increase?

ANSWER. Yes. In 1978 there will be approximately 1,700 critical health manpower shortage areas—CHMSA's—and 775 communities within these CHMSA's will have submitted approved applications for NHSC assistance. At current funding leve's, 549 communities—32 percent—will have a NHSC site.

Mr. MICHEL. I note that the retention rate for the National Health Service Corps physicians beyond their required years of service in the community is only 48 percent. What happens to the community when they leave? Are other people assigned there, or is the community back where it started from?

ANSWER. The 1978 retention rate of 48 percent for the Corps represents a significant increase over the 1977 rate of 43 percent. The fact that Corps assignments are in critical health manpower shortage areas that have not been able to attract or keep physicians on their own makes the 48 percent retention rate a significant achievement.

Assignees who elect not to stay in the Corps are usually replaced, providing that the utilization, need, and continued support of the physician still exist in the community. The fact that the NHSC has supported a site for 2 years enhances the ability of an area to attract health professionals. In many cases, the area attracts its own physician and Corps support is no longer needed. The NHSC intends to further increase the retention rate to the extent possible.

Mr. MICHEL. What about those communities that go independent? Do they have any problem in losing their physician and not being able to get another?

ANSWER. The Corps has not initiated studies on the retention rate of independent sites. We have experienced a few instances where sites have become independent and within a year's time have again requested Corps assistance in hiring medical personnel. Using this experience as a guide, independent sites usually are able to retain their physician and continue in operation.

MATERNAL AND CHILD HEALTH

Mr. MICHEL. In your opening statement you said that you anticipate having statewide maternal and child health systems in all 57 States and jurisdictions by 1982. How many are there now? In what States? Why is it going to take until 1982 to complete coverage to every State?

ANSWER. In too many States the approach to child health lacks the full effectiveness it would have if it were more systematic. Referral of children to the most effective resources often does not take place. Many times there is not an ef-

ficient working relationship among State and local health care providers. It is sometimes true that Federal programs are not well integrated into overall patterns of child care.

Because of such conditions, it was concluded that there was a necessity to provide a special stimulus and financial assistance to States in order to focus on orderly development of systematic approaches to child health. We feel that we can deal effectively with nine of these activities during 1978 on a startup basis. Until we have sufficient experience with the requirements of development and implementation, we believe that the estimate of having significant statewide systems activities underway in all 57 States and jurisdictions by 1982 is a prudent one. It should be mentioned that there already has been movement in this area, aimed especially at improved pregnancy outcome. During last fiscal year special grants were made for areas where morbidity and mortality were greatest. In these projects emphasis is on providing services to adolescents and other high risk populations. We believe that these projects are prototypes and will develop into important aspects of statewide child health systems in the six States where they have been launched: Alabama, Arkansas, Mississippi, Illinois, South Dakota, and West Virginia. None of the system building activities as envisioned in the opening statement are now underway.

Mr. MICHEL. From your justifications, it appears that you are going to maintain current service levels while holding the budget constant. In light of current levels of inflation in the health service area, can you realistically expect to do that? Why isn't a constant budget going to result in a cutback in services?

ANSWER. While inflationary impact in other program areas has been somewhat offset by management and productivity improvements, these programs are subject to other constraints. These funds are used by States to purchase hospital and other medical care services. The national inflation rate is projected at 12–14 percent. President Carter is attempting to hold this to 10 percent. We will achieve some offsets but an inflation induced deficit will remain. If a constant funding level is maintained, it would have some adverse impact upon the scope of services provided. However, we anticipate continuing services to the same numbers of people.

Mr. MICHEL. Can you tell me what progress has been made in your administration of the sudden infant death syndrome information and referral program? How many projects have you funded? How many people are you serving with such programs? How do you coordinate this program with the National Institute of Child Health?

ANSWER. In 1978, 31 SIDS projects will counsel approximately 1,500 families; and information activities will be conducted to involve health providers, public safety officials and the general public in an awareness of SIDS.

The SIDS counseling and information program is coordinated with research activities administered by the National Institute of Child Health and Human Development (NICHD), both directly with the Institute staff and through the activities of the interagency panel on SIDS established by the Assistant Secretary for Health.

Mr. MICHEL. This appears to be another area in which you are involved in family planning and adolescent health, particularly teenage pregnancy. How are you avoiding duplication of effort with, for example, the separate family planning programs?

ANSWER. The Bureau of Community Health Services is involved in the child health strategy which has been developed to correct specific problems and deficiencies in the health care system for mothers and children. The strategy focuses on the high risk population with emphasis on adolescents and individuals with income below 150 percent of poverty. The services to be provided through this strategy are to five major areas of concern: family planning, prenatal care, perinatal care, child health care, and adolescent health. States will be required to develop a plan for assuring that all programs—whether funded by BCHS programs, such as family planning, other federal programs, and State and local programs—provide adequate levels of services with concentration on high risk populations.

These integrated statewide comprehensive health care delivery systems will determine the need for services which will aid in achieving the objectives of reducing infant mortality, reducing the incidence of low birth weight and medically retarded babies, reducing the number of adolescent pregnancies, and increasing the number of children immunized, screened, and referred for diagnosis and

treatment and coordinate all available resources to assure that the needs are met. These plans will preclude duplication of effort with all health provider programs.

Mr. MICHEL. How do you propose to improve coordination between the early and periodic screening program and the States' title V agencies?

ANSWER. Some of the ways that coordination between the EPSDT program and the State's title V agencies is being improved are: (1) Federal and State representatives of title V and the EPSDT program have established an ongoing series of activities to coordinate the two programs; (2) during 1976, Federal representatives from the central and regional offices conducted a series of site visits to State agencies of title V (maternal and child health) and EPSDT (medicaid) to discuss the written agreements between the agencies; (3) these agreements provide for methods of delivery description of services provided, rates of reimbursement, and program evaluation; (4) all States are expected to have completed cooperative agreements during 1977. The agreements of most States will have been reviewed in 1977; (5) the review of State agreements have shown a need for more definitive guidance on EPSDT for both State agencies. The Bureau of Community Health Services and the Medical Services Administration will soon issue new guidance material on EPSDT. This material will stress early identification of all health problems and better prevention. Another focus of the guidance will be to link title XIX (medicaid/EPSDT) with that family care concept now evolving through the child health strategy and primary health care initiative; (6) In 1977, the improved coordination has resulted in a 5 percent increase over 1976 in the numbers of screenings, immunizations, and referrals for comprehensive treatment.

Mr. MICHEL. Can you tell me more about the work of the regional pediatric pulmonary centers? Where are they located? What is the level of support for such centers under this program?

ANSWER. The purpose of the PPC program is to train graduate physicians and other health professionals in the specialized care of children suffering from chronic pulmonary diseases such as asthma, chronic bronchitis, and cystic fibrosis. The type of training offered by the centers is not usually available in most medical centers, nor is it a part of the undergraduate medical curriculum. In addition to training, the centers also provide direct health services to approximately 38,000 children with pulmonary diseases. These centers are located in universities and children's hospitals. The level of support ranges from $106,000 to $369,000 with an average cost of $200,000.

Mr. MICHEL. Are you satisfied with the numbers of people who take advantage of existing programs in maternal and child health? Is there anything that could be done to increase awareness of such programs among the target population? What sort of outreach effort is made in these programs?

ANSWER. There needs to be more coordination and integration between maternal and child Health and crippled children and other Federal programs to increase referral mechanisms. The Child health strategy is an approach directed toward this.

States have good network systems affecting outreach at the local level and use the media (radio, television, papers) frequently to reach the population at risk.

Mr. MICHEL. You appear to support a fairly major immunization program. To what extent is your work in this area coordinated with that of the Center for Disease Control? How much of your budget goes for the immunization program? How do you avoid overlapping with the CDC?

ANSWER. Overlapping of immunization efforts are avoided by complete coordination with CDC. CDC activities are to supply States with vaccines and biologicals as well as technical and professional assistance and support. Our immunization effort is administered through the MCH (title V) program and focuses on organizational and stimulatory programing on a statewide basis. States receiving child immunization funds are expected to assess and report on immunization levels, identify and establish working relationships with all providers having immunization responsibilities, secure the cooperation of professional organizations, and develop educational programs to encourage parental concern.

The Maternal and Child Health reporting system does not identify how much money is spent on immunizations, as it is only one facet of the total health care services.

JUSTIFICATION OF THE BUDGET ESTIMATES

HEALTH SERVICES

For carrying out [, except as otherwise provided,] 1/ titles III, V, X, XI, [and sections 1303, 1304(a) and 1304(b)] 2/ *XII*, 3/ *and XIII* 2/ 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, *title VI of Public Law 94-63, as amended,* 4/ and titles V and XI of the Social Security Act, [$1,016,021,000,] *$1,144,315,000,* 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 funds contained herein for carrying out section 1304(k)(2) of the Public Health Service Act which are unobligated on September 30, 1978, shall remain available through September 30, 1979:* 5/ *Provided further,* That any amounts received by the Secretary in connection with loans and loan guarantees under title XIII and any other property or assets derived by him from his operations respecting such loans and loan guarantees, including any money derived from the sale of assets, shall be available to the Secretary without fiscal year limitation for direct loan and loan guarantees, as authorized by said title XIII, in addition to funds specifically appropriated for that purpose: *Provided further,* That this appropriation shall be available for payment of the costs of medical care, related expenses, and burial expenses, hereafter incurred, by or on behalf of any person who has participated in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932, in such amounts and subject to such terms and conditions as prescribed by the Secretary of Health, Education and Welfare, and for payment, in such amounts and subject to such terms and conditions, of such costs and expenses hereafter incurred by or on behalf of such person's wife or offspring determined by the Secretary to have suffered

injury or disease from syphilis contracted from such person: *Provided further,* That when the Health Services Administration operates an employee health program for any Federal department or agency, payment for the estimated cost shall be made by way of reimbursement or in advance to this appropriation: *Provided further,* That in addition, [$40,121,000] *$34,934,000* 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. *(Additional authorizing legislation to be proposed for $489,479,000.)*

Explanation of Language Changes

1/ Deletion of superfluous language.
2/ Referencing the title rather than the individual sections shortens the appropriation language.
3/ Legislation amending Title XII of the Public Health Service Act extending the authorization for the Emergency Medical Services program had not been passed at the time the 1977 appropriation was passed; extension legislation was subsequently passed.
4/ Legislation extending the authorization for the Home Health Services program had not been passed at the time the 1977 appropriation was passed; extension legislation for 1977 was subsequently passed.
5/ Section 1304(k)(2) mandates that not less than 20 per centum of funds appropriated to fund initial development of health maintenance organizations be set aside for non-metropolitan area projects; section 1304(k)(2) further stipulates that such funds that are set aside may remain available for obligation for the year succeeding the year in which they are appropriated if it is not possible to obligate them in the year in which they are appropriated.

Language provision	Explanation
Provided further, That any amounts received by the Secretary in connection with loans and loan guarantees under title XIII and any other property or assets derived by him from his operations respecting such loans and loan guarantees, including any money derived from the sale of assets, shall be available to the Secretary without fiscal year limitation for direct loans and loan guarantees, as authorized by said title XIII, in addition to funds specifically appropriated for that purpose:	This provision makes explicit what is generally authorized by section 1308 of the PHS Act: that the Secretary may deposit receipts for the operation of the HMO Loan and Loan Guarantee Fund into the Fund; it goes further, however, in stating that these deposits will remain available for obligation without fiscal year limitation.
Provided further, That this appropriation shall be available for payment of the costs of medical care, related expenses, and burial expenses, hereafter incurred, by or on behalf of any person who has participated in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932, in such amounts and subject to such terms and conditions as prescribed by the Secretary of Health, Education, and Welfare, and for payment, in such amounts and subject to such terms and conditions, of such costs and expenses hereafter incurred by or on behalf of such person's wife or offspring determined by the Secretary to have suffered injury or disease from syphilis contracted from such person.	There is no authorizing legislation for this provision. It represents a moral obligation of the Department.
Provided further, That when the Health Services Administration operates an employee health program for any Federal department or agency, payment for the estimated cost shall be made by way of reimbursement or in advance to this appropriation.	The Economy Act of 1932 authorizes the crediting of reimbursements to regular appropriation accounts and the crediting of advances to special funds; however, this provision authorizes the crediting of both reimbursements and advances to a regular appropriation account.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES ADMINISTRATION

Health Services
Amounts Available for Obligation 1/

	1977	1978
Appropriations	1,016,021,000	1,144,315,000
Proposed supplemental	68,151,000	---
Subtotal, Appropriations	1,084,172,000	1,144,315,000
Comparative transfers to:		
"Office of the Assistant Secretary for Health": for the transfer of the Division of Health Maintenance Organizations Qualifications and Compliance activity	-811,000	
"General Departmental Management" for support of the Grants Appeals Board function	-26,000	
Comparative transfer from:		
"General Departmental Management": for the transfer of long term care and mental health nursing home improvements position from the Region III Director	+31,000	
"National Cancer Institute": for the transfer of one position to establish linkages between research activities in NIH and operating HSA programs	+36,000	
Receipts and Reimbursements from:		
"Federal funds"	23,023,000	23,895,000
"Trust funds"	40,121,000	34,934,000
"Non-Federal funds"	1,400,000	1,500,000
Unobligated balance, start of year	6,456,000	1,184,000
Unobligated balance, end of year	-1,184,000	-1,184,000
TOTAL, obligations	1,153,220,000	1,204,644,000

1/ Excludes the following amount for reimbursable activities carried out by this account: 1977-$8,618,000 and 130 positions; 1978-$7,903,000 and 130 positions.

Summary of Changes

1977 Estimated obligations	1,153,220,000
1978 Estimated obligations	1,204,644,000
Net Change	+ 51,424,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. 1977 Annualization of October 1976 pay raise...	---	6,874,000	---	+ 514,000
2. Annualization of 77 new positions authorized in 1977.....	77	954,000	---	+ 743,000
3. Within grade and longevity increases.....	---	157,030,000	---	+2,293,000
4. Increase in employee benefits.....	---	1,080,000	---	+ 37,000
5. Increase for HSA Service and Supply Fund.....	---	1,638,000	---	+ 698,000
6. Increase for Federal Telecommunications System....	---	2,268,000	---	+ 95,000
7. Increase for Bureau of Employee compensation....	---	734,000	---	+ 254,000
8. Increased rates for postage.....	---	598,000	---	+ 90,000
9. Increased rate for Standard Level User Charges (SLUC).....	---	4,255,000	---	+ 436,000
10. Increased rates for communications, utilities, and miscellaneous rates.....	---	3,823,000	---	+ 298,000
11. Increases for contract medical care, services, supplies and equipment...	---	40,067,000	---	+2,684,000
12. Increased cost of operations of reimbursable health units....	---	6,588,000	---	+ 972,000
13. Costs of positions transferred from the Office of the Assistant Secretary in 1976.....	---	---	---	+ 264,000
14. Increase required to maintain PHS hospital service levels consistent with PL 93-155...	---	---	---	+1,529,000
Subtotal.....			---	+10,907.000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
B. Program:				
Community health services:				
(a) Community health centers - alternative to abortion initiative.....	---	---	---	+14,000,000
(b) Family planning - alternative to abortion initiative.....	---	---	---	+10,000,000
(c) National health service corps - increase for 274 new positions.....	701	25,354,000	+274	+12,033,000
Quality assurance:				
(a) Medical care standards - for support of the maximum allowable Cost of Drugs Project.....	---	---	---	+1,500,000
(b) Professional standards review organizations - increase will provide for the expansion of the PSRO program and conversion of 83 planning PSRO's to conditional status ($18,746,000); support operating expenses for 40 new PSRO positions ($805,000)....	180	50,864,000	+40	+19,551,000
(c) Program support - SLUC increase associated with 40 new positions.....	---	1,212,000	---	+39,000
Subtotal.....			+314	+57,123,000
Total increases.....			+314	+68,030,000
Decreases:				
A. Built-in:				
1. One day less pay.....	---	402,000	---	-402,000
2. PHS hospital repair and modernization projects-non-recurring.....	---	5,272,000	---	-5,272,000
3. Decrease for DHEW working Capital Fund.....	---	1,459	---	-432,000
4. Equipment purchases associated with new PSRO positions.....	---	30,000	---	-20,000
5. Equipment purchases associated with DHMO program support....	---	3,870,000	---	-13,000

Obligations by Object

	1977 Estimate	1978 Estimate	Increase or Decrease
Total number of permanent positions	8,074	8,373	+299
Full-time equivalent of all other positions	366	359	- 7
Average number of all employees.	7,927	8,508	+581
Personnel compensation:			
Permanent positions	$121,855,000	$133,271,000	$+11,416,000
Positions other than permanent	5,984,000	5,984,000	---
Other personnel compensation	6,447,000	6,503,000	+ 56,000
Special personal services payments	27,000	27,000	---
Subtotal, personnel compensation	134,313,000	145,785,000	+11,472,000
Personnel benefits	25,314,000	29,259,000	+3,945,000
Benefits for former personnel.	---	---	---
Travel and transportation of persons	4,129,000	4,658,000	+ 529,000
Transportation of things	1,670,000	2,335,000	+ 665,000
Rent, communications and utilities	6,025,000	6,549,000	+ 524,000
Standard level user charges	4,255,000	4,730,000	+ 475,000
Printing and reproduction	1,101,000	1,115,000	+ 14,000
Other services	29,910,000	29,235,000	- 675,000
Project contracts	66,454,000	77,435,000	+10,981,000

Obligations by Object

	1977 Estimate	1978 Estimate	Increase or Decrease
Supplies and materials.....	17,721,000	19,371,000	+1,650,000
Equipment.....	5,073,000	5,792,000	+ 719,000
Lands and structures.....	2,875,000	---	-2,875,000
Investments and loans.....	---	---	---
Grants, subsidies and contributions.....	854,580,000	878,580,000	+24,000,000
Subtotal.....	1,153,420,000	1,204,844,000	+51,424,000
Deduct quarters and subsistance charges (-).....	- 200,000	- 200,000	---
Total obligations by object.....	1,153,220,000	1,204,644,000	+51,424,000

Significant Items in House and Senate Appropriations Committee Reports

Item	Action Taken or to be Taken
1977 House Report	
Family Planning	
1. Committee directive to target a portion of family planning funds to address the problem of teenage pregnancy. (page 16)	1. Approximately $7,800,000 of the $13,000,000 increase will be used to address the problem of teenage pregnancy.
1977 Senate Report	
Migrant Health and Family Planning	
1. Committee directive that increased amounts in the Bureau of Community Health Services as well as additional funds for Migrant Health and Family Planning, be used to mount a child health initiative in both rural and urban areas. (page 29)	1. BCHS has developed a child health strategy to address the health needs of mothers and children, with a special emphasis on mothers and children in categories of high risk of morbidity and mortality. The basis of development is through State-based child health care systems. Five State systems are planned for installation in 1977. Other aspects of the strategy are to increase the health services, especially immunizations, of children in migrant projects and provide increased accessibility to family planning services for adolescents as a high-risk group.
Community Health Centers	
2. Committee directive to act expeditiously to provide start up funds for approved Community Health Center projects. (page 30)	2. In 1977, 130 new community health centers (primary health care centers) will be started; additionally 96 will be funded for the second year and 42 will be funded for the third year.
Hypertension	
3. Committee directive that additional funds allowed for hypertension program be carefully spent and coordinated with the National High Blood Pressure Education Program in the NHLBI. (page 33)	3. BCHS is working closely with the National Heart, Lung, and Blood Institute in all aspects of the hypertension program. In 1977, BCHS will cosponsor with NIH a seminar on hypertension control for State Health Departments.

Significant Items in House and Senate Appropriations Committee Reports

Item	Action taken or to be Taken
4. Committee directive that additional funds be used to support new positions within the Bureau of Community Health Services where the Maternal and Child Health, Family Planning Health Service, and Migrant Health programs have received increases. (page 35)	4. The House Report directed that the funds were for mandatories and the Senate Report directed that the additional funds were to support new positions. The Department of Health, Education, and Welfare determined the increased funds were to be used for mandatories.
Patient Care and Special Health Services	
5. Report on the burn program. (page 28)	5. The Secretary of Health, Education and Welfare forwarded the Burn Center Report to the Senate on September 23, 1976.
1977 Conference Report	
Patient Care and Special Health Services	
1. The Conferees direct HEW to develop a master plan for the modernization and renovation of the Public Health Service Hospital and Clinic System. This plan shall be submitted to the Appropriations Committees within 30 days following the enactment of this bill. (page 11)	1. A master plan to modernize and renovate the Public Health Service Hospital and Clinic System has been developed. The plan will be transmitted to Congress prior to the beginning of the appropriation hearings to consider the fiscal year 1978 President's budget.
1976 Supplemental - Senate Report	
Hypertension	
1. Committee directive to develop proper regulations for expenditure of hypertension funds and target the program on populations of high need as well as the general population; also to work closely with NHLBI to ensure no duplication. (pages 28-29)	1. The Bureau of Community Health Services, in coordination with NHLBI, has developed guidelines which will be published in January 1977.

Authorizing Legislation

	Amount Authorized	1978 Budget Request
Community Health Services:		
a. Community health centers (Public Health Service Act (PHS Act), Sec. 330)	1/	229,148,000
b. Home health services (Public Law 94-63, Title VI)	1/	3,000,000
c. Comprehensive health grants to States (PHS Act, Sec. 314(d))	1/	90,000,000
d. Hypertension (PHS Act, Sec. 314 (d)(7)(B))	1/	9,000,000
e. Maternal and child health (Social Security Act (SSA) Title V):	2/	
1. Grants to States	2/	315,000,000
2. SIDS (PHS Act, Title XI)	1/	1,716,000
3. Research and training	2/	28,708,000
f. Hemophilia:		
1. Treatment centers (PHS Act, Sec. 1131)	1/	2,500,000
2. Blood separation centers (PHS Act, Sec, 1132)	1/	500,000
g. Family planning:		
1. Family planning services (PHS Act, Sec. 1001 and 1002)	1/	117,500,000
2. Training (PHS Act, Sec. 1003)	1/	3,000,000
3. Research (PHS Act, Sec. 1004)	1/	2,515,000
4. Information and education (PHS Act, Sec. 1005)	1/	600,000
h. Migrant health (PHS Act, Sec. 329)	1/	30,000,000
i. National health service corps (PHS Act, Title III, part C, subpart II)	47,000,000	37,599,000
j. Program support (PHS Act, Sec. 301)	Indefinite	23,886,000
Quality Assurance:		
1. Medical care standards (PHS Act, Sec. 301 and 311)	Indefinite	5,718,000
2. Professional standards review organizations (SSA, Title XI, part B)	Indefinite	72,181,000
3. Program support (PHS Act, Sec. 301 and SSA, Title XI, part B	Indefinite	1,348,000

	Amount Authorized	1978 Budget Request
Health care services and systems:		
a. Patient care and special health services:		
1. Hospitals and clinics (PHS Act, Titles III, V, XI, and XIII.....	Indefinite	135,346,000
2. Federal employee health (Public Law 79-658 (5 USC 7901)).....	Indefinite	641,000
3. Payment to Hawaii (PHS Act, sec. 331).....	Indefinite	1,200,000
b. Health maintenance organizations (PHS Act, Title XIII).....	45,000,000	18,100,000
c. Emergency medical services (PHS Act, sec. 1207(a)).....	55,000,000	33,625,000
d. Program support (PHS Act, sec. 701).....	Indefinite	9,779,000
Buildings and facilities.....	Indefinite	---
Program management (PHS Act, sec. 301)..	Indefinite	6,474,000
Other unfunded authorizations:		
Sec. 1221, PHS Act--Programs relating to burn injuries.....	7,500,000	---
Sec. 1207(b), PHS Act--Emergency medical services research.....	5,000,000	---

1/ Authorization expires on September 30, 1977. Extension legislation is proposed.

2/ Authorization for all programs under Title V of the Social Security Act is $350,000,000.

Health Services

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1968	410,632,000	383,439,000	384,242,000	383,839,000
1969	513,509,000	454,880,000	457,880,000	456,380,000
1970	453,540,000	461,330,000	463,240,000	463,240,000
Trust fund transfers	4,320,000	4,320,000	4,320,000	4,320,000
1971	519,831,000	519,831,000	525,973,000	521,281,000
Trust fund transfers	4,320,000	4,320,000	4,320,000	4,320,000
1972	652,252,000	656,270,000	697,151,000	667,720,000
Trust fund transfers	3,112,000	3,112,000	3,112,000	3,112,000
1973	689,948,000	735,188,000	828,690,000	735,188,000
Trust fund transfers	7,237,000	7,237,000	7,237,000	7,237,000
1974	811,688,000	811,688,000	855,038,000	917,856,000
Trust fund transfers	20,551,000	20,551,000	20,551,000	20,551,000
1975	910,915,000	918,794,000	945,389,000	945,389,000
Trust fund transfers	32,694,000	32,694,000	32,694,000	32,694,000
1976	683,896,000	976,463,000	991,080,000	985,471,000
Trust fund transfers	26,321,000	26,321,000	26,321,000	26,321,000
1977	635,265,000	919,099,000	994,099,000	1,015,253,000
Trust fund transfers	39,121,000	40,121,000	40,121,000	40,121,000
Proposed Supplemental	68,151,000			
1978	1,144,315,000			
Trust fund transfers	34,934,000			

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 1978 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 continue efforts to improve project management through the analysis of program indicator and funding criteria data now being collected. Emphasis will be placed on increasing support for direct service delivery and on maximizing the collection of third-party reimbursements. In addition, the National Health Service Corps will be expanded and, through the Primary Health Initiative, resources from components of several Bureau of Community Health Services programs will be integrated to serve their beneficiaries more efficiently. Activities also will be focused on providing alternatives to abortions by increasing the capacity of the health care system, expecially in underserved areas, to provide family oriented health care. As part of these activities, special emphasis will be placed on addressing the health needs of teenagers.

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. The PSROs

provide a mechanism for professional control over the inappropriate utilization of health services and for monitoring of medical practice. In fiscal year 1978, the coverage of conditional PSROs will be extended across the country.

The Bureau of Medical Services will continue to provide health care to American seamen, Public Health Service Commissioned Corps, and other statutory recipients. In addition, the Health Maintenance Organizations program will continue to demonstrate improved means of providing a more efficient type of health care delivery system, while the Emergency Medical Services program will provide funds and leadership in the establishment of systems throughout the country for provision of emergency treatment of the victims of injury and sudden illness.

Community Health Centers

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants	---	$ 215,148,000	---	$229,148,000	---	+$ 14,000,000

The prime responsibility of the Community Health Center program is the development of health services delivery capacity in 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). Efforts are focused upon the development of integrated systems of health care, linking Community Health Centers with other Federal, State and locally funded health programs. Centers are intended to serve as catalysts for the development of new and innovative approaches to health care delivery, especially in urban and rural underserved areas.

Project grants are awarded to public or nonprofit private entities to assist them in meeting costs associated with the planning and development, and to the degree necessary, the costs of continuing operations, of Community Health Centers.

In 1978, the request includes an increase of $14 million for activities to expand family-oriented health services in projects of the Community Health Centers Program, including those funded as part of the Primary Care Initiative. The services to be provided include family planning, health education and counseling, and pre- and post-natal care, counselling, and outreach services to identify and provide services to high risk populations. Efforts also will be made to deliver health services to individuals in the context of their membership in a family unit and to establish linkages with other health educational and social service agencies with which the family may be involved. Special attention will be directed to adolescents, especially regarding the problem of teenage pregnancy, by increasing capacity in those centers which may provide access to large numbers of teenagers and which are located in areas where teenagers currently have only limited access to such services. The major goal for the activities funded with this increase will be to increase the alternatives available to pregnant teenagers. Adolescent pregnancy involves a variety of health risks - high fetal death rate, high incidence of premature births, low birth weight infants, and high infant mortality. Teenagers also experience a greater number of social, psychological, and economic problems when they become pregnant than do those who become pregnant at a more mature stage. These risks affect all teenagers, but are even greater in the medically underserved areas where Community Health Centers are located.

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In 1978, efforts to improve management efficiency and quality of care will continue in order to maintain or expand the availability of effective health care services to those who live in medically underserved areas. As an example, the application of sound performance measurement (Program Indicators and Funding Criteria) will provide data that will allow project assessment on the basis of objective and uniform performance criteria. Among the criteria considered is the proportion of funds used for administrative activities as opposed to service delivery functions. Strong emphasis will be placed upon increasing the support for direct service delivery activities. Significant program emphasis will continue to be placed on maximization of third-party payment collection. It is anticipated that such reimbursements will increase from 31 percent of the total project operating costs in 1977 to 36 percent in 1978.

The 164 on-going Community Health Centers and 348 Primary Health Care Centers will provide a range of preventive, curative, and rehabilitative ambulatory services and arrange for inpatient services to about 4,154,000 persons in medically underserved areas. This represents approximately 9.3 percent of the total estimated population of such areas. Medically underserved areas are areas designated by the Secretary, DHEW, as having a shortage of personal health services or a population group designated as having a shortage of such services. The factors considered in designating these areas are as follows: ratio of primary care physicians to population; infant mortality rate; percentage of population which is age 65 or over; and percentage of the population with family income below the poverty level. At present, there are 1,500 counties, 1,509 Minor Civil Divisions and Census County Divisions, and 5,215 Census Tracts which have been designated as medically underserved areas having a shortage of personal health services. The total number of people residing in these medically underserved areas is estimated to be approximately 44,100,000.

Through the primary Health Care Initiative, components of the Community Health Centers, Migrant Health, Appalachian Health, Family Planning and National Health Service Corps programs integrate resources to serve populations of all these programs. The Centers supported with these resources are rural (including centers originally funded as part of the Rural Health Initiative) and urban ambulatory health service projects designed to establish health delivery capacity in areas of extreme need and medical underservice. The centers provide primary health services and develop linkages with existing secondary (specialist and inpatient) and tertiary (medical center) care resources. Continuity of care, quality of care and comprehensiveness of care, especially prevention, are emphasized. The primary health care centers established as a part of this initiative are expected to play a crucial role in assuring our ability to deliver services authorized by health care financing programs. This will be especially crucial for areas which currently lack sufficient health care providers and facilities even when adequate financing is available.

The following table illustrates the impact of the 1978 budget:

		1976 Appropriation	1977 Estimate	1978 Estimate
I.	Budget Data			
	Budget Authority	$196,648,000	$215,148,000	$229,148,000 1/
	On-going CHCs	($180,476,000)	184,288,000	193,878,000
	Primary Health Care Centers	($16,172,000)	(30,860,000)	(35,270,000)
	1st Year	($11,952,000)	(21,500,000)	(15,250,000)
	2nd Year	($4,220,000)	($7,680,000)	(14,000,000)
	3rd Year	(---)	($1,680,000)	($3,840,000)
	4th Year	(---)	(---)	($1,680,000)
	Third Party Patient Receipts	$93,685,000	$114,509,050	$156,364,207
	State, Local and Other Contributions	$36,949,000	$41,759,165	$48,760,899
	Total, Funds Available	$327,282,000	$371,416,000	$434,274,000
II.	Total Projects	302	422	512
	On-going CHCs	164	164	164
	Primary Health Care Centers	138	258	348
	Estimated Potential Service Population	6,565,000	7,765,000	8,665,000
	Number of persons served	2,539,160	3,328,000	4,154,000
	Number of Encounters	9,984,304	11,727,200	16,509,400
III.	Cost per Person Served	$129	$112	$104
	CHC grant funds	$75	$65	$55
	Other sources	$54	$47	$49

1/ Includes $14 million as part of a special effort to increase services to 136,000 people in projects of the Community Health Centers Program, including centers funded under the Primary Health Care Initiative. The services to be provided include family planning, health education and counseling, pre-and post-natal care, outreach services to high risk populations, especially adolescents.

Home Health Services

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants	---	$3,000,000	---	$3,000,000	---	---

The Home health service activities represent a medically desirable and often cost-saving alternative to institutionalized care in hospitals and nursing homes. In awarding grants under this program, priority is given to areas which have a high percentage of individuals who are elderly, medically indigent or both and do not already have home health services or to areas in which residents do not have adequate access to such services.

Project grants are awarded for the purpose of providing support for the establishment and initial operation of home health agencies by public and non-profit private entities, and for meeting the costs of compensating professional and paraprofessional personnel during the initial operation of such agencies.

In FY 1978 the program will continue its capacity building effort to expand the number of home health agencies certifiable under Medicare standards. Support will be directed to such activities as development of home health staff competence, and technical assistance in developing new programs or expanding services in existing programs. Currently there are over 788 counties with a total population of 12 million persons without the services of a Medicare certified Home Health Agency. A significant number of this population are eligible for coverage but unable to obtain the benefits because of the absence of certified agencies. In 1978 approximately 40 additional projects will support provision of services for approximately 15,000 persons. Like numbers will be served with funds provided to initiated projects in 1976 and 1977.

The following table illustrates the impact of the 1978 budget:

		1976 Appropriation	1977 Estimate	1978 Estimate
I.	Budget Data			
	Budget Authority	$3,000,000	$3,000,000	$3,000,000
	New Home Health Agencies	800,000	1,000,000	1,000,000
	Expansion of Existing Home Health Agencies	2,200,000	2,000,000	2,000,000

	1976 Appropriation	1977 Estimate	1978 Estimate
II. Workload Data			
Total Projects	56	40	40
New	16	20	20
Expansion	40	20	20
Number of Certified Home Health Agencies	2,377	2,397	2,417
Average Hospital Cost Per Day/Per Patient	$125	$144	$166
Average Cost per Home Health Visit Under Title XVIII	$20	$23	$26
Estimated Number of Home Health Visits per project per year:	5,357	7,500	7,500
Number of persons served	15,000	15,000	15,000

Comprehensive Public Health Grants to States

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants	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. Legislative authority is extremely flexible, allowing States and communities to set their own priorities to meet their unique needs in the area of public health services. The program provides support for comprehensive public health services for both the general population and for high risk groups in such areas as alcoholism, cancer, chronic disease, communicable disease control, dental health, environmental health, heart disease, home health, and mental health. Data indicate that approximately four percent of all State health department budgets are supported by 314(d) funds.

The 1978 level of funding will provide a resource of funds which will be used to meet some of the needs identified through State and local health planning activities which are funded and strongly supported through other Departmental programs. Health services improvement will continue through technical assistance and consultation provided to State Health Agencies by regional office staff and through the assistance given to States by the 63 State-assignee positions.

Comprehensive Public Health Grants to States -- Hypertension

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants	---	$9,000,000	---	$9,000,000	---	---

Formula grants are awarded to State health authorities for support of hypertension programs. Awards are made on the basis of a formula which provides a base amount of $10,000 to each State and distributes the remainder with a State's population and financial need weighted by the extent of the hypertension problem. Funds may be used to assist in meeting the costs of establishing and maintaining programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension. Prevention is an integral part of family oriented primary care.

The 1978 level of funding will permit the States to maintain existing programs or shift emphasis within the control program in conformance with service plans completed and approved in 1977. Additional program emphasis will include 1) improvement of quality of care through use of guidelines for State hypertension control activities; 2) evaluation of quality of services to patients using standards prepared by the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure; and 3) provision of appropriate professional and technical assistance, training and information programs related to the control of hypertension.

Maternal and Child Health

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Subactivities:						
(1) Grants to States.....	---	$315,000,000	---	$315,000,000	---	---
a) (Section 503-Maternal and child health services).....	---	(201,035,524)	---	(201,075,724)	---	(+$40,200)
b) (Section 504-Crippled children's services)...	---	(91,500,000)	---	(91,500,000)	---	---
c) (Section 516-Supplemental allotment...	---	(22,464,476)	---	(22,424,276)	---	(-40,200)
(2) Sudden Infant Death Syndrome (Title XI).....	---	1,716,000	---	1,716,000	---	---
(3) Research and Training.....	---	28,708,000	---	28,708,000	---	---
a) (Section 511-Training)...	---	(23,408,000)	---	(23,408,000)	---	---
b) (Section 512 - Research)...	---	(5,300,000)	---	(5,300,000)	---	---
Total.....	---	$345,424,000	---	$345,424,000	---	---

The Title V maternal and child health and crippled children's programs enable each State to extend and improve services for promoting the health of mothers and children and to reduce infant mortality and morbidity. In addition to providing services, standards of care are developed, facilities are licensed, clinical research findings are implemented, and health professionals are trained. The program also develops and improves services for locating, diagnosing and treating children who are crippled or suffering from conditions which lead to crippling, and for providing these children with medical and rehabilitative care.

The program's goals are achieved through State and local health agencies funded by a formula grant program for maternal and child health and crippled children's services. Project grants for research and training also are provided to public and nonprofit agencies and to institutions of higher learning.

Under Title XI of the PHS Act, an information gathering and dissemination program on sudden infant death syndrome is administered.

The 1978 budget request provides $315,000,000 for grants to States. $1,716,000 for sudden infant death syndrome (SIDS), and $28,708,000 for research and training.

The major thrust of the 1978 request for maternal and child health grants to States is the Child Health Strategy. This initiative seeks to improve the availability, accessibility, quality and effectiveness of the health care provided to mothers and children through the development of State-based child health care systems in all 57 States and jurisdictions by 1982. These "State-wide systems" are developing, monitoring and coordinating systems designed to identify needs, to allocate all available resources to meet such needs, and to develop linkages with other Federal, State and local programs that impact upon maternal and child health care. These activities will focus on 5 major areas: family planning, prenatal care, perinatal care, child health care, and adolescent health, especially teenage pregnancy. The ultimate goal of these activities is to decrease morbidity, disability and mortality. The budget request includes sufficient funding for 9 Statewide systems in 1978.

Another major objective in 1978 will be improved coordination between the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) and State Title V agencies. The impact of this coordination is reflected in additional referrals for services both to the Crippled children's agencies funded under Title V and to other appropriate Federal, State and local agencies that can provide the needed care.

Emphasis in the Crippled Children's program in 1978 will be on increasing capacity to integrate new diagnostic categories such as diabetes, hemophilia, and congenital heart disease into crippled children's agencies in all 57 States and jurisdictions.

The 1978 request for research and training will support 104 projects. Funding will continue in 1978 for 55 projects in clinical and applied research concerned with methods of advancing maternal and child health and crippled children's services. The training program will support 12 regional pediatric pulmonary centers which provide specialized clinical training to 152 persons, and services to 38,000 children suffering from such illnesses as asthma, chronic bronchitis and cystic fibrosis; 21 unviersity-affiliated centers which will train 484 health professionals in the care of mentally retarded and multiply-handicapped children; and 16 nurse-practitioner and nurse midwife projects training over 150 individuals.

The sudden infant death syndrome program will continue funding, at the 1977 level, 31 projects involved in counseling approximately 1,500 families, and information gathering and dissemination activities. There are 7,500 to 10,000 cases of infant deaths identified as sudden infant death syndrome annually.

The following table reflects the impact of the 1978 budget in selected areas:

		(Non-add columns)	
	1976 Actual	1977 Estimate	1978 Estimate
Grants to States:			
Services provided:			
Mothers receiving prenatal and post-natal care	600,000	632,000	632,000
Infants admitted for comprehensive services	166,000	171,500	171,500
Children attending well-child conferences	1,805,000	1,865,500	1,865,500
Children registered for comprehensive services	568,000	611,550	611,550
Women receiving nursing services	1,968,000	2,060,000	2,060,000
Children receiving nursing services	3,063,000	3,145,500	3,145,500
Children receiving dental treatment	984,000	993,000	993,000
Screenings provided to children:			
Visual screening	9,846,000	10,235,000	10,235,000
Audiometer testing	6,564,000	7,000,000	7,000,000
Dental screening	3,282,000	3,410,000	3,410,000
Total screenings	19,692,000	20,645,000	20,645,000

	1976 Actual	1977 Estimate	1978 Estimate
Immunizations provided to children:			
Polio	3,008,000	3,125,000	3,125,000
Rubella	3,282,000	3,500,560	3,500,560
Diphtheria	3,282,000	3,500,560	3,500,560
Total immunizations	9,572,000	10,126,120	10,126,120
Crippled children receiving physician services	550,000	560,000	560,000

Hemophilia

	1977 Estimate		1978 Estimate		Increase or Decrease	
	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 provide services; to train professional and paraprofessional personnel in hemophilia diagnosis, research, and treatment; and to counsel hemophiliacs and their families.

The legislation also authorizes grants and contracts to develop and expand, in existing facilities, blood separation centers to make blood components available for distribution to providers of blood services and manufacturers of blood fractions.

Recent estimates from the National Hemophilia Foundation indicate that there are 140,000 persons in the United States who suffer from hemophilia. Approximately 100,000 of these are considered mild to moderate cases, while 40,000 are characterized as severe cases. The yearly cost of treatment, which must continue throughout the patient's life, ranges from $3,400 for mild cases to $25,000 for serious cases.

Support will continue at the same level as in 1977 for 17 Federally assisted treatment centers which provide services to an estimated 2,300 persons. This represents less than 2 percent of the total population in need of services.

The following table reflects the impact of the 1978 budget:

(Non-add columns)

	1976 Actual	1977 Estimate	1978 Estimate
Diagnostic and Treatment Centers			
Existing centers.....	17	17	17
Number of patients served in funded centers.....	2,300	2,300	2,300
Range of cost per funded center.....	$50,000 to $300,000	$50,000 to $300,000	$50,000 to $300,000

Family Planning

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Subactivities:						
(1) Family planning services	---	$107,500,000	---	$117,500,000	---	+$10,000,000
(2) Training and Education	---	$3,600,000	---	$3,600,000	---	---
(3) Services delivery improvement	---	$2,515,000	---	$2,515,000	---	---
Total	---	$113,615,000	---	$123,615,000	---	+$10,000,000

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.

The 1978 level of funding will provide resources for the continuation of 1) services to low-income and high-risk clients (teenagers and older women); 2) expansion of delivery sites through the primary care initiative to unserved and underserved areas; 3) better quality of services through standards/guidelines for family planning to all BCHS funded service projects and family planning grants; and 4) research and training to improve the delivery of family planning services.

The 1978 request includes an increase of $10 million to expand family planning services to include another 278,000 high risk persons, especially teenagers, through existing Family Planning Centers. This is in addition to the estimated 3 million persons expected to be served in FY 1978 through the ongoing family planning program funded through Title X.

Emphasis will be directed towards improving the total health care of adolescents, and increasing the awareness of this high risk group to the availability of a full range of options for family planning. Increased counselling, outreach and identification of high risk persons will be activities stressed in this effort. Additionally, efforts will be intensified to increase relationships with schools, social service agencies, as well as other health care providers who might work with adolescents regarding special health problems such as teenage pregnancy.

The priority target groups are:

Women at risk of unwanted pregnancies in families with incomes below 150 percent of poverty	6,200,000*
Never married teenagers in families above 150 percent of poverty who because of obstacles other than income have difficulty receiving services from private physicians	2,200,000
Total	8,400,000

Workload Data

The organized family planning programs funded by Federal, State and local governments, and non-public agencies will serve an estimated 4.5 million patients in 1977 and 1978.

Title X funds will partially support clinics which will provide services to an estimated 3,278,000 of these patients.

	1976 Actual	1977 Estimate	1978 Estimate
Family Planning (Title X-PHS Act)	$94,500,000	$107,500,000	$117,500,000
Title V SSA	25,000,000	25,000,000	25,000,000
Amounts Available to all organized programs from third-party reimbursement programs:			
Medicaid (Title XIX-SSA) and Social Services (Title XX-SSA)	50,000,000	55,000,000	55,000,000
State and local governments and non-public agencies and fees collected from patients	43,000,000	45,000,000	45,000,000
Total funds, organized family planning programs	$212,500,000	$232,500,000	$242,500,000

*Not included are persons with incomes above 150 percent of poverty in need of subsidized services from organized programs.

	1976 Actual	1977 Estimate	1978 Estimate
Number of Title X grants	227	227	227
Number of clinics partially funded by Title X of the PHS Act	4,410	4,410	4,410
Number of family planning medical visits at clinics partially funded by Title X PHS Act	4,650,000	5,300,000	5,790,000
Number of patients served by all organized program clinics	3,800,000	4,200,000	4,478,000
Number of patients receiving services in clinics partially funded by Title X PHS Act	2,600,000	3,000,000	3,278,000
Number of family planning workers	40,300	46,500	50,800
Number of people trained	8,700	8,850	10,000

Migrant Health

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants	---	$30,000,000	---	$30,000,000	---	---

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 include diagnostic, therapeutic, and follow-up medical services, linkages with other health service programs and other federal programs serving migrants, referral for dental health care, counseling, preventive and outreach services.

In FY 1977 and 1978, 499,000 migrants and seasonal farmworkers and their families will be served in 125 projects. Of these, 99,000 will be served in 33 new Primary Health Care Centers. These centers are supported with resources of the Migrant Health, Community Health Centers, Appalachian Health, Family Planning and National Health Service Corps programs and serve populations of all these programs. The Centers provide basic health services traditionally offered by a general practitioner (primary care services) and encourage the development of linkages for provision of specialty care with emphasis placed on the continuity of care and comprehensiveness of care (including prevention).

Efforts to improve management efficiency, program effectiveness and the quality of care will continue for the maintenance of high quality care for migrants and seasonal farmworkers. High priority will be to deliver services to catchment areas in which 6,000 or more migratory agricultural workers and members of their families reside for more than two months in the calendar year and second priority will be to catchment areas in which fewer than 6,000 but more than 1,000 migratory agricultural workers and members of their families reside for more than two months in the applicable calendar year.

An analysis of the migrant labor housing study and the cooperative EPA/BCHS pesticide study will be made in 1978 to identify, expand and upgrade the environmental sanitation activities in the health projects service areas.

In 1978, 11 of the 125 migrant service delivery projects will be enrolled in the hospitalization program serving 3,000 migrants and their dependents.

The following table illustrates the impact of the 1978 budget:

	1976 Appropriation	1977 Estimate	1978 Estimate
I. Budget Data			
Budget Authority	$25,000,000	$30,000,000	$30,000,000
II. Workload Data			
Number of projects and centers	97	125	125
Primary Health Care Centers	(20)	(53)	(53)
Potential Eligible Population (Total)	2,714,000	2,700,000	2,700,000
Migrants	(714,000)	(700,000)	(700,000)
Seasonal farm-workers	(2,000,000)	(2,000,000)	(2,000,000)
Persons Served (Total)	400,000	499,000	499,000
Migrants	(267,000)	(334,000)	(334,000)
Seasonal farm-workers	(133,000)	(165,000)	(165,000)
Number of Encounters	800,000	998,000	998,000
Cost per person served (from Migrant grant funds)	$53	$53	$53
Cost per medical encounter 1/	$23	$25	$25

1/ Includes Laboratory, Pharmacy and X-ray services (Data from Migrant Reporting System).

	1976 Appropriation	1977 Estimate	1978 Estimate
Hospitalization Program[2/]			
Total Cost	$2,500,000	$3,000,000	$3,000,000
People served	3,125	3,333	3,000
Average cost per stay	$800	$900	$1,000
Sanitation Program			
State program assistance contracts	$450,000	$500,000	$500,000
Migrant Labor Housing Study and BCHS/EPA Cooperative Study	$250,000	---	---
Program Costs			
Budget	$25,000,000	$30,000,000	$30,000,000
Estimated Third Party Collection	$3,120,000	$3,800,000	$3,800,000
Other Sources of funds[3/]	$10,880,000	$13,200,000	$13,200,000
Total Project Cost	$39,000,000	$47,000,000	$47,000,000
Total average cost per person served	$98	$94	$94

2/ Hospitalization program initiated January 1, 1974.

3/ Includes patient payments and grantee, State and local contributions.

National Health Service Corps

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Field Activities	701	25,354,000	975	$37,599,000	+274	+$12,245,000

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 country where availability of health personnel is inadequate or where health care resources are inaccessable. To alleviate the conditions in Critical Health Manpower Shortage Areas (CHMSA's), the NHSC recruits and places health teams consisting of appropriate combinations of physicians, dentists, nurses, and allied health professionals in these areas. Concurrently the NHSC undertakes activities and policies that will encourage medical professionals, once placed, to remain in the shortage areas on a non-Federal basis. The NHSC also 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.

CHMSA's are designated by the Secretary after consultation with State or local health planning agencies. In general, evidence of a manpower shortage is a ratio of less than one physician per 4,000 population or one dentist per 5,000 population. As physicians and dentists die, retire or relocate, areas which once were adequately served may become Critical Health Manpower Shortage Areas.

In fiscal year 1978, it is anticipated that 975 field assignees will provide health services to 932,000 people in 453 communities. Major program emphasis will be focused upon the development of multi-provider sites, and upon participation in the Primary Health Care Initiative.

Multi-provider sites are staffed by more than one assignee. When applications by communities for National Health Service Corps assistance are approved, the number of assignees needed at the proposed site is determined. In the past, in an effort to satisfy as many applicants as possible, one assignee often would be placed in a community which might have required as many as three or four. A major emphasis in 1978 will be to develop practices with at least two assignees. Multi-provider sites are preferred because one provider often cannot meet all the needs of the community and because it is difficult for physicians and other health personnel to work in professional isolation. Multi-provider sites

have been shown to have a significant impact on efforts to increase the retention rate. It is estimated that this rate will increase from 43 percent in 1977 to 48 percent in 1978. One-third of those extending will remain at independent sites while the balance will extend their period of Federal service.

In 1978 the National Health Service Corps will continue extensive participation in the Primary Health Care Initiative. Approximately 170 of the new Corps personnel will be assigned to primary health care centers operated in conjunction with other health services programs, including the Community Health Centers and Migrant Health programs. These centers deliver health services in areas of extreme need and medical underservice. The centers focus on a narrow scope of health care and provide primary health services and emphasize continuity, quality and comprehensiveness of care, especially prevention.

Other program goals in 1978 include the development of community self-sufficiency which will be accomplished by the provision of pre-operational technical assistance to locations; significant improvements in site reporting, billing and records systems to allow early identification of areas where technical assistance may be crucial in helping sites attain self-sufficiency; and use of physician extenders to increase productivity and thereby enhance site economic viability.

It is anticipated that the retention rate will increase to 48 percent in 1978 by improvements in the assignee matching process to better meet the needs of assignees and communities, the development of multi-provider sites, increasing the number of board eligible physicians from 65 percent in 1977 to 70 percent in 1978, and ensuring the continued development of linkages to other health providers.

The following table illustrates the impact of the 1978 budget on number of sites, service population and manpower:

	1976 Appropriation	1977 Estimate	1978 Estimate
Site Data			
Critical health manpower shortage areas	1,400	1,550	1,700
Communities with approved applications	645	710	775

	1976 Appropriation	1977 Estimate	1978 Estimate
Sites staffed with at least one assignee	331	421	453
Independent sites	98	149	188
Service Data			
Actual people served	574,000	670,000	932,000
Patient fees collected and returned to treasury	$3,216,000	$4,800,000	$6,400,000
Cost per encounter	$15	$16	$17
Manpower Data			
Assignees needed for designated areas	3,500	3,875	4,250
Total Assignees in field	701	701	975
- Physicians	450	450	633
- Dentists	130	130	176
- Other	121	121	166
Non-Federal support personnel employed at sites	988	1,544	1,813

Program Support

Bureau of Community Health Services

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program Support	713	$22,894,000	709	$23,886,000	-4	+$992,000
Standard Level User Charges	---	(940,000)	---	(1,020,000)	---	(+80,000)

Program support activities relating to Bureau activities will be increased slightly in 1978 over the 1977 level. This estimate supports continuation of both central and regional activities. The following activities have been of primary interest to each Bureau program in 1977. Many of these objectives are ongoing from year to year and others will be terminated in 1977 at their completion and replaced with other program initiatives.

Community health centers - Emphasis will continue to be placed on increasing third-party reimbursements to 35 percent for projects funded under this program; 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; and expansion of service delivery capability through the Rural Health Initiative.

Maternal and child health - Continue the development of Title V State Plan system to include the PSRO and EPSDT programs; establish criteria for development, implementation, funding and monitoring of Maternal and Child Health and Crippled Children's Services State Plans; implement a service, education and information program for Sudden Infant Death Syndrome incorporating evaluation criteria which assess the impact of the program on SIDS 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; continue the research priorities based upon determined needs, and develop and implement a strategy for the research program in accordance with these needs; continue the training priorities based upon determined needs and implement a strategy for the training program in accordance with these needs; offer technical assistance to 56 jurisdictions and gather information to improve program 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; 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; implement mechanisms for improving project performance and a long range service improvement strategy.

Migrant health - Continuation of the delivery of health services to migrant and seasonal farmworkers; implement programs to improve environmental sanitation; 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.

National health service corps - Objectives of this program are as follows: recruit and place health manpower professionals; develop and approve new project sites and designated areas; monitor and assist operating sites toward financial and operational self-sufficiency. Other objectives are to improve quality and coverage of services 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.

Quality Assurance

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Medical care standards.....	159	$4,215,000	155	$5,665,000	-4	+$1,450,000
Professional standards review organizations....	180	61,125,000	220	72,234,000	+40	+11,109,000
Program support..	40	1,212,000	40	1,348,000	---	+136,000
Payment to GSA...		(412,000)		(521,000)		+(109,000)
Total.....	379	66,552,000	415	79,247,000	+36	+12,695,000

Introduction

The Bureau of Quality Assurance provides national leadership and direction for efforts to assure the quality of health care services provided under the Medicare, Medicaid, and Maternal and Child Health programs. The Bureau also serves as the national focus for assuring accountability to health care consumers for the quality of health care services.

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. These responsibilities include assuring the quality of care provided under the End-Stage Renal Disease (ESRD) Program which was designed to provide Medicare eligible ESRD patients with essential medical services, assuring patient access to treatment facilities which provide comprehensive care, and assuring quality and appropriateness of services rendered.

The Professional Standards Review Organizations (PSROs) program was designed to assure the quality of care and the appropriate utilization of health services provided to the beneficiaries of the Medicare, Medicaid, and Maternal and Child Health Programs.

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Medical care standards...	159	$4,215,000	155	$5,665,000	-4	+$1,450,000

The Bureau of Quality Assurance (BQA), has principal responsibility for providing the professional health expertise in carrying out the quality assurance provisions of Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act. These responsibilities increased as a result of the 1972 amendments to the Social Security Act which significantly strengthened the quality assurance and standards requirements for the Medicare and Medicaid programs. The amendments included expanded utilization of review requirements, particularly for Medicaid; new long-term care facility requirements; validation of voluntary accreditation surveys; end-stage renal disease quality assurance requirements; and other provisions strengthening the health safety standards for Medicare and Medicaid. As an ongoing activity, BQA provides consultation and directly assists 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 quality assurance system health and safety standards; and policies, and methods for the certification of providers and suppliers participating in these Federally financed programs. The Standards must be continuously evaluated and revised to assure their validity, and upgraded to reflect statutory changes and advances in current medical care practices and technology.

Impact of 1978 Budget:

Provider Standards and Certification Programs

The budget provides $3,840,000 and 145 positions for this program in 1978.

Activities for the Provider Standards and Certification Program include: (1) the development and revision of standards which improve and modify the conditions of participation by health care providers under the Medicare and Medicaid programs; (2) the development and implementation of methods that more efficiently accomplish provider certification; revised standards will have a greater performance orientation than existing standards; (3) training of State surveyor personnel who are responsible for applying the standards for provider participation; (4) participation in the surveying and certification

of facilities; (5) Federal validation of provider certifications; (6) development of standards and certification procedures for clinical laboratories; and (7) the development of quality care standards including regulations, guidelines, and survey procedures associated with the End-Stage Renal Disease Program and assuring the quality of covered services.

The basic surveyor training program will be primarily supported through State tuition financing which will be provided by contract with HEW. This tuition approach to funding basic surveyor training was initiated as a pilot project in 1977. Federal staff will still be required to serve as coordinators, faculty and evaluators. It is estimated 500 to 600 surveyors will be trained in 1977 and 1978.

End-Stage Renal Disease Program

The budget provides $325,000 and 10 positions for this program.

The Bureau has responsibility for implementation and management of program activities for the new End-Stage Renal Disease Program. These new activities include administrative responsibility for implementation of the newly established ESRD networks and the statutorily required Medical Review Boards; development and analysis of data on statutorily required minimum utilization rates through the ESRD Management Information System; and the application and analysis of ESRD reimbursement principles. These activities are designed to ensure that Medicare expenditures for End-Stage Renal Disease are supporting the most efficient and effective care for ESRD patients. As in the past, administrative support for the ESRD program in 1978 will be carried out primarily through the use of existing resources. In order to effectively support the facilities certification program, minimal support will be provided to ESRD Networks and Medical Review Boards, and continuation of the ESRD Management Information system will be curtailed.

Included in the final ESRD regulations, effective September 1, 1976, are requirements for the establishment of 32 Network Coordinating Councils and Medical Review Boards. Implementation of these regulations will be initiated in 1977. Financial support for the establishment and operation of the ESRD Network Coordinating Councils and Medical Review Board will be provided from the Medicare Trust Funds through the facilities reimbursement mechanism. For the most part, Federal staff support for implementation of these activities will be very limited.

The following tables illustrate the workload encompassed by the 1978 budget for the Medical Care Standards Program.

1. Table of Certified Medicare/Medicaid Providers and Suppliers --

Hospitals	
JCAH Accredited	4,912
Non-JCAH Accredited	1,838
Psychiatric	384
Skilled Nursing Facilities	7,111
Intermediate Care Facilities	8,406
Home Health Agencies	2,265
Independent Laboratories	3,094
Outpatient Physical and Speech Therapy	119
End-Stage Renal Disease	870
Portable X-rays	133

Ambulatory Care Centers - The provider status of 500 of these centers is being studied and conditions of coverage may be required.

2. Number of Provider Validation Surveys Conducted --

1977	1978
870	900

3. Number of ESRD facilities - (as of October 30, 1976)

Hospital-operated dialysis facility	479
Free-standing dialysis facility	204
Transplantation and dialysis facility	183
Transplantation facility	4
Total	870

4. Number of ESRD patients - (as of June 30, 1976)

Number of Medicare entitled patients. 45,225

Number who have died..... 14,703

Number of living patients..... 30,522

5. ESRD Benefit payments -

Period	Number	Amount
7/1/73 - 8/31/76	--	$795,000,000
FY 1977	33,000	600,000,000
Calendar year 1981	50,000 - 60,000	1,256,000,000

Maximum Allowable Cost of Drugs Program

A Departmental activity not previously included in this budget is the Maximum Allowable Cost of Drugs project. This activity was previously financed by three participating Department agencies, the Public Health Service (PHS), the Social Security Administration (SSA), and the Social and Rehabilitation Service (SRS).

The Maximum Allowable Cost of Drugs program is designed to control the growth in Federal expenditures for drugs under the Medicare, Medicaid, and Public Health Service Programs. There are three basic parts of this program. These include: (1) MAC - this establishes a ceiling on the level of reimbursement made for multiple source drugs; (2) Estimated Aquisition Cost (EAC) which is designed to control Medicaid expenditures for drugs, and (3) the "Drug Price Book" which is designed to provide comparative drug price information to physicians, pharmacists, and consumers.

The 1978 request for the MAC program will cover the cost of: (1) supporting 10 to 12 meetings of the Pharmaceutical Reimbursement Advisory Committee, (this group is responsible for advising the Secretary on specific MAC ceilings), (2) research on reimbursement methods under MAC, and (3) printing and distributing biannual editions of the MAC Price Book.

Summary: The budget request provides $5,665,000 and 155 positions for the Medical Care Standards activity.

The following table reflects the difference between 1977 and 1978:

1977 estimate	$4,215,000
Increases:	
Built-in:	
Annualization of 1976 pay raise	+3,000
Within grade and longevity increases	+93,000
Program:	
Maximum Allowable Cost of Drugs Program	+1,500,000
Sub-Total increases	+1,596,000
Decreases:	
Built-in:	
One less day of pay	-11,000
Program:	
Absorption of within grade increases resulting in a reduction of 3 man-years	-82,000
A decrease of 4 in management support positions	-53,000
Sub-Total decreases	-146,000
1978 estimate	5,665,000

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Professional standards review organization.....	180	$61,125,000	220	$72,234,000	+40	+$11,109,000

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 nation-wide 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.

Impact of 1978 Budget:

A total of 220 positions and $72,234,000 is requested for this activity. This represents an increase of 40 positions and $11,109,000 over the 1977 budget. This program is funded by Social Security Trust Funds ($34,934,000) and direct appropriated funds ($37,300,000).

During 1978 the entire country will be covered by PSROs. A total of 83 planning PSROs will be converted to conditional status for a total of 203 conditional PSROs. It is estimated that the 203 conditional PSROs will perform review of approximately 6.3 million Medicare/

Medicaid hospital admissions in their areas, about 60% of all Medicare and Medicaid hospital admissions. Forty conditional PSROs will perform long-term care review and 10 conditional PSROs will be performing ambulatory care review. Eighteen Statewide Councils will be supported and will perform their legislative responsibilities of conducting appeals, coordinating and disseminating information among PSROs in the State and evaluation of the PSROs within their States.

LONG-TERM CARE REVIEW

The PSRO legislation requires that PSROs review Medicare, Medicaid, and Maternal and Child Health patients in long-term care facilities. There are currently eight community based long-term care review projects that were started by Medicare before the beginning of the PSRO program. Because these projects are precursors to PSRO long-term care review, rather than let them expire, the Bureau began funding them in 1975.

During 1978, forty conditional PSROs will perform long-term care review which will then allow them to move from conditional to operational status as soon as they demonstrate their effectiveness in performing long-term care review.

AMBULATORY CARE REVIEW

Legislation for the PSRO program gives PSROs the option to undertake ambulatory care review. Prior to 1978, several PSROs will have conducted ambulatory care review on a demonstration basis. During 1978, 10 PSROs will be continuing the ambulatory care review demonstrations. The experience of these PSROs will be instrumental to the development of methodologies for ambulatory care review that will be applicable to all PSROs.

IMPACT OF PSRO REVIEW

It is clearly too early to assess the full 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. However, early indications from conditionally designated PSROs have found evidence that where PSRO review is implemented, hospital lengths of stay are shorter than under previous conditions, quality is improved, and unnecessary use of services is controlled. Examples of the impact of PSRO review are as follows:

Multnomah Foundation for Medical Care, Oregon

In this PSRO, comparison between pre-PSRO (1974) and post PSRO (1975) experience showed reductions in average lengths of stay of 10.4% for Medicare patients and 23.5% for Medicaid patients. This translates into 48,852 fewer patient days of care after the initiation of PSRO review over a period of one year.

South Carolina Medical Care Foundation

In a study over two six month periods, pre-PSRO (Oct. 74-Mar. 75) and post-PSRO (Oct. 75-Mar. 76) conducted by the South Carolina Department of Social Services, it was found that review in this PSRO resulted in .9 days reduction in average lengths of stay for Medicaid patients. The reductions were statistically significant when compared both to pre-PSRO experience and to a control group of hospitals not yet under PSRO review.

Delmarva Foundation for Medical Care, Maryland

In this PSRO, 1976 data on the length of stay of the 3 largest hospitals was compared to length of stay data in 1974 and 1975, which was prior to PSRO review. The results show that average length of stay was reduced by about .5 days for both Medicare and Medicaid patients.

Wyoming Health Service

A comparison of 1974 pre-PSRO lengths of stay to 1975 post-PSRO lengths of stay in Wyoming show a reduction of .98 days in the average Medicare length of stay and .17 days in the average Medicaid length of stay. There was also a reduction in the number of Medicare admissions of 24%.

Sacramento Foundation for Medical Care

A study of the Sacramento PSRO Certified Hospital Admission Program (CHAP) by the Office of Research and Statistics (ORS) of the Social Security Administration showed overall reductions in hospital utilization as a result of the review program. The analysis revealed that after the first year of Medicare CHAP review, patient days per 1,000 enrollees dropped by 5.3% in the CHAP area, while they rose by 4.6% in five comparison areas. ORS estimated that CHAP review resulted in a savings of 16,500 days of care in the first year with estimated dollar savings of almost $1 million compared to program costs of only $279,000.

It is believed that nationwide PSRO hospital reviews will continue to result in dollar savings from reduced utilization by curtailing the provision of unnecessary services and/or preventing payment for services provided at inappropriate levels of care. Although extensive data is not available at this time to make a precise estimate of the amount of these savings, all relevant studies continue to demonstrate a positive cost benefit.

Several major efforts regarding futher evaluation of the PSRO program will be carried out. Of greatest significance to the program will be the determination of the effect of PSRO activities on

health care expenditures. The Agency will be specifically assessing this issue both with respect to total health care expenditures as well as PSRO Program costs. In addition, recognizing the potential importance of behavorial elements on the program, the Bureau will be assessing the extent to which physician patterns of practice are changed by PSRO activities.

During 1978, the Bureau of Quality Assurance will convert 83 planning PSROs to conditional status to encompass all 203 designated areas of the country. The capability of the 203 conditional PSROs to review approximately 6.3 million Medicare/Medicaid hospital admissions will be made possible through implementation of the financing system called for in the Medicare Amendments of 1975 which allows all hospital review costs to be reimbursed through Trust Funds. Forty conditional PSROs will be funded to perform long-term care review and 10 will perform ambulatory review. In addition, 18 Statewide Councils will be funded and the Bureau will support technical assistance efforts to ensure the efficient and effective operations of PSROs.

Summary:

The 1978 budget request provides $72,234,000 for the PSRO program, a net increase of $11,109,000 over the 1977 level. The total request provides project contract funds of $65,866,000 and $6,368,000 to support 220 positions and operating expenses.

The following table reflects the difference between 1977 and 1978:

1977 estimate	$61,125,000
Increases:	
Built-in:	
Annualization of 1976 pay increase	+26,000
Within grade and longevity increases	+110,000
Annualization of 1977 new positions	+484,000
HSA Service and Supply fund	+17,000
Federal Telecommunications System	+9,000
Penalty mail	+4,000
Bureau of Employees Compensation	+14,000
Program:	
Support costs for 40 new positions	+805,000
Expansion of the PSRO program and conversion of 83 planning PSROs to conditional status	+18,746,000
Sub-total increases	+20,215,000

Decreases:

DHEW Working Capital Fund	-88,000
One less day of pay	-13,000
Equipment purchases associated with new positions	-20,000
Non-delegated hospital review costs for one quarter of year	-8,985,000
Sub-total decreases	-9,106,000
1978 ESTIMATE	72,234,000

The following table illustrates the workload encompassed by the 1978 budget:

	1977 Estimate	1978 Estimate
No. of conditional PSROs	120	203
No. of Medicare/Medicaid admissions in conditional PSRO areas	6,500,000	11,000,000
No. of Medicare/Medicaid admissions to be reviewed	4,200,000	6,300,000
No. of hospitals in conditional PSRO area	4,200	7,100
No. of hospitals under review	2,900	5,700
Total number of physicians in conditional area	238,000	340,000
Total physicians PSRO members in conditional areas	155,000	255,000
Percent PSRO members in conditional PSROs to total U. S. Physicians	45%	75%
Percent PSRO members	65%	75%

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program support.	40	$1,212,000	40	$1,348,000	--	+$136,000

The Program Support Activity provides $827,000 to support a total of 40 positions and $521,000 for payment to General Services Administration for rental charges. This represents an increase of $136,000 above the 1977 level.

Positions supported by this activity provide direction to the planning and management of BQA programs. This includes administrative support services in general administration, financial management, contracts management, and management planning and analyses activities. Rental payments to GSA are made for programs under the Bureau of Quality Assurance.

Summary: The following table reflects the difference between 1977 and 1978:

1977 estimate	$1,212,000
Increases:	
Built-in:	
Annualization of 1977 new positions	+19,000
Within grade increases	+10,000
Payment to GSA	+70,000
Program:	
Rental payment to GSA associated with 40 new PSRO positions	+39,000
Sub-total	+138,000
Decreases:	
Built-in:	
One less day of pay	-2,000
1978 estimate	1,348,000

Hospitals and Clinics

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Hospitals and clinics.....	5,479	$148,653,000	5,479	$153,346,000	--	+$4,693,000
Reimbursable obligations..		17,835,000		17,835,000		---
Direct obligations.....		130,818,000		135,511,000		+ 4,693,000

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 under the legislative mandate of Section 818 of Public Law 93-155, which provides that the eight PHS general hospitals continue to furnish all patient care services at the operating level of January 1, 1973, unless Congress approves a change.

The 1978 budget proposes to continue operations of the system, as required by law.

Impact of 1978 Budget:

Workload	1977	1978	Change
Average daily patient load (ADPL) in PHS hospitals	1,615	1,635	+20
Average daily outpatient load (ADOL) in:			
PHS hospitals	3,758	3,978	+220
PHS outpatient clinics	3,420	3,725	+305
Contract care:			
ADPL in non-PHS hospitals	102	102	---
ADOL to contract physicians and dentists	500	500	---

Federal Employee Health Services

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Federal employee health services	306	$7,217,000	306	$8,201,000	---	+$984,000
Reimbursable obligations	279	6,588,000	279	7,560,000	---	+ 972,000
Direct obligations.	27	629,000	27	641,000	---	+ 12,000

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 1977, 100 consultations to Federal agencies, executive boards, and associations will be provided on the evaluation and establishment of Federal employee health activities. Occupational health services will be provided to approximately 240,000 Federal employees in 146 health units.

Impact of 1978 Budget: The $641,000 in appropriated funds will provide for continuation of employee health activities at the 1977 level. Reimbursable authority will permit the program to continue to provide reimbursable occupational health services.

The following illustrates the impact of the 1978 Budget:

	1976 Actual	1977 Estimate	1978 Estimate
Consultations	100	100	100
Population served	222,000	240,000	240,000
Health Units (Reimbursable)	124	146	146

Payment to Hawaii

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Payment to Hawaii	---	$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 through 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 1978 Budget:

- Cost borne by the State of Hawaii will increase by $87,800 to $716,800.

The following table illustrates the impact of the 1978 budget request:

	1976 Actual	1977 Estimate	1978 Estimate
ADPL	127	122	118
Patient Days	46,314	44,530	43,070
Inpatient per diem cost	$37.57	$39.84	$43.17
Outpatient visits	2,206	2,349	2,586
Per visit cost	$24.39	$23.36	$22.24
Total program cost	$1,793,800	$1,829,000	$1,916,800
Appropriation request	$1,200,000	$1,200,000	$1,200,000

Health Maintenance Organizations

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Health maintenance organizations...	---	$18,100,000	---	$18,100,000	---	---

The Health Maintenance Organization Act of 1973 (P.L. 93-222), amended by P.L. 94-460, is a program 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 five years of operation.
4. Mandatory access to enrollment markets for duly qualified HMOs.

Genesee Valley Group Health Association in Rochester, New York, is an example of an HEW assisted HMO that is doing well. GVGHA became operational in August of 1973 and as of September 30, 1976, has 25,209 members. Their inpatient utilization is 302 days per 1,000 members per year. The comparable Blue Cross utilization rate for the Rochester area is 673 days per 1,000 members per year. This translates to a savings of 371 hospital days per 1,000 members per year for GVGHA over the traditional Blue Cross Plan.

If GVGHA averages 27,000 members for the year 1977, and if the same trend in inpatient utilization continues, GVGHA members will experience 10,017 fewer inpatient days than the same number of members under Blue Cross.

Using the average hospital cost of $227 per day as reported by GVGHA under the National Data Reporting Requirements, the 10,017 days will amount to a $2,273,859 savings per year.

Impact of the 1978 Budget: The table below illustrates the funding pattern to be implemented:

	1977			1978		
	No.	Average Cost	Total Cost	No.	Average Cost	Total Cost
Feasibility	---	---	---	---	---	---
Planning	12	$125,000	$1,500,000	---	---	---
Initial Development	21	790,475	16,600,000	23	787,000	18,100,000
Non-metropolitan area projects	(7)	---	(3,620,000)	(5)	---	(3,620,000)
	33		18,100,000	23		18,100,000
Loans for Initial Operation	30	2,000,000	(60,000,000)	36	2,500,000	(90,000,000)

At a grant availability of $18,100,000, selection of projects will be based on highest probability for success and will permit the funding of 23 development projects. The 23 development projects will be funded at an average of $787,000 each.

The loan and loan guarantee fund will continue to support 48 operational projects funded in 1975, 1976, and 1977. An additional 36 operational loans will be made. The number of new loans to be placed in 1978 is based on program projections which assume that 90% of the initial development projects funded in 1977 will proceed into operations and seek and receive loan support.

Summary: The 23 initial development projects to be funded, plus the loans for initial operations to be placed, will eventually generate HMOs which at maturity, will have a potential of serving 1,710,000 enrollees. The 23 initial development HMOs will be eligible to apply for Federal qualification status and thus, when duly qualified, may be eligible to receive assistance from the Loan and Loan Guarantee Fund.

Emergency Medical Services

	1977* Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Emergency medical services.....	---	$33,625,000	---	$33,625,000	---	---

* Continuing Resolution Level

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 HEW and other Federal agencies to interrelate and get the most benefit from the Federal investment in such components as training and education, transportation, communications, consumer information, equipment, recordkeeping and evaluation, and disaster coordination that contribute to plan, develop, and operate a total EMS system.

- 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 appropriate categorized facilities providing specialized critical care units.

- Each State and Territory has now established an organization to be responsible for EMS activities.

- A national network of 300 regional EMS systems have been defined by the State agencies to provide national coverage for all States and Territories. At the conclusion of F.Y. 1976, 235 regions have received planning or implementation assistance through the EMS grant program. The remaining 65 regions have, as yet, not received financial assistance under Title XII. Currently, 12 regional EMS systems have completed the developmental process and are no longer eligible for

funds. Another 98 regional EMS systems are in the development process with one to four years of eligibility for additional funds. Finally, 125 regional EMS systems have completed the planning phase, and are awaiting initial operational funds.

Impact of 1978 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, to include adequate community support and reimbursement mechanism, and (2) the development of the manpower and employment profile to staff a quality EMS system.

- The 1978 budget level will provide support to 87 regional EMS systems in some phase of operation, an increase of 11 systems above 1977. On a cumulative basis, with the award of F.Y. 1978 grants, it is projected that of the 300 regional EMS systems the following results will be achieved:

	EMS Regions
Completed development	36
In development process	119
In planning phase	97
SUBTOTAL	252
No funds awarded	48
TOTAL	300

The following table illustrates the impact of the 1978 Budget:

	1976 Actual	1977 Estimate	1978 Estimate
Feasibility and planning:			
No. of systems funded.....	-0-	8	9
Amount.....	-0-	800,000	900,000
Initial operations:			
No. of systems funded.....	51	33	45
Amount.....	$21,836,475	$17,200,000	$20,600,000
Improvement:			
No. of systems funded.....	12	35	33
Amount.....	$ 7,278,825	$11,700,000	$12,125,000
Subtotal:			
Number.....	63	76	87
Amount.....	$29,115,300	$29,700,000	$33,625,000
Research:			
No. of grants awarded.....	31	28	-0-
Amount.....	$ 3,990,700	$ 3,925,000	-0-
Total Amount	$33,106,000	$33,625,000	$33,625,000
Number of EMS systems which have completed funding under the EMSS Act.....	8	12	36
Identified regions which have received no EMS funding under this Title.....	65	57	48

Summary

The EMS Program has had a significant impact on the delivery of emergency medical care. 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 areawide planning and the delivery of emergency health care. Instead of supporting fragmented and isolated services, they integrate and coordinate resources

and services on a regional 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 1978 budget level will provide for continuity of these programs at approximately the same level as the 1977 President's budget.

Program Support
Bureau of Medical Services

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program support...	219	$9,466,000	216	$9,779,000	-3	+$313,000
Standard level user charges....	---	(2,356,000)	---	(2,565,000)	---	(+209,000)

The purpose of the program management activity is to administer and provide support to the Bureau of Medical Services' operating programs.

In fiscal year 1978, 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 PHS Hospital and Clinic system; Federal Employee Health program; the program for assisting regional communities in establishing emergency medical services systems, and the demonstration program of establishing health maintenance organizations.

Health Maintenance Organizations

The 1978 budget request for this subactivity supports a staff necessary to:

- Administer the grant program for the development of HMOs;
- 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, and disseminate program policy and guidances;
- Provide technical assistance to and monitor the operations of the increasing number of HMOs, which have received loan assistance, to assure compliance with statutory loan requirements.

Emergency Medical Services

The 1978 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.

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. Annualization of Oct. 1976 pay raise.....		$316,000		+$6,000
2. Within grade and longevity increases.....		7,833,000		+57,000
3. Increase in Federal Tele-Communications Services.....		384,000		+27,000
4. Increases in employee benefits (FICA).....		15,000		+1,000
5. Increased rates for standard level user charges (SLUC).....		2,356,000		+209,000
6. Increase for Bureau of Employees' Compensation...		541,000		+164,000
7. Increase for other services, supplies, and equipment.....		287,000		+13,000
Total increases.....				+477,000
Decreases:				
A. Built-in:				
1. One less day of pay.....		17,000		-17,000
2. DHEW Working Capital Fund.....		376,000		-93,000
3. Decrease in program equipment cost (HMO).....				-13,000
Sub-total.....				-123,000
B. Program:				
1. Decrease in three management support positions.....				-41,000
Total decreases.....				-164,000
Net change.....				+313,000

Buildings and Facilities

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Buildings and facilities...	---	$5,272,000	---	---	---	-$5,272,000
(Budget authority)...	(---)	(---)	(---)	(---)	(---)	(---)

This activity includes all proposed direct construction items of Health Services Administration except construction of Indian Health facilities. The 1977 estimate provides for the continued upgrading of PHS facilities, especially the Carville Leprosarium, with funds appropriated in prior years.

Impact of the 1978 Budget:

- Projects obligated, but not completed, will be completed.

Program Management

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program Management	214	$5,700,000	210	$6,474,000	- 4	+$774,000
Standard Level User Charges.....	---	(547,000)	---	(624,000)	---	(+ 77,000)

Impact of 1978 Budget:

The budget provides $6,474,000 and 210 positions to support the Health Services Administration's Office of the Administrator in 1978. The Office of the Administrator 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 accomplishment. Also, staff assistance is provided in the areas of contracts and grants administration, financial management, personnel management, property management, legislative services, communications and public affairs, equal employment opportunity, and general services.

In addition, the Office of the Administrator will provide policy and program leadership, and monitor and evaluate progress in achieving ongoing program objectives related to the provision of health care to Indians and Alaska Natives and to other Federal beneficiaries. The Office of the Administrator will also provide policy guidance to the areas of standards setting for quality assurance activities, implementation of the Professional Standards Review Organization program and in the overall management of the family planning, maternal and child health, neighborhood health centers, National Health Service Corps and Federal employee health programs.

1977 Estimated Obligations.....	$5,700,000
1978 Estimated Obligations.....	$6,474,000
Net Change	$+ 774,000

	Change from Base Amount
Increases:	
A. Built-in:	
1. Annualization of 1976 pay increase	+30,000
2. Penalty mail	+3,000
3. Within grade and longevity	+98,000
4. Increased payments to the Service and Supply Fund	+629,000
5. Standard Level User Charges	+77,000
Total Increase	+837,000
Decrease:	
A. Built-in:	
1. One day less pay	-10,000
B. Program:	
1. Reduction of four management support positions	-53,000
Total Decrease	-63,000
Total Changes	+774,000

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services -- Community health centers (PHS Act, Section 330)

1977 Estimate		Authorization	1978 Budget Estimate	
Pos.	Amount		Pos.	Amount 2/
---	$215,148,000	1/	---	$229,148,000

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.

Explanation: Under Section 330 of the Public Health Service Act, project grants are awarded to public or nonprofit private entities to assist 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 1977: During 1977, 164 on-going Community Health Centers provided a range of preventive, therapeutic, and rehabilitative ambulatory services to 2,100,000 persons. In addition, 1,228,000 persons were served in 258 Primary Health Care Centers of which 120 were first year and 138 were second and third year projects. These centers were jointly funded with the Migrant Health, Appalachian Health, Family Planning and National Health Service Corps programs to serve populations of all these programs. These centers were designed to build health service capacity in medically underserved rural and urban areas. Due to improved management capabilities, third-party reimbursements increased to 31 percent of total operating costs compared to 29 percent in 1976.

1/ Legislative authority for the program expires September 30, 1977. New legislation has been proposed.

2/ Includes $14 million as part of a special effort to increase services to 136,000 people in projects of the Community Health Centers Program, including centers funded under the Primary Health Care Initiative. The services to be provided include family planning, health education and counseling, pre-and post-natal care, outreach services to high risk populations, especially adolescents.

The continued application of the Program Indicators and Funding Criteria resulted in an increase of primary physician encounters per hour from 2.4 in 1975 to 2.5 in 1976 to 2.7 in 1977. The percent of total ambulatory costs that are direct ambulatory care costs increased to 64 percent in 1976 from 59 percent in 1975. Approximately 9.3 percent of the medically underserved population of 44.9 million were served, an increase of 1.6 percent over 1976.

Objectives in 1978: Efforts to improve management efficiency, program effectiveness and the quality of care will continue. Approximately 4,154,00 persons will be served in 164 on-going Community Health Centers and 348 Primary Health Care Centers. Of these, 290,000 will be served in 90 new Primary Health Care Centers- projects designed to build health services delivery capacity in medically underserved rural and urban areas. Third-party reimbursements are expected to increase to approximately 36 percent of the total operating costs, an increase of 5 percent over 1977.

In 1978, the request includes an increase of $14 million for activities to expand family-oriented health services in projects of the Community Health Centers Program, including those funded as part of the Primary Care Initiative. An additional 136,000 people are expected to be served as a result of these activities. The services to be provided include family planning, health education and counseling, and pre-and post-natal infant care, counseling and outreach services to identify and provide services to high risk populations. Efforts also will be made to deliver health services to individuals in the context of their membership in a family unit, and to establish linkages with other health educational and social service agencies with which the family may be involved. Special attention will be directed to adolescents, especially regarding the problem of teenage pregnancy, by increasing capacity in those centers which may provide access to large numbers of teenagers and which are located in areas where teenagers currently have only limited access to such services. The major goal for the activities funded with this increase will be to increase the alternatives available to pregnant teenagers.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services -- Home health services (Title VI, P.L. 94-63, as amended)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$3,000,000	1/	---	$3,000,000

Purpose: The purpose of this program is to provide support for the establishment and initial operation of public and non-profit private agencies which will provide home health services to 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 project support.

Accomplishments in 1977: In 1977, 40 Home Health Agencies were supported; 20 of these were projects for the development of new agencies and 20 projects provided funding to existing agencies for expansion of services. Approximately 15,000 people were served as a result of these activities.

Objectives in 1978: In 1978 the program will continue its capacity building efforts to expand the number of certified home health agencies. An estimated 40 projects will be supported. Of these, 20 will be new and 20 will be expansion. Approximately 15,000 people will be served through these efforts.

1/ Legislative authority for the program expires September 30, 1977. New legislation has been proposed.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services -- Comprehensive public health grants to States (PHS Act, Section 314(d))

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
63	$90,000,000	1/	63	$90,000,000

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 1977: Some of the program areas for which these funds were used included 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 1978: The program will continue providing funds to assist in meeting the costs of providing comprehensive public health services; to provide technical assistance and consultation to State Health Agencies by regional office staff; and to assist States by supporting 63 positions.

1/ Legislative authority for the program expires September 30, 1977. New legislation has been proposed.

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

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$9,000,000	1/	---	$9,000,000

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 1977: Funds appropriated were made available to State health authorities for establishing new and expanding existing hypertension programs in conformance with State service plans completed and approved in 1977. Guidelines for State hypertension control activities were published in January 1977. The Bureau of Community Health Services co-sponsored,with the National Institutes of Health, a program on hypertension control for State health department personnel responsible for implementing 314(d) programs within the States.

Objectives for 1978: The program will maintain existing programs or shift emphasis within the control program in conformance with service plans completed and approved in 1977. Further, it will continue to improve accessiblity of health care and delivery system capacity, and to provide technical assistance, training, and information programs related to the control of hypertension.

1/ Legislative authority for the program expires September 30, 1977. New legislation has been proposed.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services -- Maternal and child health, (Title V, Social Security Act as amended, Section 503, 504, 511, 512 and 516; Title XI, PHS Act as amended.)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$345,424,000	1/	---	$345,424,000

Purpose: The Title V maternal and child health and crippled children's programs enable each State to extend and improve services for promoting the health of mothers and children and to reduce infant mortality and morbidity. In addition to providing services, standards of care are developed, facilities are licensed, clinical research findings are implemented, and health professionals are trained. The program also develops and improves services for locating, diagnosing and treating children who are crippled or suffer from diseases which lead to crippling. These purposes and goals are achieved through State and local health agencies funded by 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 gathering and dissemination program is administered relating to Sudden Infant Death Syndrome.

Explanation: Section 503, Maternal and Child Health Services, and Section 504, Crippled Children's 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

1/ Authorization for all programs under Title V, Social Security Act is $350,000,000 but is indefinite by activity. Authorization for the SIDS program expires September 30, 1977. New legislation has been proposed.

population and per capita income ratio) among the States. Section 516 provides supplemental allocations to States for maternal and child health services to insure that no State receives less 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.

Under, Maternal and Child Health training and research activities, the University-affiliated Centers program provides multidisciplinary training for specialists who work with mothers and children, particularly mentally retarded or multiply-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.

Accomplishments in 1977: The 56 States and jurisdictions expanded their programs of projects in maternity and infant care, children and youth, dental care, neonatal intensive care, and family planning. The number of total projects exceeded 350. As part of the Child Health Strategy, designed to reduce morbidity, disability and mortality, 9 Statewide child health care systems were funded in 1977. The cooperative efforts with the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program increased the numbers of screenings, immunizations and referrals for comprehensive treatment by a factor of 5 percent over 1976. About 20,645,000 screenings, 953,000 more than in 1976; 101,126,120 immunizations, 9,752,000 more than in 1976; and 560,000 children referred to States' crippled children's agencies, 10,000 more than in 1976, are examples of this 5 percent increase. The crippled children's programs increased their capacity to treat additional referrals. New diagnostic categories, such as diabetes, hemophilia, and congenital heart disease, were added in several States.

Services Provided in 1977

(Non-add)

Mothers receiving prenatal and postnatal care	632,000
Infants admitted for comprehensive services	171,500
Children registered for comprehensive services	611,550
Women receiving nursing services	2,060,000
Children receiving nursing services	3,145,500

Children receiving dental treatment	993,000
Screening provided to children:	
Visual screening	10,235,000
Audiometer testing	7,000,000
Dental screening	3,410,000
Total screenings	20,645,000
Immunizations provided to children:	
Polio	3,125,000
Rubella	3,500,560
Diphtheria	3,500,560
Total immunizations	10,126,120
Crippled children receiving physician services	560,000

Thirty-one SIDS projects were funded in 1977. These projects provided counseling services to 1,500 families who lost children due to sudden infant death syndrome, increased the awareness of the public in general and community service personnel in particular, and developed and strengthened 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 1977 research activities supported 55 projects. These projects addressed such areas as child abuse, adolescent pregnancy, improving utilization of health personnel, sudden infant death, evaluation of delivery programs, perinatal care, and nutrition of mothers and children.

The training program supported 12 Pediatric Pulmonary Centers, 21 University-Affiliated Centers, 11 Nurse Practitioner and 5 Nurse Midwife projects in 1977. Approximately 800 health professionals received training in the various projects in 1977.

Objectives for 1978: The major objective for maternal and child health grants to States is the Child Health Strategy, which seeks to improve the availability, accessibility, quality and effectiveness of the health care provided to mothers and children through the development of State-based child health care systems in all 57 States and jurisdictions by 1982. These "State-wide systems" are planning, monitoring and coordinating systems designed to identify needs, to allocate all available resources to meet such needs, and to develop linkages with other Federal, State and local programs that impact upon maternal and child health care. These activities will focus on 5 major areas: family planning, prenatal care, perinatal care, child health care, and adolescent health, especially teenage pregnancy. The ultimate goal of these activities is to decrease morbidity, disability and mortality. The budget request includes sufficient funding for 9 Statewide systems in 1978.

Another objective in 1978 will be continuing the improved coordination between the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and State Title V agencies. The impact of this coordination will be reflected in additional referrals to the crippled children's agencies and in increased screenings and immunizations.

The emphasis in the crippled children's program in 1978 will be to increase the capacity to treat additional referrals and to integrate new diagnostic categories, such as diabetes, hemophilia, and congenital heart dieseas, into crippled children's agencies in all 57 States and jurisdictions.

The sudden infant death syndrome program will continue funding 31 projects involved in counseling approximately 1,500 families and in information gathering and dissemination.

The 1978 request for research and training will support 104 projects. Funding will continue in 1978 for 55 projects in clinical and applied research, concerned with methods of advancing maternal and child health and crippled children's services. The training program will support 12 regional Pediatric Pulmonary Centers which provide specialized clinical training to 152 persons, and services to 38,000 children suffering from such illnesses as asthma, chronic bronchitis and cystic fibrosis; 21 University-affiliated Centers which will train 484 health professionals in the care of mentally retarded and multiply-handicapped children; and 16 Nurse-Practitioner and Nurse Midwife projects training over 150 individuals.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services -- Hemophilia programs (Sections 1131 and 1132, Title XI, PHS Act as amended)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$3,000,000	1/	---	$3,000,000

Purpose: Section 606 of P.L. 94-63 authorizes grants and contracts for comprehensive hemophilia diagnostic and treatment centers to provide services; to train professional and paraprofessional personnel in hemophilia diagnosis, research, and treatment; and to counsel hemophiliacs and their families.

The legislation also authorizes grants and contracts to develop and expand, in existing facilities, blood separation centers to make blood components available for distribution to providers of blood services and manufacturers of blood fractions.

Explanation: Project grants and contracts are awarded to public and nonprofit entities to establish comprehensive hemophilia treatment centers and to develop and expand, within existing facilities, blood separation centers.

Accomplishments in 1977: Grants were awarded to 17 existing diagnostic and treatment centers in 12 States. These centers provided services to an estimated 2,300 persons in 1977. Grants were also awarded to study blood separation centers.

Objectives for 1978: The program will continue at the same level of effort as in 1977.

1/ Legislative authority for the program expires September 30, 1977. New legislation has been proposed.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services -- Family planning project grants and contracts (PHS Act, Title X)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Anuthorization	Pos.	Amount
---	$113,615,000	1/	---	$123,615,000

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 also 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 1977: The Title X program continued to partially fund clinics which served about 3,000,000 clients in 1977, with priority to low income persons, teenagers, and other high risk women. Emphasis was on establishing and improving access to services in underserved areas, and assuring that quality services were provided to patients served. Standards were established for the inclusion of family planning services in all BCHS service projects. Training activities were targeted toward improving the skills of personnel delivering services; improving skills of agency staffs in program planning, evaluation and fiscal management; and training of nurse practitioners to provide family planning services under the supervision of a physician. Special initiatives were undertaken in the areas of informed consent through better patient education, nutrition, and infertility counseling.

An assessment of family planning manpower development and utilization was completed, and a curriculum developed in 1976 for training instructors in natural family planning was validated. Assistance was provided BCHS

1/ Legislative authority for the program expires September 30, 1977. New legislation has been proposed.

projects to develop comprehensive family planning components.

A national clearinghouse for family planning information became operational, and informed choice patient education materials were developed for English and Spanish speaking clients.

Objectives for 1978: Title X funds will continue to be allocated for partial support of service providers expected to serve about 3,278,000 clients. Priority for services will be low-income persons, high-risk groups (teenagers and older women), and males. Efforts will continue to extend services to areas without family planning programs and to increase services in high density areas which have insufficient service capacity. Since most areas without organized services are rural, this effort will be in conjunction with other rural health programs in order to maximize limited resources.

The 1978 request includes an increase of $10 million to expand family planning services to include another 278,000 high-risk persons, especially teenagers, through existing Family Planning Centers. This is in addition to the estimated 3 million persons expected to be served in FY 1978 through the on-going family planning program funded through Title X.

The training program will continue to support training for staff involved in the provision of family planning services. However, priorities will begin to shift to reflect the changing needs of service agencies. Increased emphasis will be on training intended to improve services for specific client groups, e.g., teenagers, males and the handicapped; medical updates to keep staff informed about the newest techniques; and upgrading management skills of agency staff.

Service delivery improvement activities will focus on identifying and examining access barriers of specific target groups such as adolescents and males who remain outside the system. Special studies and demonstration programs will be undertaken in the areas of natural family planning, adolescents, males and the emotionally ill.

Development of educational materials and programs aimed at overcoming barriers to recruiting teenagers, males and other hard-to-reach populations will be undertaken.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services -- Migrant health (PHS Act, Section 319 as amended)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$30,000,000	1/	---	$30,000,000

Purpose: The Migrant Health program provides access to health care services to migratory and seasonal agricultural workers and the members of the families of such migratory and seasonal workers.

Explanation: Under Section 319 of the Public Health Service Act, as amended, grants are made to public and non-profit private entities for projects to plan, develop and continue to operate health centers to improve the health conditions of migratory and seasonal agricultural workers and members of their families.

Accomplishments in 1977: In 1977, 499,000 migrants and seasonal farmworkers and their families were served in 125 projects. Of these, 33 were developed through the Primary Health Care Initiative, a joint funding of projects with the Community Health Centers, the National Health Service Corps, and the Appalachian programs to create the capacity to serve populations that have been identified as underserved. Through this initiative an additional 99,000 migrants and seasonal farmworkers were served. In addition, 3,333 migrants were enrolled in the hospitalization program, an increase of 208 over 1976.

Objectives for 1978: In 1978, efforts will continue toward increasing the capacity to serve migrants by improving management efficiency, program effectiveness and the quality of care. An estimated 499,000 migrants and seasonal farmworkers will be served in 125 projects.

1/ Legislative authority for the program expires September 30, 1977. New legislation has been proposed.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Community health services -- National health service corps, (PHS Act, Section 331, as amended by P.L. 94-484)*

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
701	$25,354,000	$47,000,000	975	$37,599,000

*Appropriation action on this request was deferred as the authorizing legislation expired September 30, 1976 and was not extended in time for the request to be considered by Congress as part of the regular 1977 appropriation.

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 recruitment and assignment of appropriate health personnel to critical health manpower shortage areas; for assisting communities in developing the capacity to plan, build, and maintain their own systems of health care; and for concurrently pursuing policies that will encourage health professionals, once placed, to remain in shortage areas on a non-Federal basis.

Accomplishments in 1977: In 1977, there were 701 health professionals (450 physicians, 130 dentists, and 121 nurse practitioners and allied health personnel) assigned to 421 communities throughout the United States.

During 1977, the National Health Service Corps utilized information gained through review and evaluation of site activities, and continued the development and implementation of procedures useful to communities and health professionals in site operations, such as patient and practice management systems and the problem-oriented medical records system.

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During 1977, NHSC staff continued coordination of program activities with other Bureau of Community Health Services programs. These efforts helped to improve the overall Federal health delivery capacity in underserved areas.

In 1977, the number of Corps sites that were staffed increased from 331 to 421. A multiple provider site is a site that has 2 or more physicians on duty or where at least 2 medical disciplines are represented. Multiple provider sites are preferred because one provider cannot meet all the needs of the community and because professional satisfaction and consequently retention is increased. In the past, in an effort to satisfy as many applicants as possible, one assignee often would be placed in a community which might have needed as many as three or four.

The retention rate increased from 38 percent in 1976 to approximately 43 percent in 1977. The number of independent sites increased from 94 to about 149. A significant factor in the increases was the emphasis on recruitment of board-eligible physicians (from 60 percent to 65 percent in 1977), expanded continuing medical education services to minimize professional isolation and the increased emphasis on establishment of multi-provider sites.

Objectives for 1978: This request will support 975 health professionals in 453 communities.

Program activities will be continued and refined to monitor and assist sites in attaining financial and operational self-sufficiency and independence. About 100 new sites will be identified and developed to replace those becoming independent in 1978. An additional 32 sites will be developed to bring the level to 453 staffed sites. Approximately 150 areas will be newly designated as Critical Health Manpower Shortage Areas, bringing the total such areas to 1,700. Approximately 65 designated areas will be approved as eligible for NHSC assistance, bringing the total number of areas eligible for assistance to 775.

The number of board eligible physicians is expected to increase from 65 percent in 1977 to about 70 percent in 1978. The number of multiple provider sites will be significantly increased in 1978. The retention rate is expected to increase from 43 percent in 1977 to approximately 48 percent in 1978.

During 1978, there will be increased emphasis on providing comprehensive health services at sites. Also, problems of access to medical care in urban areas will be newly examined to determine desirability, extent, and possible mechanisms for provisions of assistance. The NHSC will continue active participation in the Rural Health Initiative.

The following table illustrates the impact of the 1978 budget on the number of sites, service population and manpower:

	1976 Appropriation	1977 Estimate	1978 Request
Site Data			
Critical health manpower shortage areas	1,400	1,550	1,700
Communities with approved applications	645	710	775
Sites staffed with at least one assignee	331	421	453
Independent sites	98	149	188
Service Data			
Actual people served	574,000	670,000	932,000
Patient fees collected and returned to treasury	$3,216,000	$4,800,000	$6,400,000
Cost per encounter	$15	$16	$17
Manpower Data			
Assignees needed for designated areas	3,500	3,875	4,250
Total Assignees in Field	701	701	975
- Physicians	450	450	633
- Dentists	130	130	176
- Other	121	121	166
Non-Federal support personnel employed at sites	988	1,544	1,813

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Program support - Bureau of community health services (PHS Act, Section 301)

1977 Estimate			1978 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
713	$22,894,000	Indefinite	709	$23,886,000
Standard Level User Charges	($940,000)			($1,020,000)

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 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 and contracts.

Accomplishments in 1977: In 1977, 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 1977 were met. These included the development of cost and utilization reporting requirements, and implementation of a program for assisting States in analyzing maternal and child health needs for services. Additionally technical assistance was provided to 56 political jurisdictions. Specific criteria were developed for evaluating the Program of Projects, policies were implemented for coordinating the activities of State Title V programs and local Professional Standard Review Organizations, and support was provided for the operation of the Suddent Infant Death Syndrome program.

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 1977 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 701 health professionals were active in 421 sites in 1977. Essential operational technical assistance was provided to both on-going and newly-staffed sites.

Objectives for 1978: The Bureau of Community Health Services staff will be placing primary emphasis on maximizing the use of the resources proposed for the project grants for fiscal year 1978. 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, maternal and child health projects, family planning projects, and migrant health projects.

Major efforts will also continue in relation to the following activities: the provision of technical assistance 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; 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; and 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: Quality assurance - Medical care standards (PHS Act, Sections 301 and 311)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
159	$4,215,000	Indefinite	155	$5,665,000

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 professional health aspects of Title XVIII and XIX of the Social Security Act. The Bureau's responsibilities are to provide health expertise to the Bureau of Health Insurance (SSA) and the Medical Services Administration (SRS) in the development, interpretation and evaluation of health and safety standards required of hospitals, nursing homes, and other health care providers which participate in the Medicaid Programs. These standards are prescribed by regulations, policies and procedures, and in the field administration of program requirements.

Accomplishments in 1977: In 1977, 870 provider validation surveys will be conducted. These surveys include validation of the accreditation system employed by the JCAH; validations stimulated by public complaints of conditions in health facilities; routine validations of state surveys of health facilities, and surveys as an integral part of comprehensive program reviews of state survey agencies. Also in 1977, over 17,000 proficiency examinations will be administered to physicial therapists, licensed practical nurses, cytotechnologists, clinical laboratory technologists, and psychiatric technicians. Revised regulations for hospitals and skilled nursing facilities have been developed as were new personnel standards for suppliers of clinical laboratory services. Approximately 500 to 600 State surveyor personnel will receive either basic or specialized training. Final ESRD regulations have been published which will be implemented in 1977

through support from the Medicare Trust Funds. Operation of the ESRD Medical Information System will be continued. This system collects uniform data on such factors as the utilization of ESRD facilities, types of service patterns provided, and the course of illness and treatment for ESRD patients.

Objectives for 1978: The budget request would allow for approximately 900 provider validation surveys, about the same level as in 1977. In addition, 500 to 600 State survey personnel will receive surveyor training. It is planned that implementation of ESRD Networks and Medical Review Boards will take place through support from the Medicare Trust Funds facilities reimbursement mechanism. Funds to support contracts for the development and analysis of data on minimum utilization rates for ESRD patients, the application and analysis of ESRD reimbursement principles, and continuation of the ESRD Management Information System, are not provided. The Maximum Allowable Cost of Drugs program will be funded under this activity in 1978.

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)

	1977 Appropriation		1978		
				Budget Estimate	
	Pos.	Amount	Autnorization	Pos.	Amount
Budget Authority.	---	$25,191,000	Indefinite	---	$37,300,000
Obligations.....	180	$61,125,000	---	220	$72,234,000

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. PSROs 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 1977: Significant progress of the PSRO program will have been achieved by the end of 1977 due to increased acceptance of the program by the physician community, hospitals, and the States. Such acceptance will increase the ability of PSROs to move rapidly in the implementation of review in hospitals and eliminate the duplicate utilization review program for Medicare and Medicaid patients. By the end of 1977 the 20 remaining planning PSROs will be converted to conditional status. Approximately 83 new planning PSROs will be funded and 10 Statewide Councils will be established. In addition, 40 PSROs will

begin to perform long-term care review including 14 demonstration projects. Ambulatory care demonstration projects will also be supported.

The impact of PSRO changes in hospital utilization and lengths of stay is now beginning to emerge. Initial indications from several PSROs demonstrate beneficial changes by reductions of hospital lengths of stay and improvements in the quality of health care. For example, the recently completed study of the Sacramento Foundation for Medical Care conducted by the Social Security Administration showed a cost benefit ratio of about three dollars saved for each Federal dollar invested.

Objectives for 1978: During 1978, the Bureau of Quality Assurance will convert 83 planning PSROs to conditional status to encompass all 203 designated areas of the country. Review will be performed for approximately 6.3 million Medicare and Medicaid hospital admissions. The final transition will be made from utilization review to PSRO review throughout the country. Forty conditional PSROs will be funded to perform long-term care review and 10 will perform ambulatory review. In addition, 18 Statewide Councils will be funded and the Bureau will support technical assistance efforts to ensure the efficient and effective operations of PSROs.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Quality assurance - Program support

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
40	$1,212,000	Indefinite	40	$1,348,000

Purpose: This activity provides for the planning, direction, and administrative management of the programs of the Bureau of Quality Assurance.

Explanation: The funds requested support the salaries and related costs of employees who provide direction, general administrative services, financial management, and contracts management, for the Quality Assurance Program.

Accomplishments in 1977: This activity supports Bureau staff who are responsible for the development of program support policies and provision of administrative support services for the Professional Standards Review Organization Program, and the End-Stage Renal Disease Program. Continuing emphasis is placed upon improving the management of these programs. Funds were provided to support the rental payments to GSA.

Objectives for 1978: The Program Support activity will continue to provide essential resources for the implementation of plans and provision of administive services required for effective management of the Bureau's programs. Particular emphasis will be placed upon new initiatives in the management of PSRO contracts and implementation of the End-Stage Renal Disease Program. Rental payments to GSA will continue to be provided.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Patient care and special health services--Hospitals and clinics (PHS Act, Titles III, V, XI and XIII)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
5,479	$130,818,000	Indefinite	5,479	$135,511,000
Obligations				
5,479	148,653,000		5,479	153,346,000

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, as well as 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 1977: Health care will be available to an estimated 540,000 PHS beneficiaries, in addition to beneficiaries of other Federal agencies, foreign seamen, and community programs. There will be a daily average of 1,615 inpatients and 7,178 outpatient visits to PHS facilities. Contract care in other Federal and non-Federal facilities will average 102 inpatients per day; in addition, there will be 125,000 outpatient visits to private physicians and dentists.

Objectives for 1978: The Public Health Service will continue to operate the PHS hospitals in compliance with P.L. 93-155. Workloads are expected to increase to the point where the system will be caring for a daily average of 1,635 inpatients in PHS hospitals and a daily average of 7,703 outpatient visits to PHS hospitals and clinics. Contract care in non-PHS facilities is expected to continue at the present levels.

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))

1977 Estimate			1978		
				Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount	
Budget Authority					
27	$ 629,000	Indefinite	27	$ 641,000	
Obligations					
306	7,217,000		306	8,201,000	

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 1977: In 1977, 100 consultations to Federal agencies, executive boards, and associations will be provided on the evaluation and establishment of Federal employee health activities. Occupational health services will be provided to approximately 240,000 Federal employees in 146 health units.

Objectives for 1978: The estimate for 1978 provides for continuation of employee health activities at the 1977 level. The program will continue to be responsive to Federal agencies for requested consultation and evaluation of their occupational health programs. Reimbursements will permit the program to continue to operate the 146 health units providing services to approximately 240,000 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)

1977 Estimate		1978		
			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 1977: Care will be provided to an estimated daily average of 122 inpatients. This is a continuation of the decreasing inpatient load of recent years. Of the total program costs estimated to be $1,829,000, the share borne by Hawaii is $629,000.

Objectives for 1978: The average daily patient load is expected to decrease to 118 in 1978. The total program requirements are estimated to be $1,916,800 of which the Federal Government will pay $1,200,000.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Health maintenance organizations
(PHS Act, Title XIII as amended by P.L. 94-460)

1977 Estimate		1978	1978 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$18,100,000	$45,000,000	---	$18,100,000

Purpose: The Health Maintenance Organization Act of 1973 (P.L. 93-222) as amended provides authority for a seven-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 costs
- 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: Applications for initial development awards are submitted by public and private non-profit organizations. Priority for assistance will be given to HMOs which will serve medically underserved populations and those proposing to serve non-metropolitan areas; 20% of the funds are set aside for these non-metropolitan projects.

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 five years of an HMO's operation.

Accomplishments in 1977:

The 1977 grant activity includes the funding of 12 planning projects at approximately $125,000 each and 21 initial development projects at an average cost of $790,475 each.

During 1977, 30 loans totalling $60,000,000 will be placed with a potential of providing services to approximately 900,000 enrollees at the maturity of the HMOs. Based upon the experience of newly developed HMOs, each qualified HMO should produce economic savings from reduced hospitalization costs of approximately $1,800,000 per year at maturity. Thus, these 30 qualified HMOs will produce savings of $54,000,000 annually. These estimated savings are based upon an average enrollment of 30,000 in each qualified HMO; hospital utilization at 60% of the normal area usage (1,000 days per 1,000 persons per year); and cost per hospital day of $150.

Objectives for 1978: The estimate for 1978 provides for 23 initial development awards, all of which were funded at the planning level in 1977. Approximately 36 loans for initial operations at an investment of $90,000,000 will be initiated. These grants and loans will provide the nucleus for approximately 57 HMOs with a potential for eventually serving 1,710,000 enrollees. The output of qualified HMOs from these grants and loans will produce annual inpatient cost savings of $102,600,000 at maturity.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Emergency medical services (PHS Act, Title XII, as amended by P.L. 94-573)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$33,625,000	$67,500,000	---	$33,625,000

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 1977: During 1977, an estimated 8 planning studies will be undertaken, 33 regional systems will have had financing completed toward establishing and operating basic life support emergency medical services systems, and 35 regions will be in the process of expanding and improving existing advanced life support emergency medical services systems.

Objectives for 1978: The budget estimate will provide financing for 9 regions to initiate feasibility and planning studies, and for 45 regions to initiate a program for the establishment and initial operation of an EMS system, and 33 regions will have received financing to expand and improve their existing advanced life support systems. On a cumulative basis, 119 self-supporting regional emergency medical services systems will be in some phase of operational development, and 36 regions will have completed the developmental process.

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HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Program support - Bureau of Medical Services
(PHS Act, Section 301)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
219	$9,466,000	Indefinite	216	$9,779,000

Purpose: This activity provides for the overall planning, direction, and administration of the Bureau of Medical Services' program--Hospitals and Clinics, Federal Employee Health, Payment to Hawaii, Health Maintenance Organizations (HMO), Emergency Medical Services, and Buildings and Facilities.

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 community and other recipients of grants and contracts.

Accomplishments in 1977: Program guidance and services will be 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; (3) to continue administrative support of the HMO demonstration program; and (4) continue the initial progress being made in bringing more and better emergency medical care systems to the Nation.

Objectives for 1978: Program management and review will continue to be provided for the Bureau's health care programs. Emphasis will be placed on improving the management information system, increasing productivity and developing a realistic manpower management program.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Buildings and facilities.

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
---	---	Indefinite	---	---
Obligations				
---	$5,272,000		---	---

Purpose: For construction, alterations, repairs and improvements of buildings and facilities, including preparation of plans and specifications.

Explanation: Funds appropriated for the purpose of this activity have been made available until used.

Accomplishments in 1977: Obligations are directed toward upgrading the PHS hospitals. In 1977, approximately $5 million from prior year balances will be obligated to support repair and improvement projects.

Objectives for 1978: Projects obligated in prior years, but not completed, will be carried forward toward completion.

HEALTH SERVICES ADMINISTRATION

Health Services

Program Purpose and Accomplishments

Activity: Program Management (PHS Act, Section 301)

	1977 Appropriation		1978	1978 Budget Estimate	
	Pos.	Amount	Authorization	Pos.	Amount
Program Management	214	$5,700,000	Indefinite	210	$6,474,000
Standard Level User Charges		(547,000)			(624,000)

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. The estimates also include payment to GSA for office space and related expenses.

Accomplishments in 1977: The Office of the Administrator achieves its objectives by providing policy guidance and evaluating Agency progress while monitoring major program initiatives. The expansion of Health Maintenance Organizations, Professional Standards Review Organizations, and National Health Service Corps are just a few of the projects which have been under scrutiny by the Office of the Administrator.

Objectives for 1978: 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, and program plans and to evaluate Agency progress in mission accomplishment. The Office of the Administrator will continue to structure, implement and monitor ongoing program initiatives, such as: providing health care to Indians and Alaska Natives and to other Federal beneficiaries; providing policy guidance to areas of standards setting for quality assurance activities; and providing the overall management of the family planning, maternal and child health, neighborhood health centers, National Health Service Corps and Federal Employee Health programs.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants to States for Comprehensive Health Services 1/

States	1976 Actual	1977 Appropriation	1978 Request
Alabama	$1,658,900	$1,651,000	$1,640,100
Alaska	402,800	401,800	395,600
American Samoa	257,900	250,000	250,000
Arizona	1,038,200	1,049,400	1,087,200
Arkansas	1,074,200	1,092,400	1,093,300
California	6,926,100	6,902,400	6,903,500
Colorado	1,126,800	1,123,700	1,137,200
Connecticut	1,246,200	1,234,900	1,230,700
Delaware	477,400	476,400	478,000
District of Columbia	514,900	507,800	503,200
Florida	3,009,300	3,041,500	3,174,700
Georgia	2,032,000	2,026,700	2,048,400
Guam	301,000	337,900	341,700
Hawaii	567,500	568,900	570,300
Idaho	582,400	582,000	591,800
Illinois	3,756,700	3,721,000	3,686,500
Indiana	2,073,400	2,080,400	2,067,300
Iowa	1,224,300	1,253,200	1,221,100
Kansas	1,032,800	1,037,800	1,031,400
Kentucky	1,546,800	1,533,600	1,529,200
Louisiana	1,717,900	1,685,800	1,662,700
Maine	686,000	677,700	687,000
Maryland	1,600,700	1,585,700	1,582,200
Massachusetts	2,181,800	2,156,200	2,165,700
Michigan	3,176,100	3,187,100	3,220,300
Minnesota	1,584,500	1,587,000	1,591,000
Mississippi	1,226,200	1,229,400	1,240,900
Missouri	1,913,000	1,920,200	1,904,200
Montana	552,000	556,100	556,300
Nebraska	799,500	813,300	797,800

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	1976 Actual	1977 Appropriation	1978 Request
Nevada	$ 477,800	$ 484,300	$ 487,600
New Hampshire	576,700	580,500	584,300
New Jersey	2,562,800	2,543,400	2,541,200
New Mexico	727,000	732,900	724,500
New York	5,953,400	5,893,100	5,879,800
North Carolina	2,229,100	2,229,300	2,260,400
North Dakota	498,600	504,800	509,500
Ohio	3,842,100	3,797,700	3,820,600
Oklahoma	1,267,300	1,268,900	1,243,900
Oregon	1,065,500	1,059,500	1,063,800
Pennsylvania	4,236,200	4,169,200	4,124,700
Puerto Rico	2,003,500	2,171,600	2,104,400
Rhode Island	616,000	605,700	601,400
South Carolina	1,355,900	1,340,400	1,354,500
South Dakota	533,000	540,800	544,200
Tennessee	1,821,100	1,801,700	1,812,900
Texas	4,489,500	4,499,100	4,434,000
Trust Territory 2/	452,600	488,700	491,300
Utah	733,000	736,200	740,000
Vermont	473,600	468,800	468,300
Virgin Islands	259,800	320,500	337,800
Virginia	1,949,500	1,940,800	1,948,300
Washington	1,438,000	1,433,000	1,429,100
West Virginia	971,600	960,400	945,800
Wisconsin	1,856,500	1,835,000	1,837,000
Wyoming	422,600	422,400	421,400
Total	89,100,000	89,100,000	89,100,000
Evaluation Amount 3/	900,000	900,000	900,000
Grand Total	90,000,000	90,000,000	90,000,000

1/ Allocations are awarded to States based on population and per capita income with a minimum program requirement.

2/ It is expected that the Marianna Islands will be funded as a separate health jurisdiction in 1978, in accordance with the formula of other Territories. The residue of the present Trust Territories will receive separate consideration.

3/ Authorized by P.L. 91-296.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants to States for Hypertension Program 1/

States	1976 Actual	1977 Appropriation	1978 Request
Alabama	$ 82,181	$202,136	$199,100
Alaska	12,131	15,431	14,400
American Samoa	11,886	14,869	14,900
Arizona	38,888	88,246	91,200
Arkansas	52,078	125,207	123,500
California	263,698	684,577	679,100
Colorado	39,104	87,033	87,000
Connecticut	46,268	105,903	106,300
Delaware	16,635	27,681	27,900
District of Columbia	21,736	39,757	39,400
Florida	153,533	397,583	413,700
Georgia	89,146	222,230	224,900
Guam	12,775	15,150	15,200
Hawaii	17,969	31,586	31,200
Idaho	21,074	39,065	40,000
Illinois	148,483	376,660	375,000
Indiana	80,723	204,306	203,200
Iowa	48,364	119,760	113,400
Kansas	40,986	95,431	94,600
Kentucky	67,578	160,511	158,800
Louisiana	80,662	192,357	187,000
Maine	27,517	55,114	56,900
Maryland	61,342	146,157	145,500
Massachusetts	87,961	214,167	218,400
Michigan	117,382	301,745	311,400
Minnesota	59,273	143,799	145,400
Mississippi	62,669	151,987	154,500
Missouri	84,780	214,917	213,100
Montana	19,945	37,252	37,000
Nebraska	30,544	68,735	65,200
Nevada	15,981	26,962	26,600
New Hampshire	21,200	40,568	40,800
New Jersey	102,187	257,099	259,000
New Mexico	26,131	54,177	51,500
New York	250,796	648,147	659,200

1/ Allocations are awarded to States based on estimated hypertensive population and per capita income with a minimum program requirement.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants to States for Hypertension Program 1/

States	1976 Actual	1977 Appropriation	1978 Request
North Carolina	$100,305	$251,505	$256,700
North Dakota	17,364	31,417	32,600
Ohio	155,234	392,763	404,100
Oklahoma	55,850	134,157	127,500
Oregon	41,879	94,259	93,700
Pennsylvania	190,865	484,855	481,900
Puerto Rico	155,140	239,899	236,900
Rhode Island	24,029	46,137	45,800
South Carolina	61,176	143,979	145,600
South Dakota	19,941	38,599	39,500
Tennessee	84,271	203,661	205,200
Texas	186,679	484,149	462,100
Trust Territory 2/	24,164	49,789	50,300
Utah	24,907	49,663	49,100
Vermont	17,432	29,001	28,800
Virgin Islands	11,869	14,867	14,900
Virginia	80,045	196,037	196,100
Washington	53,655	124,421	123,400
West Virginia	42,818	95,565	92,500
Wisconsin	74,061	176,889	177,500
Wyoming	14,710	22,083	21,500
Total	3,750,000	8,910,000	8,910,000
Evaulation Amount	---	90,000	90,000
Grand Total	3,750,000	9,000,000	9,000,000

1/ Allocations are awarded to States based on estimated hypertensive population and per capita income with a minimum program requirement.

2/ It is expected that the Marianna Islands will be funded as a separate health jurisdiction in 1978, in accordance with the formula of other Territories. The residue of the present Trust Territories will receive separate consideration.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services

Actual and Estimated Awards 1/
Fiscal Years 1976-8

States	1976 Actual 2/	1977 Appropriation	1978 Request
Alabama	$4,509,600	$4,562,300	$4,564,500
Alaska	444,000	427,300	398,200
American Samoa	166,400	172,800	172,100
Arizona	1,692,800	1,947,100	2,059,200
Arkansas	2,534,700	2,716,100	2,742,300
California	10,171,100	10,446,500	10,538,600
Colorado	1,668,500	1,877,100	1,897,400
Connecticut	1,402,600	1,392,500	1,349,600
Delaware	583,400	588,100	575,600
District of Columbia	497,000	468,200	439,100
Florida	5,588,200	6,034,000	6,297,400
Georgia	6,159,700	6,482,500	6,359,400
Guam	306,600	381,000	371,100
Hawaii	554,400	633,400	658,500
Idaho	922,700	1,086,900	1,148,100
Illinois	6,050,400	6,269,000	6,136,300
Indiana	4,766,700	4,963,900	4,870,100
Iowa	2,511,900	2,525,300	2,486,600
Kansas	1,604,100	1,654,800	1,686,400
Kentucky	4,493,000	4,618,800	4,530,400
Louisiana	4,687,500	4,852,200	4,727,900
Maine	1,310,200	1,327,800	1,281,800
Maryland	3,626,800	3,580,800	3,589,800
Massachusetts	3,093,600	3,097,900	3,027,600
Michigan	6,666,600	6,884,700	6,931,600
Minnesota	3,137,700	3,237,100	3,331,900
Mississippi	3,789,000	3,896,300	3,962,700
Missouri	4,146,700	4,498,300	4,563,200
Montana	810,500	875,100	930,000
Nebraska	1,269,500	1,358,300	1,378,300

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services

Actual and Estimated Awards 1/
Fiscal Years 1976-8

States	1976 Actual 2/	1977 Appropriation	1978 Request
Nevada	$ 383,400	$ 400,200	$ 407,200
New Hampshire	801,300	831,000	826,200
New Jersey	3,303,200	3,471,500	3,489,600
New Mexico	1,292,500	1,408,800	1,437,200
New York	9,747,400	9,799,600	10,026,500
North Carolina	6,885,500	7,216,500	7,044,500
North Dakota	611,200	650,700	644,900
Ohio	8,581,600	8,634,200	8,589,900
Oklahoma	2,389,000	2,525,600	2,580,700
Oregon	1,934,900	2,095,500	2,242,500
Pennsylvania	9,275,300	9,316,600	9,137,200
Puerto Rico	5,635,800	6,739,400	6,477,000
Rhode Island	515,800	513,500	479,400
South Carolina	4,309,700	4,521,800	4,523,100
South Dakota	793,700	843,900	880,200
Tennessee	4,413,300	4,540,800	4,497,400
Texas	9,790,200	10,084,600	9,932,700
Trust Territory 3/	448,400	575,300	551,900
Utah	1,580,900	1,955,800	2,108,900
Vermont	658,100	656,400	660,200
Virgin Islands	230,000	232,100	237,700
Virginia	4,647,000	4,724,400	4,630,400
Washington	2,953,900	3,017,300	3,105,500
West Virginia	2,393,000	2,520,900	2,496,700
Wisconsin	3,754,500	3,846,300	3,941,200
Wyoming	377,000	421,200	445,600
Total distribution by formula 1/	176,872,500	184,400,000	184,400,000
Special Projects for mentally retarded children	4,750,000	5,000,000	5,000,000
Other special projects	8,937,217	11,635,524	11,675,724
Total	190,559,717	201,035,524	201,075,724

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Maternal and Child Health Services

Actual and Estimated Awards 1/
Fiscal Years 1976-78

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 1978 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.

3/ It is expected that the Marianna Islands will be funded as a separate health jurisdiction in 1978, in accordance with the formula of other Territories. The residue of the present Trust Territories will receive separate consideration.

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Crippled Children's Services

Actual and Estimated Awards 1/
Fiscal Years 1976-8

States	1976 Actual 2/	1977 Appropriation	1978 Request
Alabama	$1,527,500	$1,844,500	$1,834,600
Alaska	202,900	217,600	221,400
American Samoa	147,600	149,400	149,500
Arizona	610,500	756,800	797,100
Arkansas	925,100	1,119,100	1,140,300
California	3,468,400	4,244,800	4,229,800
Colorado	656,000	790,900	802,200
Connecticut	640,800	772,400	757,200
Delaware	236,500	254,600	255,200
District of Columbia	248,400	268,200	266,300
Florida	1,829,800	2,262,600	2,361,500
Georgia	1,916,700	2,348,700	2,358,500
Guam	158,700	166,100	167,500
Hawaii	277,700	309,900	313,300
Idaho	347,200	427,100	431,500
Illinois	2,231,500	2,649,300	2,601,200
Indiana	1,789,800	2,178,000	2,136,500
Iowa	1,039,800	1,204,800	1,163,800
Kansas	674,400	798,500	779,400
Kentucky	1,464,000	1,759,900	1,755,600
Louisiana	1,578,700	1,878,100	1,846,600
Maine	452,800	547,200	557,600
Maryland	1,005,500	1,212,400	1,192,100
Massachusetts	1,232,300	1,474,400	1,502,400
Michigan	2,457,600	2,963,500	3,007,900
Minnesota	1,299,000	1,548,200	1,516,600
Mississippi	1,253,800	1,542,000	1,558,600
Missouri	1,416,000	1,732,300	1,717,600
Montana	299,000	362,300	365,100
Nebraska	508,700	609,800	595,900
Nevada	230,100	255,200	258,400
New Hampshire	298,700	373,400	382,400
New Jersey	1,275,800	1,498,600	1,473,800
New Mexico	468,400	570,300	571,200
New York	3,220,500	3,990,700	4,053,300

HEALTH SERVICES ADMINISTRATION

Allocations of Grants for Crippled Children's Services (Cont'd)

Actual and Estimated Awards 1/
Fiscal Years 1976-8

States	1976 Actual 2/	1977 Appropriation	1978 Request
North Carolina	$2,412,500	$2,930,600	$2,962,500
North Dakota	275,300	316,000	307,000
Ohio	3,000,500	3,590,800	3,593,800
Oklahoma	886,500	1,095,500	1,065,300
Oregon	712,400	863,200	856,200
Pennsylvania	3,333,000	3,967,400	3,895,100
Puerto Rico	1,925,300	2,623,900	2,736,300
Rhode Island	286,600	311,400	309,100
South Carolina	1,360,300	1,657,300	1,661,100
South Dakota	318,600	370,600	369,000
Tennessee	1,624,300	1,925,300	1,944,400
Texas	3,422,200	4,181,700	4,092,800
Trust Territory 3/	164,600	173,400	177,000
Utah	427,000	515,900	533,700
Vermont	254,200	302,800	300,100
Virgin Islands	154,000	161,900	164,300
Virginia	1,631,700	1,973,700	1,969,900
Washington	959,100	1,148,900	1,147,800
West Virginia	870,700	1,040,800	1,036,500
Wisconsin	1,579,400	1,866,800	1,852,600
Wyoming	199,100	213,000	216,100
Total distribution by formula 1/	63,187,500	76,312,500	76,312,500
Special projects for mentally retarded children	5,000,000	5,000,000	5,000,000
Other special projects	8,312,500	10,187,500	10,187,500
Total	76,500,000	91,500,000	91,500,000

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 1976-8

(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 1978 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.

3/ It is expected that the Marianna Islands will be funded as a separate health jurisdiction in 1978, in accordance with the formula of other Territories. The residue of the present Trust Territories will receive separate consideration.

HEALTH SERVICES ADMINISTRATION

Supplemental Allocations of Grants for Maternal and Child Health Services

Estimated Awards
Fiscal Years 1976-8

States	1976 Actual	1977 Appropriation	1978 Request
Alabama	$ 21,657	---	---
Alaska	---	---	---
American Samoa	---	---	---
Arizona	---	---	---
Arkansas	---	---	---
California	---	---	---
Colorado	2,019,260	$1,675,760	$1,644,160
Connecticut	353,388	231,888	289,988
Delaware	---	---	---
District of Columbia	4,437,134	4,446,134	4,477,134
Florida	685,700	---	---
Georgia	---	---	---
Guam	---	---	---
Hawaii	554,847	443,647	415,147
Idaho	---	---	---
Illinois	3,403,431	2,767,031	2,947,831
Indiana	---	---	---
Iowa	---	---	---
Kansas	---	---	---
Kentucky	---	---	---
Louisiana	---	---	---
Maine	---	---	---
Maryland	2,969,732	2,808,832	2,820,132
Massachusetts	1,624,126	1,377,726	1,420,026
Michigan	279,000	---	---
Minnesota	---	---	---
Mississippi	---	---	---
Missouri	---	---	---
Montana	---	---	---
Nebraska	729,320	539,420	533,320
Nevada	24,448	---	---
New Hampshire	---	---	---
New Jersey	---	---	---
New Mexico	---	---	---
New York	8,398,938	7,576,538	7,287,038

HEALTH SERVICES ADMINISTRATION

Supplemental Allocations of Grants for Maternal and Child Health Services

Estimated Awards
Fiscal Years 1976-8

States	1976 Actual	1977 Appropriation	1978 Request
North Carolina	---	---	---
North Dakota	---	---	---
Ohio	---	---	---
Oklahoma	---	---	---
Oregon	---	---	---
Pennsylvania	---	---	---
Puerto Rico	1,031,802	---	---
Rhode Island	---	---	---
South Carolina	---	---	---
South Dakota	---	---	---
Tennessee	---	---	---
Texas	---	---	---
Trust Territory[1/]	---	---	---
Utah	---	---	---
Vermont	---	---	---
Virgin Islands	607,500	597,500	589,500
Virginia	---	---	---
Washington	---	---	---
West Virginia	---	---	---
Wisconsin	---	---	---
Wyoming	---	---	---
Total	$27,140,283	$22,464,476	$22,424,276

1/ It is expected that the Marianna Islands will be funded as a separate health jurisdiction in 1978, in accordance with the formula of other Territories. The residue of the present Trust Territories will receive separate consideration.

New Positions Requested

	Grade	Number	Annual Salary
National Health Service Corps			
Medical Officer	Full	192	$2,491,315
Dental Officer	Full	52	674,312
Subtotal		244	3,165,627
Nurse Practitioner	GS-11	3	51,168
Physician Assistant	GS-11	2	34,112
Nurse Practitioner	GS-9	14	197,358
Physician Assistant	GS-9	6	84,582
Nurse Practitioner	GS-7	3	34,569
Physician Assistant	GS-7	2	23,046
Subtotal		30	424,835
Total New Positions		274	3,590,462

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New Positions Requested

	Grade	Number	Annual Salary
Professional Standards Review Organizations			
Public health program specialist	GS-14	3	$86,175
Public health advisor	GS-14	2	57,450
Public health program specialist	GS-13	7	170,156
Public health program specialist	GS-12	5	102,210
Public health advisor	GS-12	5	102,210
Public health program specialist	GS-11	5	85,280
Program analyst	GS-9	2	28,194
Program analyst	GS-7	1	11,523
Secretary	GS-5	10	93,030
Total new positions		40	736,228

THURSDAY, MARCH 17, 1977.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

WITNESSES

DR. FRANCIS N. WALDROP, DEPUTY 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
KARST J. BESTEMAN, DEPUTY DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE
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
WILFORD FORBUSH, DEPUTY ASSISTANT SECRETARY, BUDGET, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. FLOOD. We are still with the Department of Health, Education, and Welfare.

We have the Alcohol, Drug Abuse, and Mental Health Administration. The presentation will be made by Dr. Francis N. Waldrop, Deputy Administrator. We have here a biographical sketch, Doctor, which we will place in the record at this point. Your statement will also be placed in the record.

[Curriculum vitae and statement follow:]

CURRICULUM VITAE

Name: Francis N. Waldrop

Date and Place of Birth: October 5, 1926, Asheville, N.C.

Board Certification: Diplomate, American Board of Psychiatry and Neurology, 1957

Education and Training:

B.A. - University of Minnesota, 1946
M.D. - George Washington University, 1950

Intern, George Washington University Hospital, 1950-51
Psychiatric Resident, Saint Elizabeths Hospital, 1951-54

Experience:

Chief, West Lodge Psychiatric Service, Saint Elizabeths Hospital, 1954-56
Chief, Male Receiving Service, SEH, 1956-58
Chief, William A. White Clinical Research Division, SEH, 1958-60
Associate Director for Research, SEH, and Special Assistant, Clinical Neuropharmacology Research Center, NIMH, 1959-61
Director, Behavioral and Clinical Studies Research Center, SEH, 1961-68
Director, Division of Professional Training, SEH, 1963-68
Deputy Director, National Center for Mental Health Services, Training, and Research, NIMH, 1968-71
Associate Director for Planning, Division of Manpower and Training Programs, NIMH, 1971-72
Director, Division of Manpower and Training Programs, NIMH, 1972-75
Acting Deputy Administrator, Alcohol, Drug Abuse, and Mental Health Administration, 1975
Deputy Administrator, ADAMHA, 1975-

Professional Memberships:

Alpha Omega Alpha Honorary Medical Society
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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Statement by Deputy Administrator
Alcohol, Drug Abuse, and Mental Health Administration

on

"Alcohol, Drug Abuse, and Mental Health"

Mr. Chairman and Members of the Committee:

It is a pleasure to appear before this Committee today to discuss the programs and plans 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 magnitude of alcohol, drug abuse, and mental health problems in the Nation has been--and is--enormous.

Inroads have been made on these problems. We have good reason to hope for further advancements in the years ahead. Nonetheless, alcoholism, drug abuse, and mental illness are still crippling realities for millions of Americans and their families and a great burden to our economy. It is our responsibility--and a cherished goal--to help relieve this pain and burden.

There are about nine million alcoholic men and women in the country today. Among young people, the use of alcohol is increasing, and starting at earlier ages. Nearly 40 percent of junior and senior high school students drink

some alcoholic beverage, particularly beer, at least once a week, according to the largest survey ever made of that age group. And a recent survey of fourth, fifth, and sixth graders in the Western United States indicates that 45 percent of these children consider themselves current users of alcohol, with 8 percent drinking at least once a week. 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 but it wastes vast human potential.

The abuse of drugs, both licit and illicit, continues at worrisomely high levels. Granted, we are not faced with the surging epidemic of the early 1970's. Recent surveys show that marihuana is the only drug that continued to show a definite upward trend in use in the past two years. Slight downward trends have been noted in the use of amphetamines, LSD, and barbiturates. But we have reason to be guarded in our optimism, remembering the erratic and discouraging course of heroin use, which a few years ago appeared to be contained and declining, only to rise again. Current survey data show that 4 percent of the population between the ages of 18-25 have used heroin and .5 percent of the youth between 12 and 17 have tried the drug.

One in ten of our citizens--or approximately 20 million Americans--suffers at some time 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 two million Americans alive today will experience some degree of disruption in their lives as a result of schizophrenia.

I am glad that I am able to report to you today that we are making progress in our programs to deal with this broad spectrum of human problems and their impact on our national well-being, and later on I should like to give you some examples of this progress. They are not sensational breakthroughs or miracle cures but the culmination of years of scientific research, controlled treatment programs, dedication and hard work. We fully realize that much more of all these is needed.

Before dealing briefly with each of the ADAMHA Institutes, I would like to touch on some major features of the proposed fiscal year 1978 budget--features which affect more than one of the Institutes.

Research was the original and, for a long time, the sole mission of the National Institute of Mental Health, the organization from which ADAMHA evolved. Today, the importance of research remains unchanged. The budget allows $23.6 million for new alcohol, drug abuse, and mental health research projects.

It is our basic philosophy that research activities should be and are the highest priority of the Agency. Since research offers the ultimate answer to our problems in these three areas, a strong research program is the best investment that can be made in promoting our primary goals.

Similarly, prevention makes good sense in terms of both economics and ultimate results, and with that in mind NIDA's prevention funds have been increased. You may also be interested to know that we have recently sponsored a conference with representatives of Great Britain and Canada to exchange knowledge and experience in defining prevention as it applies to substance abuse and mental illness and in developing and implementing preventive strategies.

The 1978 budget proposes that all projects providing services to individuals be maintained at levels slightly higher than the previous year. This will provide services to 300,000 alcohol abusers. CMHC's will provide mental

health services to approximately 2.2 million persons. In drug abuse, the 102,000 treatment slots which are supported in part by NIDA funds will be maintained and will provide treatment for approximately 175,000 people. Federal funds provide partial funding for about 55 percent of drug treatment programs, with NIDA responsible for about 40 percent of the total. Within the amount requested for drug abuse demonstration projects, new funds are available to develop and evaluate promising approaches to treatment and rehabilitation services.

The 1978 budget recommends funds for training equal to the 1977 level. This includes over $20.5 million in new awards in clinical training and a redirection of the NIMH training programs which I will describe in detail later in my statement. In research training, funds are available for a number of postdoctoral fellowships.

I should now like to report on some of the activities of the individual Institutes.

In 1978, the NIAAA will fund alcoholism service projects, with full implementation of an alcohol matching-rate funding policy which provides for a gradual phasing down of Federal support to individual projects over a maximum of six years. Emphasis continues to be placed on supporting programs reaching communities composed of poverty and minority and other special population groups which have a high incidence

of alcoholism and which have traditionally been lacking in services. In addition, programs are supported which meet the particular needs of drinking drivers and alcoholics in the work setting. The 1978 estimate provides continuation support for the 26 States which had previously enacted the Uniform Alcoholism Intoxification and Treatment Act, and new support for ten States in which such legislation is expected to be enacted.

Data from Institute-supported alcohol grants show that 71 percent recovery rates persist at 18 months following entry into treatment. Recovery is defined as an average drinking rate of less than one ounce of alcohol per day. Behavioral impairment due to alcoholism is reduced by similar amounts, and the unemployment rate decreases by 28 percent. The data also indicate that group counseling is as effective as individual psychotherapy.

In addition to the treatment effectiveness shown by these NIAAA-funded alcoholism treatment centers, there has been a continuing improvement in the efficiency of treatment delivery. The cost of treating clients decreased 44 percent between 1973 and 1976. This reduction corresponds to the shift in emphasis to outpatient services, the increase in the number of clients served, and changes in staffing patterns to employ more paraprofessionals.

The increase in the centers' client employment rate and the increase in average wages provides over $1 million in added earned income per month. In addition, the number of clients institutionalized--either in hospitals or in jail--decreased 74 percent, 180 days after intake into the center program.

Turning now to the National Institute on Drug Abuse, NIDA is currently supporting 333 research grants and contracts. From these have come major advances in our understanding of the basic mechanisms involved in opiate action at the molecular level, including isolation in the brain of naturally occuring morphine-like substances called endorphins which may lead to a greater understanding of the physiological phenomenon of drug tolerance and dependence. Other recent achievements are the development of a drug delivery mechanism which has the potential of giving the narcotic antagonist naltrexone a one-month duration of action, initiation of large-scale clinical testing of the long-acting synthetic narcotic known as LAAM, and completion of small-scale testing of naltrexone preparatory to applying for FDA approval of large-scale testing.

In 1978, NIDA will support a survey of nonmedical use of prescription drugs with an emphasis on measurement of consequences of their use; epidemiological studies of women, elderly persons, and addicted infants; studies of the impact of policy change in the U.S. on drug abuse; and investigations of the effects of drug use on performance, such as driving, economic behavior, commission of crimes, and suicide.

Treatment assessment research will seek to determine the most effective therapeutic procedures for reducing drug abuse, including the introduction of LAAM as a standard therapeutic drug in the treatment of heroin addiction, and the completion of clinical testing of naltrexone for eventual use as a standard therapeutic drug. Clinical research will be continued at the Addiction Research Center in Lexington, Kentucky, using new pharmacologic agents in a therapeutic context, and with volunteer patients rather than prisoner subjects as has been in the past.

It is expected that in 1978 statewide contracts will be operational in 50 states and territories. These contracts are awarded primarily to state agencies, who subcontract with local agencies to provide drug abuse services.

This mechanism gives the states the discretion as to the allocation of drug abuse treatment funds within the states. Since priority emphasis is to be given to the treatment of heroin addicts and the correlative concentration of heroin in urban areas, the majority of drug abuse treatment should be directed toward the cities.

Clients treated in drug abuse treatment programs show a significant continued improvement in their behavior years after their initial treatment experiences. The most striking changes for clients are in any use of illicit drugs (decrease of 66%); any use of opiates (decrease of 74%); and daily use of heroin (decrease of 92%). Less dramatic, though significant, changes also occurred in employment (any part-time or full-time employment) which showed an increase of 30% and any illegal income which decreased nearly two-thirds.

New demonstration projects will develop and evaluate vocational rehabilitation programs specifically designed for the drug abuser, and outreach techniques for polydrug abusers, women, and people referred by the criminal justice system. An effort will be made to integrate successful prevention strategies into state plans and to support a series of grants for the development of model prevention projects primarily aimed at school age children.

In the National Institute of Mental Health, the research effort in 1978 will, for the most part, constitute an extension of existing programs which are steadily expanding our knowledge. There will be a continuing effort to increase understanding of the problems of schizophrenia, depression, and mental illnesses of children, as well as research into the cause and prevention of rape. The Institute will continue programs of basic psychological, biomedical, and genetic research into the causes of schizophrenia. In the area of depression, NIMH will move forward with collaborative research on psychological, psychosocial, and cultural factors which influence the development and course of depression. 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, and problems of early adolescence.

Schizophrenia and depression also continue to be the target of much of the NIMH Intramural Research Program. Basic researchers work on the interrelationships of brain function and behavior. They also work in concert with clinicians to generate, synthesize, test and disseminate new knowledge to develop diagnostic and treatment methods.

Among other accomplishments, one group of investigators has found that recovered depressives differ from normal individuals in their biochemical response to stress. Other studies have shown that depression, particularly manic-depressive illness, has a genetic component. These combined findings open the possibility that potential depressives may be diagnosed through testing of body fluids, treated accordingly, and thus avoid depression completely.

Several events have occurred within the field of training which the Agency and NIMH are addressing. The Health Professions Educational Assistance Act of 1976 (P.L. 94-484) has dramatically altered federal emphasis on manpower training. It is incumbent upon the Agency to assure that the programs administered by ADAMHA remain consistent with the overall objective of the Act while still maintaining an independent focus on mental health because of its unique problems. To this end, the Deputy Administrators of Health Resources Administration (HRA), Health Services Administration (HSA), and ADAMHA have been meeting on a regular basis to discuss how the Act affects each agency and the overall PHS manpower training effort. Also, I chair an Agency Coordinating Group for the implementation of the Act. Specific task groups have been designated to work with HSA and HRA in developing those regulations in areas of interest to ADAMHA.

Of specific concern is the fact that P.L. 94-484 places severe restrictions on immigration and eligibility for student visas for physicians seeking to enter the United States. If the flow of FMG's is significantly reduced as anticipated, the total number of psychiatry residents will be reduced as a consequence (possibly up to 40%) resulting eventually in a decline in the total numbers of psychiatrists. Particularly affected will be state mental hospitals where over 50% of hospital staff physicians are foreign medical graduates.

Another problem which is of mutual concern to the Agency and the Committee is that of maldistribution. We have recently submitted a report to the Committee, at its request, on the situation. Professionals of all types are disproportionately located in the northeastern United States and California. Psychiatry has the greatest degree of maldistribution, that of other disciplines is less great. We have been working with the HRA to designate shortage areas for placement of psychiatrists in the National Health Service Corps.

These and other problems are also addressed through the redirection of the NIMH training programs which is being initiated in fiscal year 1977, and which will be continued in 1978. Based on needs identified through a long-range planning process and on Congressional concerns in the manpower area,

we are proposing the development of new mental health services manpower programs. The new approaches are being developed to address two basic issues; first, the lack of a systematically derived body of data, knowledge, and technology for planning the effectiveness and efficiency of training programs; and second, the maldistribution of mental health manpower. The second issue addresses maldistribution both in the geographic sense and also in terms of services to special target populations such as minority group members, children and the aged. The new initiatives include activities to strengthen the leadership and capacity of State and local mental health agencies in mental health services manpower planning and development. NIMH will also expand research and development activities on such issues as recruitment, distribution, utilization, and retention of mental health personnel.

Research and demonstration is needed, for example, on data systems which are essential to provide the basis for effective manpower planning and evaluation. NIMH will also increase the support of research and development on the mental health training of primary care providers. In addition to these new initiatives, NIMH will continue its support of basic training in the core mental health disciplines for programs that are particularly responsive to service-related

priorities, such as community mental health, deinstitutionalized populations, underserved populations, minority training, and prevention.

In community programs--or community mental health centers--the 1978 appropriation request will support 654 continuations awards. The community mental health center program in total has supported 670 centers. Of this total, 599 will be operational by the end of fiscal year 1978, and approximately 2.2 million patients will be treated during that year.

In conclusion, Mr. Chairman, the appropriation request for Alcohol, Drug Abuse, and Mental Health in 1978 is $877,656,000, an increase of $1,985,000 above the 1977 level of budget authority. This represents an increase of $371,000 in alcohol research, and $2,333,000 in community service programs in all three Institutes, and $350,000 for buildings and facilities. These increases are offset by a reduction of $1,069,000 in Agency operating funds.

Mr. FLOOD. Would you like us to meet some of your people?

Dr. WALDROP. I would like to introduce to my right Mr. Forbush from the Office of the Assistant Secretary, Comptroller; Dr. Robert DuPont, Director of the National Institute of Drug Abuse; Dr. Ernest Noble, Director of the National Institute on Alcohol Abuse and Alcoholism; to my left, Mr. Jack Mahoney, Director of the Division of Financial Management; and to my extreme left, Dr. Brown, Director of the National Institute of Mental Health.

MENTAL HEALTH RESEARCH

Mr. FLOOD. Now, Doctor, your 1978 mental health research budget, that's the same level as 1977. Is this budget going to permit you to meet the costs of all of the grants at the same level?

Dr. WALDROP. Mr. Chairman, the budget for 1978 will not only permit us to meet all our continuation requirements but in addition allow us $26 million for new starts and competing renewals.

Mr. FLOOD. Well, I was going to ask you, will you be able to initiate any new research projects under this budget?

Dr. WALDROP. Yes, sir; we will be able to. The budget provides $16.7 million for new starts.

Mr. FLOOD. If so, in what areas? In what research budgets will you invest this money?

Dr. WALDROP. I am going to ask Dr. Brown to respond to that.

Dr. BROWN. Mr. Chairman, the whole level budget will permit us, of course, en masse, to barely stay afloat in terms of the cost of inflation. We will have funds for new programs. We will continue the efforts we started last year in, say, the clinical research sense. We will make a new effort to bring together the patients and scientists in one place and make progress in depression and schizophrenia. We will continue to support basic research, research in practical fields such as learning disabilities, childrens' problems, and problems around old folks.

MENTAL HEALTH PROBLEMS OF THE ELDERLY

Mr. FLOOD. Well, Doctor, this committee included $2 million in the 1977 supplemental appropriations bill to support research on all the mental health problems for the elderly. You know about that.

How much do you plan to spend in 1978 in that particular area?

Dr. WALDROP. In the area of mental health of the elderly?

Mr. FLOOD. That's right.

Dr. WALDROP. The National Institute of Mental Health plans to spend approximately $7.7 million in fiscal year 1978. This includes both research and training programs.

MENTAL HEALTH PROBLEMS OF CHILDREN

Mr. FLOOD. Now the budget material, a lot of it, also indicates that you continue—you just touched on this—continue your research efforts in the area of schizophrenic depression and mental illness of children. Suppose you describe or tell us about some of your research efforts in this area, particularly the mental illness of children.

Dr. WALDROP. Mr. Chairman, in the area of mental health problems of children, the amount spent by NIMH in the last 7 years has grown from 9 percent of its budget to approximately 23 percent of its budget.

It's clear that the problems of mental illness in children continue to be a major concern. Although there has been a progressive fall off and decrease in the number of patients in State mental hospitals, we are concerned that there is an increasing number of new admissions, and a disproportionate number among children.

We are concerned about the fact that there were 27,000 suicides in this country in 1975, making it the ninth leading cause of death; however among young people it was the third leading cause of death.

We have serious concerns about reading and learning disabilities in children that handicap their ability to make a reasonable and normal adjustment in our rather complex society. These are some of the areas in which we would continue to do active work.

Mr. FLOOD. What have you learned in the last couple of years about the mental illness of children that's found its way finally into the health care delivery system.

Dr. WALDROP. I would like Dr. Brown to give you some examples.

Dr. BROWN. We found out several things that have proved useful. Depression was always a puzzler.

Mr. FLOOD. The big thing is delivery, delivery.

Dr. BROWN. A good example would be depression in children. We know that children sometimes start to act peculiar in school, not pay attention, wander. At times it's unclear whether this is just family tensions, some kind of illness, whether it would respond to drugs, whether it's social or emotional.

We have begun to see that quite often it's a childhood form of depression and that medical treatment will straighten out the learning problem, for example. This has been practically applied now for many thousands of children.

In addition, as you know, many kids are hyperactive, overactive, jumpy, or don't sit still. Here quite often treatment is tried on a medical basis to give them amphetamines, a sensitive topic.

Mr. FLOOD. Is that bad when they don't sit still?

Dr. BROWN. Yes, when they don't sit still enough so they can learn. That's the problem. Some of them need that kind of help.

Mr. FLOOD. I know what you mean.

Dr. BROWN. Some of them have been getting the wrong kind of help. The concept of helping those kids learn the social changes in the classroom instead of giving them drugs—that's found itself into the delivery system and is an active program in our intramural research.

DEPRESSION

Mr. FLOOD. Any breakthroughs on this horizon, especially on the point of depression? You stated the case; any breakthroughs on it?

Dr. BROWN. Breakthroughs are always on the horizon.

Mr. FLOOD. What is on the horizon?

Dr. BROWN. We do have an important development in the horizon in this area. We have been taking the children of parents who have had depression, that is, the parents who have had a serious depression

and been in our hospitals. We have been studying their children in terms of how they react to stress, using biochemicals and other tests. We find there are two groups, and one of those groups seems to be more prone to depression.

We are on the verge of predicting what the genetic contribution, the heredity side, and what the susceptibility is. If we can sharpen this, we may be able to pick out those youngsters and adolescents who are prone to depression and prevent it before it happens. It's an exciting horizon, Mr. Flood, for which we need more money.

Dr. WALDROP. Mr. Chairman, I would like to add one point on delivery. As you know, the child services now are a required part of the community mental health center program. Those centers in the current year will provide services to about 500,000 children out of a total of about 2 million who will be served.

Mr. FLOOD. Is that a lot?

Dr. WALDROP. That is a considerable proportion. It is not enough. There are 7 million who probably require or would benefit from such care.

HOSPITAL IMPROVEMENT PROGRAM

Mr. FLOOD. Doctor, under this hospital improvement program that we talked about before, are the State hospital free to use that money just as they please?

Dr. WALDROP. They are free to use the money within the conditions of the grant award. During the coming year, the NIMH is considering a significant redirection of the hospital improvement program and the hospital staff development program to prepare staff of State mental hospitals to deal with people who are inappropriately institutionalized and to promote more effective deinstitutionalization, both of children and of adults.

Mr. FLOOD. How successful have you been in getting State mental hospitals to develop their own community programs or to affiliate themselves with an existing community program?

Dr. WALDROP. There has been some progress. I would characterize it as modest.

Mr. FLOOD. How much of that $4.9 million in this budget is going to be used to help State hospitals in their development of these community programs?

Dr. BROWN. The redirection, Mr. Chairman, is an important one in that to date we dealt with, as you remember, 500,000 people in the State hospitals. Last year's figure was less than 193,000, half of which we still think should not be there. That was a dream, you remember, we shared 10 years ago. What we are going to do now is take those funds and redirect them to the community where the chronically ill, emotionally handicapped person needs a support system. You have to pardon our usual fancy name of calling it the community support system approach. We want to pull together the hospital community link, along with organizations like HUD that provide housing. We also want to link the program to vocational rehabilitation. We want to make the Labor-HEW bill come together to serve patients in the community. Hopefully, that is the way we are going to be using these funds next year.

MALDISTRIBUTION OF MENTAL HEALTH MANPOWER

Mr. FLOOD. Last year, Doctor, you will recall the committee expressed a considerable concern about the maldistribution of mental health manpower. Specifically, now, in this budget, have you begun to solve this problem of maldistribution?

Dr. WALDROP. Mr. Chairman, that is one of the most bedeviling problems, I think, in the whole health arena.

Mr. FLOOD. That is an understatement.

Dr. WALDROP. I think that is an understatement, too.

There are several ways of approaching this problem. One, we have a better fix today on the problem of maldistribution, and it is, indeed, very severe.

Mr. FLOOD. You have a better what?

Dr. WALDROP. A better fix, understanding. Certainly for mental health professionals in all categories, we are confronted with a very severe maldistribution problem.

Second, we are working with our colleagues in the Health Resources Administration in implementing the Health Manpower Act that was recently enacted. This act provides, among other things, for the identification of shortage areas and shortage institutions which will be filled by persons serving in the National Health Service Corps and otherwise with a payback obligation. This will have some impact on addressing the problem of maldistribution, but more fundamentally the issue of maldistribution, as well as other problems in mental health manpower, are being addressed by a proposed significant redirection of the NIMH training activity.

I will ask Dr. Brown to elaborate on those details.

Mr. FLOOD. Are those three initiatives you list, are they separate efforts or are they part of an overall plan?

Dr. WALDROP. They are part of an overall strategy.

Mr. FLOOD. How did you develop the strategy?

Dr. WALDROP. Dr. Brown can outline its development.

Dr. BROWN. By a combination of task force, hard work, and sweat and tears. I think I would like to make this next year, Mr. Chairman, redistribution or bust. I think the maldistribution issue is a real one. I think the public funds ought to be used to place professionals we train where they are most needed, and we put together three initiatives you have in the budget before you, as well as most important, redirecting our core professional training to meet the needs that are called for by the public and the patients in need.

NEW INITIATIVES

Mr. FLOOD. Doctor, how much of the 1978 clinical training budget are you going to devote specifically to supporting these new initiatives we are talking about?

Dr. WALDROP. Approximately 33 percent.

Mr. FLOOD. Is that all?

Dr. WALDROP. Seventy percent of new and competing awards would be directed in this way.

Mr. FLOOD. Is that all of the clinical training budget?

Dr. WALDROP. No; it is not. We are still going to continue to support the basic core disciplines of psychiatry, psychology, social work, and nursing and at the same time begin to direct these programs to address the problem of maldistribution and other problems that Dr. Brown has mentioned.

Mr. FLOOD. Are you talking about manpower, are you planning to tie your manpower programs, the needs of—the service delivery system?

Dr. BROWN. The underlying concept is to make the manpower part of the service delivery program. That is what it is for.

Mr. FLOOD. I hope. We hope.

Well, with all of those grantees who are applying for this clinical training, are they going to be required to provide evidence to show that they are meeting the service priority or that they have some affiliation with a community mental health center or a State mental hospital we talked about before?

Dr. WALDROP. As Dr. Brown has mentioned, we are attempting to link the training programs with services delivery needs. We will certainly promote such an integration as rapidly as is possible.

STEPS TO SOLVE MALDISTRIBUTION PROBLEMS

Mr. FLOOD. I will tell you what to do for the record. Suppose you submit an implementation plan which lays out in detail all of these steps that you will take to follow through with these so-called issues—your pet word—which will, first of all, begin to solve the maldistribution—let's go back to that—and, two, will meet the needs of the delivery system. You can do that for the record. You can see that we are not convinced that all these concerns are going to be met. So let's have the record show that.

Dr. WALDROP. Yes.

[The information follows:]

PROPOSED NIMH SOLUTIONS FOR MANPOWER MALDISTRIBUTION PROBLEM

There is no single way to solve the problem of maldistribution of mental health manpower and meet the needs of the service delivery system. The causes underlying the present situation are complex, and must be addressed with a variety of interlocking strategies. The methods NIMH proposes are as follows:

1. State mental health manpower development grants to enable mental health authorities at the State and sub-State levels to design and implement effective plans for meeting manpower needs: These grants can be in the areas of (a) planning; (b) manpower training to upgrade the skills of existing personnel and educate them for new roles and responsibilities; (c) special projects to conduct conferences, institutes, and seminars to examine common issues and problems; or(d) research and development to generate the knowledge and technology necessary to address specific manpower problems in areas such as recruitment, retention, utilization, etc. By working directly with the State Authorities responsible for the planning and delivery of service NIMH can continually check to see that its goals and assessments of needs are realistic and its methods for meeting these needs are effective.

2. Grants for the specialized training of professional and paraprofessional personnel for the delivery of mental health services: Support to training institutions is vital in order to maintain the capacity and excellence which have been built up over the years. The maldistribution problem can never be solved if there is a shortage of manpower, but the training programs of NIMH go beyond attempting to increase the supply of well trained personnel. Priority in the award of training grants will be given to those programs having a plan to meet service needs and which are affiliated in some way with service delivery institutions, and which have their curricula specifically designed to address training in the areas of community-based services, deinstitutionalization, prevention of mental illness and the provision of services to underserved populations such as children, the aged, the poor, minority groups and those living in remote or rural areas. There will also be special grants for the development of training programs in States or areas with a shortage of mental health manpower, and to those institutions which emphasize the training of minority mental health professionals. Applications for clinical training grants will have to specify the significance and relevance of the project objectives to national mental health service needs and priorities, provide details as to how the program will address these needs, describe the expected job location and activities of the programs's graduates, and give a plan for evaluating the success of the program both in the training and placement of students.

3. Service payback requirements in return for training support: It is expected that programs encouraging trainees to work voluntarily in underserved areas will succeed. There is at present, however, no way to compel a student to take a certain job or work in a certain location. If the methods outlined above are not successful in remedying the maldistribution problem NIMH will seek amendments to PHS legislation to include a mandated service payback provision, perhaps through the National Health Service Corps. In this way students receiving support for their training would have to work for a given number of years in mental health manpower shortage areas.

4. Research and development grants to generate, disseminate and apply knowledge and technology about, among other things, the causes and potential cures for the maldistribution problem: These studies will provide information that can be used both by the training program directors to support those professional education programs which have a promise of a high pay-off, and by State authorities in their service delivery facilities to recruit and retain professional personnel more efficiently and to utilize their services more effectively.

5. Training of primary care givers in mental health knowledge and practice: Until there are a sufficient number of mental health specialists equitably distributed throughout the country, many people will have to rely on primary care physicians, such as family practitioners, internists, and pediatricians for the diagnosis and often for the treatment of mental health problems. In general, these health professionals are more likely than mental health specialists to be available in rural or remote areas, and thus be the natural first contact for people in mental distress. It is important, therefore, that they have the training to enable them to recognize emotional problems, treat those of mild severity themselves, and know which ones to refer to specialists. Future grants will support the training of these primary care physicians and also stress in the education of psychiatrists an ability to consult with their medical colleagues.

6. Designation of psychiatric manpower shortage areas for the placement of psychiatrists in the National Health Service Corps and for loan repayment: With the passage of P.L. 94-484, many graduating physicians will have an obligation to work for a period of years in an underserved geographic area or facility as a way of repaying support received during their education. NIMH is working with HRA in developing criteria for the designation of shortage areas and priorities for placement so that psychiatrists with a service obligation will work in areas where they are most needed and in facilities where their services will be given to the entire community.

7. Improved data systems to measure distribution and utilization of mental health manpower: Present efforts to train mental health professionals and paraprofessionals to work where they are most needed are hampered by a lack of detailed information on the present location of personnel, the perceived needs for different categories of manpower, and the current utilization of these people. An improved data collection system will not only provide this information, but indicate how staff can be most effectively utilized not only for the provision of services but for their own satisfaction and retention. This information will, in turn, be of help in planning training and continuing education programs and in providing technical assistance to State mental health authorities.

The simultaneous use of these various methods should enable NIMH to make substantial progress in solving the maldistribution problem and in developing manpower to meet the needs of the service delivery system.

Mr. FLOOD. Mr. Natcher.

SPECIAL TRAINING NEEDS

Mr. NATCHER. Doctor, where in your mental health training initiatives will you give attention to the special mental health service needs of such groups as minorities and the elderly?

Dr. WALDROP. I would like to refer that question to Dr. Brown.

Dr. BROWN. In all four of the areas. Let me give you just a quick example from each. For example, we are going to be working closely with State and local officials in terms of their overview of the States' needs, and in the most underserved areas and populations which are very often the minority groups, as you know. The State has special responsibility.

Therefore, the program—which links the training folks, the university folks, with the State folks—will have to address the minority and underserved issues.

Another example would be in our experimental training programs where new curricula, new types of approaches to minority programs would be developed, giving attention to cultural sensitivities, special needs, et cetera.

The other side of the coin involves promoting the actual number of minority people being trained, that is, to have the actual professional staffs, the psychologists, psychiatrists, social workers, nurses, and others increase the proportion of minority people in this activity.

I would be glad to provide for the record our current success—and I should say lack of success in this area.

Mr. NATCHER. Suppose you submit that.

Mr. Chairman, with your permission, we will incorporate the pertinent part of it.

Mr. FLOOD. Without objection, that will be done.

[The information referred to follows:]

NIMH EFFORTS TO MEET MINORITY TRAINING NEEDS

The investment in minority mental health training is projected to remain at 13 percent of the total training budget from fiscal year 1976 through fiscal year 1978. In effect, we will be maintaining these programs at a constant proportion to our essentially level budget for these 3 years.

The training projects reviewed by the NIMH minority center study section had a lower rate of approval in fiscal year 1976 (4 percent) than in fiscal year 1975 (10.5 percent), an indication that technical assistance and consultation with applicants should be emphasized in the minority mental health area. However, the reduction of operating funds and restrictions on travel hamper any increased effort in this area.

Lack of predoctoral research training support hits minority programs the hardest, particularly fellowships in the core disciplines. The current fiscal year 1978 budget will impede efforts to develop a significant and targeted program of support for minority research manpower development. The reductions in research training grant support will impede efforts to develop the research and research training capacities of minority institutions and nonminority institutions specifically committed to developing minority researchers. The elimination of support for predoctoral fellowships will result in the termination of the NIMH Minority Center's research fellowship program. This program is geared to providing research training fellowships at the predoctoral level to minorities in the areas of psychiatry, sociology, social work, psychology, and psychiatric nursing. NIMH would like to extend this targeted effort to all NIMH research training programs because of the success of its minority center projects, particularly in view of the critical shortage of minority research scientists.

Mr. NATCHER. Anything else, Doctor?

MINORITY NEEDS

Dr. BROWN. I could go on to describe how we are going to meet minority needs by going through one or two of the other initiatives. For example, in the primary care area, where we try to increase the abilities of doctors, nurses, other primary health folk to meet mental health needs. They often need special efforts to understand the minority communities and minority needs. That will be part of our support in this area.

TRAINING MANPOWER R. & D.

Mr. NATCHER. Now, in the budget you talk about training and manpower R. & D. What kind of R. & D. projects do you plan to support?

Dr. WALDROP. These will be largely in the development of new and improved curriculums, the training of new types of people to deliver services, and the examinations of ways in which services can be delivered in shortage areas. This will be done through continuing education and improved training of existing providers of services delivery personnel such as primary care providers and others. We will equip them to deal more effectively with the emotional health aspects of the patients that they would normally be serving. However, it is basically an experimental approach to test new and improved methods of training, types of people being trained, and a means of getting knowledge—if not the people—into the areas of shortage.

NATIONAL HEALTH SERVICE CORPS

Mr. NATCHER. How will your mental health manpower programs relate to the National Health Service Corps?

Dr. WALDROP. The primary way it will relate is through the discipline of psychiatry. As you know, the Manpower Act requires a payback for all of those who, as medical students, will have received a scholarship or in some cases have received a loan. They may have the option of paying back at least in substantial part through service in a shortage area.

If we get to the point where 40 or 50 percent of medical students who graduate have such a payback obligation, then the proportion that would be entering psychiatry would also be 40 or 50 percent. Upon completion of their residency training—and the law allows them to have up to 3 years after graduating from medical school for such training before beginning their payback—they would then pay back by serving in a shortage area. They would be paying back by serving as psychiatrists.

This arrangement does not necessarily apply to other mental health professionals, such as psychologists, social workers, nurses.

Mr. NATCHER. Doctor, I hope when you come back next year you will have results to show to the committee in terms of having solved, or attempting to solve the maldistribution problem so that the limited supply of money that you have now in your budget—and it is limited—can be used to obtain the best results and maybe justify an increase in your next appearance before our committee.

FOREIGN MEDICAL SCHOOL GRADUATES

Now, Doctor, how will the pending restrictions on foreign medical graduates affect staffing of State mental hospitals? Will there be any change?

Dr. WALDROP. Yes, sir, there will be a change.

In my view this will have a profound impact upon the delivery of services, psychiatric services, in our State and county hospital system. Today well over 50 percent of all the psychiatric services provided in our State and county mental hospitals are provided by foreign medical graduates, either those currently in training on J visas or those who came in for training and remain as permanent citizens. This arrangement will no longer obtain. It will be much more difficult for foreign graduates to enter the program for such training; and those centers located in State hospitals will have to be affiliated with medical schools and so forth for their continued operation.

The point is that there are two circumstances at present which are of considerable concern to us. One is that we are faced with what will be a significant reduction in the availability of foreign medical graduates. At the same time, there has over the past 4 years been a trend downward in the absolute numbers of American medical graduates who enter the field of psychiatry. Today there are 400 fewer American graduates training in psychiatry than was the case 4 years ago. That difference has been made up in the last several years by an increase from 29 percent to 39 percent trainees who are foreign medical graduates.

Now, that is going to be reduced. What this means is that we are going to have to work closely with the entire professional and service field in mental health toward improving the supply of psychiatrists, improving their distribution, and working with them toward the most effective possible utilization of the unique skills of the psychiatrist in the mental health team. It is going to be a serious problem.

SUPPLY OF DOCTORS

Mr. NATCHER. Do we have an oversupply of doctors generally in this country? You know in the last 3 or 4 weeks, the President has indicated that the uniform services setup that was placed in operation about a year ago should be brought to a halt. They have some 32 or 33 students. These students, according to the announcement, will be placed in medical colleges around the country, if possible. Do we have an oversupply, Doctor?

Dr. WALDROP. Well, when the Congress enacted——

Mr. NATCHER. Not just as to psychiatrists, but generally as far as doctors are concerned?

Dr. WALDROP. When the Congress enacted the Health Manpower Assistance Act recently, it found that there was no longer an overall shortage of doctors in the country. On the basis of that, plus other general information shown, I think it would be difficult to argue today that overall we have an insufficient number of physicians. However, there is no doubt that there are inadequacies in distribution, so that in some areas and for some populations there is, in effect, a short-

age. In the area of psychiatry, we feel that there will be on the basis of the most minimal and conservative grounds, a shortage of approximately 12,000 psychiatrists in the United States by 1985.

TRAINING OF FOREIGN DOCTORS

Mr. NATCHER. Doctor, do you have any data which compares the performance of foreign trained doctors working at State mental hospitals with the performance of doctors trained in this country?

Dr. WALDROP. I am not aware of any specific data which has tried to measure that. However, knowledge of the national culture and facility in the language is particularly important in a field such as psychiatry. This has been a difficulty for many of our foreign medical graduates.

Mr. NATCHER. Do you have any plans to conduct special training programs for the foreign doctors that are now working in State hospitals?

Dr. WALDROP. I would like to ask Dr. Brown to tell you his plans.

Mr. NATCHER. What about that, Dr. Brown?

Dr. BROWN. This is a good example of how those new initiatives will help out. As far as the States are concerned, since 50 percent of their medical staff are foreign medical graduates, we will use our training programs to improve their manpower efforts, provide better staff utilization and development, provide language training, and bring them up to date.

We plan to have conferences, though we know that conferences aren't enough, and to provide some resources to deal with this issue. However, I would like to reiterate Dr. Waldrop's point. It's a forthcoming major issue for the field of mental health and psychiatry; 50 percent plus of the doctors taking care of those patients are foreign medical graduates. That supply is being cut off.

SOURCE OF FOREIGN MEDICAL GRADUATES

Mr. NATCHER. When we speak of foreign doctors in this particular field now, where are they coming from mainly? The Philippines?

Dr. WALDROP. That is one major source. Other major sources are South Korea, Cuba, India, Latin America, and other Far Eastern countries. There are also some from Europe. We do not consider Canadian graduates in this category.

Mr. NATCHER. Thank you, Mr. Chairman.

Mr. FLOOD. Any questions, Mr. Patten?

ALCOHOLISM RESEARCH CENTERS

Mr. PATTEN. Well, it's always a pleasure to have Dr. Brown, Dr. DuPont, and Dr. Noble before this committee.

I would like to reiterate my interests. You didn't want to see our monthly catalog from the national alcoholics center? This is No. 12.

For the record, are we going to make any progress on establishing these alcoholic centers?

Dr. NOBLE. As you know, Mr. Patten, $2 million was earmarked in the 1977 supplemental appropriations bill which was just passed by this committee. We have assembled a group of six experts to develop guidelines so that NIAAA will be able to obligate the funds before the end of the fiscal year if they are appropriated.

We have established the areas in which more research needs to be done. One of these would be in the area of the central nervous system. We have recently found that alcohol damages pregnant mothers' fetuses. We feel that this is a very important area where research should be accomplished. We also like to have centers conduct studies on the role of the media and its effect on alcoholism and alcohol abuse.

So we feel that if the $2 million can be realized in 1977 the funds can be adequately used to begin funding four research centers.

Mr. PATTEN. By the way, do you have a lot of requests that are unfunded?

Dr. NOBLE. For these research centers?

Mr. PATTEN. Yes.

Dr. NOBLE. In the past few months, 35 different institutions have indicated a great deal of interest in these centers.

Mr. PATTEN. Doctor, remember Nader commented on our community health centers 3 or 4 years ago?

Now we have a little more experience. Do you feel as good about this program as when we started out? Or do you feel better about it?

PROGRESS OF CENTERS PROGRAM

Dr. BROWN. I am just short of manic, starting from a state of anxiety 15 years ago. That program has now spent 1½ billion Federal dollars, $5 billion if you add up the State, local and other funds. Two million people received care last year.

Mr. PATTEN. I send them there. A lot of them.

You know what our trouble is. Our trouble is if we took this on for the entire nation, the request would be billions of dollars, and we would have 3,000 centers.

If it ever catches on, every town will want to have a community center. We will be financing a bill bigger than the Defense Department. That's the real reason why we are stymied, Mr. Chairman. Isn't it similar to that?

DOMESTIC OPIUM PRODUCTION

Mr. PATTEN. By the way, Dr. DuPont, you know, we had a little shortage on opium. Do we grow opium? Do we grow poppies? Do we raise a lot of these drugs?

Dr. DUPONT. No, we don't. Hearings are currently being held before the Drug Enforcement Administration about a specific proposal to, for the first time in the United States begin the growth of the opium-related poppy brachiatum.

Most of the pharmaceutical manufacturers in the country are testifying in favor of brachiatum cultivation. The issues are very complicated because we did have a world opium shortage during 1975 and 1976; however, evidence now indicates the world is experiencing an

era of opium surplus. Therefore, the argument that there is insufficient opium to make codeine in the United States, a potentially serious problem, is invalid.

I am going to testify this afternoon on a drug called thebaine which is used to make newer chemicals. Complicated and technical issues also surround this subject, Mr. Patten.

DECRIMINALIZATION OF MARIHUANA

Mr. PATTEN. Let's go to something fundamental. Marihuana is on the front page again. Do you want to give us your professional opinion about that?

Dr. DUPONT. Yes, sir, I think the answer is con on marihuana. We are against marihuana. The problem is how to discourage the increasing consumption of marihuana in the United States.

The President's Special Assistant on Health Issues testified recently before a Select House Committee on Narcotics in support of the removal of criminal penalties for the simple possession of marihuana. This position is often perceived as being promarihuana, while actually it is not. Our primary concern is to find the best ways of discouraging marihuana use.

Mr. PATTEN. Doctor, I know what you mean. [Laughter.]

Dr. Noble, you know, we expect you to be an advocate for some of these things, all of you.

I can just tell you in case you get a little weak about it we will document the value of our community mental health center for alcoholics, for the drugs, for others who are sick, the counseling of the parents who have to live with these people.

Thank you, very much.

PRIMARY CARE PHYSICIANS

Mr. FLOOD. All right, Doctor. Again in your justification material, you say you intend to involve the primary physicians. You have been at this for some time in the provision of the mental health services.

Well, what role do you have planned for the primary care physician? You talked about that last year. We said we would mention it again this year.

Dr. BROWN. I think we would like them to do the job they have even more skillfully. One thing that isn't well known, Mr. Chairman, is that the general physician, the internist, the pediatrician, and surgeon see among their own clientele some 10 or 15 percent who have serious emotional disturbances or mental illnesses.

They see as many as the mental health professionals.

Now, sometimes the best thing is to refer, get it off their hands, it's too tough, too complicated. They must deal with a lot of them, because there is no place else to send them, or it's part of the general medical care they are giving.

Our primary role is to strengthen their ability to deal with the patients coming to them. We don't want them to replace the psychiatrists and the other mental health professionals.

STATE PROGRAM DEVELOPMENT

Mr. FLOOD. Now, Doctor, again in the justifications, you state you intend to help the States develop their own capacities in the areas of mental health manpower, training and administration.

Well, how do you plan to do this?

Dr. WALDROP. Mr. Chairman, one way that can be accomplished is to include in the State planning administration for services appropriate projections and plans for the manpower resources they will require to operate those services; and to utilize their State funds, along with any Federal funds that are available, for training directed toward meeting the manpower needs required to operate their own service delivery system. It would be that kind of a planning expertise that we are seeking to build in the State.

HEALTH PLANNING

Mr. FLOOD. As you know the Health Planning Act requires the local health system agencies to collect data on the health manpower needs in these areas.

Now, what role will these agencies, play in helping the States identify their mental health manpower needs?

Dr. WALDROP. There would be an interaction between these.

Mr. FLOOD. There has to be.

Dr. WALDROP. As the local health system agencies undertake their planning in local health area for the needs of their citizens this is going to have to be related to the activities at the State level for planning the overall State requirements which may serve many health service areas and State hospitals.

This is going to have to be coordinated in a way that makes possible mental health plans, alcohol plans, drug plans consistent with the subordinate local planning as well as the overall State planning for health.

Mr. FLOOD. That's good. Then can you assure this committee that your counterparts in the States will work closely with the planning of these agencies to determine what the mental health manpower needs are?

Dr. WALDROP. I can assure you of our continued effort to urge them to accomplish that. I think we have made progress through technical assistance, through conferences and through consultations. I agree with you as to the importance that the coordination take place.

COMMUNITY MENTAL HEALTH CENTERS

Mr. FLOOD. Now again your budget on the community mental health centers, here we see it's approximately the same as the last year's level.

Now is this level sufficient to meet all of these continuation costs that we hear about of all of the operational centers in 1977?

Dr. WALDROP. Yes, sir.

Mr. FLOOD. You said so. All right.

Dr. WALDROP. To meet the continuing costs?

Mr. FLOOD. Well, all right.

Now how many centers will reach their eighth and final year of support in 1977?

Dr. WALDROP. Forty-seven.

Mr. FLOOD. How many in 1978?

Dr. WALDROP. Forty-two.

Mr. FLOOD. Did you think I was going to ask you that? [Laughter.] Now here is one. Of these centers reaching their 8th year of support in 1978, how many would—do you think will require this distress grant money?

Dr. WALDROP. On the basis of our history, past experience with this program, we would estimate between one-fourth and one-third would require it.

Mr. FLOOD. That's a hard one to determine. Well, you have examined it.

Dr. WALDROP. Yes, sir.

CMHC TIES WITH OTHER HEALTH SERVICE PROGRAMS

Mr. FLOOD. What progress are you making in getting the community mental health centers to establish formal working relationships with the other health service programs in their own catchment area?

Dr. WALDROP. That's been very substantial. I would like Dr. Brown to respond in greater detail.

Mr. FLOOD. Last year you told us this would be a high priority. We are talking about working with community mental health centers, working with the HMO's last year, et cetera, et cetera.

Dr. BROWN. I would like to submit, for the record, more detail on the et cetera. We have made progress with the HMO's, with the rural health centers.

[The information follows:]

Community Mental Health Center Relationships With Other Health Service Programs

Since the inception of the Community Mental Health Centers (CMHC) Program in 1964 with passage of P.L. 88-164, there have been a variety of working relationships with health facilities, starting first with general hospitals. For example, 301 CMHCs (out of 649) are sponsored by general hospitals (102) or special purpose corporations (199); and 377 (in addition to 102) have specific general hospital affiliations.

In addition, CMHCs have been expected for some years to address the needs of alcoholism and drug abuse. One hundred and sixty-six CMHCs are providing direct alcohol services through an alcohol project grant (NIAAA) or a CMHC staffing grant. One hundred and thirty-one alcohol agencies, affiliated with CMHCs, are offering alcohol services. A similar pattern is to be noted for drug abuse programs. One hundred and twenty-seven CMHCs offer direct services to drug abuse clients and an additional 109 drug abuse agencies are affiliated with CMHCs.

A number of CMHCs have broadened service programs to meet the diagnostic and treatment needs of special groups. Examples are, the developmentally disabled and other neurologically handicapping conditions, such as epilepsy and cerebral palsy.

The consultation/education service, one of the original CMHC essential services, has long been a valuable tool used frequently in a hospital setting. Examples are mental health consultants called to a pediatrics floor, surgical unit, or general medical ward.

P.L. 94-63 Section 206 (c) (1) (C) 1 calls for cooperative agreements between CMHCs and Health Maintenance Organization (HMO's) to the extent practicable. The requirement is new and, in many cases, HMO's are not established in catchment areas served by CMHC's. In other cases, the HMO's are not fully operational and thus are not prepared to develop such relationships. Very limited experience also indicates the possibility that some HMO's choose to offer the mental health services or would like to take over the CMHC. There is also one example of a CMHC developing into an HMO.

Regional office personnel will promote outside relationships for centers review of each subsequent CMHC project application, monitoring, site visiting, and technical assistance. These relationships may also be promoted through liaison activities between regional office mental health program people, and HMO program personnel.

Mr. FLOOD. What are the results of the study conducted by your agency and the Bureau of the Community Health Services to investigate these various relationships between the community health centers and the mental health centers?

Dr. BROWN. We have shown that there are places where they can work together very well, and others where there are real difficulties. That has to do with the fact that different health services serve different populations. Some are served by geography, others by illness category.

In that sense the diversity of the United States is its blessing and curse, Mr. Chairman. Bringing order out of that chaos is not easy. That's why I think the HSA's you mention may turn out to be critical. They have the responsibility for all mental health services in their area.

Dr. WALDROP. Another example has been in the rural health areas where we have a fair number of community mental health centers and alcoholism centers located.

Mr. FLOOD. In the last few years especially?

Dr. WALDROP. That's right. Last year there were about 140 rural health initiatives undertaken within all agencies of the Public Health Service. These involved 82 community mental health centers, approximately 50 alcoholism treatment centers, and 10 drug treatment programs. These activities are coordinated with other health services to improve delivery services to medically underserved rural areas.

Mr. FLOOD. How many of these mental health centers provide drug abuse and alcoholic treatment?

Dr. WALDROP. At the present time about 236, either through direct operation or through affiliations provide drug abuse services and 297 by affiliation or direct operation provide alcoholism services.

CMHC STAFFING STANDARDS

Mr. FLOOD. Now another area that we studied last year was the development of the staffing standards or the community mental health centers. You told us that you were in the process of developing these standards. Have you completed that task?

Dr. WALDROP. That process is still ongoing. Dr. Brown, you might want to detail it.

Mr. FLOOD. It seems inconceivable, this program has been around quite a long time. We think you should have the staffing standards, because how in the world can you develop quality care? How can that be delivered in these centers if you have no agreement upon the staffing standards?

Dr. BROWN. We are trying hard and it's proving——

Mr. FLOOD. I know that.

Dr. BROWN. It's proving difficult. We have worked with the JCAH. We have a report that is almost with you, Mr. Chairman. To develop staffing standards for a program that is evolving is important but very difficult. I agree with you we need it so we can make clear projections as to personnel needs. We don't want to make incorrect projections.

Mr. FLOOD. We don't want you to. You can write us a letter.

NEW CMHC PROJECTS

All right. Here is one. Doctor, why is there no money in that budget for starting new community mental health centers? How come?

Dr. WALDROP. Mr. Chairman——

Mr. FLOOD. Are you waiting for that President's Commission on Mental Health to report on how these mental health services should be organized? Are you going to wait for them? Have you slowed down these starts until these training activities begin to develop affiliations?

Dr. WALDROP. Mr. Chairman, we are looking forward to the Commission playing an important role in thinking through our whole service delivery system in mental health. The basic issue here is this is a hold the line budget.

As you will note, we are going to have 94 centers switching to the new act where they will support 12, not 5 basic services. It is going to require about $55 million in continuations just for those 94 that are switching.

It is because of this higher level of continuation costs required to change from the old law to the new law, that no new awards may be made under a level budget.

Mr. FLOOD. Mr. Obey.

Mr. OBEY. Thank you, Mr. Chairman.

DEPRESSION

Doctor, let me ask a few questions and I will come back later because I have more than my 10 minutes will allow.

How many people suffer from mental depression in this country?

Dr. BROWN. We estimate, if you define depression as something that knocks you out for more than a few days of the blues, something that takes you out from work, and incapacitates you, 4 to 8 million people each year in the United States.

Mr. OBEY. 4 to 8 million?

Dr. BROWN. Yes.

Mr. OBEY. How many of those people are treated with antidepressive drugs?

Dr. BROWN. Our best guess would be perhaps 1½ million, 2 million, Mr. Obey.

Mr. OBEY. 1¼ to 2 million, you say? Roughly what percent? You are a better mathematician than I am.

Dr. BROWN. Somewhere between 40 percent—anywhere from a half to a quarter.

ANTIDEPRESSANTS

Mr. OBEY. How would you describe the effectiveness of those drugs? Are they effective for all of the people who are affected?

Do they work as quickly as we would like? Do they work the same way in all people? What is your judgment on that?

Dr. BROWN. Just briefly, for some people, they work very well but not quite fast enough. They do turn around the depression, and get a person back to functioning. It may take several weeks to a month or two. For a certain number of people with depression, the drugs don't

work at all; and for a middle group, they help somewhat, though they don't seem to do enough.

Just distinguishing between those three groups is a very important challenge we are faced with right now.

DEPRESSION RELATED RESEARCH

Mr. OBEY. How much do we know about the reasons why those drugs react differently to different people?

What I am trying to lead up to is what kind of research are you conducting in your shop to find new drugs which might work faster and assist more people who aren't responding to present drugs?

Dr. BROWN. Well, there are two sets of activities. We perform intramural research in our own laboratories, and there is also the grant-supported extramural research program. Out in the field we have approximately $6.3 million of extramural activities this year, but we also have one of the most exciting programs in the world, in our own intramural shop. The staff ranges from basic scientists to people like Dr. Julius Axelrod, who deal with brain mechanisms and neural transmitters.

We have Dr. William Bunney who has done magnificent work, bringing together the clinical and biochemical side of depression in patients. A team of outstanding clinicians and basic researchers is working on this right now.

Mr. OBEY. How many positions would you say you have dedicated to that kind of work in your shop and how much money? How much is your budget?

Dr. BROWN. I would say in terms of the depression, perhaps 20 people and $2.5 million of effort.

Mr. OBEY. That is out of how many people in your total shop?

Dr. BROWN. We have about 373 full-time permanent employees plus approximately 120 temporary appointees in the shop. The program is about $26 million in size overall.

Mr. OBEY. To a nonexpert in the area, that would seem a rather small commitment. What would your response to that be? Why do you have so few people in that area?

Dr. BROWN. Restraint of resources to give a straightforward answer. This is one of the areas that clearly could and should expand if we had the resources, Mr. Obey.

Mr. OBEY. Does the million plus increase in your budget for intramural help to any great degree?

Dr. BROWN. Not at all. We are basically going to hold the line. Relatively little is actually going to the intramural laboratories although some of it is for pay increases, the rest is for payment to the NIH management fund; and replacement of equipment that is worn out.

Mr. OBEY. What in your professional opinion would be needed to do an adequate job in that area?

Dr. BROWN. I would like to give it some careful thought. I think we clearly, without being expansive, could double the size of our intramural efforts which are modest. Rather than answer here, I would like to give you a sharper answer for the record.

Mr. OBEY. All right.

[The information follows:]

PROFESSIONAL JUDGMENT ESTIMATES FOR INTRAMURAL RESEARCH

Professional Judgment of the estimated 1978 needs for the intramural research program would be a total of $26,626,000 of which approximately $2,775,000 would be used in the area of depression. This would be an increase of $1 million over and above the current budget estimate. The increase would be used for 40 scientific support and patient care personnel to support a new laboratory for clinical studies not now being done in NIMH Laboratories on mental illness incident to old age. This is in addition to ongoing efforts to further the primary aim of the intramural research program which is to relieve suffering from mental illness through diagnostic and treatment methods plus contribute to the basic knowledge which will explain the onset of these disorders, and lead to their prevention.

REPROGRAMING OF CMHC FUNDS

Mr. OBEY. I have a couple of other questions in this area I would like to submit to you and ask for your professional judgment on. I did have an additional question I would like to ask you before my time runs out. It's something I don't understand—there is a lot I don't understand in your shop, but there is something I don't understand in your justifications.

Your justifications say that the 1977 appropriations for your program was $232,324,000, which is about $522,000 short of what I thought we had appropriated last year.

Can you explain that to me?

Dr. BROWN. I would like to defer to Dr. Waldrop and Mr. Mahoney on that?

[Laughter.]

Dr. WALDROP. Mr. Obey, the answer to that is complicated and I will try to be brief and clear. In 1976, the funding for the Office of the Assistant Secretary of Health was reduced. As a consequence of that reduction, 29 positions were assigned to the Alcohol, Drug Abuse, and Mental Health Administration. These were all located in the regional office and they were in the grants management area.

No funds came with those positions and our internal program support budget was not adequate to support them. Therefore, with the permission of the Congress we reprogramed $522,000 from the community mental health centers program to support those positions since they were substantially, if not almost entirely, involved in work related to that program.

In 1977, this year, again we are faced with a similar situation and we are proposing to handle it in the same manner. The 1977 column of the budget shows, therefore, 522,000 being transferred from the CMHC program to program support for this purpose. In 1978, we are faced with the same problem. The 1978 budget does not contain support funds for these positions. After final action is taken by the Congress on the 1978 budget we will propose action, if necessary, so that all positions requested in the budget can be supported. That's basically the situation.

Mr. OBEY. Mr. Chairman, that's all the questions I have for you now.

Thank you.

Mr. FLOOD. Well, I have no further questions. If you have any, you may go ahead a couple of minutes. Do you want to submit them for the record?

Mr. OBEY. I think we could do that just as well in the interests of time.

Mr. FLOOD. If there is no objection, we will have those questions submitted for the record.

Mr. FLOOD. I thank you, gentleman. See you at 2 o'clock.

[AFTERNOON SESSION]

DRUG ABUSE RESEARCH

Mr. NATCHER. The committee will come to order.

Doctor, for the drug abuse program, the budget, as you know, calls for a reduction in regular research grants.

Is there enough money in here to support all noncompeting continuation grants?

Dr. WALDROP. Mr. Natcher, before I answer your question, I would like to introduce Karst Besteman, the Deputy Director of the National Institute on Drug Abuse. He will be replacing Dr. DuPont for this afternoon's session.

Do you want to respond to that particular question, Mr. Besteman?

Mr. BESTEMAN. There is not a reduction in the overall research program. My numbers indicate the amount is precisely level for fiscal year 1978 when compared to fiscal year 1977.

Mr. NATCHER. You mean it is at the 1977 level?

Mr. BESTEMAN. Yes. While the overall level is the same, some reduction does occur in regular research grants. However, there are funds for competing renewal, and new grants in addition to support for noncompeting continuation projects.

Mr. NATCHER. Do you feel that there are ample funds in the bill now before the committee for carrying on this particular program, that is regular research grants?

Mr. BESTEMAN. Yes. We can continue to carry on our research program at this level.

Mr. NATCHER. How many new research grants will you support? How many new ones?

Dr. WALDROP. 25 new contracts will be supported, along with 50 new grants.

Mr. NATCHER. Doctor, how does that compare with last year?

Dr. WALDROP. Last year there were 10 new contracts that were started new, and there were 30 new grants in the research area.

NEW RESEARCH ACTIVITIES

Mr. NATCHER. In what areas do you plan to support new research activities?

Mr. BESTEMAN. It is our hope that we will be able to support some new research in epidemiology in terms of looking at certain specific drug patterns, particularly in subpopulations such as the aging. We will continue to try to develop new chemotherapies, particularly around the antagonists in examining some of these substances; and we will try to do more treatment assessment in terms of being able to describe more precisely the effectiveness of treatment on our populations.

Mr. NATCHER. What would you identify as your most promising results in the last few years?

Dr. WALDROP. In the area of research?

Mr. NATCHER. In the area of research.

Dr. WALDROP. There are a number that would have to be pointed out. First has been the clinical testing of a substance known as LAAM, levo alpha acetyl methadol. This is a substance like a long-acting methadone so it can be administered with less risk of diversion, less frequently to the patient and therefore will permit him a more normal type of community life.

The development of this compound is now being carried out and we hope in 1978 it will be introduced into clinical practice.

Mr. NATCHER. Right at that point now on this particular matter you have just discussed for the committee, how has it found its way into the health care and delivery system.

How do you pass the word?

Mr. BESTEMAN. As the second step in introducing LAAM, we have chosen to use existing clinical sites where methadone was previously being dispensed to patients. Here the practitioners who will ultimately have to use and dispense this new substance on a regular basis accumulate valuable experience in its use while at the same time they supply us with ongoing clinical research data to evaluate its efficacy at the community level. When LAAM is approved, it will be a familiar mechanism which can be more easily transferred into clinical community than a totally new substance.

Mr. NATCHER. Go right ahead now with your next one, please.

Dr. WALDROP. There are two other areas I would like to mention. One is the continuing study of the effects of certain drugs upon skilled human performance. Here, in particular, the impact of marihuana on driving and other skilled motor activities is being investigated.

There continues to be concern that this compound, when used may indeed impair motor performance, perhaps in ways similar to alcohol.

Finally, there is an area I would like to underscore as important at a very basic level. That has been the discovery very recently of an entirely new type of substance in the human body generally called the endorphins. These are analgesic-like, opiate-like substances not previously known to occur in man.

Now, they have been discovered there. The importance of these substances is that as naturally occurring analgesics, they may open the door to some new approaches, at the basic research level, to the cellular mechanisms that are associated with the phenomenon of tolerance and dependence on opiates such as heroin.

As a fundamental new approach to this area, we consider this important. I might add there is some preliminary evidence, very preliminary, not yet certain by any means, which might link these compounds in some ways to the underlying biochemistry of schizophrenia.

DRUG ABUSE AND THE ELDERLY

Mr. NATCHER. Doctor, in your justifications that we have before the committee, you indicate that you intend to conduct special studies of nonmedical drug use by the elderly.

Is this a serious problem; and what are you doing about it now currently?

What is under way?

Dr. WALDROP. We think this may be a serious problem. Certainly, it warrants some study to determine how serious it is.

We are concerned largely with the misuse of prescription drugs and perhaps the prescribing practice of physicians who administer large numbers of particularly tranquilzing substances to the elderly.

We need to find out to what extent the elderly may be misusing these drugs, and if they are responsible in part for some of the infirmity that may be associated with the aging process.

At the present time we are preparing to try to assess how serious this problem in fact actually is. The fundamental approach to it ultimately would have to be a matter of education, not only of patients but also of physicians and nurses.

CAUSAL FACTORS OF DRUG ABUSE

Mr. NATCHER. Another area of research identified in the budget justification is studies of the factors which may predispose individuals to abuse drugs.

Have you identified any specific factors to date?

Mr. BESTEMAN. No; there is no single factor that has been identified. There are various studies that seem to indicate that a constellation of factors puts one person more at risk than others. Those studies in some way, you might say, confirm commonsense. But we cannot make a more definite statement at this time.

Mr. NATCHER. Once you get a better understanding of the factors that predispose individuals to abuse drugs, how will you use this information to prevent drug abuse?

How will you use it?

Mr. BESTEMAN. It would depend somewhat on the precise nature of the constellation of characteristics which predispose some persons to abuse drugs.

Assuming that these characteristics are amenable to communication and within the person's conscious behavior; that is trainable, educable, I would expect that we would strongly support a prevention activity involving the transmission of this information to what we would define as a vulnerable or at risk population.

If drug abusing behavior stems from more subtle factors, or from factors which would require a more fundamental restructuring of the social situation, their amelioration may be beyond the capability of the National Institute on Drug Abuse. At least we would have the information to present to people who find it relevant in other behavioral disciplines.

NUMBER OF DRUG ADDICTS

Mr. NATCHER. Do you have good and solid data on the number of heroin users in the country? Do you have wide, reliable information as to the number?

Mr. BESTEMAN. We have information with which we are considerably more comfortable than we were a few years ago.

When we use our methods of—and we still use the term "estimating"—the number of heroin addicts not presently in treatment in the country, we have to allow for a fair percentage of error; but we feel the error is in the 10 to 20 percent range instead of, let's say, 100 percent 5 or 8 years ago.

Mr. NATCHER. Could you give me any idea as to a figure, approximate?

Mr. BESTEMAN. We estimate there are 500,000 heroin addicts who are not presently in treatment.

Mr. NATCHER. Is the trend up or down?

Mr. BESTEMAN. From our surveys and indicators the trend currently appears very stable. There are indications of very, very slight decreases in some parts of the country, while in certain cities there are indications of an increase. As a national situation, therefore, it appears very stable in comparison with a few years ago when very significant increases were apparent.

Mr. NATCHER. Do we have solid data about the users of other abusable substances?

Mr. BESTEMAN. Yes. I think we have more accurate data about other substances because we have found in the survey situation that individuals are more willing to provide precise information about these drugs than heroin.

Heroin use does not occur frequently in the general population, and people seem unwilling to disclose their personal habits in these surveys.

USE OF NIDA RESOURCES

Mr. NATCHER. Unless we have quite good data and understand generally what the situation is, how are we to know that we are using our resources properly?

Do you feel that we are?

Mr. BESTEMAN. When you ask how we are using our resources, or are we using them properly, you have to look at what we are trying to accomplish and what is our purpose.

The majority of Institute resources go into community services for people who are already having some dysfunctional behavior as a result of their drug abuse. This has been a drug abuse prevention priority for the last several years.

We have excellent data about the number of persons who are receiving treatment; we have excellent data as to their behavior while in treatment; and we are beginning to accumulate data on their behavior at certain periods following treatment.

Treatment effectiveness data are encouraging. It leads us to the conclusion that treatment is cost-saving to the community. There obviously is disappointment that the treatment of dysfunctional drug abusers has not resulted in a dramatic shrinkage in the pool of drug abusing persons.

While this reduction regrettably did not happen, I think we can say that treatment money is being usefully spent. In terms of our research expenditures, they have been relatively stable for the last 3 years. New research findings are being increasingly applied to clinical services for drug abuse patients.

In each program area we are reaching our planned goals within certain limits and planned timeframes.

I, therefore, believe our expenditures for drug abuse prevention programs are bringing their designed results.

DRUG ABUSE DATA DEVELOPMENT

Mr. NATCHER. Doctor, are you moving in the direction of attempting to obtain better statistical data on drug abuse.

Dr. WALDROP. Yes, sir. Not only is there a continuing refinement of the existing statistical systems and assessment systems, but the Institute will, in the coming year, implement a new follow-up study, called the treatment outcome prospective study which will be aimed at following over a period of years those who have received treatment in a variety of settings and a variety of modalities.

So, for the first time, we hope to have in place a means which will provide an effective assessment of the outcome of a variety of treatments. I think this will be one of the most significant additions to our statistical and data systems that we can devise.

Mr. NATCHER. Mr. Roybal?

SERVICE RELATED TRAINING

Mr. ROYBAL. Thank you, Mr. Chairman.

Dr. Brown, in your recent report to our committee on maldistribution of mental health personnel, you point to the lack of adequate manpower and community health services, especially in rural and intercity areas.

What plan of action have you developed specifically in the Institute training program to place mental health personnel in these underdeveloped areas that you talk about?

Dr. BROWN. Mr. Roybal, we have developed a plan for redirection of our whole clinical training effort. I would be glad to give you a brief rundown, but let me summarize briefly since the chairman asked for a full implementation plan to be put in the record.

First, we propose to redirect our support of the core disciplines as we call them, psychiatry, psychology, social work and nursing, so they address themselves to these issues where their trainees or their programs do or do not meet the city needs. This is the maldistribution problem. Second, we are a starting new initiatives to assist in the training of primary care workers, the doctors and nurses out there, so they can do a better job for emotionally disturbed and mentally ill people. Third, we will work with State and local governments and officials who have the responsibility for many of these areas. Fourth, we plan and to have experimental manpower and training programs that address themselves directly to this issue, for example, developing curriculum programs for minority communities.

Mr. ROYBAL. I am interested in finding out just how you include the local officials in the program. It seems to me that it is important that you do.

Dr. BROWN. I think the heart of the matter is making a linkage, if you don't mind that word, between a local university department

and a local HSA, or health officer, or community health center director, or neighborhood health center director.

That linkage has not been made except in a few cases. On the State level we want to bring the university people together with the State officials who are responsible, say, for the State institutions.

We are going to promote those linkages with funds we get from you.

Mr. ROYBAL. I knew the entire subject matter was centered around money. [Laughter.]

RACIALLY SENSITIVE HEALTH PROGRAM

Mr. ROYBAL. Now, I have received reports concerning the lack of racially sensitive health programs in various disadvantaged communities. What action has the institute taken to eliminate cultural, language and class barriers in community mental health programs?

Dr. BROWN. As you know, we had a special vigorous effort in the minority area which can be looked at as a half-full glass or a half-empty glass. By needs, I think it's half empty in terms of meeting the program and the people's needs.

In terms of what we accomplished in the few years since we established the minority center and our minority prority, I think it is impressive.

Let me focus on training where I had a table made up with the actual number of minority trainees and the portion of money going into minority efforts in our training programs.

Mr. ROYBAL. Would you also include in that the percentage of Spanish-surnamed individuals that you have working in the institutes?

Dr. BROWN. Certainly.

[The information follows:]

Data on Minority Involvement

MINORITY EFFORT IN MENTAL HEALTH TRAINING GRANTS
(In thousands of dollars)

Discipline/ Program	1976 Actual			1977 Estimate			1978 Estimate		
	No. of Grants	No. of Trainees	Amount	No. of Grants	No. of Trainees	Amount	No. of Grants	No. of Trainees	Amount
Psychiatry	24	56	734	24	60	770	23	59	754
Psychology	108	432	3,113	101	432	3,032	96	406	2,991
Social Work	62	222	2,784	60	227	2,815	59	218	2,690
Nursing	19	136	1,001	21	157	1,130	22	155	1,137
Exper & Special	23	50	1,026	25	56	1,157	30	65	1,344
Cont. Ed.	4	12	243	4	10	217	4	10	218
Paraprofessional	8	15	325	8	16	339	10	19	390
Social Sciences	30	210	2,095	32	223	2,145	28	221	2,164
Total	278	1,133	11,321	275	1,181	11,605	272	1,153	11,688
% of total NIMH trainees		(12.0%)			(12.6%)			(12.5%)*	
% of total NIMH dollars		(13.3%)			(13.4%)			(13.5%)	

EMPLOYMENT OF SPANISH SURNAMED INDIVIDUALS *

Report Period: December 1976

	Number Hispanic Employees	Percentage Institute Employment
NIMH.....	8	.7
NIDA.....	5	1.3
NIAAA.....	2	1.4
Office of the Administrator.....	3	1.4
Total.....	18	1.0

*Excludes Regional Office Personnel

Mr. ROYBAL. If we examine it very closely, you are not doing very well?

Dr. BROWN. That glass is one-eighth full and seven-eighths empty.

MINORITY INVOLVEMENT

Mr. ROYBAL. I think we talked about this last year and came to the conclusion that a lot had to be done in that area. Have you made any progress at all during the last year?

Dr. BROWN. Yes. A very distinguished individual, Dr. Juan Ramos was selected as director of the special mental health programs. That is a large division which has crime and delinquency, minority, metropolitan mental health, disaster assistance, youth, and rape prevention.

It's one of the most important jobs in the institute. We also have at this point 18 full time employees within ADAMHA who are Spanish surnamed. It should be a lot more.

PREDOCTORAL SUPPORT

Mr. ROYBAL. Well, I am concerned also about the recent budget recommendation to discontinue predoctoral support in mental health. What effect is that going to have in the community, in the staffing of community mental health facilities?

Dr. BROWN. Two sides to that coin. The general impact of the predoctoral cutback will be disastrous for our research training efforts. Over 80 or 90 percent of our psychology trainees are predoctoral.

In the behavior and social sciences it's 85 percent, even in some of our medical fields. I want to contrast that with the NIH scene where most of the physicians are postdoctoral trainees.

In our field they are mostly predoctoral.

Mr. ROYBAL. Why are you making the recommendation to discontinue if it's so important?

Dr. BROWN. I haven't made that recommendation. It's been made to me. I am not very happy about it.

Mr. ROYBAL. What I would like to know is, first of all, who made the recommendation and under what——

Dr. BROWN. Mr. Forbush can perhaps handle that.

Mr. FORBUSH. The predoctoral cutback is in research training; it's not in the core disciplines.

Mr. ROYBAL. That's not my understanding. What is the situation?

Dr. WALDROP. The situation, Mr. Roybal, is that this proposal applies only to research training, not to training for clinical services.

Dr. BROWN. It is specifically within the field where we support students who are a part of a research training endeavor. It does not apply to all of psychology, social work and nursing. That would be a total wipeout of the program, since most of the trainees are being supported for their basic degrees. However, even for research training, trainees tend to be in their last 2 years of their Ph. D., where you are focusing in on a problem such as depression.

Specifically it hits hardest at the minority community because there are so few minority researchers. Before the proposed phaseout of predoctoral fellowships we were in the process of developing a proposal

to extend the program so it could begin at the first 2 years of graduate training, rather than just the last 2 years.

Mr. ROYBAL. Isn't it true that Hispanics, for example, comprise less than 1 percent of both the psychology and social science doctorates?

Dr. BROWN. Yes, I think that is accurate.

Mr. ROYBAL. Shouldn't a further effort be made then to get more of these people interested in this field and make something available to them so that they do enroll?

Dr. BROWN. I think that is very important. I would be supported by Dr. Mio Pedija, who heads the Spanish Speaking Research and Development Center, one of our minority thrusts where you see a small group of researchers, a half dozen in the country who are at the production and Ph. D. level.

The need to expand this by 10 or 15 fold is so reasonable when you consider we are talking about a population of 15 million in the country or so.

Mr. ROYBAL. Then we do agree on one thing and that is that a great deal more has to be done in, first of all, increasing the number of Spanish-speaking employees within the department, and, second, that more opportunities be made available to have young men and women come into a program that at the moment is really apparently not very attractive to them.

If that is the case, why is it that we don't get more people involved in this thing? It seems to me that this is such a broad and interesting field that I wish I had known about it when I was going to college.

At that time the opportunities were not made available. We could only go into certain fields. This field, to me, is an open door; and we should have more and more people interested in it.

Dr. BROWN. I think I can give you a very brief and serious answer to that question. It strikes me that quite often, when the doors open up to the minority communities just at the time that the back door for the field is closing. That is why it does not interest young minority people to go into research. It comes at the end of a 10-year decrease in research resources in our field. They know that. They are not going to go into a field that is closing down.

Last year, as you know, the House had an amendment which after a 10-year decline in real dollars, leveled off our research budget. I think they see this as well as anybody else.

INSTITUTE FUNDING

Mr. ROYBAL. That is probably the best explanation that I have heard up to the present time.

Now I have some questions on alcoholism.

According to the budget here you have Alcohol, Drug Abuse, and Mental Health Administration all lumped together. Can you tell me how much is spent on each one?

Dr. WALDROP. Do you mean for all activities within each institute?

Mr. ROYBAL. For all activities separated so I would know how much is spend on alcoholism, for example, how much on drug abuse and how much——

Dr. WALDROP. $154 million being proposed for NIAAA in fiscal year 1978 and $262 million for drug abuse.

Mr. ROYBAL. $262 million?

Dr. WALDROP. Yes. For mental health, $454 million.

NIAAA SPENDING AT COMMUNITY LEVEL

Mr. ROYBAL. Of the $154 million for alcoholism, how is that going to be spent in the various communities? What kind of programs do you have that—or do you have a program that can be used as a model?

Dr. NOBLE. You are talking about the entire $154 million? How will we be spending it in research, training, treatment, prevention?

Mr. ROYBAL. I am talking about the way in which you spend it in the community, at the community level.

Dr. NOBLE. Yes; well, we are using it in a variety of ways. We can divide it in terms of treatment and prevention and talk about our efforts in that area. In treatment we have a variety of programs tailored to the needs of specific population groups we are now serving. This includes Indians, and Spanish-speaking Americans. We are dealing with the poor, with drinking drivers, with women, and with youth. And there are a variety of ways we are rendering treatment in occupational programs.

We are also supporting community-based efforts aimed at preventing the alcoholism problem. One is through not only getting available information into our network at the Federal level, but after we get it here, we are disseminating it out to the people who need it.

This is done through our clearinghouse, primarily information dissemination. We are also supporting outreach programs into various organizations in the community.

For example, the PTA's, Jaycees, and a variety of groups which have an interest in dealing with problems of alcohol abuse and alcoholism.

Mr. ROYBAL. I wanted to know if you had a community program in the United States that one can use as a model? I would like to see what you consider to be the best program. I would also like to compare that with programs that I know of in California.

Dr. NOBLE. Yes, sir.

Mr. ROYBAL. I am critical of some of those in California. I would like to see a good one somewhere. Is there such a project somewhere that you can recommend I go see?

Dr. NOBLE. There are many good projects we can recommend for you to see. We can talk about some of the youth programs as an example. I can give you specific examples in other areas. I can talk about good programs in the occupational area where you can visit and see what we are doing there in early intervention and treatment.

In the area of youth, which is of great concern and a high-priority area for many of us, we are looking at our past efforts and looking at the ones that are succeeding as a way of expanding these programs.

We are funding a program at Boy's Harbor, in New York, which has to do with peer leadership. We are finding out when we train these individuals in terms of specifics about alcohol and related issues, they are more capable of helping others having trouble with alcohol.

We feel that this kind of program could be spread in other areas.

We also support some excellent detoxification programs, including some in California. There is one in San Francisco which we consider to be a model detoxification program which is also very cost effective. I can talk about other programs which we are finding out are successful.

We also have found programs which are not as successful as others and this perspective enables us to move into those areas which are showing the most promise.

Mr. ROYBAL. The reason I am interested in finding something I can use as a model, I would like to study the makeup of that program, to find out why it isn't successful, looking into the type of personnel that you have.

TRAINING

Dr. NOBLE. Yes, sir.

Mr. ROYBAL. I am critical of some of these programs that just take someone from a CETA program and all of a sudden make social workers out of them.

I don't think that we are getting our money's worth when that is done. I think that an individual has to testify a long period of training before he is left on his own.

I don't know that this is happening. I don't think that we are providing that much training for individuals. I would hate to see a program continue without having the proper personnel. You have to pay them anyway, so why not get the best you possibly can for your money.

These are the subject matters that I would like to look at.

Dr. NOBLE. I will be very happy to provide that for the record, Mr. Roybal. I can say a few things here in terms of our experience, for example, with the minorities.

Clearly, we are finding out that minorities have to be trained to run their own programs. There is the one, Esfuerzo de Salud, for example, in Santa Barbara, where Spanish-speaking individuals who know their culture and the problems of their people are much more effective in delivering those kinds of services.

We are beginning to find out that some of the general training programs are not applicable to some of the problems of the Spanish, and the same thing is true with the Indian programs. We are having Indians, trying to train Indians to run their own programs, to get their cultural values into their own system.

I will be happy to provide specific examples.

[The information follows:]

NIAAA MINORITY TRAINING PROGRAMS

INTERDISCIPLINARY TRAINING PROGRAM ON ALCOHOLISM

Vaquez de Rodriquez, Ligia
Graduate School of Social Work
University of Puerto Rico
Rio Piedras, Puerto Rico 00931
174/767-5495

The School of Social Work, University of Puerto Rico, offers graduate social work students the opportunity to participate in a community based interdisciplinary program. The training is designed to prepare students to function as a team member in treatment and prevention programs where alcohol related problems are encountered. Students participate in alcohol abuse and alcoholism seminars and are required to complete a research project on an issue concerned with the field of alcoholism. Students are encouraged to view services to alcoholic people as part of a more generic health care delivery system. Stipend support is available.

ALCOHOLISM PREVENTION - HISPANIC TRAINING PROGRAM

Brid, Federico, M.A.
Centro Hispano de Accion y Progresso
23 Pleasant Street
Northampton, Massachusetts 01060
413/586-1697

Bilingual, bicultural individuals are trained to become alcoholism counselors working with Spanish-speaking communities. Trainees are primarily from the Hampshire County area of Massachusetts. Students, utilizing the resources of Boston City Hospital for a portion of their training, will receive classroom instruction, clinical experience, and considerable exposure to Spanish-American populations. Trainees are also placed in Hampshire County working with Spanish-speaking agencies in order to become more familiar with local resources. Program evaluation includes examination of impact on clients and on agencies. A limited number of stipends is available.

MPH TRAINING IN NATIVE AMERICAN

Seiden, Richard H., Ph.D.
School of Public Health
505 Earl Warren Hall
University of California
Berkeley, California 94720
415/642-4861

The School of Public Health has designed a program to train Native Americans to administer, plan, and evaluate Indian alcoholism programs. Trainees can obtain the Master of Public Health degree after twelve to twenty-one months of coursework, including seminars on alcoholism within the context of Native American culture. Treatment, prevention, and issues of social policy are considered in depth. Stipends are available.

ROSEBUD SIOUX TRIBE ALCOHOLISM PROGRAMMING TRAINING

Sherwood, Mona
Alcoholism Treatment Program
Rosebud Indian Reservation
P.O. Box 225
Rosebud, South Dakota 57570
605/747-2229

Personnel employed in positions that relate to alcoholism on the Rosebud Sioux Indian Reservation take part in this program. Training includes the areas of counseling, administration, community leadership, and support staff training. Different groups are generally involved in these areas, but some skills are taught to all trainees in general sessions. Special content areas on culture, tradition, and spirituality are guided by local tribal Medicinemen, cultural people, and elders of the tribe. Training facilities are provided by communities of the Reservation.

M.A. INTERNSHIP DEGREE PROGRAM IN ALCOHOL/DRUG STUDIES

Benjamin, Mary E., Ph.D.
Alcohol/Drug Studies Center
Jackson State University
Jackson, Mississippi 39217
601/948-8533

This twelve-month master's degree program in alcohol and drug abuse studies will train individuals who are now working in those areas or other occupations which involve frequent contact with alcohol or drug abusers. Trainees may also include other committed individuals. The curriculum includes classroom instruction, an internship and a related bi-weekly seminar. This seminar topic will include treatment, prevention, program management, and community organization. The internship is with one of several alcoholism programs, chosen to suit students' interests. Stipend support is available.

ALCOHOLISM TRAINING FOR PARAPROFESSIONALS

Rosenberg, Chaim M., M.D., Phs.D.
Boston University School of Medicine
720 Harrison Avenue
Boston, Massachusetts 02118
617/424-5263

The Boston University, Department of Psychiatry, in conjunction with Boston City Hospital, is training paraprofessionals employed in alcoholism agencies to upgrade their skills in counseling, care of alcoholics, various treatment methods, knowledge of complications arising from alcohol abuse and record-keeping. Two distinct programs are underway: an extensive 14 months, 10 hours per week program and short term training, (16 weeks, 100-120 hours of training). Both programs involve didactic instruction, supervised field experiences, and group process training. Evaluation includes some psychometric measurement, post training placement studies and pre- and post-knowledge tests.

ALCOHOLISM TRAINING PROGRAM

Murphy, Joseph B., M.A.
Atlanta University
School of Social Work
223 Chestnut Street, S.W.
Atlanta, Georgia 30314
404/523-6229

This program contains basic and advanced modules for people working in the field of alcoholism or in other positions that significantly involve alcoholics and their families; each of these modules includes classroom and field work. A module on policy-making and planning exists to meet the needs of the State and especially the Black community. Ongoing research on needs for services reflects that orientation. A specialty in alcoholism is offered to social work graduate students planning to work with the Black alcoholic. Graduate course work and supervised clinical experiences are provided. Stipend support is available.

Mr. ROYBAL. I agree that you have to have people that understand the culture do it and get the programs going that way.

On the other hand, those same people have to have some training.

Dr. NOBLE. Yes, sir.

Mr. NATCHER. Mr. Conte?

Mr. CONTE. Thank you, Mr. Chairman. I will ask a few questions on mental health and submit other questions.

SHORTFALLS IN CMHC CONTINUATIONS

Dr. Brown, as you know, last year I submitted an amendment which increased the appropriations for new starts in the community mental health center. I have been very, very concerned about these funds in the range of $8 million or so that are being diverted for continuation costs.

As you know, we requested an evaluation of this situation by May 1 and I have the chairman's assurance that if there is indeed a shortfall in the funding for the community mental health starts that we will provide the funds in the second supplemental.

He also gave me that assurance on the floor of the House yesterday.

Can you tell me whether continuation costs are running higher than expected and what the reasons are for that situation?

Dr. BROWN. Just let me give a brief response and ask Dr. Waldrop to give an overview of the situation. We started more centers in our first year than we had expected. This was possible because the centers were less than fully operational. They didn't have the full 12 required services yet, and therefore the average cost per grant was less.

When the continuation costs hit the second year, we were therefore carrying more than we first estimated. That is where that $8 million shortfall or bite into new starts took place.

Can you perhaps sharpen that?

Dr. WALDROP. Maybe I can add to that. In 1976 it was the expectation that about 26 new mental health centers would be initiated, at a total of about $1 million each.

As it happened, many of the centers that submitted applications that were approved did not require that amount of money to start. They didn't immediately start off with all 12 services. Therefore, it was possible to support more than 26 new starts in 1976. Actually, there were 42 that were supported.

That meant then in the following year, the current fiscal year, all of those programs will require a continuation award on the basis of, not a more limited range of services, but the full range of services. It means that a number of centers, quite a number, started a year earlier than they otherwise might have.

Now, they are picking up the full continuation cost. That amount is just about $8 million.

CMHC BUDGET REQUEST

Mr. CONTE. I am disturbed that your budget requests no new starts for mental health centers in fiscal year 1978. Could you tell me the reason for that and how much did you request for new starts from OMB that was eliminated?

Dr. BROWN. Mr. Conte, there are many reasons and responses you would get to that depending upon which level of the bureaucracy you ask. My understanding is that the new administration had a limited amount of time to prepare its amendments.

As to what we recommend in the way of new starts for community programs, the agency request was $64 million over and above the $232 million comparable for 1977.

That was what the request was for the agency. It was then successively cut at the various levels as it went through a "who-struck-John" process which we would be glad to submit to you.

Mr. CONTE. OK.

[The information follows:]

History of 1978 Community
Mental Health Centers Budget Requests
(In thousands of dollars)

Category	Agency Request		PHS Request		Dept. Request		Ford Budget		Carter Budget	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount	No.	Amount
P.L. 94-63:										
Planning:										
New only....	(19)	1,500	--	---	--	---	--	---	--	---
Operations:										
New.....	(65)	45,000	(21)	15,000	--	---	--	---	--	---
94-63 cont..	(38)	29,540	(38)	29,540	(55)	43,880	(72)	53,340	(72)	53,340
Converted Staffing...	(197)	110,063	(197)	110,063	(188)	108,393	(181)	104,754	(181)	104,754
Consultative & Education:										
New.....	(37)	4,070	(37)	4,220	(23)	1,940	--	---	--	---
Cont.....	(63)	6,930	(63)	6,930	(80)	8,800	(97)	8,245	(97)	8,245
Conversion:										
New.....	(200)	28,000	(200)	28,000	(9)	2,240	--	---	--	---
Cont.....	(46)	4,800	(46)	4,800	(27)	7,000	(33)	9,372	(33)	9,372
Distress:										
New.....	(29)	9,515	(29)	9,500	(7)	2,185	--	---	--	---
Cont.....	(9)	1,485	(9)	1,485	(10)	1,500	(29)	4,988	(29)	4,988
Facilities:										
New only....	(28)	5,400	--	---	--	---	--	---	--	---
Subtotal, P.L. 94-63.....	(731)	246,303	(640)	209,538	(399)	175,938	(412)	180,699	(412)	180,699
Previous Legislation:										
Staffing....	(139)	35,579	(139)	35,579	(139)	39,920	(142)	38,247	(142)	38,247
Children's Services....	(95)	11,520	(95)	11,520	(100)	13,779	(100)	13,900	(100)	13,900
Subtotal, Previous Legisla.	(234)	47,099	(234)	47,099	(239)	53,699	(242)	52,147	(242)	52,147
Cooperative Statistics....	--	3,000	--	3,000	--	---	--	---	--	---
Total, CMHC		296,402		259,637		229,637		232,846		232,846

You didn't tell me how many—you gave me a figure there dollar figure. You didn't give me how many new starts that would have been.

Dr. WALDROP. Sixty-five.

Dr. BROWN. As you know, what we have done as a way of getting some handle on how much new starts per year would be reasonable, what we did is look at the average new starts we have had for now over 10 years, which is a good measure.

We are well into our second decade. We have marked about 65 new starts a year over that 12-year period. This is where we came up with the reasonable estimate that clearly the country can do and absorb 65 new starts.

Congress also asked us, when they passed the law, what it would take to finish the job in 5, 10 years, what-have-you.

That will be available to you. In my professional judgment, 65 new starts is a way of having momentum without going more rapidly than we should either economically or professionally.

Mr. CONTE. With that track record of 65 new starts a year, how long would it take to complete the program?

Dr. BROWN. Well, we now have 649 funded centers. We estimate approximately 1,500 as you know. I don't think that we are going to have to federally fund all 1,500, because some centers are coming into being from other sources from non-Federal funds.

I always estimate those at approximately 100, carefully, which is why I say we are halfway home. It takes approximately another 740, divide by 65, and my arithmetic tells me about 12 years.

Mr. CONTE. Twelve?

Dr. BROWN. I would say that is about what it would take.

CMHC UTILIZATION AND EFFECTIVENESS

Mr. CONTE. Can you provide me with any information on the utilization of the community health centers' services during the past year, how many visits have there been, what is the income profile of users of the mental health centers?

Dr. BROWN. I will provide that. We are awfully proud that we went over the 2 million mark last year. Just 11, 12 years ago the first grant was given out.

Mr. CONTE. Terrific. Very good.

Do you have information on the cost effectiveness of the community health centers' program?

For example, the cost of a patient visit as opposed to keeping a person in an institution. Can you estimate the effect that the community mental health center program has had on a number of people who would otherwise be institutionalized?

Can you expand on that for the record?

Dr. BROWN. I will, Mr. Conte.

[The information follows:]

Community Mental Health Centers Program - Cost Comparison Data

The number of persons served in community mental health centers is continuing to increase. The number of visits or patient care episodes increased 111% from 1972 to 1975. The following tables compare 1972 data with 1975 data:

	1972 Under Care		1975 Under Care	
	No.	%	No.	%
Patient Care Episodes:				
Service:				
Inpatient	154,683	16.8	246,891	12.6
Partial Hospitalization	67,712	7.3	128,906	6.6
Outpatient	701,527	75.9	1,584,968	80.8
Total	923,922	100.0%	1,960,765	100.0%

Family Income:	1972	1975
Under $5,000 or under $100 weekly	53.3%	54.3%
$5,000 - $15,000	41.1%	38.4%
Over $15,000	5.6%	7.3%

Since 1964, the resident population of State and county mental hospitals has dropped from about 500,000 to less than 220,000 today. Some of the reasons for this steep decline are rising costs of institutional care, influence of court decisions, availability of psychoactive drugs, opportunity for State mental health agencies to save money by transferring institutional patients to other programs federally subsidized SSI and/or Medicaid programs, and increasing availability of community alternatives.

Although actual program comparabitity for different service settings is difficult to establish, the following tables provide some estimate of the costs of inpatients and outpatients in different settings:

Inpatient Settings:	Cost per day	Median Length of stay per Admission (days)	Cost per Episode
Type of Facility:			
State and County Mental Hospital.....	$ 28	43.5	$1,218
Private Mental Hospital.....	76	22.4	1,702
General Hospital Psychiatric Inpatient Unit:			
Public (Non-federal).....	115	6.9	794
Non-Public.....	115	13.6	1,564
CMHC.....	93	17.1	1,590

Outpatient Settings:

	Private Office Practice Late 1973		Federally Funded CMHC 1974
	All Patients	Non-analytic	
Unit cost per psychiatric treatment hour (medium).....	$ 35.00	$ 35.00	$ 45.00
Average visits per person per year.....	45	26	5.3
Average cost per person per year.....	1,575.00	910.00	238.50

As a result of the shift from institutional to community care patients with a greater range of demographic and diagnostic characteristics are distributed over a wider variety of psychiatric facilities.

RESEARCH TRAINING

Mr. CONTE. There has been a great deal of interest in my district for increasing support for mental health research training support. Do fellowships and training have different purposes and different impacts on the training institutions in the field?

Dr. BROWN. They do. A research training grant will support a whole effort around a problem or a program or an area.

The fellowship is training somebody to do research. We just recently went over with Mr. Roybal, by which I meant 15 minutes ago—the harsh impact of the cutback of predoctoral research fellowships for research training.

Mr. CONTE. Did you mention earlier how the research training budget which you are proposing for 1978 squares with the National Academy of Sciences report?

Dr. BROWN. I will summarize. We are moving in the general direction of that act. I think that summarizes what were sensitive issues and we are trying to respond.

Dr. WALDROP. I would also point out that the National Academy of Sciences study, which was issued last fall, indicated that the same level of dollar effort should be continued for the research training, not only in NIMH but also in ADAMHA.

In the behavioral sciences, where most of ADAMHA's research training support falls, the study recommended that we move toward a higher proportion of postdoctorals and that this shift in emphasis be implemented gradually.

We are beginning to move quite successfully, I think, toward accomplishing that purpose.

Mr. CONTE. In your professional judgment, what would be the appropriate mixture of levels and the kind of research training supported by the NIMH programs?

Dr. BROWN. I would like to give you a careful answer for the record. The point is that I feel a balance between the two is needed rather than having all fellowships or individual stipends or all research training grants support the institution.

[The information follows:]

PROFESSIONAL JUDGMENT BUDGET FOR NIMH RESEARCH TRAINING

An increase of $2,661,000 over and above the current budget estimate would enable a strengthened research training effort in the areas of mental disorders and maladaptive behavior, mental health services research and evaluation, and social problems. Within social problems research training, minority training would receive a high priority.

With respect to fellowships, there would be no increase in funds, but there would be a redistribution of a portion of the new postdoctoral funds to enable a moderate effort at the predoctoral level with the emphasis continuing to be at the postdoctoral level. Thus $256,000 would support new predoctoral fellowships and $2,496,000 for new postdoctoral fellowships.

The recommended balance in fiscal year 1978 between institutional awards and individual fellowship awards is 77 percent institutional and 33 percent individual, i.e., $14,560,000 for grants and $4,238,000 for fellowships. The proposed total research training funding of predoctorals to postdoctoral awards in fiscal year 1978 is $10,730,000 for predoctorals and $8,068,000 for postdoctorals which translates into a distribution of 57 percent predoctoral and 43 percent postdoctoral.

The Institute would increase its training program for clinical research on mental disorders and maladaptive behavior because of the inherent importance of the area and because a basis has been laid in past efforts for improved interdisciplinary training at this time. Health services research training would be supported due to the increasingly complex system in which mental health services are delivered and a present lack of breadth necessary to understand and study the relevant variables. Skilled minority research manpower is in short supply, especially in the area of epidemiology. Additional funds would be used to encourage minority individuals to enter research in fields of high need and priority to mental health and to fund epidemiological centers and programs for minority training.

Mr. CONTE. What will be the effect of your proposed budget on minority students in the mental health professional field?

Dr. BROWN. If I can just continue the track of research training which we were on, the lack of predoctoral support will be disastrous in general in psychology, social work, behavioral sciences and totally disastrous for minority students.

For minority people, the feeing is that they can and want to start early in their training career toward a research and training career, perhaps even earlier than others of their peer group in psychology, behavioral and social science. The answer very simply is that it is a total disaster on the minority communities.

Mr. CONTE. To what extent are you tying any of your research training directly to portions of your research program?

Dr. BROWN. Very directly. We are trying to establish a relationship between some key areas that have been spelled out, such as clinical illnesses, maladaptive behavior, children and elderly. We are doing this because, after all, the research trainees are both doing work and learning how to carry out the research program as the next group who will be the principal investigators.

Mr. CONTE. How much of your mental health training is interdisciplinary?

Dr. BROWN. I think the majority of our mental health research training is interdisciplinary. This has moved from a unidisciplinary stance 15 or 20 years ago.

This is one where, if I can call on you to supplement, Dr. Waldrop, you followed that so carefully.

Dr. WALDROP. I don't have any sharper figures, but certainly I think there has been a general development in the whole field of mental health professions which recognize the interdependence to a substantial degree of many of our professional groups in delivering services, particularly in organized settings and in a community.

I think this is being reflected in training sites. Certainly in research training it is. We have seen a substantial movement toward using consortial arrangements among university students to provide a base for training in one program around a broad problem area, a variety of disciplines.

Mr. CONTE. I am told by the chairman that I have exceeded my time. I have more questions on this. I will submit those.

DRUG ABUSE TREATMENT PROJECTS

Mr. NATCHER. Doctor, you show a reduction in your drug abuse community program of 33 projects. What is the situation as to your 33, Doctor?

Mr. BESTEMAN. The redirection in number of projects supported reflects increasing use of a consolidated project support mechanism for our treatment programs. These State-level contracts act as the administrative structure for a number of treatment projects which were supported previously as independent activities.

These State-level programs provide services throughout a State, and if grantees are reaching their terminal year, or are willing to switch over to the State services contract, we will then incorporate them into that contract. For fiscal year 1977 we initiate the support of 7,000 additional treatment slots within our fully utilized treatment nework even though the actual number of mechanisms used to distribute those services was decreasing.

Mr. NATCHER. Will this mean fewer treatment slots?

Mr. BESTEMAN. No; we will support the same number of treatment slots in fiscal year 1978 as 1977.

THIRD PARTY PAYMENTS

Mr. NATCHER. Currently the Federal share of drug abuse community programs is maintained at 60 percent until alternate funding sources are available.

What success are you having in identifying alternate sources of funds?

Mr. BESTEMAN. Frankly, very little. The communities, States, counties, cities, and private organizations that are 40 percent funding are constantly coming to us and indicating their great difficulty in continuing to sustain their share of the funding. This is probably our most critical issue within our services area.

Mr. NATCHER. Doctor, approximating now, what percentage of the drug abuse treatment center's income is derived from third-party payments?

Just answer approximately.

Dr. WALDROP. Five percent.

Mr. NATCHER. In the future, do you see a larger role for private insurance companies in the financing of drug treatment or will it be such that Government programs such as in title XX will have to continue with the burden and have to pick it up?

Dr. WALDROP. I would like very much to think that third-party mechanisms other than Medicaid and so on would pick that up.

I am not optimistic that that will easily come about in the near future. I think we will have to, for the foreseeable future, rely upon this heavy burden of Federal support.

Mr. NATCHER. Is the reluctance of insurance companies to provide coverage for drug abuse and alcoholism due to the fact that the concept of treatment is for these diseases broad and that the notion of cure is relatively vague?

Is that a right fair statement?

Dr. WALDROP. I think that is partly the case. I think beyond that is the fact that so many persons who are serious abusers of drugs are unemployed; and they do not work in situations where they would normally be subject to coverage, ordinary third-party means.

STATE SERVICE CONTRACTS

Mr. NATCHER. Doctor, briefly—and then you can expand this in the record—will you explain to the committee how the statewide services contracts for drug abuse would work at the State level?

Mr. BESTEMAN. We go to the designated drug abuse agency in the State and enter into a cost-sharing contract with them. Upon signing the contract, this agency takes the responsibility for negotiating the appropriate number of subcontracts to the local communities, monitoring those subcontracts, and making sure that the Federal funding criteria and the reporting requirements of the contract are met.

Our primary relationship is therefore with the State government as the prime contractor. We provide them with certain technical, management, and data assistance to assist in managing and directing this contract.

An added benefit to this relationship is the coupling of State drug abuse planning and formula grant activities to what is happening with the project funds.

It has a very strong coordinating and integrating effect in terms of how the State approaches its drug abuse activity.

Mr. NATCHER. Who evaluates the work of the subcontractors under a statewide service contract?

Mr. BESTEMAN. The prime contractor is responsible for evaluation activities. In addition, because Federal funds are involved Federal project officers conduct site visits to determine that the clinical care meets appropriate standards. We also conduct management reviews either periodically or as requested by the States.

When I say periodic, I mean a longer period of, say, once every 2 or 3 years.

INTEGRATION OF DRUG ABUSE AND ALCOHOLISM PROGRAMS

Mr. NATCHER. Have any States integrated their drug abuse and alcoholism programs under a statewide service contract?

Mr. BESTEMAN. I am not aware of any.

Mr. NATCHER. Is it possible?

Mr. BESTEMAN. Technically, yes.

Mr. NATCHER. Should it be done?

Mr. BESTEMAN. This is a philosophical issue that could start a fight, even at this table.

There are several sites in the United States where drug-abuse services and services to alcohol abusers are delivered in a totally integrated manner.

These instances are still relatively rare in the drug-abuse field, and I assume this situation also prevails in the alcohol field.

Increasingly the management, planning, and fiscal control mechanisms are integrated at the State level and the actual delivery of services is occurring separately at the community level even though they may work for the same State agency.

HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Mr. NATCHER. Doctor, what progress are you making in getting the insurance companies to provide health insurance coverage for alcoholism?

Dr. WALDROP. There has been some gradual increase to where 3 percent of the income now for alcoholism treatment programs in the country comes from private insurance companies. Another 14 percent comes from Medicare, Medicaid, public assistance payments, et cetera.

More importantly, I think, has been the effort of the NIAAA in the last year to develop a model insurance package, benefit package. This package is now, through work with the Blue Cross Association, being subject to survey and marketing potential with the view of actually field testing in the near future.

We have had some small encouragement, I think, maybe more than small, from the experience of the State of California, where the State underwrote through its nine carriers, the reimbursement for a very liberal program of alcoholism benefits. We won't know what the outcome on that will be for a while, but we are pleased with the fact that one of their carriers, Kaiser, is continuing the program without the need for this special State support and they are estimating that the annual per capita premium for that benefit is about a dollar and a half.

That is the kind of development that we find most encouraging.

Mr. NATCHER. Doctor, I understand you have a contract with the Blue Cross Association to study the problem of providing insurance coverage for alcoholism.

What is the status of this contract? Do you have anything to report at this time?

Dr. NOBLE. The contract is still ongoing. We have nothing to report.

Mr. NATCHER. Mr. Conte?

Mr. CONTE. I have submitted my questions.

Mr. NATCHER. Thank you very much, gentlemen.

We take up next St. Elizabeths Hospital.

Dr. Brown, I believe you will justify this request.

[The following questions were submitted by members of the subcommittee with the request that they be answered for the record.]

COMMUNITY MENTAL HEALTH CENTER FUNDING

Mr. MICHEL. You are proposing no funds to begin any new community mental health centers in fiscal 1978. Does that indicate a view on the part of the administration that we really don't need any more than the number funded to date?

ANSWER. No. The lack of new starts was the combination of two factors: first, a desire to hold the budget level until the new administration studies the existing programs further; and second, an increase in funding requirements for continuation costs. Continuation costs have increased because centers are required to support 12 services rather than 5. Therefore, a level budget allows no new starts.

FEDERAL SHARE OF CENTER COSTS

Mr. MICHEL. Under the law, the Federal share of total costs of operating community mental health centers declines over the eight-year period of funding. Would you tell us, for the record if necessary, what the Federal percentage is for each of the 8 years?

ANSWER. Maximum Federal support for costs of operations for providing comprehensive mental health services for a catchment area is calculated on a declining basis over an 8-year period.

Allowable Federal share is the lessor of (a) the amount by which costs exceed total funds, fees, premiums and third-party payments that can be collected; or (b) a percentage of the grantee's projected costs of operations.

The following table indicates the maximum Federal share:

MAXIMUM PERCENTAGE FEDERAL SHARE OF CMHC OPERATING COSTS

	Nonpoverty center	Poverty center
Year:		
1	80	90
2	65	90
3	50	80
4	35	70
5	30	60
6	30	50
7	25	40
8	25	30

STATE AND LOCAL FUNDING

Mr. MICHEL. Is any effort made to require the centers, prior to being approved for Federal funding, to provide a commitment from State and local governments for increased funding over the eight-year period, to make up for the decline in Federal funding and to insure that the centers will be able to make a go of it when the 8-year period is up?

ANSWER. CMHC grant applicants must submit for review specific information with respect to financial plans, including amounts and sources of funds, indicating availability of sufficient non-Federal funds, for both the immediate and future years. Such plans are reviewed and must be found approvable each year.

Specific future increasing commitments from one particular source of funds, such as a State or local government unit are not required, and would not be legally possible for some such units.

While the percentage of State and local government support has remained fairly constant, the State and local government total dollar support of CMHC programs has steadily and significantly increased each year as the number of centers has increased.

Many States have community mental health services legislation providing for State support of CMHC's, with some specifically adjusting support level in relation to the declining of Federal support levels.

Mr. MICHEL. According to your justifications, 138 centers have completed their Federal funding cycle. Are all of these successfully operating without Federal funds?

ANSWER. If failure is defined as the termination of all services and staff, only one CMHC is under threat of closure. While the termination of Federal staffing funds is a contributing factor, other factors appear to be as important. Several other centers have had to reduce the level of services somewhat. It appears that all of the 138 centers which have terminated Federal staffing support, with the exception of the one previously mentioned, will continue to provide services.

Mr. MICHEL. How many, if any, centers have closed down because they couldn't make a go of it on their own?

ANSWER. If failure is defined as the termination of all services and staff, only one CMHC is under the threat of closure as indicated in the previous answer.

CENTER DISTRESS GRANTS

Mr. MICHEL. How many centers are currently receiving financial distress grants and how many are expected to need such grants in fiscal year 1978?

ANSWER. In fiscal year 1976, 25 distress awards were made in the amount of $3,904,000. It is expected that all of these will need continuation support in fiscal year 1977 and with the current level of funds available, 16 additional centers will receive distress financing. The fiscal year 1978 budget contains funds to

support continuation requirements for 29 centers previously funded. However, it is anticipated that an additional 52 centers will apply and be approved for new distress financing in the amount of $10,400,000. No funds have been requested for these additional new distress awards.

TREND IN NONFEDERAL SUPPORT

Mr. MICHEL. What is the trend of non-Federal support for the centers? Is it on the rise, or declining?

ANSWER. In terms of dollars non-Federal support for CMHC's is steadily increasing. The table displays Federal, and non-Federal income for federally funded operating CMHC's for 1970, 1974, and 1975 (latest year for which actual income data is available).

ESTIMATED INCOME OF FEDERALLY FUNDED OPERATING CMHC'S

[In thousands of dollars]

	1970	1974	1975
Total Federal funds[1]	68,526	207,819	246,205
Total Nonfederal funds	160,157	481,549	581,461
Total from all sources	228,683	689,368	827,666

[1] Includes Federal staffing, research, training, and other funds.

The Federal percentage of total CMHC support has been constant, at 30 percent each of the above years.

STATE FUNDING PRIORITIES

Mr. MICHEL. In Illinois, the patient load of the State mental hospitals has been declining rather sharply, but the State continues to put most of its funds into these hospitals rather than providing increased funding for the community centers. There is a reluctance to change funding priorities, despite a changing situation. Is the picture the same in other States as well?

ANSWER. While there is considerable variability from one State to another in the extent to which they have been able to transfer resources to the community with the patients, many States are experiencing difficulties similar to those in Illinois. For example, in the recent GAO study of deinstitutionalization in five States, the GAO found that three of the States studied had approximately 80 percent of their mental health system resources tied up in institutions, although a large proportion of the patients are now being seen in the community. The other two States studied had been somewhat more successful in transferring resources to the community.

Very often it is not so much a reluctance on the part of State administrators to change funding priorities as it is the existence of powerful counterpressures. Experience has shown that reducing the population of hospitals does not automatically result in substantial cost savings. There are large fixed costs of maintaining and staffing institutional plants, along with the need to maintain adequate quality in the institutions. Sometimes, administrators must make very substantial investments in the hospitals to meet standards and avoid loss of Federal funds. In addition, plans to close institutions or convert them to other purposes run into strong community opposition from groups who have relied on the hospital for employment, or from groups who object to the alternative uses proposed for the institutional plant.

Mr. MICHEL. Do you make any effort to work with the States to try and induce them to change their funding priorities?

ANSWER. There are a number of ways through which the Federal program influences State funding priorities. An approved State plan for mental health services, which is a prerequisite for a grant award, includes an annual review and statement of the State's funding priorities. These are formally reviewed by the regional office staff, and consultation continues throughout the year both with respect to the overall plan and in relation to specific project review. Fed-

eral funding priorities are stated each year, in turn influencing State priorities. Continuing consultation by central and regional office staff to both State and community programs, also influences State and local program development and support.

PEORIA COMMUNITY MENTAL HEALTH CENTER

Mr. MICHEL. The Peoria Community Mental Health Center will receive continuation funding in fiscal year 1978, will it not?

ANSWER. Each of the initial operations grants in the series of 8 years of funding is a discrete grant. In order for a community mental health center to receive continued funding, the center must each year submit a new application which is formally reviewed and must, of course, be approvable before funding can occur. Funding decisions about continuing support for those grantees recommended for approval are made by the Regional Health Administrator dependent on the availability of funds. For fiscal year 1978 it is estimated that necessary funds for initial operations continuations are available and no difficulties are forseen in refunding the Peoria CMHC.

FOREIGN MEDICAL GRADUATES

Mr. MICHEL. I was particularly struck by one item in your statement that over 50 percent of State mental hospital staff physicians are foreign medical graduates. Why is the percentage that high in that particular field?

ANSWER. The percentage of staff physicians and staff psychiatrists in State mental hospitals who are foreign medical graduates is high for several reasons. These jobs are not viewed as desirable ones, as they are often in rural areas, with relatively low pay and low prestige. Foreign medical graduates are recruited because American-trained physicians are in short supply and difficult to hire. Recent controversy about the number of foreign physicians who do not speak English well and are often unlicensed has led many States to impose higher standards and require that physicians be fully licensed. When the supply of foreign medical graduates entering the country is curtailed, as a result of Public Law 94–484, a shortage of psychiatrists may well occur.

MENTAL HEALTH PERSONNEL SHORTAGE

Mr. MICHEL. Is there really a shortage of trained personnel in the mental health field, or is it primarily a maldistribution problem?

ANSWER. Yes; there is definitely a shortage of trained mental health personnel, and particularly of psychiatrists. This shortage is compounded by the severe maldistribution problem, but it exists apart from maldistribution. Nationally the utilization of mental health services is rising, and the manpower supply must be increased to provide these services. At present rates of production and an increase in utilization of 1 percent, we expect the demand for psychiatrists to exceed the supply by 11,000 in 1980. Figures on the other disciplines are less precise.

NIMH projections have been made of the number of additional personnel necessary to fully implement the CMHC program throughout the Nation. These new centers alone would absorb the total graduating classes of psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses for several years to come. Attrition and natural growth in other areas and types of employment would, of course, increase the demand.

MENTAL HEALTH TRAINING GRANTS

Mr. MICHEL. Your justifications show over a 100 percent increase in new training grants. What is the justification for such a sizeable increase?

ANSWER. Total funding for the clinical training grants program is constant at $68,263,000 for both fiscal year 1977 and fiscal year 1978. However, due to an unusual number of continuation awards with their last year of funding in fiscal year 1977, continuation costs are less in fiscal year 1978 than in fiscal year 1977, and an additional $8,930,000 becomes available for new and competing clinical training grants. The majority of these funds, $7,327,000 will be used to support mental health's new training initiatives in the training of primary core givers, research and demonstration projects in manpower development, and

State manpower development projects. The remaining $1,603,000 will be used to fund new and competing training projects in the core disciplines of psychiatry, nursing, social work, and psychology.

Mr. MICHEL. Psychiatrists are the biggest recipients of Federal training grants, but last year we were told that almost half of the psychiatrists who received these grants have gone into private practice, where the financial rewards are the greatest, rather than into some of the greater shortage areas, such as mental health centers, mental hospitals, etc. Isn't this a good argument for reducing funding for training, as President Ford proposed?

ANSWER. No; reduced funding would place a severe strain on training institutions and lead to a decrease in the production of psychiatrists, further exacerbating the present shortage and maldistribution problems. Furthermore it would mean that we would no longer be able to encourage the training of psychiatrists in community mental health, child psychiatry, minority mental health, and other priority areas. Reduction of funds for psychiatry training grants would result in fewer psychiatrists for mental hospitals, community mental health centers, and other public service institutions.

It should also be noted that many, if not most, psychiatrists who are primarily in private practice also spend a portion of their time in hospitals, clinics, community mental health centers, courts, and correctional institutions, et cetera.

FUNDS FOR MENTAL HEALTH RESEARCH

Mr. MICHEL. Are you satisfied that we are providing sufficient funding for mental health research?

ANSWER. Naturally a program advocate is rarely satisfied with his funding level. Our 1977 research appropriation was the first reversal of a dramatic downward trend for mental health research funding: in terms of constant dollars, the mental health research budget had declined by over 30 percent from 1969 through 1975. At a time when NIMH needs to rebuild its research programs, the proposed level fiscal year 1978 budget with its higher commitment base would mean that we would be able to make 40 percent fewer new awards in 1978. We have carefully planned new research programs in areas of high public health need: the effectiveness of psychosocial treatments for mental illness; research on aging, a neglected area that will assume increasing importance as the proportion of elderly persons in our population rises over the next decades; and expanded research into the causes and prevention of the major mental illnesses, schizophrenia, and depression. However, the administration must view these programs within the total budgetary constraints.

ALCOHOLICS DEFINED

Mr. MICHEL. You indicate that we presently have 9 million alcoholics in this country today. How do you define "alcoholic"?

ANSWER. An "alcoholic" is a person who suffers from alcoholism. Alcoholism is a chronic illness that manifests itself as a disorder of behavior. It is characterized by the repeated usage of alcoholic beverages to any extent that exceeds customary dietary use or compliance with social customs of the community and that interferes with the drinker's health or his economic or social functioning. There are 9 million alcoholics or problem drinkers in America.

TEENAGE ALCOHOLISM

Mr. MICHEL. What was that survey which found that 40 percent of junior and senior high school students drink some alcoholic beverage at least once a week? How reliable is the finding?

ANSWER. You are referring to a survey conducted by Research Triangle Institute in 1974 and sponsored by NIAAA. The results of that survey showed 39.9 percent of the students drank 3–4 days a month or more often and 23.3 percent drank 1–2 days a week or more often. The reliability of these proportions —what we would expect on repeated samplings—are high as indicated by the sampling errors 38.1 to 41.7 percent for 3–4 days a month and 21.5 to 25.1 percent for 1–2 days a week or more.

The sampling errors are calculated for a national probability sample of the "in school" population and therefore excludes high school dropouts, those teen-

agers who have completed high school, and those who are in institutions or not in school for some other reason. However, indications are that alcohol abuse is, if anything, higher among these other groups.

Mr. MICHEL. Did the survey show where the students obtained the alcohol? Was it generally consumed with the parents blessing, or without their knowledge?

ANSWER. The survey did not ask these specific questions. However, it did ask how often they had been given alcohol by their parents as a measure of "parental sanction of drinking." The results show that the heaviest teenage drinkers had the more liberal parents in this regard—that is, 64–67 percent of the moderate to heavy teenage drinkers had been given drinks several times or more often by their parents as compared to 46 percent for infrequent drinkers and 10 percent for abstainers. A question was also asked as to where they could procure alcoholic beverages if they were having a party—over 50 percent indicated a friend or someone else they knew would buy it for them and 32 percent indicated a friend would give it to them, whereas only 15 percent indicated they would get it from home.

Other studies analyzing alcohol and youth literature from 1960–75 show that one-third of the students who drink away from home obtain the alcohol from their parents, one-third from their peers, and one-third buy their own. Another study which measured changes in drug use in Toronto high school students between 1972 and 1974 found that 42 percent of teenagers who drink do so at home with their parents.

ALCOHOLISM PROBLEM

Mr. MICHEL. Is the alcohol problem in general becoming worse?

ANSWER. This question is difficult to answer without defining what is meant by the "alcohol problem." Although the total volume of alcoholic beverage sales has increased annually over the past several years, the largest increase in per capita consumption, based on beverage sales, occurred from about 1960 to 1970 for all alcoholic beverages. Since 1970, per capita beer and wine consumption have continued to increase at 2 or 3 percent per year, but spirits have leveled off in terms of the per capita absolute alcohol consumption. The general leveling off tendency demonstrated by sales information is also shown in general population survey data on consumption. Survey data over the past 5 years has also shown no significant trends in change in problem drinking.

Despite the above, the prevalence of problems associated with the use of alcohol are still very significant and continue unbated. Of the two-thirds of the adult population that drink, 10 percent or 10 million persons have frequent symptoms of problem drinking and another 25 percent or 24 million persons have potential problems as a result of drinking. In the youth population, 70 percent of junior and senior high school students report drinking occassionally—40 percent drink 3 to 4 times per month or more. Of the 24 million in-school teenage population 11 percent, which is equivalent to 2.6 million teenagers nationally, can be defined as heavy drinkers. That is drinking at least once a week in amounts of 5–12 drinks per occasion.

The current estimated cost of alcohol abuse and alcoholism runs approximately $31 billion annually. About 40 percent of all fatal motor vehicle accidents are alcohol-related and alcohol is involved in 26–36 percent of all deaths due to accidents. From 50–70 percent of homicidal deaths and 25–37 percent of suicides are alcohol-related with approximately one-half in each case being related to alcoholism.

The prevalence of consumption, problem drinking, and abuse is highest in the male, age 20–30 group. In this group, 85 percent report drinking during the past month and 67 percent report having drunk alcohol at least monthly, sometimes in large amounts, at one time or another during their lifetime. In this group, 60 percent report having driven a car while drunk, 38 percent reported not being able to remember what happened to them as a result of drinking, and 41 percent report having had problems at work, with family, friends, the law, or their health as a result of drinking. Although comparable data for the teenage population is very sparse, studies have shown that 27–43 percent of adolescents arrested for committing a crime had been drinking at the time, and 47 percent of assaults by juveniles were committed while under the influence of alcohol. The 1974 Research Triangle Institute survey of junior and senior high school students indicates that 28 percent report getting drunk four or more times a year or reported two or more areas of negative consequences due to drinking.

OUTPATIENT SERVICES

Mr. MICHEL. What is the nature of the outpatient services provided at the alcoholism treatment centers?

ANSWER. Outpatient services provide a wide range of medical and psychosocial treatment including, but not limited to, individual, family and group therapy, chemotherapy, counseling, Alcoholics Anonymous activities, and appropriate occupational and recreational activities. In outpatient care, assistance may also be provided in such areas as jobs, housing, and legal problems.

The vital importance of outpatient services to the needs of the total alcoholic population in a service area are reflected in provision of staff to provide alcoholism services, geographic accessibility, and daily availability of services to include evening hours and Saturdays.

ALCOHOL TREATMENT CENTERS

Mr. MICHEL. How many of these alcoholic treatment centers are there currently in existence?

ANSWER. Forty-three such centers are currently receiving institute support.

Mr. MICHEL. Do States receive any special consideration, when the community program funds are awarded, for doing a good job in establishing alcohol treatment programs?

ANSWER. States receive an incentive grant under the Uniform Act, once they have made a commitment to provide health care for public intoxicants rather than subjecting them to criminal prosecution. Aside from this aspect, States do not receive special consideration from the Federal Government.

STATE EFFORTS

Mr. MICHEL. How many States are generally doing a good job, and how many are not really making much of an effort?

ANSWER. All of the States are working diligently to establish Statewide networks of services and programs to meet the State's needs. The degree of fulfillment in each State depends greatly upon the availability of resources, especially financial resources.

Mr. MICHEL. Where would you say Illinois stands in this regard?

ANSWER. Illinois has progressed well over the past several years. Considerable citizen input into the State's alcoholism program has been accomplished through regional planning and implementation. In 1974, Illinois enacted its alcoholism and intoxication treatment act. It became fully effective on July 1, 1976. By delaying the effective date and by providing $4 million in State funds, the State agency was able to plan and prepare for implementation of the act. Illinois has also set high priorities on programs for women and teenagers which is in keeping with congressional priorities. It is anticipated that the State will receive about a $665,000 continuation award under the Uniform Act provisions in 1978.

NIAAA SERVICES

Mr. MICHEL. Your statement indicates that services will be provided to 300,000 alcoholic users. How does that compare with the figures in 1973, when supposedly the cost per individual was 44 percent higher?

ANSWER. In 1973, service was provided to approximately 109,000 alcoholic users with most treatment in a hospital setting. Since then it has been found that outpatient care is as effective for certain problems as treatment in an inpatient setting. Therefore, outpatient care has been utilized to provide more appropriate care at a lesser cost per patient. Also, the staffing patterns have been modified utilizing paraprofessional staff to a greater degree in NIAAA's treatment programs, there are more drinking drivers programs which generally require less treatment, and more emphasis is being placed on early intervention.

LABOR-MANAGEMENT COMMITTEE ON ALCOHOLISM

Mr. MICHEL. Last year reference was made to a labor-management committee on the alcoholic problem. Is it still in existence and is it making any progress?

ANSWER. The labor-management committee referred to in testimony before the Appropriation Committee continues to operate in the development of local

labor management committees in ten metropolitan areas across the United States. Mr. James Roche, past chairman and director of General Motors and Mr. George Meany, president AFL-CIO, serve as co-chairman for this national effort.

The objectives and accomplishments of this committee are at two levels. First is their continuing work on the task of recruiting their peers in ten selected metropolitan sites. To date 80 top level labor and management leaders have been recruited to obtain commitments from their colleagues to create occupational programs in their establishments. In addition, the top labor-management committee will meet in 1977 for the purpose of assessing the current status of the project and determine from available data the action needed to further promote the goals of the project.

A second level of functioning for this committee is also national in scope and is a continuing activity of the committee. This objective is to mount a continuing nationwide movement by leaders of labor, business and Government to restore the employed alcoholic person to good health and productivity through the stimulation and initiation of soundly designed employee alcoholism programs by all American employer organizations.

Through individual contacts they continue to be available throughout the year using their personal influence in the initiation and support of new program development throughout industry.

RESEARCH ON EFFECTS OF DRUG USE

Mr. MICHEL. I note you are planning to emphasize research on the effects of drug use on performance of individuals, such as driving, economic behavior, criminal activity, etc. I would have thought studies along this line would have been undertaken a long time ago?

ANSWER. NIDA has had several ongoing projects in the area of drugs and performance. These projects have brought us to the point at which further research is called for. For example, during the past year, new pharmacokinetic techniques were developed that are both sensitive and reliable enough to measure blood levels which could be correlated with performance. The next step in our research will be to survey certain specific populations, such as drivers who have had accidents or persons who have been arrested for a particular crime, to see what the relationship is between those activities and the measurable levels of drug in the blood.

The relationship of drugs to crime and economic behavior is an extremely complex one and it is difficult to obtain precise data or to establish cause/effect relationships. Over the past year, we have devoted considerable staff time to the development of experimental design and methodological approaches which are more likely to provide unequivocal answers to the multitude of questions in this area. We are now better prepared to undertake major program initiatives in this area.

In addition, I think it is important to note here that the primary responsibility for measuring the effect of drugs on complex human performance was originally with the Department of Defense (DOD). However, a recent congressional action (94–517) proscribed DOD from doing any further research on drugs with the assumption, expressed in the regulation, that drug research activity would be assumed by NIDA. Despite the many demands made on our research budget, NIDA is trying to take up the leadership in this field to fill the gap created by the ban imposed on the Department of Defense, although no additional funds have been provided for this purpose.

DRUG ABUSE PREVENTION PROJECTS

Mr. MICHEL. Apparently funds are to be used to develop model drug prevention projects primarily aimed at school age children. Isn't that what the drug abuse education program operated under the Office of Education has been doing?

ANSWER. The Office of Education, Division of Drug Education, Nutrition, and Health programs has for the last few years solely funded training or college-based programs to encourage trained teams of teachers to initiate prevention processes on return to their communities. The OE has never published manuals or curricula materials for use as prevention tools in schools, nor has it funded directly specific school programs since 1974. Such activities as have been initiated by the school-based teams have necessarily been of limited nature, reaching only a small proportion of the school systems of the Nation.

NIDA, on the other hand, works directly with schools not involved in the OE-trained teacher-team approach, to help them develop prevention programs at the county, district, and local levels. Increasingly, NIDA has looked to community based organizations to help schools conduct drug abuse prevention activities. Through grants to these organizations, NIDA either trains teachers for drug abuse prevention education or provides programs in the schools themselves.

STUDY ON DRUG USE AND CRIME

Mr. MICHEL. Last year you apparently spent $219,000 for a study on drug use and crime which suggested that we experiment with ways of lowering heroin prices to see if that would reduce crimes by addicts. What was your attitude toward that suggestion?

ANSWER. The study referred to was a project designed to develop a state-of-knowledge summary of what is known about the relationship between drug use and criminal behavior and to develop guidelines for drug-crime research. A panel of experts on drug use and criminal behavior was convened, met a number of times, commissioned additional analyses of existing data, and wrote a number of sustantive papers on various aspects of the question. The contractor, Research Triangle Institute, prepared a summary of the papers and recommendations in its final report.

The contractors' final report included, among many other suggestions for further research, the observation that is might be informative to examine the variation in herion prices nationally by relaxing the narcotic law enforcement in a particular area or by establishing "an experimental heroin maintenance program." This suggestion was a minor thought, not a major research project recommended by the panel.

The report says that it is unlikely that current addicts involved in criminal lifestyles will cease criminal activity because heroin is freely available and that "Clearly, this 'pacification' effect is an intolerable policy for reducing crime."

The report goes on to say, however, that it is possible that free or legal heroin may have some impact on new addicts who have not yet established a life of crime. The report concludes that "* * * a relaxation of supply reduction efforts is likely to produce a small short-run reduction in criminal activity among current users and a potentially large long-run effect on the number of drugs users who choose criminal occupations and try to maintain high levels of income." By ways of clarification, none of the suggestions or directions recommended by the panel constitutes a mandate to the NIDA.

The entire report is primarily advisory in nature. All the recommendations are being carefully reviewed.

My attitude toward the suggestion is that I would be extremely reluctant to introduce experimental heroin maintenance for a number of reasons. Heroin is a short-acting drug requiring intravenous administration four or five times every day to maintain a habit. Thus, either the patient must remain virtually full-time in a clinic or he must be given take-home heroin. The potential problem with the diversion of heroin to uninitiated subjects makes the latter prospect unacceptable, and the former does not seem practical from the user's or the program's point of view. Another objection is that such an effort would simply move the heroin-related social cost out of the criminal area and into the health area. Under such circumstances, there would probably be far more heroin users and the pattern of social costs for heroin might resemble the current health costs of tobacco and alcohol, which exceed a staggering $35 billion annually. In my judgment, the total cost associated with heroin use might be higher under "legalized" conditions than they are today under a policy of strict prohibition. I intend, however, to keep an open mind to the possibility that these objections might be successfully countered so that a carefully controlled experiment would someday be possible.

Mr. MICHEL. Was a study coming up with suggestions like that really worth the $219,000 expenditure?

ANSWER. As we have just mentioned, the suggestion to experiment with heroin maintenance was a minor one and infinitesmal compared with the many statements summarizing the state of knowledge and the many other suggestions for directions of future research. This was the first attempt in many years to bring order to a mass of separate studies and statements of relationship on this subject. A number of important conclusions were brought to our attention such as the fact that drug use is supported by a variety of legal and illegal sources,

not only by predatory income-generating crime. Also, a significant number and percentage of addicts appear to be employed and earn legitimate incomes. These are only two examples of a number of insights gained from the panel report. Considering the enormous cost of crime presumed to be caused by drug use, counted in the billions, the cost of this study seems modest. It may, by enlightening us on the relationship between drugs and crime, eventually lead to new ways of cutting that social cost.

MARIHUANA RESEARCH

Mr. MICHEL. If the administration has already made up its mind on this issue, why do we continue to spend millions on marihuana research?

ANSWER. Indications are that marithuana is not safe. The idea that it is safe, although accepted by some of the public, is clearly not endorsed by most of the research community. It is doubtful that the use of small amounts of marihuana of low potency on an infrequent basis causes significant harm. The possible hazards appear to be related to functioning while intoxicated and lung impairment after heavy long-term use. Since there are an estimated 15 million current American users of marihuana and since surveys have shown that among high school seniors regular marihuana use exceeds regular alcohol use, clearly, a potentially dangerous situation exists. Therefore, considering this widespread use of marihuana in our society, it is imperative that we more fully understand the long-term effects of the drug.

DECRIMINALIZATION OF MARIHUANA

Mr. MICHEL. I understand the Carter administration has expressed support for the decriminalization of marihuana. Why?

ANSWER. President Carter has expressed a deep concern about the problem of drug abuse. His policy is to discourage the abuse of all drugs, including alcohol and tobacco. At the same time, however, the mechanism for discouragement should not be more damaging to the individual than the drugs themselves. The administration wishes to continue to discourage marihuana use, but believes that criminal penalties that brand otherwise law-abiding people for life are neither an effective nor an appropriate deterrent.

MR. NATCHER

ALCOHOLISM RESEARCH CENTERS

Mr. NATCHER. Doctor, the Comprehensive Alcoholism Act of 1976 provides for the support of alcohol research centers. Is there any money in this budget for these centers?

ANSWER. No. Not in the 1978 administration request to the Congress.

Mr. NATCHER. How much will it cost to continue the alcohol research centers initiated as a result of the funds included in the 1977 supplemental appropriation?

ANSWER. We estimate that they would require $2 million for their second year of activity in fiscal year 1978. This, of course, is not included in the 1978 request, since the $2 million add-on in 1977 was made subsequent to the administration's 1978 budget request.

RESEARCH

Mr. NATCHER. Doctor, I noticed in the budget justification that you are reducing your support for regular research grants while providing some increase for alcoholism contracts and research scientist development awards. Why is this shift away from regular research grants necessary?

ANSWER. It is not a de-emphasis of regular research grants, but a necessary reduction within the resources available. The research contracts are necessary to synthesize existing knowledge in a number of subject areas, such as the relationship of alcohol abuse to heart disease, certain forms of cancer, liver disease and the effect of alcohol use on the unborn fetus. This knowledge must be summarized for the preparation of the Alcohol and Health Report to the Congress, as required by law. Other research contract which measure the incidence and prevalence of alcohol abuse among the general population, and specific segments of the population such as youth, women, minorities and the aged, are also an increasing NIAAA requirement which we cannot ignore.

The research scientist development awards are really regular research grants, but with the added dimension of recruiting talented new scientists into the field of alcoholism and stimulating a career interest in alcoholism problems on the part of these promising individuals. Their increase is due to a larger commitment base in 1978—the number of new is even a little less.

Mr. NATCHER. Is there enough money in the alcoholism budget to meet the cost of all noncompeting continuation grants in 1978?

ANSWER. Yes, provided that the 1977 supplemental request does not provide any money, continuation requirements could be met, and the budget would also allow for about $2 million in new and competing grants.

Mr. NATCHER. Doctor, what has been the most promising alcoholism research results to come out of your Institute in the last two or three years and what areas of research will you be emphasizing in he near future?

ANSWER. The latest, most promising research supported by the NIAAA is the discovery that two substances found in the blood, alpha amino-n-butyric acid and leucine, may serve as a specific blood test to identify chronic alcoholism. These substances, known as amino acids, are normally found in the blood of every person. However, in the person who is abusing alcohol, the ratio of alpha amino-n-butyric acid to leucine is very high. This finding has the potential for developing into an objective laboratory test for identifying the alcohol abuser.

Another finding of great significance was the discovery that alcohol has a direct toxic effect on the liver, which leads to the alcohol-related liver, alcoholic hepatitis, and cirrhosis. These conditions were induced in animals despite the fact that they were maintained on a well balanced, nutritious diet. This means that persons consuming large amounts of alcohol still run the risk of liver injury even if they eat well and are well nourished.

For the near future, we will emphasize three areas of research: one, The central nervous system; two, nutrition and the gastrointestinal tract; and three, the endocrine system.

In the Central Nervous System, little is known about the mechanism underlying alcohol intoxication. Studies are needed to determine alcohol effects on brain cell membranes and its neurochemistry. More information is needed on the pharmacokinetics of alcohol and there is the need to develop pharmacological agents which abort or mitigate alcohol intoxication.

In the nutrition and gastrointestinal tract area, investigations need to be done on alcohol induced damage to the lining of the stomach and the intestinal tract, as well as the mechanism underlying malabsorption of vitamins and other nutrients resulting from chronic and excessive use of alcohol.

In the endocrine system area, investigations have shown alcohol ingestion has a profound effect on the hormonal control of water and mineral balance. The manner in which alcohol may affect the production and release of hormones is not well understood. The NIAAA supports only one or two studies on the effects of alcohol on the endocrine system. This is an entirely insufficient commitment to an area of investigation of such potential importance. In view of the great technical and scientific advances made in the past 20 years in endocrine research, it is expected that the NIAAA will gradually increase its support base for endorine-alcohol research. This area of research appears to be one of the most promising and in need of expansion in financial support.

MANPOWER STUDY

Mr. NATCHER. When you testified last year Dr. Noble, you told us that you were planning to initiate a study of manpower needs in the field of alcoholism. What is the status of this study?

ANSWER. This contract was awarded in late May 1976. A final report for phase I is expected late next month. This contract will essentially provide a basis for planning our manpower effort through development of needs estimates, and will provide data on one State (North Carolina) as a pilot test. The contract will attempt to address such issues as geographical distribution of service personnel and the large number of such part-time alcoholism workers as physicians in private practice who treat alcoholic patients, without necessarily diagnosing them as alcoholics. We have schedu'ed a meeting with the contractor in order to determine the feasibility of using the knowledge and data acquired thus far as a basis for developing an information and prediction system than can be applied nationwide.

Mr. NATCHER. How will this study tie in with the manpower studies to be conducted by the health systems agencies and the manpower studies required by the Health Manpower Act?

ANSWER. If the results of our study prove useful, we will be communicating them to the Health Reservices Administration—which administers aspects of both the health planning and health manpower programs—and, through State alcohol agencies, to State and local health planning bodies. In the meantime, we have been working with our sister institutes within ADAMHA and with HRA to incorporate some consideration for high alcoholism prevalence in the definition of health manpower shortage areas.

OCCUPATIONAL ALCOHOL PROGRAMS

Mr. NATCHER. Another area that the committee is interested in doctor, is the occupational alcoholism programs. How many of these do we have in operation in this country?

ANSWER. An informal survey in 1974 by NIAAA indicated that about 300 had been initiated in the previous year as a result of the stimulus of NIAAA funds. In total there are approximately 1,000 programs in operation ranging from large employers covering thousands of employees to small employees with just a few employees.

Mr. NATCHER. How much money do you have in this budget to encourage additional occupational alcoholism programs?

ANSWER. None; the 1978 budget request only provided for continuation costs of treatment projects of which $4.1 million is for occupational alcoholism programs.

Mr. NATCHER. Is industry picking up more of the cost of these occupational programs?

ANSWER. Industry is increasingly initiating alcoholism programs under the stimulus of Federal, State, labor, industrial, and voluntary organizations. Federal funds in the occupational area do not pay for treatment. Rather, they fund the organizing of occupational programs.

Mr. NATCHER. Well, do you see some point in time when it will no longer be necessary for you to invest Federal dollars in this area?

ANSWER. For at least the next 10 years we see a continuing need to further stimulate occupational groups and industries not yet covered. Efforts to date have focused on the largest employers. Tens of thousands of small employers and specific professional groups have yet to be reached.

FORMULA GRANTS

Mr. NATCHER. Doctor, the alcoholism formula grant money is distributed to States on a formula which is supposed to take into consideration—among other things—the need for more effective alcoholism programs. How do you assess the need for more effective alcoholism programs in the various States?

ANSWER. Public Law 94-371 requires that NIAAA use some measure of incidence and prevalence of alcohol abuse within the States in determining State need for more effective prevention, treatment, and rehabilitation of alcohol abuse and alcoholism.

As you know, there are many techniques for estimating rates of alcohol abuse and alcoholism—among them, extrapolations based on per capita sales of distilled spirits, deaths from cirrhosis of the liver, arrests for driving under the influence of alcohol, and utilization of treatment facilities. While some of these indicators have been used to estimate the extent of alcohol abuse and alcoholism in the United States population on a national basis, none is appropriate for comparing the extent of alcohol abuse and alcoholism from one State to another—largely because definitions and reporting practices vary greatly from one jurisdiction to another. Furthermore, State alcohol agencies have expressed reluctance to have allotments based on such indicators.

Therefore, NIAAA has proposed using a "synthetic" estimate of need in each State. These estimates would be based on multivariate statistical analysis of survey data on problem drinking applied to demographic characteristics associated with alcohol abuse.

While this approach does not yield a direct measure of incidence and prevalence within the States, it should be highly correlated with incidence and prevalence.

Moreover, even if the results underestimate the absolute level of alcohol abuse, the degree of underestimation should be reasonably constant from State to State, because the estimate is based on data defined and collected uniformly in all the States, and should not distort the relative need of States for more effective prevention, treatment, and rehabilitation of alcohol abuse and alcoholism.

In order that the "need" factor in the allotment formula may continually reflect the most current data and state of the art, NIAAA plans to periodically review and, as appropriate, revise the demographic characteristics, definitions of "problem drinking," and sample surveys it uses in carrying out the proposed methodology.

COST PER PATIENT

Mr. NATCHER. In your budget justification you state that the cost of clients served per month in alcoholism treatment centers is declining. What does it cost to treat a patient at these centers?

ANSWER. The Federal costs of client treatment have declined in the alcoholism treatment centers from an average of $303 per client per month in 1973 to $170 in 1976. This reduction is related to the change in emphasis from inpatient to outpatient care, earlier intervention on the part of treatment projects, and revisions in staffing patterns.

ALCOHOLISM PREVENTION ACTIVITIES

Mr. NATCHER. How much will you spend for alcoholism prevention activities in 1977 and 1978?

ANSWER. For all prevention related activities, an estimated $7,779,000 in 1977 and $5,608,000 in 1978. The following table breaks these figures down into more detail:

[In thousands of dollars]

	1977	1978
Prevention grants	[1] 2,283	[1] 112
National Clearinghouse for Alcohol Information	2,000	2,000
Formula grants	8,880	[2] 8,880
Total	13,163	10,992

[1] Estimated obligations.
[2] Estimated amount represents 16 percent of formula grants of which 6.3 percent is for prevention activities ($3,496) and 9.8 percent for intervention activities ($5,384).

Mr. NATCHER. What kind of prevention activities will you support and how much emphasis will you give to teenage drinking problems?

ANSWER. The Institute is continuing to fund a limited number of quality controlled demonstration projects. During 1977, 19 grants will be funded, 11 of which were for programs for youth. Four of the most promising efforts aimed at youth are as follows: (1) A teacher training and curriculum development program; (2) A community organization approach to impacting the school environment; (3) A comprehensive university model which combines both individual and environmental strategies; and (4) A peer leadership program which approaches alcohol use in relation to life goals.

In addition to programs for youth in 1977, we are continuing the State prevention coordinator program which supplies a staff position in 48 States to develop and enhance alcohol abuse prevention capability at the state level.

Also national public awareness campaigns and public education programs are being carried out by the National Clearinghouse for Alcohol Information. The Clearinghouse has disseminated publications, periodicals, directories, and information packages for a number of different audiences and responds monthly to an average of individual requests for factual information on alcohol and alcohol abuse. One particular outreach effort, the University 50 plus 12 project, centers on stimulating prevention activities among 63 pilot universities.

No appreciable increase in funding is in 1978 because that budget is based on funding of continuation costs. In 1978, the Clearinghouse will continue to provide targeted information packages to appropriate audiences and to motivate exist-

ing organizations and agencies throughout the country to devote a portion of their efforts to combating alcoholism problems. This outreach program includes an alcohol awareness project on college campuses, collaborative efforts with national youth organizations, minority organizations, and women's groups.

In addition, NIAAA is now proposing a plan for a national teenage alcohol education program. This plan, developed in response to a request from the Senate Subcommittee on Appropriations for Labor and Health, Education, and Welfare will require a long-term commitment from may segments of our society to affect the problem of alcohol abuse among young people in any significant way.

Mr. NATCHER. Are you working closely with the school systems in developing alcoholism prevention programs?

ANSWER. With regard to the school systems, the NIAAA has seen as its role the development and testing of prevention strategies which are specific to the area of alcohol abuse among youth. A limited number of youth demonstration projects have been funded, among which are a teacher training and K–12 curriculum development model; and a university model which combines individual and environmental strategies. As the effectiveness of these strategies are analyzed, replicated and further field tested, dissemination of such modalities will be coordinated with the Office of Education which maintains a network with all of the State and local departments of education throughout the country.

Also, through the National Clearinghouse for Alcohol Information, a university project was started to encourage the university community to focus on the issue of alcohol use and abuse and to stimulate efforts on campus. Sixty-three universities, in each state and 13 private and/or minority schools were visited. Two important stages of this program included: (1) National University Seminar held at Notre Dame brought together the 63 schools to plan prevention activities; (2) publication of the *Whole College Catalog* containing information on setting up prevention programs on campuses and ideas on what some schools have already done.

SERVICES INTEGRATION

Mr. NATCHER. Doctor, have you been able to integrate mental health services, drug abuse services, and alcoholism services at the community level?

ANSWER. Under the new community mental health centers legislation centers are now required to provide drug and alcohol abuse services unless the Secretary determines that there is not sufficient need, or that the need is currently being met. This provision has enabled the Agency to actively promote the most beneficial integration of these services at the community level. Due to local circumstances this may not always mean a common organizational structure or location but it does mean a close working relationship. In addition, our State program development effort and other technical assistance initiatives provide us with the opportunities to work with States in helping them promote better coordination of alcoholism, drug abuse, and mental health services at the State and local levels. Currently, 236 centers or their affiliates are providing drug abuse services while 297 are providing alcoholism services.

Mr. NATCHER. What efforts do you plan to make in 1978 to achieve greater integration of those three services at the local level?

ANSWER. We are planning to support a study of the feasibility of developing a methodology and criteria for measuring the effectiveness of publicly funded organizational models at State and local levels for delivering alcohol, drug abuse, and mental health services. Several States have made formal requests to ADAMHA for assistance with respect to the development of combined plans and programs in the areas of alcohol, drug abuse, and mental health. A number of officials of programs at State and local levels have expressed interest in coordinated services delivery.

In addition to strengthening ADAMHA's knowledge concerning the effectiveness of several different organizational models for delivering services, the results of the study will enable the Agency to be more responsive to State and local program officials in this subject area. The results of it should also be of use to local service providers in the planning and delivery of services. In addition, we anticipate issuing guidelines during ths year enablng States to facilitate the submission of a combined State plan for alcoholism, drug abuse, and mental health services. This would encourage the coordination of program development activities at the State level and simplify reporting requirements.

MR. CONTE

APPROVAL OF CMHC APPLICATIONS

Mr. CONTE. If we could get back to community mental health centers for a moment, how many approved unfunded applications do you have pending at the moment for new community mental health centers? How much money would it take to fund all of them?

ANSWER. As of March 17, 1977, there were 36 approvable unpaid initial operations grants totalling $30,968,303.

Mr. CONTE. When do your Councils meet to consider additional applications for CMHC's?

ANSWER. Meetings of the National Advisory Mental Health Council for review of applications are held three times a year. These meetings are currently scheduled for January, May, and September.

Mr. CONTE. Could you see that my office receives notification on a continuing basis after each Council, of the number and dollar value of approved unfunded CMHC applications?

ANSWER. We will arrange to notify your office on a continuing basis after each Council meeting with respect to the number and dollar value of applications recommended for approval by the National Advisory Mental Health Council, and the current number and dollar value of approved unfunded CMHC applications.

CMHC CONVERSION

Mr. CONTE. Would you explain the process of conversion to the new centers' multiservice program? What are the new services, of which I believe there are 12, authorized under the most recent CMHC legislation?

ANSWER. A center must provide all of the services which are required in the CMHC amendments. The existing CMHC's were given 2 grant years in which to increase the services that they are providing to include the 12 comprehensive services listed in the law. The conversion grant mechanism was developed to provide for special Federal assistance to offset any remaining deficit, after all income from other sources is taken into account, due to the addition of these new services. This support is limited to two such grants per center.

The original five required services were: Inpatient services, outpatient services, emergency services, partial hospitalization and day care services, and consultation and education services. The newly mandated services are: Specialized services to children, specialized services to elderly, screening services to courts and other public agencies, followup services, and transitional halfway house services. Services for alcoholism and alcohol abuse, and services for drug addiction and drug abuse are required unless the Secretary determines that no need exists or that the need is already being met.

COMMUNITY-BASED TREATMENT

Mr. CONTE. There have been claims that community-based mental health treatment is not actually treatment at all, but simply management technique. Would you want to comment on that, and particularly on the therapeutic value of community-based mental health treatment?

ANSWER. The aim of community-based treatment is to insure that a wide range of appropriate mental health services are readily accessible and tailored to a person's needs. Certainly, effective management is necessary to insure coordination between community agencies and the ready availability of treatment. However, community mental health care extends beyond management technique. Community-based mental health care, for example, has promoted the utilization of such services as partial hospitalization, emergency care, consultation and education and other services not otherwise readily available. In addition, high quality clinical inpatient and outpatient services are expected to be the core of any center program. By promoting access, by providing early intervention, by introducing new services and by developing comprehensive programs, community mental health has enhanced the therapeutic impact of mental health treatment.

MENTAL HEALTH RESEARCH REQUEST

Mr. CONTE. Between 1969 and 1975, funds for the research programs of the National Institutes of Health increased by more than 34 percent in terms of actual buying power while comparable support for mental health research declined by nearly 31 percent. Last year I offered a successful amendment for mental health research, and we turned this trend around—or at least the continual decrease in mental health research support. How much are you requesting for mental health research this year?

ANSWER. A total of $106,908,000 is requested in the current budget proposal for research. This level is the same as the 1977 appropriated level.

Mr. CONTE. Could you break that down into the amounts for research requested by NIMH, by the Department, and then finally provided by OMB?

ANSWER. The NIMH requested a total of $122,597,000 for research, including an additional $10,000,000 to cover the continuation costs of the 1977 Conte amendment, the Department requested a total of $109,200,000 or a decrease of $13,397,000, and the OMB requested a total of $106,908,000 or a decrease of $15,689,000 below the NIMH request.

MENTAL HEALTH RESEARCH PRIORITIES

Mr. CONTE. What do you believe should be the major priorities and focal points of mental health research in the next several years?

ANSWER. There are a number of research areas in which it is absolutely essential that we move ahead as rapidly as possible. First, research on the major mental illnesses—schizopherenia and depression—must have first priority because of the toll they take in human suffering and in economic terms and because we have gotten to a point in our research where we can expect to make real progress through additional effort. We want to address this area in several ways. We want to increase our regular research grant program and our program of collaborative research. In work on schizophrenia, we want to concentrate on studies of high-risk children and on cross-cultural research on the family role and its impact on the development of schizophrenia. On depression, we want to undertake a major collaborative study of its genetic and psychosocial components, to look more intensely at several diagnostic issues, and to support a major collaborative study to evaluate the benefits of lithium and the tricyclic antidepressants in combination. We feel it is important to expand the clinical research centers program that we are starting with fiscal year 1977 funds because these centers not only offer a base for major research in this area, but also are important resources for training clinical researchers. We also want to start a major new treatment assessment research program to look at what kinds of treatment, with which specific groups of patients, are most effective. In our intramural programs, too, we want to increase our clinical work. The major effort we want to start is a new clinical research laboratory on psychoses in old age.

Underlying all of our clinical research is work on basic biological and developmental processes. This research base has resuffered over the past decade as inflation has eaten away at our resources. It is essential that we rebuild this part of our basic research program.

There are special populations on which we must do more research. In addition, to the clinical research on psychoses incident to old age, we must do more work on how to deliver better mental health services to the elderly. We need a whole range of increased research on children. One area where we are making a significant contribution is in work on early adolescence—ages 10 to 15—a critical period in development. With the participation of minority researchers, we are marking out those areas of greatest need regarding the mental health of minorities.

IMPACT OF BUDGET REQUEST ON RESEARCH

Mr. CONTE. Which of these important areas will suffer the most from lack of support under the budget which you are proposing?

ANSWER. All of these areas will suffer because of the costs of inflation. New programs proposed in the forward plan cannot be launched. For example, the proposed intramural laboratory on psychoses incident to old age couldn't be started at all without both additional funds and positions. The laboratory would

be for clinical research and would require not only new scientific personnel and their support staff, but patient care personnel.

Similarly, the treatment assessment program is a new effort which would suffer from lack of support.

The clinical centers program would have to be held at the two or three centers we will be able to start from our fiscal year 1977 funds.

POLICY ON DECRIMINALIZATION OF MARIHUANA

Mr. CONTE. Dr. DuPont, I know you have recently been on the Hill testifying on behalf of revisions in certain drug law revisions. What is the administration's policy on the decriminalization of marihuana?

ANSWER. As mentioned before, the administration's policy is to discourage the abuse of all drugs, including alcohol and tobacco. However, it is believed that the mechanism for discouragement should not be more damaging to the individual than the drugs themselves. Criminal penalties that brand otherwise law-abiding people for life are neither an effective nor an appropriate deterrent. It is the position of the the administration that individual States should determine whether they wish to decriminalize their laws for the possession of small amounts of marihuana for personal use and that the Federal Government should not seek in any way to influence that decision. However, it is believed that to maintain the option entirely in the hands of the State, the Federal law which is now rarely enforced with regard to simple possession should be decriminalized along the lines suggested in the bill recently submitted to the Congress.

SERVICES FINANCING

Mr. CONTE. There has been a lot of discussion in recent years to increase third-party funding for the programs which come under the ADAMHA umbrella. To what extent have ADAMHA and its three Institutes assisted treatment programs to qualify and obtain dollar support for services from third-party sources?

ANSWER. ADAMHA and its Institutes have a variety of efforts underway to help alcohol, drug abuse, and mental health programs maximize third-party payments. Since the financing of alcohol, drug abuse, and mental health services through third-party mechanisms has generally lagged behind efforts in physical health, the ADAMHA efforts include the development of treatment standards and the expansion of coverage for treatment of alcoholism, drug abuse, and mental illness in public and private insurance plans. What follows are some examples of Institute efforts in this important area.

Each Institute has contracted with the Joint Commission on Accreditation of Hospitals to develop accreditation standards for alcoholism, drug abuse treatment programs, and community mental health centers.

NIDA and NIAAA have developed a model health insurance benefit plan for the treatment of alcoholism and drug abuse to serve as a guide for the development of appropriate insurance coverage for drug abuse and alcoholism treatment. Preliminary results from a test of the alcoholism benefit package in California indicate that the annual cost for this insurance benefit was $2.05 per subscriber. In addition, the NIAAA is working with Blue Cross Association to assess the feasibility of installing a broadened alcoholism benefit in the Blue Cross plans throughout the country. The NIAAA has developed a health insurance resource kit which includes studies of cost effectiveness, a model benefit package and insurance carrier experience.

Lastly, the NIMH has developed a comprehensive set of information on the financing, utilization and quality of mental health care in the United States. This is an important resource book for policy discussion about the nature and extent of mental health benefits under any health insurance plan.

Mr. CONTE. Have you assisted treatment programs to develop reimbursement procedures and to identify specific additional financing mechanisms for a full range of needed services? What have you done to assist them with useful accounting procedures? How extensive are your efforts in this area? Isn't this crucial in attempting to minimize health care costs to the Federal Government?

ANSWER. Each Institute supports a range of technical assistance activities which are designed to assist treatment programs to develop high quality cost effective services. These include conferences, training courses, seminars and

other efforts in this high priority area. The NIMH has a program of intensive technical assistance to enable CMHC's to develop their general management capability particularly in cost accounting systems, rate setting and billing systems. The staff college of the NIMH has conducted several seminars on management issues and additional seminars on fiscal management and management information systems are planned.

The National Institute on Drug Abuse has developed and is distributing to States and treatment programs a "Report Series." This publication provides valuable information on third-party payers and pertinent experience with third-party payment for drug abuse services. The Institute has developed a training course for treatment programs entitled "Introduction to Third-Party Payments." In addition, NIDA has supported a demonstration program to establish a health services funding office in six States. We expect this project to provide useful information about the development and utilization of third-party payments.

The National Institute on Alcohol Abuse and Alcoholism efforts include support for a variety of on-site technical assistance efforts to improve the operating effectiveness of community alcoholism projects and a recently concluded series of regional seminars designed to help alcoholism projects increase their general management capability.

UNIFORM ALCOHOLISM ACT

Mr. CONTE. We in the Congress have consistently supported the NIAAA's efforts to have States adopt the Uniform Alcoholism Act. It is a good investment. But there is a difference between the adoption of legislation and its successful implementation in local programs. What has NIAAA done to assist State and local alcoholism programs to realize the emphasis of this legislation on the quality of care and rights of citizens?

ANSWER. NIAAA staff has provided consultation to States prior to and after adoption of the Uniform Act to assist in planning and implementing effective programs at State and local levels. The Institute continuously seeks out State needs in relation to uniform legislation and responds as appropriate. For example, one of the greatest needs in implementing the Act was training law enforcement personnel to assume their new role in relation to individuals found intoxicated in public places. To assist the States in this area, NIAAA contracted with the National Association of Chiefs of Police to develop a training manual and instructors guide. These are now being given wide distribution.

Mr. CONTE. Much of the emphasis as far as publicity is concerned in this area has been on the decriminalization of public drunkenness. What is the NIAAA doing to help in the crucial follow through activities needed to make the goals of the uniform act a reality?

ANSWER. There is a strong emphasis in the Uniform Act on the development of a continuum of coordinated treatment services. One method utilized by NIAAA to insure such a continuum is through the Special Grants for Implementation of the Uniform Alcoholism and Intoxication Treatment Act. No funds are made available until decriminalization is in effect and no proposed use of grant funds is allowed unless it will contribute to such a continuum. Also, through review of State plans and progress reports and in meetings with State alcoholism program directors, the service network is monitored and assistance provided to those States in need. State directors are assisted in identifying and utilizing all currently available resources. The hospital non-discrimination section in our legislation has opened many emergency room doors to the alcoholic person.

Mr. CONTE. Could you report on the implementation of the Uniform Act in Massachusetts?

ANSWER. Massachusetts passed the Uniform Act in 1971. It took full effect in July, 1973. In the interim, the State agency conducted a comprehensive survey of needs and developed a plan for implementation. One goal established was the provision of 500 new beds for detoxification. That goal has been accomplished. Prior to the effective date of the act, extensive training was provided for law enforcement personnel. Committed to a continuum of care, the State increased the alcoholism budget from $3 million in fiscal year 1973 to $6.8 million in fiscal year 1975. Their Federal award for this program will be about $431,000 in 1978.

PROFESSIONAL JUDGMENT BUDGET FOR ALCOHOLISM

Mr. CONTE. Dr. Noble, alcoholism is one of the very top health problems in this country. In your professional judgment, is the 1978 budget which you are proposing commensurate with the need for Federal support of alcoholism programs? What was the amount of NIAAA's initial budget request? How much was it reduced at the departmental and OMB levels?

ANSWER. The NIAAA originally requested $255.9 million for 1978; the Department allowance totaled $164.7 million, and the OMB allowance of $154.1 million is reflected in the budget request before you.

RESEARCH CENTERS

Mr. CONTE. It appears that there are no funds requested for the national alcohol research centers? Is that the case? Could you explain that? Where was that decision made?

ANSWER. No funds are included for national research centers in the 1978 budget. The original request for these centers was $6 million, the amount authorized in our program legislation, and subsequently was reduced to $3 million under the Department allowance, and taken out completely in the President's budget request. While the institute was given the discretion to program within its overall research budget allowance, to include research centers within a limited budget would have essentially eliminated all new regular grants.

FORMULA GRANTS

Mr. CONTE. There also don't appear to be any funds provided for the hold-harmless application of the new formula for the State alcoholism grant program. Why not?

ANSWER. An allowance of $55.5 million for formula grants was established as the 1978 budget ceiling prior to the enactment of the new alcoholism legislation requiring a redistribution of State formula funds. It was not until the new distribution formula was mandated that the need emerged for a "hold-harmless" provision. Unfortunately, no funds were subsequently added to cover the hold-harmless provision.

NIAAA ADDITIONAL FUNDING

Mr. CONTE. I understand that Secretary Califano had requested a $10 million increase for the NIAAA to be directed largely toward women and youth alcoholism programs. This appears to have been eliminated by OMB as well. Is this true? How much will the NIAAA be spending on women and youth alcoholism programs? Isn't this one of the priority areas—or shouldn't it be?

ANSWER. Although no additional funding was included in the 1978 President's budget request for new programs serving women and youth, the Secretary has expressed his concern for needed expansion in these two critical areas. In 1978, the Institute will continue support for 21 programs serving women and youth.

INSTITUTE AUTONOMY

Mr. CONTE. What are some of the procedures which have been taken and implemented by ADAMHA to assure the autonomy and integrity of each of its Institutes?

ANSWER. Title II of Public Law 93-282 in defining the role of the Institute within the Alcohol, Drug Abuse, and Mental Health Administration states that the Institutes carry out "* * * the administrative and financial management, policy development and planning, evaluation, and public information functions required for the implementation of such programs and authorities." Consistent with the intent of this law, the Office of the Administrator's functions are that of a coordinator of the Institute's programs. The agency has implemented this legislation through its delegations of authorities. All programmatic delegations of authorities which the agency has received from the Secretary have been

redelegated to the Institutes. Most administrative authorities have likewise been redelegated. The only authorities retained by the agency are those administrative authorities which cannot be redelegated or are required to effectively coordinate agency operations.

Several other examples highlight the autonomy of the Institutes. Perhaps the most obvious symbol of Institute autonomy within ADAMHA is the budget before you which clearly delineates the amount requested for each of the Institutes and their programs. This budget was developed through a planning-budgeting process which recognized the unique aspect of each of the Institutes.

Each of the Institutes maintain a separate clearinghouse. Through these vehicles each of the Institutes can focus their public information programs on the specific needs of their clientele.

Each of the Institutes maintain their own National Advisory Council and Initial Review groups which review grants and judge the scientific merit of their proposals.

ADAMHA's role in the implementation of alcoholism, drug abuse, and mental health programs has been primarily that of coordinating activities, ensuring that the Institutes receive appropriate and equitable support, and providing guidance and assistance to the Institutes in their activities.

GOVERNMENT PARTNERSHIPS

Mr. CONTE. What are the program ties of each Institute to State and local governments in realizing effective services at the community level? To what extent are these policy units at State, county, and city levels working in partnership with the Federal Govrnent on these health problems?

MENTAL HEALTH

ANSWER. The State plans for comprehensive mental health services provide a basis for dialogue between the Federal and State governments. They are a precondition to receipt of project grant funds under the Community Mental Health Centers Act and formula grant funds under section 314(d) of the Public Health Service Act. As such, they provide an articulation of State policies and practices in the development and delivery of mental health services. State government is perceived not only as a provider of many direct services, but also as a system coordinator responsible for assuring quality and enhancing access. The annual review of the State Plans provides an opportunity for the States and the Federal Government to assess progress in the provision of effective community services and in the attainment of both national and local goals.

There are numerous formal mechanisms by which the States and communities provide information to the NIMH. The annual meeting of the State and Territorial Alcoholism, Drug Abuse, and Mental Health Authorities permits an extended discussion of key policy issues and problem areas. Continuing liaison is maintained with the Association of State Mental Health Program Directors, the National Council of Community Mental Health Centers, and the National Mental Health Association. Representatives of State and local mental health programs continually serve on various work groups and task forces dealing with specific issues of mutual concern. Examples of this are the NIMH Manpower Task Force and the ADAMHA Combined State Plans Work Group.

The major service delivery thrust of NIMH over the past decade has been in the development of community mental health centers. Applicants may be nonprofit corporations or units of either State or local government. The NIMH role includes the review of proposals, the provision of partial funding on a declining basis, periodic examination of program effectiveness, and technical assistance in such areas as evaluation, financing and data systems. State and local government participation is involved in all of these activities with participation ranging from advice input to full partnership collaboration.

DRUG ABUSE

The National Institute on Drug Abuse is tied to the state and local governments through its drug treatment services grants, the State formula grants, and especially the statewide service contracts. Through this program States subcontract with local jurisdictions to promote greater State and local involvement in NIDA treatment efforts.

The Institute provides formula grant funds to the single State agencies for the development and implementation of State plans for the provision of drug services throughout the state. A prime responsibility of the Institute has been to enter into a partnership with State and local programs to insure that these formula grant funds are spent effectively and efficiently.

In terms of substate planning, in the proposed regulations for section 409, published on January 14, 1977, there is included in subsection 54(b).111 a subsection (e) on substrate planning. This was included at the urging of the National League of Cities, U.S. Conference of Mayors, and with the full concurrence of NIDA. This subsection requires that the (State plans) survey of need and resource allocation plans must include information relating to the needs and current and projected resources of sub-state regional, county, and other local areas. To insure such inclusion, the State plan must incorporate by reference procedures under which the State agency will, as part of the State planning process: (1) solicit such information from elected officials of local units of government (e.g., county and metropolitan) and organizations and individuals engaged in the provision of direct or ancillary drug abuse prevention, treatment, and rehabilitation services; and (2) take such information into account in the preparation of the survey of need and resource allocation plans, particularly with respect to the planning of programs to meet the need for services in the respective sub-state regional, county, and other local areas.

ALCOHOLISM

NIAAA maintains a close working relationship with the State alcoholism authorities to plan jointly to meet the needs of alcoholic persons throughout the country. Several NIAAA/State authority task forces have been established to coordinate Institute and State activities. One such task force is working on training strategies to assure that NIAAA training efforts are directed towards training needs in the States which will result in more effective community programs. NIAAA also works with the National Association of Counties and the U.S. Conference of Mayors/League of Cities to promote effective services at county and city levels.

ADVISORY COUNCIL MEMBERSHIP

Mr. CONTE. Are there members on the Institutes' advisory councils from county, State, and local governments? Elected officials? If not, why not?

ANSWER. There are no members with the affiliations specified on the National Advisory Council on Mental Health. The lack of such membership is coincidental, and such individuals would be considered.

The National Advisory Council on Drug Abuse, a 12-member council, includes two members, who at the time of their appointment in November 1976, were local government officials. Mrs. Lenore Lambert was a county commissioner of Yakima, Wash., until her defeat at the polls in the fall of 1976. Council member Carlow Velarde currently serves as a superior court judge in Los Angeles. Both of these persons were appointed to the council because of their qualifications. The other council members not only possess expertise in particular aspects of the drug abuse field, but are also active participants in the affairs of their local communities.

Of the 12 members on NIAAA's Advisory Council four members are State or local elected officials or have been extensively involved with State and local governments. The four members are: Dr. June Jackson Christmas from New York City; Mr. Loran Archer, former director of the California State Agency on Alcoholism; Mrs. Katherine Pike from San Marino, California; and Rev. Philip Hansen from Minnesota.

ALCOHOLISM RESEARCH TRAINING

Mr. CONTE. Why is the NIAAA proposing to phase out research training grants and predoctoral fellowships? What will be the impact of such a phaseout on your continued ability to find qualified researchers and professionals in the alcoholism field?

ANSWER. The phaseout of research training grants and predoctoral fellowships supports the administration's policy of greater emphasis on postdoctoral fellowships. Since postdoctorals are at a point in their education development where

career decisions are made, it is felt that this approach will in fact insure an optimum opportunity for highly qualified researchers to establish their work in alcohol research.

Mr. CONTE. How do you explain your proposed 82-slot reduction from alcoholism community programs?

ANSWER. The reduction of 82 grants for community assistance programs is the net result of projects ending federally committed support offset by 10 new awards to assist States in implementing the Uniform Act. Thirty-nine treatment projects will have finished their sixth year of support—the last under the Institute's funding policy, 34 Indiana alcoholism projects will have received 6 years of support by NIAAA and are proposed for transfer and are included in the fiscal year 1978 budget request of the Indian Health Service. One staffing grant will have reached its last year of funding and 18 prevention projects will be ending.

PROGRAM BENEFICIARIES

Mr. CONTE. You are proposing to decrease the number of alcoholism program beneficiaries next year. How can you really justify such a reduction, when alcoholism rates continue to increase?

ANSWER. The reduction in the number of beneficiaries being served is directly related to the reduction in the grants. Within the 1978 level of funding there is a reduction of 74 grants for treatment. This reduction is primarily the net effect of projects finishing their sixth year of support—the last under the Institution's funding policy. However, I hope that these projects will have demonstrated their importance so that the State and local governments will support them after the sixth year. Furthermore, 34 will be transferred to the Indian Health Service for future funding. In this sense the number of beneficiaries being served will at least be maintained.

Mr. CONTE. With no effective increase in NIAAA funding, how do you expect to meet increased responsibilities in the provision of services to women, youth, minorities, migrant workers, and so forth?

ANSWER. The 1978 budget request provides sufficient funding for existing grants only. There is no provision for expansion in this budget for services except $4.1 million for new awards to States which have passed the Uniform Act. The NIAAA will attempt to influence the States and localities to direct larger amounts to these important priority areas but our direct impact will be necessarily limited.

Mr. CONTE. I'm very concerned about the fact that funding for community alcoholism programs has remained practically constant for the past two years, while costs have increased dramatically. When you factor in such inflation costs, aren't you really requesting a significant program level decrease from last year? What level of funding would be required to maintain these programs at a realistic constant level of support?

ANSWER. Given a relative level budget, the impact of inflation naturally would decrease the program level. It is difficult to estimate the exact inflationary impact upon our community alcohol programs over the past 2 years. However, a 10 to 15-percent increase would be our best guess as to the amount needed to maintain a constant program level.

A particularly pertinent example is the NIMH's services research and development program, organized in the context of the Division of Mental Health Services. Topically, this program focuses on special services for families and children, financing and standards, new services for the aged, services for minority people, new methods for healing chronically mentally ill persons, services for rural mental health, methods of evaluation for mental health programs, improved procedures in clinical facilities, and alliance of mental health services with health, educational, and social services.

Beyond content the process implemented is of central importance. It entails a four-phase procedure involving (a) learning from providers of services across the Nation the most critical problems they face and their greatest needs for knowledge, (b) retrieval and synthesis of existing knowledge not already fully utilized, (c) support of research to develop missing knowledge, and (d) development and implementation of more effective methods of disseminating the needed knowledges and improving its utilization. The latter phase is of particular importance and beyond individual project diffusion and utilizaton, the Institute supports a number of intensive approaches toward increasing the impact of the

R. & D. program on services improvement. For instance, source books on new treatment and delivery techniques are sent to all CMHC's and hospitals. These contain comprehensive outlines, together with sources of further help for agencies wishing to adopt new techniques. Further, CMHC's and hospitals are invited to submit requests for technical assistance on problem areas. Volunteer consultants who themselves are members of CMHC and hospital staffs are provided intensive information on new research findings and are trained in consultation on organizational adoption of new findings. They, then serve the requests for assistance. Summaries of NIMH reseach findings appropriate for immediate use in service programs are published and distributed widely to service providers. Evaluation of that program has indicated that it has led to widespread increase in the use of new knowledge.

MR. ROYBAL

TEENAGE ALCOHOL ABUSE

Mr. ROYBAL. You indicated that alcohol consumption and abuse is increasing among younger people and high school students. What specific programs have you devised to counteract this trend?

ANSWER. In response to the Senate's directive in the fiscal year 1977 appropriation report language, NIAAA has developed a plan for a comprehensive public education and dissemination program for a national campaign in the country's schools and social organizations to counteract the increasing use of alcohol consumption and abuse among younger people. A report to the Senate has been forwarded.

The goal sought in this program, entitled the "National Teenage Alcohol Education Program," is to reduce the destructive use of alcohol among the Nation's youth through the development and implementation of a comprehensive alcohol and alcoholism education program. To accomplish this goal, the Institute is proposing in the report the initiation of a 3-year program and has developed budgets which will be submitted with the report. No funds are available within the Institute's current budget to carry out this program, and these cost and resource estimates are included at the request of the subcommittee.

It is obvious that the above goal will not be easy to reach but we believe it is achievable. It can be measured by a decrease in alcohol related problems. A long-term commitment will be necessary to achieve this goal. Additionally, time will be needed to assess the effectiveness of program activities as young persons reach an age where drinking is likely to occur and then go on to assume their adult drinking patterns.

LICIT DRUG ABUSE

Mr. ROYBAL. Have you developed any method of impressing on people that the overuse of even licit, doctor-prescribed drugs can be as harmful as the overused illegal drugs?

ANSWER. Information regarding the harmful effects of the overuse of licit drugs—such as, barbiturates, amphetamines, and opiates—is widely disseminated through the general and technical publications of our National Clearinghouse for Drug Abuse Information.

In its efforts to deal with licit drug abuse, NIDA has developed statistical techniques for predicting the amount of licit schedule II substances that will be needed to meet the needs of the community. These data are turned over to FDA and DEA to set quotas for the amount of these substances to be produced. NIDA continuously monitors these projections in order to insure that the quotas are set in terms of need, thereby reducing the possibility of overproduction. The recent Nelson hearings on amphetamines in November 1976 cited much data provided by NIDA that may soon yield even more rigid controls on the legitimate use of amphetamines.

INCIDENCE OF MENTAL ILLNESS

Mr. ROYBAL. You cite statistics which indicate that millions of people will suffer from mental depression and other forms of mental illness. Are these percentages increasing from generation to generation? If so, to what do you attribute the cause?

ANSWER. Overall rates of treated cases of mental illness have risen in recent years (1946-73), although proportionately more outpatient and less inpatient care is given. Time trend data on differential diagnosis and age groups for total treatment facilities are not available, but can be estimated from data on admissions to State and county mental hospitals. Admissions for alcohol disorders have risen (from 1969 to 1973) for both sexes and all ages; admission for drug disorders have risen for both sexes and for all ages under 45. Total admissions for schizophrenia and the depressive disorders have decreased, but they have increased for ages 18–34. Survey data collected in the early 1970's also found high levels of depressive symptomatology in the younger ages (18–30), which was not the case in surveys before 1968. Increased rates of suicide and attempted suicide in the young (under 30) may also be taken an evidence of increased depression, or simply interpreted as mental health problems in themselves. Increases over time, and age differences in factors known to be associted with mental illness (for example, unemployment, poverty-level income, being a single parent) might also be used to predict increases or age differences in mental illness.

These data would suggest that recent generations are suffering from higher rates of mental illness, particularly depression. However, other interpretations are possible. A long-term longitudinal study of age cohorts that is, several groups of individuals of similar age for each group, would be necessary to separate the age from the cohort effect.

If indeed the young today are more depressed than the young of the past, the causes are as yet unknown. Speculation should be based on what we know of factors associated with the specific illness. With respect to depression, candidates would include, for example, biological/biochemical factors, genetic factors, stress, learned helplessness, early separation and loss and alienation/anomie. More research is needed to specify the crucial factors.

ALCOHOLISM RECOVERY RATE

Mr. ROYBAL. You indicate that your recovery rate from alcoholism is 71 percent. You define recovery as the use of 1 ounce or less of alcohol per day. Isn't this a high rate of alcohol use to still classify a person as recovered?

ANSWER. One ounce of alcohol per day is considered to be less than a damaging amount. One accepted safe level limit of drinking is known as Anstie's limit which is the equivalent of 1.5 ounces of absolute alcohol per day. Also, the amount of alcohol consumed by the average drinker is approximately 1 ounce per day.

Mr. ROYBAL. What would your rate be if you defined recovery as the use of ½ ounce or less of alcohol per day?

ANSWER. Recovery rate based on an average of ½ ounce of alcohol consumption per day or less would produce a 60 percent recovery rate.

Mr. ROYBAL. What happens to the 29 percent who aren't classified as recovered?

ANSWER. The 29 percent not classified as recovered are reported as consuming alcohol breaks down to 13 percent using 1–3 ounces per day and 16 percent over 3 ounces per day. We hope that these people will continue to seek treatment.

RESEARCH ON CAUSES OF ALCOHOLISM

Mr. ROYBAL. Have you done any research on the causes of alcoholism? What are they?

ANSWER. The NIAAA has always and continues to support research on the causes of alcoholism in addition to research on the medical and social consequences of alcohol abuse and alcoholism. Most probably, alcoholic drinking is an interactive combination of several factors such as physiological predisposition, psychological characteristics and environmental influences. The research program of the NIAAA reflects these factors. As examples of NIAAA supported research in these three areas, may I mention three projects:

The NIAAA funded a study of the inheritance of alcoholism by children of alcoholic parents. It was found that approximately 30 percent of the underlying causes of alcoholism can be accounted for by genetic inheritance.

Another project is attempting to determine the personality characteristics of alcoholic women. This study showed that alcoholic women tend to have lower self-esteem, higher anxiety, and feelings of alienation

In the sociocultural area, we are studying drinking practices and attitudes about drinking among teenagers and youth. Peer pressures and cultural attitudes have a marked influence on the initiation of drinking, and when and where drinking occurs among our young people.

EARLY INTERVENTION

Mr. ROYBAL. Have you set up a program to counsel people who may become alcoholics before they reach that stage?

ANSWER. Yes; many of our programs are geared toward reaching individuals at an early stage of their problem with alcohol. Our occupational programs and drinking driver programs are principally involved with early intervention activities, plus many of our other programs have an outreach function capable of identifying and giving counseling service to clients at an early stage of their alcoholism problems.

ENDORPHIN RESEARCH

Mr. ROYBAL. You mentioned, and I have heard, that research has discovered that the body makes a substance similar to morphine. Can you give us some more information on this research and the consequences of the findings?

ANSWER. In the past 5 years, methods were perfected which allowed us to detect highly specific opiate receptors in the brain. It seemed unlikely that man would be endowed with opiate receptors unless there was some naturally occurring opiatelike substance in the body which would be the target of the receptors. This speculation, after much basic research, led to the discovery of endorphins, opiates which naturally occur in the body. These are peptides which combine with the opiate receptors and produce the effect of opiates such as morphine. A variety of information suggests that the body's ability to appropriately respond to pain and emotional states may, to a large extent, be dependent on the endorphine system. This potential role of endorphins in emotional behavior and and mental health generally will undoubtedly be explored by researchers outside the field of drug abuse.

In terms of drug abuse specifically, the most exciting implication of this research is the idea that an endorphin deficiency might be related to narcotic addiction. There are two basic hypotheses involved with this general idea. The first postulates that it may be possible that some individuals are either born with or acquire an "endorphin deficiency" much the same as a diabetic has an insulin deficiency. Such an individual might be lacking in what we term "normal affect," that is, his emotional life might be flat or even depressed. Should such an individual be exposed to a narcotic, his proneness to addiction might be overwhelming due to the fact that the narcotic tends to enable his brain to work in a more normal fashion. Substantiation of this hypothesis would be of extreme significance in developing treatment modalities and in our view of narcotic addiction as a disease. It would also explain the relatively high rate of recidivism after abstinence, as well as the success of replacement therapy with methadone.

The second related hypothesis suggests that during narcotic addiction the presence of the narcotic in the body "signals" to the body that too much endorphin is present and, as a result, the production and/or release of the naturally occurring substance ceases. This process would provide an explanation of the difficulties related to withdrawal as well as some of the mechanics of addiction itself.

USE OF VOLUNTEER SUBJECTS

Mr. ROYBAL. I note that in your statement you say that you see test drugs on volunteers rather than on prison subjects. This is something I have favored for a number of years. Would you tell us what prompted this change?

ANSWER. In 1974–75 several groups focused attention on the use of prisoner volunteers for research. The Kennedy and Kastenmeier committees addressed the issue in their hearings and as a result of this attention the Bureau of Prisons formed a task force to examine the situation.

In February 1976, the Bureau of Prisons Task Force on Medical Research notified the National Institute on Drug Abuse of its decision to ban the use of prisoner subjects for medical research. The Bureau of Prisons indicated that the Addiction Research Center (ARC) should phase out the participation by Federal prisoners in research projects performed at the ARC. ARC discontinued the use of prisoners as of December 1976.

It is felt that many of the ABC studies formerly conducted on prisoner volunteers can be continued with nonprisoner volunteers. This approach presents two serious problems: 1) Finding an appropriate population of volunteers; and 2) meeting the higher costs in terms of logistic support. A methodology for the use of volunteer subjects is now being developed at the ARC and will be put into operation during fiscal year 1978.

TREATMENT EFFECTIVENESS

Mr. ROYBAL. What is the rate of recovery of people who enter drug clinics financed by you? How do you define recovery?

ANSWER. The most comprehensive study of posttreatment behavior or recovery of heroin addicts in recent years has been the drug abuse reporting program (DARP), which provides basic information for determining treatment effectiveness and community impact. The program collected information on performance criteria generally considered to be indicators of recovery which are: opiate usage, any illicit drug usage, alcohol consumption, criminality indicators (time in jail, number of arrests and self-reported illicit activity), and productive activities (education, employment, homemaker skills and vocational rehabilitation).

The entire study involves a file of approximately 44,000 admissions into 53 NIDA supported agencies from June 1, 1969 through March 1973, divided into three cohort groups. Preliminary evaluative information is now available on the first cohort of patients entering treatment programs during 1969–71 and is based upon admission and bimonthly evaluation forms routinely collected, and subsequent interviews with a sample of these former patients an average of 4 years after terminating treatment.

The following table provides information on performance criteria for a subsample of block and white males in this first cohort.

TREATMENT FOLLOWUP

Criterion	Percentage of subsample		
	Pretreatment	Since termination	At interview
Any illicit drug use [1]	100	73	34
Any nonopioid use [1]	62	54	23
Any opioid use	87	64	23
Daily or weekly nonopioid use [1]	34	34	9
Daily opioid use	73	46	6
Any time in jail	[2] 75	47	[3] 12
Any illegal support	51	(4)	18
Any part-time or full-time employment	40	90	52
Any major problem with alcohol	[2] 8	24	7
Enrollment in any other treatment	52	61	28

[1] Does not include marijuana use.
[2] Unlike other variables this is a lifetime figure.
[3] This 12 percent spent most of the 2 months before interview in jail. An additional 11 percent were booked on charges during the 2-month period preceding the interview, although about one-half involved only minor charges (such as traffic violations).
[4] Not available.

Findings such as these suggest that drug treatment programs have a direct impact upon decreased drug usage, decreased criminality, and increased employment and other productive activities. However, the information from the drug abuse reporting program provides a retrospective picture of what happens to clients after treatment. This year NIDA will be initiating a national prospective study to identify more specifically the impact and effectiveness of treatment programs.

BIOCHEMICAL CAUSES OF MENTAL ILLNESS

Mr. ROYBAL. Is there any research into the possibility that enzymes in the body may make one person more susceptible to mental illness than another person, even though both are facing similar pressures?

ANSWER. The National Institute of Mental Health supports a wide range of research into the possibility that enzymes and other chemicals in the body may make one person more susceptible to mental illness than another person. Current support includes more than 26 research grants in this area at an annual level of more than $3 million.

This research spans the gamut from normal behavior to behavior of psychotic states and from infancy to old age. It covers studies of the relation of stress to cortisol—an adrenal steroid hormone—excretion rates in infants to determine whether infants react to a psychologically meaningful stress with altered endocrine response in ways similar to adults. Other studies are investigating chemical imbalance—such as excess serotonin, which transmits nerve impulses in the central nervous system—in autistic and retarded children. Also included is research on the relation of normal and abnormal behaviors to a wide range of biochemical variables, such as enzymes which have direct and/or indirect influence on the central nervous system. These biochemical variables also include chemicals responsible for transmission and modulation of nerve impulses in the central nervous system—an imbalance in this system may be related to abnormal, psychotic behavior—enzymes capable of converting normally occurring chemicals to chemicals with hallucinogenic properties; enzymes related to skeletal muscles—these have been shown to be elevated in acute psychotic states and may be predictive of impending psychosis—hormones that influence the central nervous system and behavior—these hormones may be modulators of the known neurotransmitters—and hormones that vary with changes in the rest-activity and circadian rhythm cycles—these have been shown to precipitate changes in behavior such as agitation, depression. Research is also being conducted on a variety of psychoneuroendocrine variable in relation to sleep disorders and to aging.

MENTAL HEALTH SERVICES MANPOWER PROGRAM

Mr. ROYBAL. You indicate that you are proposing the development of a new mental health services manpower program. You indicate that it will address maldistribution in a geographic sense and in terms of special target populations such as minority groups, the aged, and children.

Would you elaborate on what the program will do in this regard?

ANSWER. The National Institute of Mental Health, through its manpower and training programs, will attempt to remedy these problems in a variety of ways: (1) Designation—with HRA—of psychiatric manpower shortage areas for placement of psychiatrists in the National Health Service Corps and service for loan repayment; (2) targeted grants to institutions and development of training programs in shortage areas; (3) working for the incorporation of mental health content in the training of primary health care personnel; (4) aid to States and regions for the planning and development of a comprehensive mental health manpower strategy; (5) training of minority manpower and others to work with underserved population; including children and the aged; minorities, and (6) efforts to collect better data on distribution and present and optimal utilization of all categories of manpower.

MENTAL HEALTH SPECIAL PROJECTS

Mr. ROYBAL. I understand that the Institute has specific grant authority to support the development of improved methods relating to the care, treatment and rehabilitation of the mentally ill under section 303(a)(2) of the Public Health Service Act. (Also known as title V special projects.) What specific plans has the Institute developed to carry out this emphasis toward improving services?

ANSWER. The previous title V project grant project stimulated and was phased into a number of program developments throughout the institute, with support under the basic research grant authority as of 1969.

Early evaluations of the demonstration plan employed with the original title V program confirmed that impetus had been given to virtually all the major movements in mental health services at the time—aftercare, emergency services, partial hospitalization, consultation and education for the community, outpatient services, and halfway houses, among others. For example, all components of services encompassed by the CMHC program originally were demonstrated through title V projects. Many of the topical emphases originally encompassed by the program have been organized under special centers and other program units within the Institute; these include topics of crime and delinquency, metropolitan studies, problems of minority people, and social problems.

Mr. ROYBAL. I am informed that this program has been successful in providing innovative service and training needs such as foster care as an alternative to

hospitalization; suicide referral services; practical nurse preparation for the care of the mentally ill; and hospital and community coordination for aftercare:

(*a*) Why not use this authority to improve bicultural and bilingual services, and to strengthen community outreach and family focused demonstrations?

(*b*) Why not use this provision to find ways of reducing the rising cost of hospitalization?

ANSWER. These programs, funded under sufficient current authority, already have provided significant contributions to these problem areas, and most certainly they will continue to do so. Toward improving bicultural and bilingual services, for example, one project is devoted to studying how minority clients and mental health workers can communicate more effectively. Another study is attempting to gain understanding of the cultural values and attitudes of persons residing in ethnic neighborhoods, an area of underutilization of mental health services, and is investigating alternative approaches to providing services to ethnic groups. Indian children, Chicano youth, Puerto Rican, and black populations are involved in such studies.

Various approaches to community outreach have been studied and are continuing. For example, early projects on neighborhood store-front centers have been followed by widespread use of the satellite facilities and other kinds of extension services of CMHC's across the country, taking the services to those in greatest need. Another project is developing an innovative service for teenagers on a 24-hour basis. It serves youth who may be particularly distrustful of traditional service agencies, but who have problems that they cannot handle on their own. The youth take responsibility for decisions about their own lives through discussion of alternative ways to work out problems.

Family focused studies represent a topic of increased priority for the program. One project involves working with mothers and their children in the mothers' posthospitalization, to assist the overall family functioning of one important type of high-risk family. Another is dedicated to providing comprehensive crisis service to adolescents and their families. The service includes counseling, therapy, foster placement, legal, medical, educational and job assistance, and referral.

With respect to reducing the rising costs of hospitalization, work has been done on establishing cost accounting methods for various hospital services. A primary thrust has been aimed at finding community alternatives to hospitalization that are considerably more economical as well as more effective. An example is evaluation of a neighborhood social center for the urban elderly directed toward persons who are suffering from organic brain dysfunction yet for whom hospitalization may not be asoblutely essential.

Mr. ROYBAL. For each of fiscal years 1974, 1975, and 1976, specifiy the number of Hispanics at senior level positions in program development and administration at the National Institute on Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism. Specify same as in above, but expressed as percentages of the total ADAMHA manpower in each category.

[The information follows:]

Mr. ROYBAL. For each of fiscal years 1974, 1975, 1976, specify the number of projects and respective funding levels specifically involving the Hispanic population funded by NIMH, NDA, and NIAAA, and express percentage of total ADAMHA projects and funding level for each category.

ADAMHA PROJECTS INVOLVING HISPANIC POPULATION BY INSTITUTE

	Fiscal year—					
	1974		1975		1976	
	Number of projects	Amount	Number of projects	Amount	Number of projects	Amount
NIMH	151	$28,199,000	157	$27,512,000	182	$38,307,000
Percent of ADAMHA	3.9	3.6	4.2	3.7	6.3	5.3
NIDA	21	$9,720,000	27	$4,524,000	24	$6,470,000
Percent of ADAMHA	2.6	1.3	.31	.61	.43	.89
NIAAA	10	$1,525,000	18	$2,958,000	12	$1,626,000
Percent of ADAMHA	1.0	.20	.20	.40	.14	.22
Total	182	$39,444,000	202	$34,994,000	218	$46,403,000
Percent of ADAMHA	3.3	5.1	3.7	4.7	5.1	6.4

SENIOR LEVEL ADMINISTRATION POSITIONS—GS GRADE 13 AND ABOVE

Organization	1974			1975			1976		
	Hispanic	Percent	Total	Hispanic	Percent	Total	Hispanic	Percent	Total
OA	1	2.04	49	3	4.91	61	2	2.63	76
NIAAA	1	2.50	40	2	3.92	51	2	2.73	73
NIDA	0	0	83	1	1.14	87	1	1.09	91
NIMH	1	.40	250	2	.80	250	2	.83	239
Total ADAMHA excluding SEH	3	.71	422	8	1.78	449	7	3.53	479
St. Elizabeths Hospital	6	3.14	191	6	2.85	210	8	3.53	226
Total ADAMHA including St. Elizabeths Hospital	9	1.46	613	14	2.12	659	15	2.13	705

Mr. ROYBAL. How many of the projects in the above have Hispanic principal investigators and Hispanic grantee organizations? Specify percentage of total in each category.

ANSWER.

	Hispanic principal investigators by activity			Hispanic grantee organization by activity		
	1974	1975	1976	1974	1975	1976
NIMH	41	47	49	13	12	12
Percent of ADAMHA	(1)	(1)	(1)	(1)	(1)	(1)
NIDA	10	15	13	9	14	11
Percent of ADAMHA	(1)	(1)	(1)	(1)	(1)	(1)
NIAAA	5	13	8	4	9	5
Percent of ADAMHA	(1)	(1)	(1)	(1)	(1)	(1)
Total	56	75	70	26	35	28
Percent of ADAMHA	(1)	(1)	(1)	(1)	(1)	(1)

[1] Not available. The total number of grantee organizations and principal investigators funded by ADAMHA is not an information item normally kept and would involve the hand tabulation of thousands of grant award statements. Since not all projects have principal investigators per se and some organizations have more than one award, it would not be the same number as total projects in the previous question.

Mr. ROYBAL. What goals has ADAMHA set for Hispanic representation among NIMH staff, NIDA staff, and NIAAA staff?

ANSWER. ADAMHA has an approved affirmative action plan (AAP) that represents the formulation of specific goals and objectives for all employees. Included in the AAP are some specific action items for the Hispanics. These action items are described below:

1. Identify qualified persons in all pay plans and grade levels of job series endemic to the jobs in ADAMHA.
2. Develop and distribute special recruitment literature aimed at Spanish surnamed.
3. Establish a bank of Spanish-speaking prospective employees in the lower and midlevel categories.
4. Develop and implement a producer to identify Spanish-speaking employees at all levels with unutilized talents and skills.
5. Make available pertinent announcements to those Spanish-speaking employees qualifying.

Mr. ROYBAL. What goals has ADAMHA set for Hispanic representation among ADAMHA-funded fellowships/traineeships recipients?

ANSWER. ADAMHA has no numerical goals for Hispanic representation among ADAMHA-funded fellowships/traineeships recipients. ADAMHA's fellowship and training programs are intended to provide support for development of high quality manpower in areas of national need and relevance to ADAMHA's mission. Consistent with this objective, the Agency has engaged in efforts to encourage recruitment of minorities into research and service careers related to alcoholism, drug abuse, and mental health. For example, the National Institute of Mental Health supports grants to several national professional organizations to

recruit and assist in supporting minority students in disciplines central to the field of mental health.

Mr. ROYBAL. What specific mechanism(s) has ADAMHA established to achieve these goals and monitor its progress with that respect?

ANSWER. The specific mechanism that ADAMHA utilizes to monitor the progress of the action items is described above in references to the ADAMHA affirmative action plan for 1977–78.

Mr. ROYBAL. I have been told that you have implemented support guidelines which limit funds to the last 2 years of graduate school. The authorization legislation allows you to support students for 3 years of graduate school. Why have you limited support to only 2 years?

ANSWER. Presumably this question refers to the requirement in ADAMHA's research training (National Research Service (NRS) award) programs that a predoctoral individual complete at least 2 years of graduate work prior to receiving ADAMHA stipend support. In accordance with the NRS act, an eligible individual may receive up to 3 years support under the ADAMHA NRS award program, and with justification this 3-year limitation may be waived for an individual, for example, to enable an individual to complete predoctoral and postdoctoral training).

Since 1972, ADAMHA has required that a predoctoral fellowship applicant have completed two years of graduate work as of the proposed beginning of his or her fellowship. With the initiation of the NRS award program, and the specific legislative requirement to provide support only in identified areas of need, ADAMHA extended this requirement to individuals supported under research training grants. This policy is aimed at targeting ADAMHA's predoctoral support to individuals who have demonstrated competence in graduate work and who have made a choice to focus their predoctoral research—which is undertaken after several years of graduate course work is completed—on a subject relating to the problems of alcoholism, drug abuse, and mental health, as required by law. Such targeting of predoctoral support takes on even more importance as ADAMHA moves to decrease its emphasis on predoctoral support—with a concomitant increase in postdoctoral support—in response to the findings and recommendations of recent national manpower studies.

Mr. ROYBAL. Has ADAMHA studied and considered the impact of the guidelines mentioned above on the Hispanic population? If so, what were the results and implications of such study?

ANSWER. ADAMHA has not undertaken a study to consider the impact of the predoctoral support guidelines on the Hispanic population. The NIMH has been considering the establishment of a program similar to that of NIH which would allow minorities to receive fellowships for their first 2 years of predoctoral training under the authority of the Public Health Service Act.

Mr. ROYBAL. Has ADAMHA studied and considered the possible impact of NIMH's forward plan on the Hispanic population? If so, what were the results and implication of such study?

ANSWER. A subcommittee of ADAMHA's Minority Advisory Committee is presently reviewing the ADAMHA forward plan for fiscal years 1978–82 as well as the plans of all three ADAMHA Institutes. We look forward to the subcommittee's findings and recommendations. The committee plans, and ADAMHA expects it, to play a more active role in the actual development of the plan for fiscal years 1979–83.

Mr. ROYBAL. Has ADAMHA undertaken any efforts to evolve NIMH's Center for Minority Group Mental Health Programs into a separate, permanent institute, with its own corresponding legislative base? If so, what has been the nature of these efforts? Have any results been obtained?

ANSWER. There is conceptual planning currently in progress for an extensive examination of the scope and functions of the Center for Minority Group Mental Health Programs to specifically add various program activities which would considerably increase the Center's impact. This process will involve consultation with various minority groups, as well as executive and legislative bodies, as appropriate. However, no formal proposal has been forwarded to evolve the Center into an institute.

Mr. ROYBAL. Has NIMH released a 1974 report entitled, An Analysis of NIMH Efforts with Respect to Minority Groups? If not, why not? If yes, to what extent has it been disseminated? How can it be obtained?

ANSWER. The report was undertaken in response to a request from the National Advisory Mental Health Council to furnish that organization information on

NIMH efforts and plans in the area of support for minority mental health programs.

When completed, the report was found to contain numerous inaccuracies and errors of fact. As a result, the report was not formally released outside the NIMH. A summary of the report was presented orally to the NAMHC. If desired, a copy can be made available to the committee, along with an analysis developed by NIMH, outlining its principal deficiencies and omissions.

Mr. ROYBAL. For each of fiscal years 1974, 1975, and 1976 specify the number of Hispanics on the Initial Review Groups of NIMH, NIDA, and NIAAA.

	Fiscal year 1974	Fiscal year 1975	Fiscal year 1976
NIMH	8	11	11
NIDA	0	0	6
NIAAA	1	1	1

Mr. ROYBAL. Specify same as in above, but expressed as percentage of the total of initial review group members for each of the three institutes comprising the ADAMHA.

[In percent]

	Fiscal year 1974	Fiscal year 1975	Fiscal year 1976
NIMH	4.2	5.3	5.1
NIDA			10.3
NIAAA	6.6	4.5	3.8

Mr. ROYBAL. What specific mechanism(s) has ADAMHA established to identify and appoint Hispanic research/scholars on initial review committees? How have these mechanisms been monitored to insure progress? What specific mechanism(s) has ADAMHA established to identify and appoint Hispanic research/scholars as consultants to ADAMHA, site review members, and membership on the national advisory councils of each of the three institutes?

ANSWER. Nominees for the advisory councils are submitted to the director of the three institutes from various community and professional organizations and other interested groups. After establishing professional qualifications, a proportional balance of age, sex, and minority status, which includes ethnic background, is a consideration used in appointing members to the ADAMHA Initial Review Committee. Furthermore, the minority advisory committee has been established by the administrator to advise on matters relating to minorities. This committee has Hispanic representatives and may make recommendations regarding potential candidates. A substantial increase has been made in appointing Hispanic and other minorities to ADAMHA review committees and now a total of 27 Hispanics are serving on these review committees. The makeup of advisory committees is monitored by the ADAMHA Committee Management Office.

MR. STOKES

NUMBER OF PSYCHIATRISTS

Mr. STOKES. Dr. Waldrop you have indicated in the oral portion of your testimony that, "There is currently no shortage of doctors in the United States." Moreover, on page 12 of your written testimony you have indicated that the problem is one of "maldistribution." Dr. Waldrop how many doctors are there in the United States?

ANSWER. I have agreed with the findings of Congress, as stated in Public Law 94-484 that "there is no longer an insufficient number of physicians and surgeons in the United States." There does appear, however, to be a shortage of physicians specializing in psychiatry, and this shortage is compounded by the maldistribution of psychiatrists in this country.

At present we estimate that there are 28,000 psychiatrists and child psychiatrists in the United States, including residents in training. Approximately 40 percent of these residents are foreign medical graduates, and if the number of these physicians entering the country is severely curtailed, as seems probable

as a result of the provisions of Public Law 94–484, the production of new psychiatrists may not equal attrition from the field due to death and retirement, and the overall supply of psychiatrists may actually decrease in the future. We must do all that we can to encourage young American-trained physicians to enter the field of psychiatry.

Mr. STOKES. What is the ratio of doctors to Americans?

ANSWER. Currently there are approximately 13 psychiatrists and child psychiatrists for every 100,000 people in the United States. This ratio includes residents in training and psychiatrists who are serving in the Armed Forces, as well as those primarily engaged in teaching, administration, and research. Thus there are probably no more than 8 or 9 fully trained, service providing psychiatrists per 100,000 people at this time.

Mr. STOKES. Do you consider this an adequate ratio?

ANSWER. No, we do not consider this to be an adequate ratio.

Mr. STOKES. If not what would the adequate ratio be?

ANSWER. It is difficult to give a flat ratio in view of the many complexities involved, such as the rising utilization of mental health services, the problems of maldistribution, and the fact that many psychiatrists are necessarly engaged in teaching, administration of hospitals and clincs, and research. If pressed, I would say that a ratio of approximately 18 psychiatrists to every 100,000 people would probably be adequate, if they were more evenly distributed over the country.

PSYCHIATRISTS FROM MINORITY GROUPS

Mr. STOKES. Dr. Waldrop what is the ratio of minority physicians to the minority population in the United States?

ANSWER. Data are very poor on the racial or ethnic background of practicing psychiatrists, but there is no doubt that many minorities are underrepresented in the field. For example, probably only 2 percent of all psychiatrists are black, which would yield a ratio of 2.4 per 100,000 black population. The proportion of Spanish speaking and Asian psychiatrists is much higher proportionate to the number of members of these groups in the United States.

Mr. STOKES. Do you consider this an adequate ratio?

ANSWER. No, we do not consider this to be an adequate ratio, particularly for blacks.

Mr. STOKES. If not, what would be an adequate ratio?

ANSWER. We would like to see the proportion of minority psychiatrists equal to the proportion of these population groups in the United States, and the overall ratio of minority psychiatrists to minority population the same as that for nonminorities. As previously stated, this would be approximately 18 psychiatrists per 100,000 people.

Mr. STOKES. Dr. Waldrop what does the Alcohol, Drug Abuse, and Mental Health Administration specifically plan to do to correct the severe shortage of minority physicians?

ANSWER. The Alcohol, Drug Abuse, and Mental Health Administration is hampered in what it can do to increase the number of minority psychiatrists by the fact that minority students are underrepresented in medical schools, a situation over which ADAMHA has no control. In addition, psychiatry must compete with the other medical and surgical specialties (including primary care) in attracting minority graduates for advanced training.

The National Institute of Mental Health supports training in human behavior principles and in undergraduate psychiatry for medical students in minority medical schools both to provide mental health content to all future physicians and to interest these students in psychiatry as a specialty. Short-term stipends are often given in connection with these grants. In addition, institutional awards for psychiatry residency training are given to all minority medical schools and stipends are given to the trainees. Nonminority institutions are encouraged to recruit minority residents and to provide training in the treatment of minority psychiatric patients.

Mr. STOKES. Dr. Waldrop, of the total appropriaton request of $877,656,000, what exact dollar amount is to be allocated for the training and placement of minority physicians in order to correct the serious shortage and maldistribution?

ANSWER. I cannot give you an exact dollar amount, as programs to be funded out of this appropriation are selected in a competitive process that does not make these racial distinctions. However, the training of minority mental health manpower is one of the highest priorities of the division of manpower and

training programs of the National Institute of Mental Health and every encouragement is given to applications for training grants from minority institutions and for educating minority students in all the mental health disciplines.

For example, the psychiatry education branch of NIMH is expected in fiscal year 1978 to have a total budget of app.oximately $23,600,000 in fiscal year 1976, with roughly the same total budget, about $1,450,000 was awarded to minority medical schools or institutions serving minority populations and for stipend support to minority students in these institutions. Additional funds were of course awarded for the training of minority psychiatrists in nonminority institutions and for training all psychiatrists in the psychiatric treatment of the mental health problems of minority group members.

In addition, division of special mental health programs, NIMH, plans to spend $175,000 for minority fellowships in psychiatry, as a way of encouraging minority physicians to specialize in psychiatry and insure excellence of training in both service delivery and research.

Mr. STOKES. Dr. Waldrop, how many new minority psychiatrists can we expect to see as a result of the Alcohol, Drug Abuse, and Mental Health Administration's efforts?

ANSWER. I cannot tell you with assurance how many new minority psychiatrists will be trained as a result of ADAMHA's efforts. As indicated in the previous question, I can state that NIMH already supports substantial ongoing efforts for minority institutions and psychiatry departments that if withdrawn, would leave these departments in grave financial difficulty with their ability to attract and support minority and other residents considerably reduced. Some may even be forced to terminate their psychiatry training programs. The result will be that even fewer minority psychiatrists will be produced than is now the case.

ALCOHOLISM COMMUNITY PROGRAM FUNDING

Mr. STOKES. Dr. Waldrop, on page 5 of your testimony you state that, "Emphasis continues to be placed on supporting programs reaching communities composed of poverty and minority and other special population groups which have a high incidence of alcoholism and which have traditionally been lacking in services." Dr. Waldrop, name these supporting programs and what does the emphasis that you make reference to mean in terms of appropriation dollars?

ANSWER. The American Indian alcoholism treatment program and treatment for other poverty programs including blacks and Spanish-speaking populations are the programs which continue to be supported. The total amount requested for appropriation in 1978 is $23,373,000 for these programs and serve an estimated 64,000 beneficiaries.

Mr. STOKES. Also, Dr. Waldrop what communities have you targeted for assistance? Specifically, name these communities and state what funds are to be appropriated and what is the estimated population to be serviced?

ANSWER. Communities per se are not targeted for assistance. The Institute tries to respond to specific requests for assistance throughout the country and in doing so targets available resources to high-priority areas. The communities which receive grants to support the programs are often composed therefore of poverty, minority, and other special population groups which have a high incidence of alcoholism and which have traditionally been lacking in services.

PSYCHOSURGERY

Mr. STOKES. Dr. Waldrop, on page 10 of your testimony you state that, "Schizophrenia and depression also continue to be the target of much of the NIMH intramural research program." Basic researchers work on the "interrelationships of brain function and behavior." Dr. Waldrop, does any of this research involve the proposed or actual use of psychosurgery?

ANSWER. The NIMH intramural research program is not doing any research that involves psychosurgery. Nor is any such research supported by the extramural grants program of the Institute. The National Commission for the Protection of Human Subjects of Biomedical and Behaviroal Research has looked into the question of psychosurgery. The Commission contracted for several studies to develop information on the effects and extent of psychosurgical operations. Adequate data were hard to come by, and the studies of the Commission are significant in that they represent some of the first systematic data on psychosurgery. Generally, the Commission found evidence that psychosurgery was beneficial in more than half of the cases in which effects could be determined.

A few patients were worse and the rest unchanged. None experienced significant neurological/psychological impariment due to psychosurgery.

Mr. STOKES. If so, what is the racial composition of the patient or the subject population involved in psychosurgery research?

ANSWER. On the extent of psychosurgery, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research estimates that about 400 operations are performed in the United States each year. Most of these are on white, middle-aged private patients with illnesses of long standing. A study of 600 psychosurgery cases found very small involvement of minority and special group populations: 1 black, 2 Orientals, 6 Spanish Americans, 7 children, 3 prisoners.

MENTAL HEALTH RESEARCH

Mr. OBEY. Now when we examine the budget for your whole research operation we discover that the additional 2 million that goes to the intramural program comes out of the extramural grants program causing a projected decrease of 157 grants in the number of grants out next year. Doctor, can you tell me how many approved research grants you were unable to fund in fiscal year 1976, fiscal year 1977 and the estimate for fiscal year 1978?

ANSWER. First, it should be noted that the actual increment to the intramural research program was $663,000, and not the $2,090,000 amount shown as the total increase for the direct operations account. The bulk of the increase, or $1,427,000, represented increased assessments by NIH for services it provides the NIMH. A major portion of this increase relates to maintaining the clinical beds and the processing and reproduction of research grant applications. The approved but unpaid backlogs for research grants for the period 1976–1978 are as follows (data as of end of the year):

	Projects	Annual amount	Cumulative amount
1976 actual	293	$15,699,000	$15,699,000
1977 estimate	582	19,207,000	34,906,000
1978 estimate	1,028	29,059,000	63,965,000

Mr. OBEY. Dr. Brown, in your professional opinion, what would be needed for an adequate effort in your intramural program?

ANSWER. Professional judgment of the estimated 1978 needs for the intramural research program would be a total of $26,626,000. This would be an increase of $1,000,000 over and above the current budget estimate. This increase would be used for 40 scientific support and patient care personnel to support clinical studies not now being done in NIMH laboratories, and to staff wards specializing in mental illness incident to old age. These increments would further the primary aim of the intramural research program, which is to relieve suffering from mental illness through diagnostic and treatment methods plus contribute to the basic knowledge which will explain the onset of these disorders, and lead to their prevention.

Mr. OBEY. Can you give us an idea what would be needed to adequately support the extramural research program.

ANSWER. Professional judgment of the estimated 1978 needs for the extramural research program would be a total of $103,374,000. This would be an increase of $22,092,000 over and above the current budget estimate which would maintain the 1977 appropriated level in real dollars for new and competing funds; and provide for several new initiatives. These initiatives would establish two clinical reserach centers to serve as national focal points for clinical research on the major mental disorders; expand treatment assessment in the areas of psychotherapy and related psychosocial research; expand research into the causes and treatment of depression and schizophrenia; support of high-potential areas in the basic biological and developmental sciences; expand research on the mental health of the aged in such areas as knowledge development, organization, and delivery of mental health services to the elderly, and analysis of community support systems and issues relating to institutionalization and its alternatives; research on community-based care of the chronically mentally ill; and expansion of research into the effectiveness of programs and services for rape victims, their families, and offenders plus research on sexual assaults on children, as well as women, and attacks in correctional institutions.

JUSTIFICATION OF THE BUDGET ESTIMATES

Appropriation Estimate

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH

For carrying out the Public Health Service Act with respect to mental health, [and except as otherwise provided, parts A, B, and D of] 1/ the Community Mental Health Centers Act, *as amended* [(42 U.S.C. 2681, et seq.)], 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, *as amended*, [$763,141,000] *$877,656,000*, 2/ *of which $350,000 for modernization and improvement of intramural research facilities, is to remain available until expended.* 3/ *(Departments of Labor, and Health, Education, and Welfare Appropriation Act, 1977; additional authorizing legislation to be proposed for $46,594,000.* 4/ *)*

Explanation of Language Changes

1/ This language is superfluous and therefore should be deleted.

2/ Portions of the regular appropriation for this account for 1977 had not been enacted at the time this budget was prepared. A temporary continuing resolution is in effect for the period October 1, 1976, to March 31, 1977. A supplemental request for $111,049,000 for FY 1977 is being submitted for alcohol community programs, along with a supplemental request for $1,481,000 for the FY 1977 pay raise.

3/ Extended availability is required as the lead time for negotiating and letting modernization contracts often does not permit the obligation of funds in the year which appropriated.

4/ Includes $19,309,000 for research training awards and $22,605,000 for awards to community mental health centers, and $4,680,000 for research into the causes and prevention of rape.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Alcohol, Drug Abuse, and Mental Health Administration

Amounts Available for Obligation

	1977 Appropriation	1978 Estimate
Appropriation	$763,141,000	$877,656,000
Proposed supplemental	112,530,000	---
Subtotal appropriation	875,671,000	877,656,000
Unobligated balance, start of period	+1,129,000	---
Total obligations	876,800,000	877,656,000

Summary of Changes

1977 Estimated obligations	$876,800,000
1978 Estimated obligations	877,656,000
Net change	+856,000

	1977 Base Pos.	1977 Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Within grade increases	---	---	---	+963,000
2. Increased payment to Health Service and Supply Fund	---	3,406,000	---	+483,000
3. Increased payment to DHEW Working Capital Fund	---	857,000	---	+569,000
4. Increased payment to NIH Management Fund	---	9,415,000	---	+2,312,000
5. Increased payment for FTS.	---	402,000	---	+57,000
6. Increased payment for Postage	---	2,004,000	---	+93,000
7. Increased payment to GSA for rental of space (SLUC)	---	2,550,000	---	+516,000
8. Increased payment to Office of Federal Employees Compensation	---	97,000	---	+44,000
Subtotal	---	---	---	+5,037,000
B. Program:				
1. General Mental Health:				
a. Research - direct operations - replacement of intramural laboratory equipment	---	23,536,000	---	+500,000
b. Community Programs: Operation of CMHC's - represents amounts necessary to meet continuation costs	---	232,324,000	---	+522,000
2. Drug Abuse:				
a. Research direct operations - reflects increase in intramural research activities	102	2,813,000	---	+713,000
b. Community Programs: Project grants and contracts - reflects limited increases in prevention projects	---	160,000,000	---	+1,500,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
3. Alcohol:				
a. Research direct operations - relocation of clinical research efforts at NIH campus...	37	1,871,000	---	+890,000
b. Community Programs: Project grants and contracts - provides for support of National Clearinghouse and Education Center.....	---	68,408,000	---	+311,000
Subtotal.....	---	---	---	+4,436,000
Total Increases.....	---	---	---	+9,473,000
Decreases:				
A. Built-in:				
One less day of pay.....	---	---	---	-185,000
B. Program:				
1. General Mental Health:				
a. Research - reflects a reduction in extramural research efforts	373	83,372,000	---	-2,090,000
b. Program Support - reflects reduction of $27,000 for 2 positions and $1,969,000 in operating costs in both central and regional offices.....	664	28,502,000	-2	-1,996,000
2. Drug Abuse:				
a. Research - reflects reduction in extramural research efforts	---	31,187,000	---	-744,000
b. Program Support - reflects reduction of $13,000 for 1 position and $536,000 in operating costs.....	315	16,686,000	-1	-549,000
3. Alcohol:				
a. Research - reflects reduction in extramural research efforts	---	10,937,000	---	-1,426,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
b. Program Support - reflects reduction of $13,000 for 1 position and $409,000 in project contracts.....	158	9,538,000	-1	-422,000
4. Buildings and Facilities - reflects net reduction of $779,000 in obligational authority. $350,000 for modernizing and improving the NIMH Intramural research facilities is requested.....	---	1,129,000	---	-779,000
5. Program Management - reflects reduction of $13,000 for 1 position and $413,000 in operating costs.....	201	7,197,000	-1	-426,000
Subtotal.....	---	---	-5	-8,432,000
Total Decreases.....	---	---	-5	-8,617,000
Net Change.....	---	---	-5	+856,000

Obligations by Activity

	1977 Comparable Appropriation		1978 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
General Mental Health						
Research	373	$106,908,000	373	$106,908,000	---	$---
Training	---	86,600,000	---	86,600,000	---	---
Community Programs:						
Construction	---	---	---	---	---	---
Oper. of CMHC's	---	232,324,000	---	232,846,000	---	+522,000
Subtotal	---	232,324,000	---	232,846,000	---	+522,000
Program Support	664	28,502,000	662	27,695,000	-2	-807,000
SLUC		(1,092,000)		(1,313,000)		(+221,000)
Subtotal GMH	1,037	454,334,000	1,035	454,049,000	-2	-285,000
Drug Abuse						
Research	102	34,000,000	102	34,000,000	---	---
Training	---	10,000,000	---	10,000,000	---	---
Community Programs:						
Proj. Gr. & Contr.	---	160,000,000	---	161,500,000	---	+1,500,000
Grants to States.	---	40,000,000	---	40,000,000	---	---
Subtotal	---	200,000,000	---	201,500,000	---	+1,500,000
Program Support	315	16,686,000	314	16,572,000	-1	-114,000
SLUC		(415,000)		(497,000)		(+82,000)
Subtotal Drug Abuse	417	260,686,000	416	262,072,000	-1	+1,386,000
Alcoholism						
Research	37	12,808,000	37	13,179,000	---	+371,000
Training	---	7,200,000	---	7,200,000	---	---
Community Programs:						
Proj. Gr. & Contr.	---	68,408,000	---	68,719,000	---	+311,000
Grants to States.	---	55,500,000	---	55,500,000	---	---
Subtotal	---	123,908,000	---	124,219,000	---	+311,000
Program Support	158	9,538,000	157	9,468,000	-1	-70,000
SLUC		(567,000)		(680,000)		(+113,000)
Subtotal Alcoholism	195	153,454,000	194	154,066,000	-1	+612,000
Buildings & Facilities	---	1,129,000	---	350,000	---	-779,000
(Budget Authority)	---	(---)	---	(350,000)	---	(+350,000)
Program Management	201	7,197,000	200	7,119,000	-1	-78,000
SLUC		(476,000)		(576,000)		(+100,000)
Total ADAMHA	1,850	876,800,000*	1,845	877,656,000	-5	+856,000
(Budget Authority)	---	(875,671,000)	---	(877,656,000)	---	(+1,985,000)

* Includes a proposed supplemental for $112,530,000 of which $111,049,000 is for Alcoholism community programs and $1,481,000 is for FY 1977 pay raise.

Obligations by Object

	1977 Appropriation	1978 Estimate	Increase/ Decrease
Total number of permanent positions...	1,850	1,845	-5
Full-time equivalent of all other positions.....	312	312	---
Average number of all employees.....	2,099	2,102	+3
Personnel compensation:			
Permanent positions.....	$37,728,000	$38,293,000	+$565,000
Positions other than permanent.....	4,115,000	4,173,000	+58,000
Other personnel compensation.....	1,030,000	1,049,000	+19,000
Subtotal, personnel compensation..	42,873,000	43,515,000	+642,000
Personnel benefits.....	5,374,000	5,488,000	+114,000
Travel and transportation of persons..	2,414,000	2,414,000	---
Transportation of things.....	151,000	191,000	+40,000
Rent, communications and utilities....	7,151,000	7,817,000	+666,000
Printing and reproduction.....	1,544,000	1,544,000	---
Other services.....	19,198,000	21,083,000	+1,885,000
Project contracts.....	130,345,000	140,447,000	+10,102,000
Supplies and material.....	2,506,000	2,506,000	---
Equipment.....	1,490,000	2,490,000	+1,000,000
Grants, subsidies and contributions...	663,754,000	650,161,000	-13,593,000
Total obligations by object.....	876,800,000	877,656,000	+856,000

Significant Items in House and Senate
Appropriations Committee Reports

Item	Action taken or to be taken
1977 House Report	
Maldistribution of Mental Health Personnel	
1. Committee directive that it be kept informed of the progress the Department is making in solving the problem of maldistribution of mental health personnel (page 49).	1. A report was transmitted to the Committee on January 12, 1977 describing current and future activities undertaken by the National Institute of Mental Health to resolve the maldistribution problem.
1977 Senate Report	
Mental Health and the NIA	
2. Committee directive that the NIMH develop a very closely coordinated program with the National Institute on Aging and report to the Committee on progress in this area (page 70).	2. The National Institute on Aging and the National Institute of Mental Health have established several formal and informal relationships to coordinate these programs. A report describing these was submitted to the Committee on January 27, 1977.
Drug and Alcohol Abuse Education Program	
3. Committee directive that the Commissioner of Education and the Director of ADAMHA submit a report on what effects, if any, a transfer of the OE program would have (page 81).	3. Both the Office of Education and the ADAMHA believe that the OE Drug and Alcohol Abuse Education Program can best meet its objectives through administration by the Office of Education. A joint report will be submitted to the Committee.

Item	Action taken or to be taken
Teenage Alcoholism	
4. Committee directive that the NIAAA develop a comprehensive public education and information dissemination program dealing specifically with teenage alcoholism programs, including specific budget and position needs (page 72).	4. The NIAAA is currently developing a plan for the teenage alcoholism education and information dissemination program, including position and dollar needs. A report will be submitted by March 31, 1977, within six months from enactment of the Appropriation, as requested.
Restored Positions	
5. Committee directive that restored positions above the budget estimate shall be for research, grants and contracts review, information dissemination programs, and community programs (pages 70, 71, and 72).	5. Positions have been restored consistent with Congressional intent.
Consultant Travel	
6. Committee directive that a report be given to Congress on the specific reasons for this apparent abuse of travel by consultants (page 72).	6. In addition to costs of travel incurred by usual categories of consultants, ADAMHA travel costs have included those costs incurred by consultants hired on behalf of other programs for whom ADAMHA is reimbursed and by special consultants hired in lieu of established training committees. An in-depth report is to be submitted at the time of the hearings.
Research Training Committees	
7. Committee directive that an additional report at the time of the 1978 hearings be given to the	7. On October 21, 1976, three research training committees were chartered. With these

Item	Action taken or to be taken
Committee as to the status of all research training committees (page 72).	three committees, ADAMHA currently has all the research training committees needed. A letter has been transmitted to the Committee notifying it of their establishment.
1976 Supplemental - House Report	
Committee on Mental Health of the Elderly	
8. Secretary should proceed with the appointment of the Committee on Mental Health of the Elderly as required by P.L. 94-63 (page 19 and page 33 of the 1976 Supplemental - Senate Report).	8. The Committee was established and began meeting in September 1976. It is anticipated that a report on future program needs related to the mental health of the elderly will be submitted to the Secretary by July 31, 1977. Funds for the Committee were derived from existing funds within the National Institute of Mental Health.
1976 Second Supplemental - Senate Report	
Alcohol Prevention Programs	
9. Committee directive that NIAAA develop a resource program to utilize existing communication vehicles of State and local Chambers of Commerce to extend knowledge of all alcohol abuse prevention (page 69).	9. The NIAAA funds a variety of prevention efforts through national, voluntary, and citizens organizations including the Jaycees as well as through the National Clearinghouse for Alcohol Information. These programs have supported prevention activities in business and industry, and among other special target groups. A letter was sent to the Committee on November 2, 1976 regarding NIAAA funding of prevention programs sponsored by national and voluntary organizations.

Authorizing Legislation

Legislation	Authorized	1978 Budget Request
General Mental Health		
Research:		
General - PHS Act, Sec. 301	Indefinite	$102,228,000
Rape Prevention and Control - CMHC Act, Sec 231(d)	Expired 1/	4,680,000
Training:		
Clinical Training - PHS Act, Sec. 303	Indefinite	70,463,000
Research Training - PHS Act, Sec. 472	Expired 1/	16,137,000
Community Programs:		
Staffing - CMHC Act, Sec. 203(e)(3)	Sums Necessary	38,247,000
Childrens Services - CMHC Act, Sec. 203(e)(3)	Sums Necessary	13,900,000
Planning - CMHC Act, Sec. 202(d)	Expired 1/	---
Initial Operation - CMHC Act, Sec. 203(d)(1)	Expired 1/	---
Operation Continuation - CMHC Act, CMHC Act, Sec. 203(d)(2)	Sums Necessary	158,094,000
Consultation and Education - CMHC Act, Sec. 204(c)	Expired 1/	8,245,000
Conversion Grants - CMHC Act, Sec. 205(c)	Expired 1/	9,372,000
Financial Distress - CMHC Act, Sec. 213	Expired 1/	4,988,000
Facilities Assistance - CMHC Act, Sec. 228	Expired 1/	---
Program Support:		
Other Expenses - PHS Act, Sec. 301	Indefinite	26,382,000
Standard Level User Charges - PHS Act, Sec. 301	Indefinite	1,313,000
Drug Abuse		
Research:		
PHS Act, Sec. 301	Indefinite	34,000,000
DAOT Act, Sec. 503	7,000,000	---
Training:		
Clinical Training Grants - PHS Act, Sec. 303	Indefinite	2,894,000
Research Training - PHS Act, Sec. 472	Expired 1/	906,000
Contracts - PHS Act, Sec. 301	Indefinite	6,200,000
Community Programs:		
NARA Contracts - NARA Act, Sec. 607	Sums necessary	200,000
Technical Assistance and Neuropsychiatric Contract - PHS Act, Sec. 301	Indefinite	2,250,000
Special Project Grants and Contracts - DAOT Act, Sec. 410	160,000,000	159,050,000
Grants to States - DAOT Act, Sec. 409	45,000,000	40,000,000
Program Support:		
Other Expenses - PHS Act, Sec. 301	Indefinite	16,075,000
Standard Level User Charges - PHS Act, Sec. 301	Indefinite	497,000

Legislation	Authorized	1978 Budget Request
Alcohol		
Research:		
PHS Act, Sec. 301	Indefinite	$1,000,000
Comprehensive Alcohol Abuse and Alcoholism, Prevention, Treatment, and Rehabilitation Act:		
Encouragement of Research - Sec. 503	$24,000,000	12,179,000
National Research Centers - Sec. 504	6,000,000	---
Training:		
Clinical Training - PHS Act, Sec. 303	Indefinite	4,934,000
Research Training - PHS Act, Sec. 472	Expired 1/	2,266,000
Community Programs:		
Comprehensive Alcohol Abuse and Alcoholism, Prevention, Treatment, and Rehabilitation Act: Grants and Contracts for the Prevention and Treatment of Alcohol Abuse and Alcoholism and Implementation of the Uniform Act - Sec. 312	91,000,000	68,719,000
Grants to States - Sec. 301	77,000,000	55,500,000
Program Support:		
Other Expenses - PHS Act, Sec. 301	Indefinite	8,788,000
Standard Level User Charges - PHS Act, Sec. 301	Indefinite	680,000
Buildings and Facilities - PHS Act, Sec. 301	Indefinite	350,000
Program Management:		
Other Expenses - PHS Act, Sec. 301	Indefinite	6,543,000
Standard Level User Charges - PHS Act, Sec. 301	Indefinite	576,000
Total		877,656,000

1/ Authorizing legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Appropriations History

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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	653,627,000	791,502,000	835,856,000	813,402,000
1977	546,826,000	761,441,000	764,599,000	763,141,000
Supplemental Pending	112,530,000	---	---	---
1978	877,656,000			

Justification

Alcohol, Drug Abuse, and Mental Health Administration

	1977 Appropriation	1978 Estimate	Increase/ Decrease
General Mental Health	$454,334,000	$454,049,000	-$285,000
Drug Abuse	260,686,000	262,072,000	+1,386,000
Alcoholism	153,454,000 1/	154,066,000	+612,000
Buildings and Facilities	1,129,000	350,000	-779,000
(Budget Authority)	(---)	(350,000)	(+350,000)
Program Management	7,197,000	7,119,000	-78,000
Total	876,800,000 2/	877,656,000	+856,000
(Budget Authority)	(875,671,000) 2/	(877,656,000)	(+1,985,000)

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 1978 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 training the budget proposes the same level of support as was appropriated in FY 1977. However, it does not allow for new starts in research training grants or predoctoral fellowships. For community programs the budget proposes a level of support approximately equal to the FY 1977 appropriated amount. For alcohol community programs, this assumes approval of a $111,049,000 supplemental request in FY 1977 to provide funds at the continuing resolution level.

1/ Includes funds being requested in supplemental totalling $111,049,000 for alcohol community programs.
2/ Includes funds being requested in supplemental totalling $111,049,000 for alcohol community programs and the proposed supplemental of $1,481,000 for FY 1977 pay raise.

I. General Mental Health

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research	373	$106,908,000	373	$106,908,000	---	---
Training	---	86,600,000	---	86,600,000	---	---
Community Programs	---	232,324,000	---	232,846,000	---	+522,000
Program Support	664	28,502,000	662	27,695,000	-2	-807,000
Total	1,037	454,334,000	1,035	454,049,000	-2	-285,000

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

	1977 Appropriation		1978 Estimate		Increase or Decreases	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research grants	---	$76,902,000	---	$74,264,000	---	-$2,638,000
Hospital Improvement Projects	---	4,900,000	---	4,900,000	---	---
Contracts	---	1,570,000	---	2,118,000	---	+548,000
Direct Operations	373	23,536,000	373	25,626,000	---	+2,090,000
Total	373	106,908,000	373	106,908,000	---	---

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

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations.....	601	$43,510,000	650	$50,724,000	+49	+$ 7,214,000
Competing renewals..	160	11,913,000	107	8,556,000	-53	-3,357,000
New projects.....	266	19,328,000	162	12,833,000	-104	-6,495,000
Small grants.....	132	916,000	132	916,000	---	---
Supplementals.....	(50)	1,235,000	(50)	1,235,000	(--)	---
Total.....1,159		76,902,000	1,051	74,264,000	-108	-2,638,000

Research Grants Program Distribution

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations:						
Behavioral Science..	171	$8,780,000	171	$9,130,000	--	+$350,000
Clinical research...	76	7,171,000	104	10,699,000	+28	+3,528,000
Applied research....	41	2,777,000	52	3,494,000	+11	+717,000
Psychopharmacology..	83	6,412,000	92	7,191,000	+9	+779,000
Epidemiology.....	15	1,862,000	9	1,429,000	-6	-433,000
Services development	38	5,392,000	38	5,581,000	--	+189,000
Crime & delinquency.	22	2,453,000	15	2,031,000	-7	-422,000
Metropolitan problems	19	1,363,000	24	1,852,000	+5	+489,000
Minority M.H.....	16	2,546,000	21	3,931,000	+5	+1,385,000
Rape.....	17	1,554,000	21	2,181,000	+4	+627,000
Research scientists.	103	3,200,000	103	3,205,000	--	+5,000
Subtotal, Continuations	601	43,510,000	650	50,724,000	+49	+7,214,000
Competing/New:						
Behavioral science...	154	6,448,000	106	4,544,000	-48	-1,904,000
Clinical research....	115	7,682,000	81	5,413,000	-34	-2,269,000
Applied research.....	69	3,198,000	62	2,253,000	-7	-945,000
Psychopharmacology...	100	5,473,000	82	3,857,000	-18	-1,616,000
Epidemiology.....	4	438,000	3	321,000	-1	-117,000
Services development.	16	2,308,000	10	1,626,000	-6	-682,000
Crime & delinquency..	14	1,236,000	6	871,000	-8	-365,000
Metropolitan problems	15	1,396,000	12	984,000	-3	-412,000
Minority M.H.....	23	2,107,000	9	1,484,000	-14	-623,000
Rape.....	27	2,316,000	14	1,631,000	-13	-685,000
Research scientist...	21	790,000	16	556,000	-5	-234,000
Subtotal New/Competing	558	33,392,000	401	23,540,000	-157	-9,852,000
Total, Grants.....	1,159	76,902,000	1,051	74,264,000	-108	-2,638,000

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 1978 budget:

The 1978 budget for new and competing awards is $23,540,000 compared with $33,392,000 in 1977. The research effort in 1978 will, for the most part, constitute an extension of programs undertaken in 1977. There will be a continuing effort to increase knowledge of the problems of schizophrenia, depression, and mental illnesses of children, as well as research into the cause and prevention of rape. During 1978, NIMH will continue programs of basic psychological, biomedical, and genetic research into the causes of schizophrenia. In the area of depression, NIMH will move forward with collaborative research on psychological, psychosocial, and cultural factors which influence the development and course of depression. In addition, tests will be continued in relation to 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; and problems of early adolescents.

The 1978 request will also provide for continued efforts in several special research areas:

... Efforts are being made to seek means to prevent depression and other mental illness in the elderly;

... A technical assistance effort is underway to increase minority participation in mental health research. The research scientist development award mechanism is being used to help support promising minority investigators to develop their potential for research careers, specifically in the area of crime and delinquency;

... A special research initiative on female crime is underway, building on present efforts relating to changing sex roles and patterns of delinquency;

... In the area of rape prevention and control, major efforts relate to the translation of changing social policies and laws into improved social programs; and to better services for victims and their families. Efforts are also being directed toward development of knowledge to deal more adequately with offenders;

... Studies in the field of metropolitan mental health problems relate to the identification of support systems to mediate stress in an urban setting.

2. Hospital Improvement Program:

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations.....	33	$3,162,000	33	$3,300,000	--	+$138,000
Competing renewals..	8	738,000	--	---	-8	-738,000
New Projects.....	10	1,000,000	16	1,600,000	+6	+600,000
Total.....	51	4,900,000	49	4,900,000	-2	---

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 an institution may not exceed 10 years and each hospital may not receive more than $100,000 in any one year.

Impact of 1978 budget:

The Hospital Improvement Program, in conjunction with the Hospital Staff Development Program under the Training activity, is being redirected in 1978. Funds will be made available to State mental health authorities to develop improved services for chronically disabled psychiatric patients who are at high risk of inappropriate institutional or community care. These individuals have comprised the long-term resident patient populations of public mental hospitals. They have traditionally been vulnerable to exclusion, neglect, and occasionally abuse. Within the 1978 proposed funding level of $4,900,000, approximately $1,600,000 will be available for new projects in this area.

3. Contracts:

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Renewals.....	27	$944,000	20	$720,000	-7	-$224,000
New.....	17	626,000	40	1,398,000	+23	+772,000
Total.....	44	1,570,000	60	2,118,000	+16	+548,000

Impact of 1978 budget:

The programs and priorities for contract awards follow those set forth for research grants, covered earlier in this justification. In Fiscal Year 1978, $868,000 is for research into the causes and prevention of rape, as compared with $1,130,000 in 1977.

4. Direct Operations:

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Direct Operations....	373	$23,536,000	373	$25,626,000	---	+$2,090,000

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 1978 budget:

The 1978 budget provides only mandatory increases which will enable the Intramural Research Program to continue its efforts in the areas of schizophrenia, depression, and mental disorders of children.

Schizophrenia and depression continue to be the target of much of the Intramural Research Program. Basic scientists work independently on the interrelationships of brain function and behavior. They also work in concert with clinicians to generate, synthesize, test and disseminate new knowledge to develop diagnostic and treatment methods. Among other accomplishments, one group of investigators has found that recovered depressives differ from normal individuals in their biochemical response to stress. Other studies have shown that depression, particularly manic-depressive illness, has a genetic component. These combined findings open the possibility that potential depressives may be diagnosed through testing of body fluids, treated accordingly, and thus avoid depression completely. These studies will be further developed in 1978.

With respect to mental disorders of children, the Intramural Research Program is working in the areas of retardation, hyperactivity, and depression. With respect to retardation, the intramural research program has identified the metabolic fault relating to phenylketonuria (PKU), a disease long associated with mental retardation. The intramural staff has proposed and tested innovative corrective measures and in doing so have discovered a new variant of the disease. From knowledge growing out of these findings, they have concluded that an effective treatment for this variant is theoretically possible. In 1978, this line of inquiry will be pursued further.

Using a multidisciplinary approach, intramural research clinicians have started a small scale operation, studying hyperactivity in children in an effort to understand the nature of the disorder and the best means of treating it. Amphetamines, the drug most commonly prescribed, are now being given to some 300,000 children in the United States. The drug is not without its hazards. Therefore, of particular interest is a project which has defined optimum plasma levels of amphetamines necessary for clinical improvement, thus making it possible to differentiate individual children who vary considerably in their response to this form of treatment. Within the resources available, these studies will be pursued further in 1978.

With respect to the special problems of childhood depression, investigators have now completed a pilot study of offsprings of patients previously admitted to NIMH clinical programs with affective illnesses. These descendants of depressive patients reveal an inordinately high incidence of pathology. The next step is to devise therapeutic interventions which will protect these children from developing depressive illness in later life. Plans for this next step will be continued in 1978.

The $2,090,000 net increase for FY 1978 reflects the following changes for intramural research:

1.	Within-grade increases.....	+$ 202,000
2.	Increased payments to NIH Management Fund.....	+1,427,000
3.	Decrease for one less day of pay.....	-39,000
4.	Replacement of obsolete equipment.....	+500,000
	Net Change.....	+2,090,000

B. Training:

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Training grants.....	1,217	$82,308,000	1,163	$80,162,000	-54	-2,146,000
Hospital Staff Develop.	48	1,200,000	88	2,200,000	+40	+1,000,000
Fellowships.....	276	3,092,000	338	4,238,000	+62	+1,146,000
Total.....	1,541	86,600,000	1,589	86,600,000	+48	---

The purposes of this activity are to train personnel for clinical service, research 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. The programs are carried out through the mechanisms of regular training grants; hospital staff development awards; and mental health fellowships.

Impact of 1978 budget:

1. Clinical training: The 1978 clinical training budget includes proposals which are directed toward two major objectives: a new initiative in clinical training; and maintaining the existing capacity of educational institutions and medical schools, while bringing about an orderly transition of priorities. Details of both sets of proposals are set forth below.

a. New Initiatives:

(1) Primary care givers: Primary care providers serve as the patient's initial contact with a health care system. For this reason, whether the patient is later referred to a mental health professional or not, the primary care giver is frequently required to deal extensively with psychiatric and emotional problems. Experience has proven that the educational system provides little mental health orientation for persons entering the general health field. To remedy the situation, NIMH is augmenting the psychiatric and psychosocial components in the training of medical students, physician residents in primary care training (family and general internal medicine, and general pediatrics), and others associated with the delivery of primary health care.

(2) Research and Demonstration Training and Manpower Projects: NIMH has for some time maintained a significant Research and Demonstration training program through the awarding of experimental and special project grants, continuing education grants, and grants to train paraprofessionals. This component of the R&D program will continue to receive funding and be expanded. A new component is now included within the R&D program which emphasizes Manpower Development issues. Initial priority will be placed upon those projects which address the problems of deinstitutionalization, quality assurance, certification, licensure, and maldistribution. In addition, special initiatives will be undertaken regarding security hospitals and similar facilities, disaster assistance, and prevention and control of rape.

(3) State Manpower Development: Most mental health services are provided through the public sector at State and local levels. Under Community Mental Health Centers legislation, States must develop, and periodically update, mental health service plans. More recently, requirements of the Health Planning and Resources Development Act of 1974 apply to mental health. Few States have had the capacity to include a comprehensive manpower assessment and development effort in their services planning process. NIMH has long maintained a modest program of technical assistance to States in the area of manpower planning. We now propose an enlarged effort to strengthen the leadership and role of State mental health authorities in this area. States will be expected to attend to the basic manpower aspects of the four NIMH national service priorities of community based mental health programs; services to special underserved target populations; deinstitutionalization and preventive services.

b. Clinical training in the core disciplines: A total of $45,996,000 is requested in 1978 for the four core disciplines of psychiatry, nursing, social work and psychology. This amount will provide approximately 77 new and competing grant awards. The objective is to maintain the existing training capacity, while effecting a redirection of training priorities for the purpose of placing greater emphasis on funding basic professional programs that are particularly responsive to service related priorities such as minority training, the maldistribution of manpower, the needs of special populations--deinstitutionalized groups, children, and the elderly.

c. Hospital Staff Development: NIMH proposes a $1,000,000 increase in the Hospital Staff Development program, which will provide a total of $1,475,000 for an estimated total number of 59 new awards in 1978. The increase, representing part of the general reorientation of the training program, reflects an NIMH initiative to improve services for the chronically disabled psychiatric patients who are at high risk of inappropriate institutional or community care. These individuals have comprised the long-term resident patient population of public mental hospitals. They have traditionally been vulnerable to various forms of exclusion, neglect, and even abuse. Often, their service options have been limited to a choice between inappropriate confinement in a hospital, or an almost total lack of assistance for survival in the community.

2. Research Training: The 1978 budget includes a proposal for the phase-out of all research training grants and predoctoral fellowships. However, new postdoctoral fellowships will continue to be supported. The budget includes funds for 209 such awards in 1978.

3. Efforts common to all programs: Several NIMH priorities are included in, and cut across, the categories described above. NIMH will strengthen its paraprofessional training programs, to insure an adequate supply of manpower in this essential field. In addition, the Institute will work to meet the needs of the aged, minorities, and children.

Workload Data: Information on numbers of awards by type of grant and program is set forth on the following tables.

Analysis of Training Grants and Contracts by Type

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Clinical Training:						
Grants:						
Regular:						
Continuations..	913	$60,658,000	768	$51,728,000	-145	-$ 8,930,000
Competing.....	6	500,000	6	500,000	---	---
New.....	95	6,805,000	208	15,735,000	+113	+8,930,000
Supplemental...	(11)	300,000	(11)	300,000	---	---
Subtotal.....	1,014	68,263,000	982	68,263,000	-32	---
Hospital Staff Development:						
Continuations..	15	375,000	29	725,000	+14	+350,000
Competing.....	11	275,000	--	---	-11	-275,000
New.....	22	550,000	59	1,475,000	+37	+925,000
Subtotal.....	48	1,200,000	88	2,200,000	+40	+1,000,000
Total Clinical Training.....	1,062	69,463,000	1,070	70,463,000	+8	+1,000,000
Research Training:						
Grants:						
Continuations...	166	11,384,000	181	11,899,000	+15	+515,000
Competing.....	---	---	--	---	--	---
New.....	37	2,661,000	--	---	-37	-2,661,000
Supplementals...	---	---	--	---	--	---
Subtotal.....	203	14,045,000	181	11,899,000	-22	-2,146,000
Fellowships:						
Predoctoral:						
Continuations..	67	536,000	46	388,000	-21	-148,000
New/competing..	32	256,000	--	---	-32	-256,000
Subtotal.....	99	792,000	46	388,000	-53	-404,000
Postdoctoral:						
Continuations..	107	1,393,000	83	1,098,000	-24	-295,000
New/Competing..	70	907,000	209	2,752,000	+139	+1,845,000
Subtotal.....	177	2,300,000	292	3,850,000	+115	+1,550,000
Total Fellowships	276	3,092,000	338	4,238,000	+62	+1,146,000
Total Research Training.....	479	17,137,000	519	16,137,000	+40	-1,000,000
Total Training....	1,541	86,600,000	1,589	86,600,000	+48	---

Analysis of Regular Grants by Program Distribution - Training

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Clinical Training:						
Continuations:						
Primary Health Care Manpower	---	---	12	$ 549,000	+12	+$ 549,000
Mental Health Manpower R&D:						
Training	125	$10,131,000	103	7,710,000	-22	-4,421,000
Manpower	44	3,580,000	20	1,604,000	-24	-1,976,000
State Manpower Development	---	---	10	706,000	+10	+706,000
Psychiatry	390	21,626,000	323	19,245,000	-67	-2,381,000
Nursing	68	8,067,000	44	6,934,000	-24	-1,133,000
Social Work	126	8,989,000	119	7,868,000	-7	-1,121,000
Psychology	160	8,265,000	137	7,112,000	-23	-1,153,000
Total Continuations	913	60,658,000	768	51,728,000	-145	-8,930,000
Competing/New:						
Primary Health Care Manpower	12	864,000	25	1,748,000	+13	+884,000
Mental Health Manpower R&D:						
Training	19	2,007,000	53	4,770,000	+34	+2,763,000
Manpower	6	500,000	37	3,032,000	+31	+2,532,000
State Manpower Development	10	1,000,000	22	2,148,000	+12	+1,148,000
Psychiatry	43	2,387,000	47	2,727,000	+4	+340,000
Nursing	2	284,000	6	707,000	+4	+423,000
Social Work	4	277,000	11	691,000	+7	+414,000
Psychology	5	286,000	13	712,000	+8	+426,000
Total Competing/New	101	7,605,000	214	16,535,000	+113	+8,930,000
Total Clinical Training	1,014	68,263,000	982	68,263,000	-32	---

Analysis of Regular Grants by Program Distribution - Training

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Research Training:						
Continuations:						
Development of Behavior.....	103	$6,095,000	109	$6,171,000	+6	+$76,000
Mental Disorders & Maladaptive Behav..	16	1,314,000	20	1,598,000	+4	+284,000
Social Problems relating to M.H.....	34	2,433,000	37	2,564,000	+3	+131,000
Services Delivery Systems, Research & Evaluation.....	13	1,542,000	15	1,566,000	+2	+24,000
Subtotal.....	166	11,384,000	181	11,899,000	+15	+515,000
New/Competing:						
Development of Behavior.....	17	1,125,000	---	---	-17	-1,125,000
Mental Disorders & Maladaptive Behav..	4	353,000	---	---	-4	-353,000
Social Problems relating to M.H.....	8	583,000	---	---	-8	-583,000
Services Delivery Systems, Research & Evaluation.....	8	600,000	---	---	-8	-600,000
Subtotal.....	37	2,661,000	---	---	-37	-2,661,000
Total, Research Trg. Grants.....	203	14,045,000	181	11,899,000	-22	-2,146,000

C. Community Programs:

Category & Funding Authority:	1977 Appropriation No.	1977 Appropriation Amount	1978 Estimate No.	1978 Estimate Amount	Increase or Decrease No.	Increase or Decrease Amount
1. Public Law 94-63:						
a. Planning.....	20	$1,000,000	--	---	-20	-$1,000,000
b. Operations:						
(1) New.....	30	18,418,000	--	---	-30	-18,418,000
(2) 94-63 Contin.	42	29,400,000	72	$53,340,000	+30	+23,940,000
(3) Conv. Staffg.	87	49,914,000	181	104,754,000	+94	+54,840,000
c. Consultation & Ed:						
(1) New.....	42	3,325,000	--	---	-42	-3,325,000
(2) Continuation.	55	4,675,000	97	8,245,000	+42	+3,570,000
d. Conversion:						
(1) New.....	33	8,640,000	--	---	-33	-8,640,000
(2) Continuation.	40	11,360,000	33	9,372,000	-7	-1,988,000
e. Distress:						
(1) New.....	16	3,100,000	---	---	-16	-3,100,000
(2) Continuation.	25	3,900,000	29	4,988,000	+4	+1,088,000
Subtotal, P.L.94-63.	390	133,732,000	412	180,699,000	+22	+46,967,000
2. Previous Legislation:						
a. Staffing.....	283	79,806,000	142	38,247,000	-141	-41,559,000
b. Child M.H.....	131	18,786,000	100	13,900,000	-31	-4,886,000
Subtotal.....	414	98,592,000	242	52,147,000	-172	-46,445,000
Total, Community Prog..	804	232,324,000	654	232,846,000	-150	+522,000

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:

1. Programs under P.L. 9463:

a. 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.

b. 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.

c. 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; followup services; and halfway house services.

d. 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.

e. 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.

f. 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.

2. 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 1978 budget:

Funds requested will provide continuation support for all awards made in previous years for which the Federal Government has a commitment in FY 1978. The budget does not propose any new awards.

Workload Data:

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	Funded	Operational	Funded	Operational	Funded	Operational
Total Centers.....	670	590	670	599	---	+9
Population Covered...	96M	89M	96M	90M	---	+1M
Patients treated:						
Children.....	501,264		534,212		+32,948	
Adults.....	1,587,336		1,691,672		+104,336	
Total Treated.....	2,088,600		2,225,884		+137,284	

Community Mental Health Centers receiving last year of support under the old legislation:

Previous	1977	1978	1979	1980	1981	1982
138	47	42	95	17	108	37

Source of Income:

Government:

Federal.....	34%
State.....	25
Local.....	8
Subtotal.....	67%
Third Party Payment....	20
Patient Fees.....	5
Other 1/.....	9
Total.....	100%

1/ Donations, fund raising, all other.

D. Program Support:

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Central Office...	522	$23,127,000	520	$22,670,000	-2	-$457,000
Regional Offices.	142	4,283,000	142	3,712,000	---	-571,000
SLUC.....	---	1,092,000	---	1,313,000	---	+221,000
Total, Prog. Sup.	664	28,502,000	662	27,695,000	-2	-807,000

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 1978 Budget:

NIMH Headquarters staff will provide consultation, technical assistance, and site visitation, on a selective basis, to recipients of an estimated 1,000 research grants. The Institute will work with approximately 1,200 training grant recipients for the purpose of bringing about an orderly redirection of the training program. It is expected that the Institute's Headquarters staff will respond to some 95,000 scientific and technical inquiries in 1978, and review up to 2,000 publications for relevant mental health content.

Regional Office and Headquarters staff will continue to provide guidance and technical assistance to an estimated 670 funded Community Mental Health Centers; and process approximately 654 continuation awards, under the CMHC program.

The 1978 budget proposes a program reduction of $1,969,000 to offset the inclusion of mandatory increases. Of this reduction, $626,000 is associated with regional office funds, primarily representing salary costs of regional office personnel. The remaining program reduction of $1,343,000 will necessitate the termination of all but a small level of support for contracts which in the past have been awarded to improve the delivery of mental health services to the public in such areas as availability, accessability, and utilization of services, and analyses of all types of services for effectiveness. Program support contracts for such things as conferences, workshops and development of manuscripts and manuals to improve the general public's knowledge of mental health problems will be discontinued. Further, the budget proposes a reduction of two administrative positions to eliminate potential overlapping of administrative functions at various organizational levels in the Public Health Service.

The $807,000 net decrease for FY 1978 reflects the following changes:

Program Support:

Within grade increases	+$367,000
Increased payments to GSA for rental of space (SLUC)	+221,000
Increased payments to DHEW Working Capital Fund	+341,000
Increased payments to PHS Service and Supply Fund	+227,000
Increased postage charges	+52,000
Increased payments for Federal Telecommunications System	+34,000
Increased payments to Office of Federal Employees Compensation	+17,000
Decrease for one less day of pay	-70,000
Decrease for 1978 position reduction	-27,000
Program Decrease	-1,969,000
Net Change	-807,000

II. Drug Abuse

	1977 Appropriation		1978 Estimate		Increase/Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research	102	$34,000,000	102	$34,000,000	---	$ ---
Training	---	10,000,000	---	10,000,000	---	---
Community Programs	---	200,000,000	---	201,500,000	---	+1,500,000
Program Support	315	16,686,000	314	16,572,000	-1	-114,000
Total	417	260,686,000	416	$262,072,000	-1	$+1,386,000

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

	1977 Appropriation		1978 Estimate		Increase/Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants	---	$ 24,690,000	---	$ 23,641,000	---	$-1,049,000
Contracts	---	6,497,000	---	6,802,000	---	+305,000
Subtotal	---	31,187,000	---	30,443,000	---	-744,000
Direct Operations:	102	2,813,000	102	3,557,000	---	+744,000
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 these problems in our society. FY 1978 funding maintains the FY 1977 level of $34 million, and includes support for new research initiatives in several high priority areas.

Research by Type Award

	1977 Appropriation		1978 Estimate		Increase/Decrease	
	No.	Amount	No.	Amount	No.	Amount
Grants:						
Regular:						
Continuation	139	$11,191,000	138	$10,297,000	-1	$ -894,000
Competing	77	5,358,000	45	3,554,000	-32	-1,804,000
New	16	1,079,000	36	2,488,000	+20	+1,409,000
Small Grants	4	23,000	4	23,000	---	---
Supplemental	(27)	549,000	(25)	499,000	(-2)	-50,000
Subtotal	236	18,200,000	223	16,861,000	-13	-1,339,000
Centers:						
Continuation	5	1,779,000	11	5,312,000	+6	+3,533,000
Competing	8	4,020,000	2	496,000	-6	-3,524,000
Subtotal	13	5,799,000	13	5,808,000	---	+9,000
Research Career Development Awards:						
Continuation	13	391,000	22	672,000	+9	+281,000
New	10	300,000	10	300,000	---	---
Subtotal	23	691,000	32	972,000	+9	+281,000
TOTAL GRANTS	272	24,690,000	268	23,641,000	-4	-1,049,000
Contracts:						
Renewals	51	5,638,000	41	4,353,000	-10	-1,285,000
New	10	859,000	29	2,449,000	+19	+1,590,000
Subtotal	61	6,497,000	70	6,802,000	+9	+305,000
TOTAL RESEARCH GRANTS AND CONTRACTS	333	$31,187,000	338	$30,443,000	+5	$-744,000

Research by Program Distribution

	1977 Appropriation	1978 Estimate	Increase/Decrease
Continuation:			
Epidemiology.....	$ 3,416,000	$ 2,520,000	$-896,000
Etiology.....	690,000	952,000	+262,000
Hazards.....	2,743,000	2,417,000	-326,000
Treatment.....	4,510,000	3,912,000	-598,000
Basic Research.....	2,020,000	1,904,000	-116,000
Gen. Res. Support...	3,450,000	2,945,000	-505,000
Centers.....	1,779,000	5,312,000	+3,533,000
R.C.D.A.....	391,000	672,000	+281,000
Subtotal Continuation.	18,999,000	20,634,000	+1,635,000
New/Competing:			
Epidemiology.....	968,000	1,109,000	+141,000
Etiology.....	818,000	947,000	+129,000
Hazards.....	1,314,000	1,099,000	-215,000
Treatment.....	2,078,000	2,496,000	+418,000
Basic Research.....	1,148,000	1,875,000	+727,000
Gen. Res. Support...	1,542,000	1,487,000	-55,000
Centers.....	4,020,000	496,000	-3,524,000
R.C.D.A.....	300,000	300,000	---
Subtotal New/Competing	12,188,000	9,809,000	-2,379,000
Total Research Grants and Contracts	$31,187,000	$30,443,000	$-744,000

Impact of FY 1978 Budget

1. Grants and Contracts: Research grants are awarded to public and private nonprofit agencies, research organizations, and academic institutions. Contracts are awarded for directed research in areas of central importance or when rapid development of a particular methodology is required. These funding mechanisms support the following major program areas:

(a) Epidemiology: The goal of epidemiology research is to estimate the extent of the drug abuse problem by providing continuously updated data on prevalence, incidence and trends of drug use. Studies, primarily employing survey technology, are designed to describe drug use for the population as a whole or for any one of a variety of special target populations. NIDA includes in its definition of "abuse" two broad categories of drug experience: 1) any use of illicit drugs; and 2) nonmedical use of prescription drugs. New projects in FY 1978 will include the NIDA survey of nonmedical drug use, with an emphasis on measurement of consequences, and, also, special studies of women, elderly persons and addicted infants.

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(b) Etiology: The goal of etiology is to determine the combinations of biological, behavioral, psychological, and societal factors most associated with increased risk to drug abuse. It includes studies of the personality correlates and behavioral factors which may predispose individuals to abuse drugs; longitudinal research studies which are concerned with medical and psychological factors that may be predictive of subsequent drug use; studies of familial factors and the influence of peers on the abuse of drugs; and experimental studies of group processes associated with behavior and attitudinal changes related to drug abuse. Among FY 1978 new initiatives will be a review of drug control systems in other countries and at different historical times, as well as studies of the impact of policy change in the U.S. Other initiatives will include studies of the relation of psychopathology to drug use and of characteristics of barbiturate users.

(c) Hazards: This component of the NIDA Research program includes studies which determine adverse effects of drugs on the physical and mental health of the individual and the consequences of drug abuse on society. In FY 1978, four major programs will be continued. They deal with the effects of drug use on impaired performance, particularly driving; the relation of drug use and crime; toxicity studies of abusable substances and treatment compounds; and determinations of the abuse potential of new drugs and drug combinations. NIDA will also undertake new studies to clarify the relation of addiction to economic behavior, commission of crimes, and suicide, and to assess the extent and effects of inhalant abuse.

(d) Treatment: Treatment research seeks to determine the most effective therapeutic procedures for reducing drug abuse. Included in this objective are the development and clinical evaluation of new pharmacological treatment methods, including antagonist and substitution approaches, the development of long-acting chemotherapeutic drugs, and investigation of innovative nonpharmacological treatment methods. New treatment research goals for FY 1978 are:

- To introduce LAAM as a standard therapeutic drug in the treatment of heroin addiction. This will serve to decrease methadone diversion and consequent "street" overdoses, and, through LAAM's longer action and decreased dosage, allow the client to develop a more normal lifestyle.

- To assess further the psychodynamic concepts and psychiatric treatment therapies for alleviation and cure of addiction and to determine whether these concepts provide clues to psychological factors predisposing individuals to substance abuse and addiction.

- To investigate what other nonchemotherapeutic treatment approaches are effective beyond the symptom-suppression of some pharmacologic therapies.

- To begin studies of the step progression concept of drug abuse treatment. This concept aims to provide a step progression of treatment modalities in a controlled environment starting with drug maintenance and gradually moving through nonchemotherapeutic stages toward achievement of abstinence within a given period of time.

- To complete clinical testing of the narcotic antagonist Naltrexone and make it available as a standard therapeutic drug.

- To conduct clinical testing of long-term depot release mechanisms for use with Naltrexone.

(e) Basic Research: The goal of biomedical basic research is to advance our knowledge of the pharmacology, biochemistry, and neurophysiology of abused drugs, their sites and mechanisms of action, their relation to analgesia, their behavioral effects, and the processes of drug tolerance, dependence and addiction. Among its initiatives in FY 1978, NIDA will:

- Conduct further studies to determine the nature and function of the newly discovered endorphins (naturally-occuring opiate-like substances), which may have profound relevance for elucidating the basic physiological phenomena of drug tolerance and dependence.

- Conduct further studies of drug effects on the so-called "reinforcing areas" of the brain to test whether they may mediate the addicting properties of drugs.

(f) General Research Support: Grants and contracts in this category provide for the development of methods and other resources required to further drug abuse research. Relevant activities are the development of quantitative drug assays, supply of controlled drugs and chemicals to researchers, analysis of research data, and the publication of monographs and reports. Initiatives for FY 1978 include development and refinement of current assay methods, quality control techniques for analyzing large numbers of assays, and implementation of a research analysis program to ensure maximum utilization of presently available research findings with minimal time loss between findings and their application.

(g) Centers: Research Centers consolidate human and technical resources within collaborative organizational settings to maximize the development and the outcome of drug abuse research. Efforts of these programs focus on clinical and behavioral studies of the addiction process, basic central nervous system mechanisms, social, psychological and etiological factors involved in drug abuse, and the ability of various theories to predict or explain drug use behavior. Of the 13 centers to be funded in FY 1978, 11 will be continuation grants and 2 will be renewals.

(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. In FY 1978, NIDA will support continuation costs of awards already committed and provide for 10 new awards, thereby helping to ensure a competent future pool of drug abuse researchers.

2. Direct Operations: This activity supports the Addiction Research Center in Lexington, Kentucky. As a result of the Bureau of Prisons decision to prohibit research using prisoners, some reorientation of A.R.C. programs has been necessary. Direct addiction studies for abuse liability assessment have been discontinued. However, the program of animal studies on abuse liability has been expanded and a treatment oriented clinical program is being developed. Also, an operations research capability has been established for systematic study, analysis, and integration of research data to provide an empirical basis for policy development. The FY 1978 request will support efforts to:

- Make possible the use of volunteer patients rather than prisoner subjects for clinical research using new pharmacologic agents in a therapeutic context.
- Further expand research on animal models for assessing the abuse liability of new analgesics, stimulants and depressants.
- Expand the program of studies initiated in FY 1977 on the basic mechanisms of tobacco dependence.

B. Training:

Activity Summary

	1977 Appropriation		1978 Estimate		Increase/Decrease	
	No.	Amount	No.	Amount	No.	Amount
Grants.....	36	$ 3,154,000	33	$ 2,894,000	-3	$ -260,000
Contracts.....	57	6,358,000	56	6,200,000	-1	-158,000
Fellowships...	42	488,000	67	906,000	+25	+418,000
TOTAL TRAINING	135	$10,000,000	156	$10,000,000	+21	$ ---

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. NIDA funds training directly through its clinical training grants and fellowships, and supports state programs through the National Drug Abuse Training Center, the Regional Resource Support Centers, and the State Training Support Program. A total of 9,489 persons will receive NIDA training support in FY 1978 compared to 10,548 in FY 1977. This budget reflects the continuing shift of training responsibility to the states.

Training by Type Award and Program

	1977 Appropriation		1978 Estimate		Increase/Decrease	
	No.	Amount	No.	Amount	No.	Amount
Clinical Training:						
Grants:						
Continuation	17	$1,573,000	19	$1,875,000	+2	$ +302,000
Competing	6	617,000	---	---	-6	-617,000
New	13	964,000	14	1,019,000	+1	+55,000
Supplemental	---	---	---	---	---	---
Subtotal	36	3,154,000	33	2,894,000	-3	-260,000
Contracts:						
NDATC:*						
Renewal	1	2,500,000	1	2,500,000	---	---
Other:						
Renewal	56	3,858,000	55	3,700,000	-1	-158,000
New	---	---	---	---	---	---
Subtotal	56	3,858,000	55	3,700,000	-1	-158,000
Subtotal Contracts	57	6,358,000	56	6,200,000	-1	-158,000
Subtotal Clinical Trng	93	9,512,000	89	9,094,000	-4	-418,000
Research Training:						
Fellowships:						
Predoctoral:						
Continuation	5	31,000	4	28,000	-1	-3,000
New	4	28,000	---	---	-4	-28,000
Subtotal	9	59,000	4	28,000	-5	-31,000
Postdoctoral:						
Continuation	10	112,000	27	371,000	+17	+259,000
New	23	317,000	36	507,000	+13	+190,000
Subtotal	33	429,000	63	878,000	+30	+449,000
Subtotal Fellowships						
Research Training	42	488,000	67	906,000	+25	+418,000
TOTAL TRAINING	135	$10,000,000	156	$10,000,000	+21	$ ---

* National Drug Abuse Training Center

Impact of FY 1978 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. This program includes the career teacher effort which trains medical school teachers to be knowledgeable about drug abuse issues. In FY 1978, thirty-three continuing and new projects will be funded.

2. Research Fellowships: Under the provisions of the National Research Service Award Act, NIDA supports the awarding of degree-oriented individual and institutional fellowships to increase the supply of biomedical and behavioral researchers. Both continuation and new postdoctoral fellowships will be funded in FY 1978.

3. Contracts: In FY 1978, NIDA will continue to support the operation of the National Drug Abuse Training Center in Washington, D.C. This center's primary responsibility is the provision of information, materials, and technical assistance to state training programs. Its functions include training for specific manpower needs on a short term basis until the states can respond, the development and validation of training courses that can be readily adopted by state training programs, the design of training models for sparsely populated states, and production of criteria for assessing work experience in terms of academic credit. In addition, contract funding will continue to support awards to single state agencies for development of state training programs, and five Regional Resource Support Centers, which serve the states as sources of training materials, courses, and technical assistance.

C. Drug Abuse Community Programs:

Activity Summary

	1977 Appropriation		1978 Estimate		Increase/Decrease	
	No.	Amount	No.	Amount	No.	Amount
Project Grants and Contracts:						
Treatment.....	175	$145,118,000	143	$146,457,000	-32	$+1,339,000
Demonstration.....	51	11,118,000	43	9,468,000	-8	-1,650,000
Prevention.....	25	3,764,000	32	5,575,000	+7	+1,811,000
Subtotal.....	251	160,000,000	218	161,500,000	-33	+1,500,000
Formula Grants.....	56	40,000,000	56	40,000,000	---	---
Total Community Prog..	307	$200,000,000	274	$201,500,000	-33	$+1,500,000

Through the projects funded under the community programs budget activity, the NIDA administers a comprehensive program of drug abuse treatment, treatment demonstration, and prevention activities. The budget recognizes that the Federal Government must continue to share a large burden of the effort in treating drug addicts and abusers. For example, more than 55% of the 260,000 treatment slot capacity in the United States is funded in whole or in part by the Federal Government. Of this, NIDA currently funds 102,000 treatment slots, or 39% of the nation's capacity. Most of these slots are currently funded with a matching Federal share decreasing to a maximum of 60% Federal funding with the intent that the Federal share will be maintained at this level until alternate funding sources have been identified. Presently, those awardees already receiving less than 60% will continue at their current rate.

Impact of the 1978 Budget

The FY 1978 community programs budget reflects an effort to more efficiently allocate funds to areas of greatest need in accordance with the mandates of the Domestic Council's White Paper on Drug Abuse. To meet this objective, the FY 1978 budget proposes the following:

- The statewide services contract program will receive increased support to provide additional responsibility for drug treatment at the state level. Limited Federal support also will be provided to the states to assist them in assuming greater administrative responsibility.

- NIDA will continue to selectively reduce the number of inpatient slots in order to reprogram funds into lower cost/higher return treatment modalities.

- The limited number of new demonstration projects in 1978 will concentrate on developing vocational rehabilitation programs specifically designed for the drug abuser, and on devising outreach techniques for the polydrug abuser, women, and criminal justice clientele.

- Two new prevention programs will be initiated: (1) an effort to integrate successful prevention strategies into the state plans; and, (2) an expansion of the project grant program.

The dollar levels for each of the various funding mechanisms and a brief description follows:

Community Programs by Type Award

	1977 Appropriation		1978 Estimate		Increase/Decrease	
	No.	Amount	No.	Amount	No.	Amount
Project Grants:						
Staffing:						
Continuation.....	14	$ 4,847,000	---	$ ---	-14	$-4,847,000
Service - 8 Yr.						
Continuation.....	86	37,713,000	83	37,468,000	-3	-245,000
Service - 3 Yr.						
Continuation.....	5	979,000	2	354,000	-3	-625,000
Competing.....	12	2,392,000	---	---	-12	-2,392,000
Subtotal.....	17	3,371,000	2	354,000	-15	-3,017,000
Demonstration						
Continuation.....	21	6,365,000	21	6,103,000	---	-262,000
Competing.....	---	---	3	600,000	+3	+600,000
New.....	7	2,000,000	4	920,000	-3	-1,080,000
Subtotal.....	28	8,365,000	28	7,623,000	---	-742,000
Prevention						
Continuation.....	11	1,265,000	12	1,275,000	+1	+10,000
Competing.....	---	---	3	500,000	+3	+500,000
New.....	12	1,199,000	10	1,000,000	-2	-199,000
Subtotal.....	23	2,464,000	25	2,775,000	+2	+311,000
Total Grants						
Continuation.....	137	51,169,000	118	45,200,000	-19	-5,969,000
Competing.....	12	2,392,000	6	1,100,000	-6	-1,292,000
New.....	19	3,199,000	14	1,920,000	-5	-1,279,000
Total Grants.....	168	56,760,000	138	48,220,000	-30	-8,540,000

	1977 Appropriation		1978 Estimate		Increase/Decrease	
	No.	Amount	No.	Amount	No.	Amount
Contracts:						
Statewide						
Renewal	49	83,190,000	50	105,285,000	+1	+22,095,000
Supplemental	(49)	12,847,000	---	---	(-49)	-12,847,000
Subtotal	49	96,037,000	50	105,285,000	+1	+9,248,000
NARA*						
Renewal	5	200,000	5	200,000	---	---
Post-Treatment Eval.						
Renewal	---	---	1	900,000	+1	+900,000
New	1	650,000	---	---	-1	-650,000
Subtotal	1	650,000	1	900,000	0	+250,000
Program Review						
Renewal	2	1,700,000	1	1,650,000	-1	-50,000
Psych. Care						
Renewal	1	600,000	1	600,000	---	---
Demonstration						
Renewal	14	1,760,000	15	1,845,000	+1	+85,000
New	9	993,000	---	---	-9	-993,000
Subtotal	23	2,753,000	15	1,845,000	-8	-908,000
Prevention						
Renewal	2	1,300,000	2	1,300,000	---	---
New	---	---	5	1,500,000	+5	+1,500,000
Subtotal	2	1,300,000	7	2,800,000	+5	+1,500,000
Total Contracts:						
Renewal	73	88,750,000	75	111,780,000	+2	+23,030,000
New	10	1,643,000	5	1,500,000	-5	-143,000
Supplemental	(49)	12,847,000	---	---	(-49)	-12,847,000
Total Contracts	83	103,240,000	80	113,280,000	-3	+10,040,000
Total Proj. Grants and Contracts:						
Continuation	210	139,919,000	193	156,980,000	-17	+17,061,000
Competing	12	2,392,000	6	1,100,000	-6	-1,292,000
New	29	4,842,000	19	3,420,000	-10	-1,422,000
Supplemental	(49)	12,847,000	---	---	(-49)	-12,847,000
Total	251	160,000,000	218	161,500,000	-33	+1,500,000
Formula Grants	56	40,000,000	56	40,000,000	---	---
Total Community Prog.	307	$200,000,000	274	201,500,000	-33	$+1,500,000

* Narcotic Addict Rehabilitation Act.

Analysis Cost/Slot*

	1977 Appropriation		1978 Estimate	
	Slots	Cost/ Slot	Slots	Cost/ Slot
Treatment Grants and Contracts:				
Staffing.....	4,092	$1,016	---	$ ---
Service 8 yr..	26,838	1,400	26,133	1,433
Service 3 yr..	2,204	1,488	231	1,532
Statewide.....	61,382	1,565	68,152	1,545
Total Treatment....	94,516	$1,493	94,516	$1,514
Other: (Slots Only)				
NARA.....	181		181	
Demonstration	2,395		2,183	
Research Prog.	1,700		1,700	
Formula Grants	3,314		3,314	
TOTAL NIDA.....	102,106		101,894	

* This data reflects only the Federal share of cost/slot.

1. Project Grants and Contracts:

   a. Staffing Grants: The Staffing Grants program was designed to provide funds to pay a portion of the salaries of drug abuse treatment professional and technical personnel in comprehensive community centers. It is anticipated that all staffing grants will either have terminated or been incorporated into the statewide service contracts; therfore, no funds have been requested for FY 1978 in this area.

   b. Service Grants: These projects provide Federal support for programs of treatment and rehabilitation which include detoxification, institutional treatment, or community-based aftercare services. Eighty-three of these programs, originally funded under Section 256 of the Community Mental Health Centers Act, will be in their fifth through eighth year and receive continuation funding in 1978. Two projects, funded since April, 1973, under Section 410 of the Drug Abuse Office and Treatment Act, will receive funding consideration in FY 1978. The FY 1978 budget reflects the anticipated incorporation of current service projects into statewide service contracts. No new grants are being awarded under this program.

c. Demonstration Grants and Contracts: Demonstration projects are awarded to develop and evaluate promising new theories or approaches relating to substance abuse treatment and rehabilitation services. There are three aspects to this activity: the gathering of data to define appropriate treatment and rehabilitation approaches for client groups with unique cultural, geographical, and/or psychological characteristics; the construction of innovative models to improve the quality of services based on these data; and evaluation methodologies designed to determine program effectiveness and to make possible the integration of new methods into community programs. Current and projected demonstration efforts include: the study of drug use among elderly, including prescription practices among physicians; the delivery of services to specific minority groups including women and youth; projects to link the community justice system with treatment resources in the community; the development, testing and implementation of treatment models for industrial settings; and the development of effective treatment approaches to the abuse of inhalants. New funds will support the development of vocational rehabilitation programs specifically designed for the drug abuser and outreach techniques for the polydrug abuser, women, and criminal justice clientele. Demonstration funds also support the Drug Abuse Warning Network (DAWN), a cooperative effort between NIDA and the Drug Enforcement Administration to collect data on a national basis regarding trends and extent of drug abuse.

d. Prevention Grants and Contracts: This activity supports programs which have the potential for developing new knowledge and methodologies which provide constructive alternatives to, and can compete successfully with, the sought-after pharmacological effects of drugs. One of NIDA's major objectives is to see that information concerning prevention programs that prove to be effective is disseminated nationally. In 1978, NIDA will move in two major directions: the mobilization of state and local community resources aimed at high risk groups with the goal of preventing, rather than merely treating, abuse of illicit substances; and the support of a series of project grants for the development of model prevention projects aimed primarily at school age children.

e. Statewide Service Contracts: This program is a cost-reimbursement, cost sharing, contractual mechanism through which the Institute can fund a number of drug treatment projects under the auspices of the single state drug authority. Subcontracts are awarded by the state to support local treatment projects which have the same basic objectives and requirements as the drug abuse service grants. This program is the primary mechanism by which states assume greater direct administrative responsibility and accountablity for their drug abuse activities. In FY 1978 this mechanism will become operational in fifty states and territories at a cost of $105,285,000.

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 1978 to provide treatment services for addicts specifically requesting or expressly directed to this program. Efforts are currently being made to integrate NARA agencies with community based projects, community mental health centers, independent drug service projects, and statewide service contracts. It is anticipated that $200,000 will be required in FY 1978.

g. Program Evaluation and Review: Two projects will be funded to review the efficacy of drug abuse treatment services. The post-treatment evaluation project is a nationwide Treatment Outcome Prospective Study designed to provide baseline data on drug abusers entering treatment and on subsequent treatment impact, including social adjustment within the community. The program review contract will monitor the efficiency of the management, fiscal, and programmatic activities of Federally funded treatment projects. This project ensures compliance with Federal funding criteria and maintenance of a fully utilized treatment capacity, validates data required by Federal reporting systems and identifies potential strengths and weaknesses, making recommendations to NIDA.

2. Formula Grants to States:

These awards are made under the authority of Section 409 of the Drug Abuse Office and Treatment Act, as amended, and were first made available in FY 1973. Financial assistance is provided to the state for planning, establishing, conducting, and coordinating projects for the development of more effective drug abuse prevention functions 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 at $40,000,000 in FY 1978. 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.

D. Program Support:

	1977 Appropriation		1978 Estimate		Increase/Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Central Office.....	295	$15,764,000	294	$15,575,000	-1	$-189,000
Regional Office.....	20	507,000	20	500,000	---	-7,000
S.L.U.C.....	---	415,000	---	497,000	---	+82,000
Total.....	315	$16,686,000	314	$16,572,000	-1	$-114,000

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 provides for the development and dissemination of drug abuse information.

The FY 1978 budget includes funding, at a reduced level, for information development and dissemination projects which support the Institute's various management information systems and the National Clearinghouse for Drug Abuse Information. The information systems provide program managers at the Federal, state, and local levels with accurate, timely, and useful information for planning resource allocations, monitoring, and evaluation. A variety of reports, both routine and special, are generated. The major information systems are: (a) the Client Oriented Data Acquisition Process (CODAP) which is concerned with the monthly collection of client data; and (b) the National Drug Abuse Treatment Utilization Survey (NDATUS), which provides information on all drug abuse treatment units, regardless of source funding. The National Clearinghouse for Drug Abuse Information distributes posters, pamphlets, publications, and other material for use by the general public, researchers, teachers, physicians, interested groups, and individuals. The budget reflects the elimination of one administrative position to eliminate potential overlapping of administrative functions at various organizational levels in the Public Health Service.

The $114,000 decrease projected for FY 1978 reflects the following changes:

Program Support:

Within grade increases.....	+134,000
Increased payment to G.S.A. for rental space (S.L.U.C.).....	+82,000
Increased cost of DHEW Working Capital Fund.....	+108,000
Increased cost of Health, Service, and Supply Fund.....	+101,000
Increased postage charges.....	+18,000
Increased Federal Telecommunications System charges.....	+10,000
Increased cost to Office of Federal Employees Compensation....	+8,000
One less day of pay.....	-26,000
1978 position reduction.....	-13,000
Program decrease.....	-536,000
Net Change.....	$-114,000

III. ALCOHOLISM

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research.....	37	$ 12,808,000	37	$ 13,179,000	--	$ +371,000
Training.....	--	7,200,000	--	7,200,000	--	---
Comm. Programs..	--	123,908,000	--	124,219,000	--	+311,000
Program Support.	158	9,538,000	157	9,468,000	-1	-70,000
TOTAL.....	195	153,454,000	194	154,066,000	-1	+612,000

NARRATIVE

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), 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 in 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

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Research Grants..	--	$ 9,770,000	--	$ 7,811,000	--	$ -1,959,000
Contracts.....	--	1,167,000	--	1,700,000	--	+533,000
Direct Operations	37	1,871,000	37	3,668,000	--	+1,797,000
TOTAL, RESEARCH	37	12,808,000	37	13,179,000	--	+371,000

The increased public awareness of alcoholism as a major health problem which can be treated within the health services community, and the likelihood of more comprehensive insurance coverage for alcoholism treatment, have created a great demand for research into the causes and effects of alcohol abuse and the development of more effective methods of alcoholism treatment and prevention.

Research is conducted in the biomedical and psychosocial aspects of alcoholism through the award of direct project grants and contracts, and through the intramural research program.

The intramural research laboratory, located at Saint Elizabeths Hospital, to be relocated in Rockville and at the campus of NIH, 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. Ultimately, the goal is to establish the entire intramural research effort on the campus at NIH.

RESEARCH GRANTS AND CONTRACTS BY TYPE

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Grants:						
Regular:						
Continuations..	86	$ 6,186,000	63	$ 4,907,000	-23	$-1,279,000
Competing.....	21	1,660,000	18	1,361,000	-3	-299,000
New.....	10	1,097,000	6	544,000	-4	-553,000
Small Grants...	4	24,000	4	24,000	--	---
Supplemental...	(15)	200,000	(15)	200,000	(--)	---
Subtotal.....	121	9,167,000	91	7,036,000	-30	-2,131,000
Res. Scientist Develop. Awards:						
Continuations.	7	213,000	18	535,000	+11	+322,000
Competing.....	3	90,000	1	30,000	-2	-60,000
New.....	10	300,000	7	210,000	-3	-90,000
Subtotal.....	20	603,000	26	775,000	+6	+172,000
Subtotal, Grants	141	9,770,000	117	7,811,000	-24	-1,959,000
Contracts:						
Renewal.....	6	517,000	9	900,000	+3	+383,000
New.....	6	650,000	9	800,000	+3	+150,000
Subtotal.....	12	1,167,000	18	1,700,000	+6	+533,000
TOTAL, RESEARCH GRANTS AND CONTRACTS	153	10,937,000	135	9,511,000	-18	-1,426,000

RESEARCH GRANTS AND CONTRACTS BY PROGRAM

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations:						
Biological.....	37	$ 2,196,000	26	$ 1,878,000	-11	$-318,000
Clinical/Medical	16	1,100,000	17	1,116,000	+1	+16,000
Clinical/Psych..	13	910,000	16	1,022,000	+3	+112,000
Behavioral.....	23	1,590,000	19	1,366,000	-4	-224,000
Epidemiology....	7	770,000	9	692,000	+2	-78,000
Scientific Eval.	3	350,000	3	268,000	--	-82,000
Subtotal.....	99	6,916,000	90	6,342,000	-9	-574,000
Competing:						
Biological.....	17	1,047,000	12	705,000	-5	-342,000
Clinical/Medical	10	838,000	8	614,000	-2	-224,000
Clinical/Psych..	13	874,000	10	615,000	-3	-259,000
Behavioral.....	9	802,000	7	579,000	-2	-223,000
Epidemiology....	4	368,000	7	597,000	+3	+229,000
Scientific Eval.	1	92,000	1	59,000	--	-33,000
Subtotal.....	54	4,021,000	45	3,169,000	-9	-852,000
TOTAL, RESEARCH GRANTS AND CONTRACTS	153	10,937,000	135	9,511,000	-18	-1,426,000

Impact of 1978 Budget:

1. Grants and Contracts: A balanced program will be maintained in 1978 between biomedical and psychosocial research, with continued emphasis upon clinical research in both medical and psychological areas. Areas of emphasis to be addressed in 1978 include the following:

a. Biological: Neurological studies will be supported to investigate the effects of alcohol on the central nervous system with particular attention to the neurochemical substances which affect the functions of the brain and neuroendocrine activity. Other areas to be addressed are the relationship of alcohol abuse to cancer and diseases of the heart and liver, and prenatal effects of alcohol.

b. Clinical/Medical: Applied research will be directed to studies regarding the rapid clearance of alcohol from the body, blocking the intoxicating effects of alcohol, and the improvement in medical care of the patient during withdrawal from alcohol.

c. Clinical/Psychological: Studies of diagnosis and treatment methods will be aimed at increasing the efficiency and reducing the cost of alcoholism treatment.

d. Behavioral: Research into the moderate use of alcohol will contribute to a better definition of the alcoholic person and alcohol abuse. Areas to be emphasized are drinking among women, youth, and the elderly.

e. Epidemiology: The Institute will develop and maintain a system of surveillance of alcohol consumption using the most accurate and complete data sources available and developing new sources where necessary. Data will be used in studies of the natural history and trends of alcohol use and abuse. Emphasis will be placed on population based research to elucidate specific risk factors, prevention techniques, and acceptable outcomes of treatment, as well as the relationship of alcohol use to illnesses such as heart disease and cancer.

2. Intramural Research: In the current year the Institute is working towards the establishment of an 8 bed clinical research facility within the NIH Clinical Center. It is anticipated that this program will be fully operational in 1978. The Institute will utilize existing positions in order to staff the Clinical Program.

A description of intramural research activities currently supported in 1977 and to be continued in 1978 is provided below.

a. Biochemical Program: Studies will continue 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.

b. Psychology Program: Studies will continue to investigate the behavioral determinants which induce alcohol ingestion and the factors which inhibit or regulate alcohol consumption.

c. Neuroscience Program: Studies will be undertaken to discover how alcohol exerts its toxic effects on certain brain functions, specifically those mechanisms which bear on intoxication, addiction, withdrawal, and alcoholic blackouts.

d. Clinical Program: Studies will be devoted to the investigation of the pathogenesis of alcoholism and the development of new treatment methods for the various medical complications resulting from alcohol abuse. Clinical research will include studies of alcoholic hyperlipidemia, hepatitis, fatty liver, cirrhosis, pancreatitis, and cardiomyopathy.

The 1978 Estimate provides funds for the treatment of alcoholic patients in a hospital setting with an initial capacity of eight beds. The program increase of $1.8 million in 1978 reflects: $.9 million in payments to the NIH management fund; $.5 million for new equipment purchases; and $.4 million for renovations, transportation, and miscellaneous expenses associated with the new facility.

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B. TRAINING

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	No. of Awards	Amount	No. of Awards	Amount	No. of Awards	Amount
Training Grants	72	$ 6,681,000	72	$ 5,757,000	--	$-924,000
Fellowships....	39	519,000	92	1,443,000	+53	+924,000
TOTAL, TRAINING	111	7,200,000	164	7,200,000	+53	---

Training grants and fellowships are awarded to defray institutional costs of facilities engaged in alcoholism training, and to provide stipends to individuals enrolled in the training programs.

The Institute provides support for various kinds of alcoholism 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 the developing service delivery systems and the needs for knowledge.

TRAINING GRANTS AND FELLOWSHIPS BY TYPE OF AWARD

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	No. of Awards	Amount	No. of Awards	Amount	No. of Awards	Amount
Clinical Training:						
Grants:						
Continuations...	47	$ 4,995,000	19	$ 1,570,000	-28	$-3,425,000
Competing.....	8	676,000	12	1,091,000	+4	+415,000
New.....	2	192,000	27	2,273,000	+25	+2,081,000
Supplemental....	(--)	---	(--)	---	(--)	---
Subtotal.....	57	5,863,000	58	4,934,000	+1	-929,000
Research Training:						
Grants:						
Continuations...	9	518,000	14	823,000	+5	+305,000
Competing.....	--	---	--	---	--	---
New.....	6	300,000	--	---	-6	-300,000
Supplemental.....	(--)	---	(--)	---	(--)	---
Subtotal.....	15	818,000	14	823,000	-1	+5,000
Fellowships:						
Predoctoral:						
Continuations....	7	48,000	8	55,000	+1	+7,000
New.....	5	35,000	--	---	-5	-35,000
Subtotal.....	12	83,000	8	55,000	-4	-28,000

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	No. of Awards	Amount	No. of Awards	Amount	No. of Awards	Amount
Postdoctoral:						
Continuations....	11	184,000	24	388,000	+13	+204,000
New.....	16	252,000	60	1,000,000	+44	+748,000
Subtotal.....	27	436,000	84	1,388,000	+57	+952,000
Subtotal.....	39	519,000	92	1,443,000	+53	+924,000
Subtotal,Res.Train.	54	1,337,000	106	2,266,000	+52	+929,000
TOTAL, TRAINING	111	7,200,000	164	7,200,000	+53	---

Impact of 1978 Budget:

The 1978 Estimate provides full funding support for the continuation of existing projects. In addition, $4,364,000 will provide support for 99 new and competing awards for which the Institute plans to expand its career teachers program in medical schools and universities. Those individuals already providing services in the health care delivery system will be given priority for continuing education in the field of alcoholism, while those in professional studies will receive alcoholism training as part of their degree program. The Institute plans to increase the knowledge of law enforcement and judicial officials who have unique opportunities for becoming rehabilitation agents in the early stages of alcoholism incidence. In conjunction with the increase in State and local activities to provide service, there is a growing need to develop alcoholism counselors who deal with the immediate treatment requirements of alcoholic people. The Institute also plans to encourage the development of family therapy as a tool in the treatment of alcoholic people.

In 1978, research training grants and predoctoral fellowships will be phased out and greater emphasis will be given to postdoctoral fellowships in the biological, psychological and social science areas.

C. COMMUNITY PROGRAMS

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Project Grants...	606	$ 65,466,000	524	$ 65,379,000	-82	$ -87,000
Contracts.....	7	2,942,000	7	3,340,000	---	+398,000
Formula Grants...	56	55,500,000	56	55,500,000	---	---
TOTAL	669	123,908,000	587	124,219,000	-82	+311,000

Alcoholism community programs support efforts in States and localities to develop and maintain alcoholism prevention, education, treatment and rehabilitation programs.

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

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Staffing Grants:						
Noncompeting.....	43	$ 7,086,000	42	$ 8,360,000	-1	$ +1,274,000
Matching Rate Policy:						
Non-poverty:						
Noncompeting....	87	12,109,000	94	11,961,000	+7	-148,000
Competing.....	89	11,095,000	68	8,796,000	-21	-2,299,000
New.....	--	---	--	---	--	---
Subtotal.....	176	23,204,000	162	20,757,000	-14	-2,447,000
Poverty:						
Noncompeting.....	142	7,941,000	147	7,304,000	+5	-637,000
Competing.....	52	3,551,000	22	3,459,000	-30	-92,000
New.....	--	---	--	---	--	---
Subtotal.....	194	11,492,000	169	10,763,000	-25	-729,000
Total, Matching Rate Policy.....	370	34,696,000	331	31,520,000	-39	-3,176,000
Indian:						
Noncompeting.....	102	8,236,000	100	10,556,000	-2	+2,320,000
Competing.....	46	4,130,000	14	1,743,000	-32	-2,387,000
New.....	--	---	--	---	--	---
Subtotal.....	148	12,366,000	114	12,299,000	-34	-67,000
Uniform Act:						
Noncompeting.....	21	7,034,000	26	9,035,000	+5	+2,001,000
New.....	5	2,001,000	10	4,053,000	+5	+2,052,000
Subtotal.....	26	9,035,000	36	13,088,000	+10	+4,053,000
Prevention:						
Noncompeting.....	19	2,283,000	1	112,000	-18	-2,171,000
Competing.....	--	---	--	---	--	---
New.....	--	---	--	---	--	---
Subtotal.....	19	2,283,000	1	112,000	-18	-2,171,000
Total Grants:						
Noncompeting.....	414	44,689,000	410	47,328,000	-4	+2,639,000
Competing.....	187	18,776,000	104	13,998,000	-83	-4,778,000
New.....	5	2,001,000	10	4,053,000	+5	+2,052,000
Subtotal.....	606	65,466,000	524	65,379,000	-82	-87,000

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
Contracts:						
Eval. of Treatment:						
Renewal.....	5	$ 1,200,000	5	$ 1,200,000	--	---
New.....	--	---	--	---	--	---
Subtotal.....	5	1,200,000	5	1,200,000	--	---
Other Contracts:						
Renewal.....	2	1,742,000	2	2,140,000	--	+398,000
New.....	--	---	--	---	--	---
Subtotal.....	2	1,742,000	2	2,140,000	--	+398,000
Total Contracts:						
Renewal.....	7	2,942,000	7	3,340,000	--	+398,000
New.....	--	---	--	---	--	---
Subtotal.....	7	2,942,000	7	3,340,000	--	+398,000
Total, Comm. Proj.:						
Noncompeting....	421	47,631,000	417	50,668,000	-4	+3,037,000
Competing.....	187	18,776,000	104	13,998,000	-83	-4,778,000
New.....	5	2,001,000	10	4,053,000	+5	+2,052,000
Total.....	613	68,408,000	531	68,719,000	-82	+311,000
Formula Grants...	56	55,500,000	56	55,500,000	--	---
TOTAL, COMMUNITY PROGRAMS	669	123,908,000	587	124,219,000	-82	+311,000

ESTIMATE OF PROGRAM BENEFICIARIES

	1977 Appropriation	1978 Estimate
Initial Contacts*:		
Staffing.....	34,000	33,000
Poverty.....	52,000	44,000
Non Poverty:		
Occupational.....	20,000	15,000
Drinking Driver....	10,000	7,000
Public Inebriate...	30,000	27,000
Indians.....	26,000	20,000
Other.....	60,000	59,000
TOTAL	232,000	205,000

*Approximately 80% of initial contacts receive treatment in the NIAAA program.

In 1978, the Institute will continue to fund alcoholism treatment projects, with the exception of staffing grants, according to the alcohol matching-rate funding policy which provides for a gradual phasing down of Federal support over a maximum of six years. Emphasis continues to be placed on supporting programs reaching 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, Native Americans, 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 1978 estimate provides continuation support for the 26 States previously enacting the Uniform Alcoholism Intoxication and Treatment Act.

In addition to the priority grant areas mentioned above, the Institute will support a limited number of evaluation contracts designed to determine the effectiveness of NIAAA-funded treatment programs.

Data obtained from Institute supported staffing grants shows that 71% recovery rates persist at 18 months following entry into treatment. Recovery is defined as an average drinking rate of less than one ounce of alcohol per day. Behavioral impairment due to alcoholism is reduced by similar amounts, and the unemployment rate decreases by 28%. The data also indicates that group counseling is as effective as individual psychotherapy.

In addition to the treatment effectiveness shown by these NIAAA-funded alcoholism treatment centers (ATCs), there has been a continuing improvement in the efficiency of treatment delivery. Costs of clients served per month in ATC's has decreased 44% from FY 73 to FY 76. This reduction corresponds to the shift in emphasis to outpatient services, the increase in the number of clients served and changes in staffing patterns to employ more paraprofessionals. The increase in the ATC client employment rate and the increase in average wages provides over $1 million in added earned income per month. In addition, the number of clients institutionalized (hospitalized or in jail) decreased 74%, 180 days after intake into the ATC program.

The formula grant program will serve an estimated 95,000 individuals. Based on historical experience, it is estimated that State-supported treatment efforts will comprise about 58% 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 1978 Budget:

In addition to continuation support for existing community project grants and contracts, the 1978 Estimate provides $4.1 million for 10 new States enacting the Uniform Act.

The 1978 Estimate provides support for Indian alcoholism treatment programs through the sixth year at full commitment levels. Programs receiving six years of support by NIAAA will be transferred to the Indian Health Service for future funding. In 1978, 34 such programs will have reached the end of committed support by the Institute, and are not included in the continuation requirements reflected in the above tables.

Under "Other Contracts" the Institute will provide partial support for the National Clearinghouse for Alcohol Information (NCALI) and the National Center for Alcohol Education (NCAE). The NCALI will be supported at a level of $1,100,000 in both 1977 and 1978 and the NCAE will be supported at a level of $642,000 in 1977 and $1,040,000 in 1978. Remaining support will come from the "Program Support" activity.

The 1978 Estimate will continue the formula grant program at the 1977 appropriation level of $55.5 million.

D. PROGRAM SUPPORT

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program Support:						
Central Office...	158	$ 8,513,000	157	$ 8,334,000	-1	$ -179,000
Regional Offices.	--	458,000	--	454,000	--	-4,000
SLUC.....	--	567,000	--	680,000	--	+113,000
TOTAL, PROGRAM SUPPORT	158	9,538,000	157	9,468,000	-1	-70,000

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 funded in this activity are a portion of the National Center for Alcohol Education and the National Clearinghouse for Alcohol Information. These projects promote public awareness about the health consequences of alcohol abuse. These efforts are at the heart of the Institute's mission since the strongest prospect for prevention of alcoholism and alcohol abuse lies in the degree to which the public can be educated with frank, accurate and up-to-date information. The budget reflects the elimination of one administrative position to eliminate potential overlapping of administrative functions at various organizational levels in the Public Health Service.

The $70,000 decrease in this activity reflects the following changes:

Program Support:

Within grade increases	$+101,000
Increase payment to G.S.A. for rental space (S.L.U.C.)	+113,000
Increase cost of DHEW Working Capital Fund.	+68,000
Increase cost of Health, Service and Supply Fund	+67,000
Increase postage charges	+14,000
Increase Federal Telecommunications System charges	+7,000
Increase cost to Office of Federal Employees Compensation	+4,000
One less day of pay	-22,000
1978 position reduction	-13,000
Program decrease	-409,000
Net Change	-70,000

MAJOR CONTRACTS BY TYPE

	1977 Appropriation		1978 Estimate		Increase/ Decrease	
	No.	Amount	No.	Amount	No.	Amount
National Center for Alcohol Education.	1	$ 438,000	1	$ 40,000	--	$ -398,000
Nat'l Clearinghouse for Alcohol Inform.	1	900,000	1	900,000	--	---
TOTAL	2	1,338,000	2	940,000	--	-398,000

Impact of 1978 Budget:

In 1978, the Institute will reduce the number of staff by 1 position. The 1978 Estimate will provide partial support for the National Center of Alcohol Education and the National Clearinghouse for Alcohol Information with the remaining support coming from the "Community Programs" activity.

IV. Buildings and Facilities

	1977 Appropriation	1978 Estimate	Increase/Decrease
Buildings and Facilities...	$1,129,000	$350,000	-$779,000
(B.A.).....	(---)	(350,000)	(+350,000)

Narrative

Funds included in this activity support alterations, construction, repairs, and improvements of buildings and facilities of the Alcohol, Drug Abuse, and Mental Health Administration and Saint Elizabeths Hospital, including preparation of plans and specifications.

No new funds were appropriated for FY 1977. The available $1,129,000 represents funds remaining from previous year appropriation for improvements and renovation at Saint Elizabeths Hospital to help remedy accreditation deficiencies cited by the Joint Commission on the Accreditation of Hospitals. These funds were used for major deficiencies in the areas of safety, patient privacy, and service to patients.

Impact of 1978 Budget:

The FY 1978 request of $350,000 is for modernization and repairs to the NIMH intramural research facility at the William A. White Building, Saint Elizabeths Hospital.

V. Program Management

	1977 Estimate		1978 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Office of the Administrator	201	$6,721,000	200	$6,543,000	-1	-$178,000
Standard Level User Charges (SLUC)	---	476,000	---	576,000	---	+100,000
Total	201	7,197,000	200	7,119,000	-1	-78,000

Narrative

The staff of the Office of the Administrator is responsible for overall direction and management of ADAMHA. Much of the staff provides necessary centralized services such as printing, computer services and personnel for the Institutes. Other 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. These efforts will continue at a reduced level in FY 1978.

The 1978 request for this activity reflects a program decrease of $413,000 associated with the absorption of all mandatory increases, as well as $13,000 for the reduction of one administrative position. Included in these mandatory increases is $100,000 for the cost of spaces assigned to the Office of the Administrator by GSA (SLUC) bringing the 1978 estimate to $576,000.

The 1978 budget request proposes the reallocation of the cost for the Regional Offices to the appropriate Institute in accordance with the Congressional request to relate management cost more directly to individual programs. It also provides for the cost of space assigned to the Institutes by GSA within their individual Program Support lines. A comparable adjustment has been made in 1977.

The overall decrease of $78,000 for FY 1978 includes the following increases and decreases:

1.	Within grade increases	+$96,000
2.	Increased payment to Office of Federal Employee Compensation	+15,000
3.	Increased cost of Health, Services and Supply Fund	+88,000
4.	Increased cost of DHEW Working Capital Fund	+52,000
5.	Increased postage charges	+9,000
6.	Increased FTS charges	+6,000
7.	Increase payment to GSA for rental of space	+100,000
8.	One less day of pay	-18,000
9.	1978 position reduction	-13,000
10.	Program decrease	-413,000

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Research - (Public Health Service Act, Section 301; Community Mental Health Centers Act, Section 231(d))

1977 Appropriation		1978 Authorization			1978 Budget Estimate	
Pos.	Amount	Act	Sec.	Amount	Pos.	Amount
373	$101,908,000	PHS	301	Indefinite	373	$102,228,000
---	5,000,000	CMHC	231(d)	Expired 1/	---	4,680,000
373	106,908,000				373	106,908,000

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 awards focus on the use of current knowledge in demonstrating improved services for patients. Research scientist development awards support individuals developing expertise in mental health research. Intramural research efforts address the causes, treatment and prevention of mental illness in a laboratory setting.

Accomplishments in 1977: A total of 593 new and competing awards were funded during 1977. Areas of study included rape prevention and control; services development; depression; schizophrenia; minority and metropolitan mental health problems; and female crime and delinquency. The intramural program addressed problems of schizophrenia and depression at the more basic level, and examined drug treatment of hyperkinetic children. The latter effort sought to develop methods of more accurately gauging optimum dosage levels for individual children.

Objectives for 1978: A total of 457 new and competing awards will be supported in 1978. The NIMH will move forward with collaborative research on psychological, psychosocial, and cultural factors which influence the development and cause of depression, as well as research into the causes and prevention of rape. Programs of basic psychological, biomedical, and genetic research into the causes of schizophrenia will be continued. Child mental health research will be directed toward studies of hyperkinetic disorders, mental health dimensions of learning disorders, and problems of early adolescents. Intramural research efforts will address the development of treatments for mental disorders of children, and will attempt to develop an early diagnosis and treatment procedure for potential depressives.

1/ Authorizing legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Training - (Public Health Service Act, Sections 303 and 472)

1977 Appropriation		1978 Authorization			1978 Budget Estimate	
Pos.	Amount	Act	Sec.	Amount	Pos.	Amount
---	$69,473,000	PHS	303	Indefinite	---	$70,463,000
---	17,137,000	PHS	472	Expired 1/	---	16,137,000
---	86,600,000				---	86,600,000

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 1977: In 1977, a total of 273 new and competing grants were awarded, including 138 institutional awards, 102 fellowships, and 33 hospital staff development projects. NIMH has implemented a redirection of the clinical training program, with the objectives of linking the training of mental health manpower more closely with service delivery needs by 1) improving the psychosocial and psychiatric components of curriculum for primary caretakers; 2) moving toward a research and development model which emphasizes short-term Federal involvement; and 3) providing technical assistance to states, to help them develop capacities in the areas of manpower planning, training, and administration, and 4) redirecting core discipline training.

Objectives for 1978: Support will be provided for 209 new postdoctoral fellowships, 208 new clinical training grants, both in core disciplines and new initiative areas, and 59 new hospital staff development awards. There will be no new research training grants or new predoctoral fellowships.

1/ Authority shared with NIH; authorizing legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Community Programs - Construction/Facilities Assistance (Community Mental Health Centers Act, as amended, Section 228)

1977 Appropriation		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$---	Expired 1/	---	$---

Purpose: Allotments are authorized to be made to states for the purpose of paying the Federal share of projects for (1) the acquisition or remodeling, or both, of facilities for community mental health centers, (2) the leasing (for not more than twenty-five years) of facilities for such centers, (3) the construction of new facilities or expansion of existing facilities for community mental centers if not less than 25 per centum of the residents of the centers' catchment areas are members of low-income groups (as determined under regulations prescribed by the Secretary), and (4) the initial equipment of a facility acquired, remodeled, leased, constructed, or expanded with financial assistance provided under payments under this part. Payments shall not be made for the construction of a new facility or the expansion of an existing one unless the Secretary determines that it is not feasible for the recipient to acquire or remodel an existing facility.

Explanation: Funds appropriated under this program are allocated to the states, in accordance with approved regulations, on the basis of (1) the population, (2) the extent of the need for community mental health centers, and (3) the financial need, of the respective states; except that no such allotment to any state, other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, in any fiscal year may be less than $100,000.

Accomplishments in 1977: No funds were appropriated.

Objectives for 1978: No appropriations are requested in 1978.

1/ Proposed legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Community Programs - Operations of CMHC's - (Community Mental Health Centers Act, as amended, Sections 202(d) (Planning), 203(d)(1) (Initial Operations), 203(d)(2) (Operations Continuations), 203(e)(3) (Staffing and Children's Services Continuations, 204(c) (Consultation and Education), 205(c) (Conversion), and 213 (Financial Distress))

1977 Appropriation		1978 Authorization			Budget Estimate	
Pos.	Amount	Act	Sec.	Amount	Pos.	Amount
---	$1,000,000	CMHC	202(d)	Expired 1/	---	$---
---	18,418,000	CMHC	203(d)(1)	Expired 1/	---	---
---	79,314,000	CMHC	203(d)(2)	Sums Necessary	---	158,094,000
---	98,592,000	CMHC	203(e)(3)	Sums Necessary	---	52,147,000
---	8,000,000	CMHC	204(c)	Expired 1/	---	8,245,000
---	20,000,000	CMHC	205(c)	Expired 1/	---	9,372,000
---	7,000,000	CMHC	213	Expired 1/	---	4,988,000
---	232,324,000				---	232,846,000

Purpose: Programs funded under this activity assist in the establishment and operation of community mental health centers in designated catchment areas.

Explanation: The funding mechanisms of this program include:

- Planning grants to develop a viable community treatment program.
- Grants for initial operations, which pay a portion of total costs.
- Grants for the provision of consultation and education services.
- Conversion grants, to help Centers add required services.
- Distress grants, to prevent reduction of services in Centers ending Federal support.
- Staffing and children's services continuations, to provide partial support for staffing costs of professional and technical personnel.

Accomplishments in 1977: The 1977 appropriation supported a total of 141 new awards, including 20 planning grants, 30 operations grants, 42 consultation and education projects, 33 conversions, and 16 distress grants. In addition, 283 staffing and 131 children's services continuation awards were made. The CMHC program in total has supported 670 centers. Of this total, 587 will be operational by the end of FY 1977, and approximately 2.1 million patients will be treated during this year.

Objectives for 1978: No new awards will be made under this program in 1978. Continuation support will be provided.

1/ Proposed legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: General Mental Health - Program Support - (Public Health Service Act, Section 301)

1977 Appropriation		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
664	$28,502,000	Indefinite	662	$27,695,000

Purpose and Explanation: This activity supports the regional office and headquarters 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, and maintenance of Institute relationships with other branches of the Administration and with state and community organizations. This activity also provides for rental payments to GSA for buildings occupied by NIMH regional office and headquarters staff.

Accomplishments in 1977: In 1977, consultation, technical assistance, and site visitation activities reached approximately 1,200 research grantees and 1,500 training grant recipients. In addition, 670 Federally funded community mental health centers were provided with guidance, support, and technical assistance. Regional office support activities of the Institute amount to a total of $4,238,000 in 1977, and $1,092,000 was provided to GSA for building rental payments.

Objectives for 1978: NIMH staff will become increasingly involved in consultation with the training grant recipients during 1978 as a result of the redirection of the training grant program. NIMH headquarters and regional office staff will assist in implementing the CMHC program and providing guidance and technical assistance to centers currently funded. The 1978 budget reduces the Institute staff by two administrative positions. The request also includes an increase of $221,000 for rental payments to GSA for buildings occupied by the Institute along with a program decrease of $1,969,000 which will cause the termination of most program contract efforts. Of this reduction, $626,000 is associated with regional office funds which primarily represent salary costs of regional office personnel.

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)

1977 Appropriation		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
102	$34,000,000	Indefinite	102	$34,000,000

Purpose: These programs encourage the development of new knowledge on the causes and effects of narcotic addiction and drug abuse, and the use of this knowledge as the basis for formulating improved methods for dealing with these problems in our society.

Explanation: Project grants are available 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 activities include basic and applied research in the field of drug abuse, including treatment research, and abuse liability testing of drugs.

Accomplishments in 1977: During 1977, NIDA provided support for 333 research grants and contracts, of which 208 were continuations. NIDA made major advances in our understanding of the basic mechanisms involved in opiate action at the molecular level, including the isolation in the brain of naturally occurring morphine-like substances called endorphins; development of a drug delivery mechanism which has the potential of giving the narcotic antagonist Naltrexone a one-month duration of action; initiation of large-scale clinical testing of LAAM, and completion of small-scale testing of Naltrexone preparatory to applying for FDA approval of large-scale testing.

Objectives for 1978: In 1978, NIDA will provide support for the following new research initiatives: 1) the NIDA survey of nonmedical drug use, with an emphasis on measurement of consequences; 2) epidemiological studies of women, elderly persons, and addicted infants; 3) studies of the impact of policy change in the U.S. on drug abuse; and 4) effects of drug use on impaired performance, economic behavior, commission of crimes, and suicide. Treatment research will seek to determine the most effective therapeutic procedures for reducing drug abuse, including the introduction of LAAM as a standard therapeutic drug in the treatment of heroin addiction, and the completion of clinical testing of the narcotic antagonist Naltrexone for eventual use as a standard therapeutic drug. Clinical research will be continued at the ARC using new pharmacologic agents in a therapeutic context, and will use volunteer patients rather than prisoner subjects. A program of studies on the basic mechanisms of tobacco dependence will also be expanded.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Training - (Public Health Service Act, Sections 301, 303, and 472)

1977 Appropriation		1978 Authorization			1978 Budget Estimate	
Pos.	Amount	Act	Sec.	Amount	Pos.	Amount
---	$6,358,000	PHS	301	Indefinite	---	$6,200,000
---	3,154,000	PHS	303	Indefinite	---	2,894,000
---	488,000	PHS	472	Expired 1/	---	906,000
---	10,000,000				---	10,000,000

Purpose: This activity supports training designed to ensure the continued availability of qualified manpower working in the area of narcotic addiction and drug abuse.

Explanation: Training grants are awarded to organizations to enable them to defray institutional costs of training programs, and to provide stipends to enrolled individuals. These are available to public and 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 and to regional support centers to assist in the development of state training programs. Fellowships are awarded in support of research training.

Accomplishments in 1977: NIDA expanded its national training system, comprised of the National Drug Abuse Training Center, fifty state training support program contracts, and five regional resource support centers. NIDA also funded 36 training grants and 42 research training fellowships in 1977.

Objectives for 1978: During 1978, the predoctoral fellowship program will be phased out. The budget provides support for 36 new postdoctoral fellowships and 14 new clinical training grants. The state training support program contracts and regional resource support centers will be continued in 1978, as will the National Drug Abuse Training Center in Washington, D.C.

1/ Authority shared with NIH; authorizing legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Community Programs - Project Grants and Contracts - (Community Mental Health Centers Act, Section 203(e)(3); Drug Abuse Office and Treatment Act of 1972, as amended, Section 410; Narcotic Addict Rehabilitation Act, Section 607; and Public Health Service Act, Section 301)

1977 Appropriation		1978 Authorization			1978 Budget Estimate	
Pos.	Amount	Act	Sec.	Amount	Pos.	Amount
---	$4,847,000	CMHC	203(e)(3)	1/	---	---
---	152,653,000	DAOT	410	$160,000,000	---	159,050,000
---	200,000	NARA	607	Sums Necessary	---	200,000
---	2,300,000	PHS	301	Indefinite	---	2,250,000
---	160,000,000				---	161,500,000

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 comprise a comprehensive program 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 1977: A total of 251 awards were made to support drug abuse treatment, demonstration, and prevention projects during 1977. These awards reflected an increase in statewide services contracts to include 49 states and territories, and a corresponding decrease in individual awards. Technical assistance was provided to the states to encourage direct administrative responsibility for treatment at the local level. During 1977, NIDA increased treatment capacity from 95,000 to 102,000 treatment slots based on demonstrated need. The Institute supported treatment projects at the prevailing declining match basis to a maximum of 60% Federal share. Federal patient care provided under the Narcotic Addict Rehabilitation Act was further reduced. Sixteen new demonstration awards, including new studies on amphetamine and barbiturate treatment, were made. Twelve new prevention grants were also awarded.

1/ Projects previously funded under the authority of the CMHC Act will be funded under Section 410 of the DAOT Act beginning in FY 1978, as they become incorporated into the statewide service contract program.

Objectives for 1978: In 1978, an effort will be made to more efficiently allocate funds to areas of greatest need in accordance with the mandates of the Domestic Council's White Paper on Drug Abuse. To meet this objective, the statewide services contract program will receive increased support to provide additional responsibility for drug treatment at the state level. It is expected that in 1978 the program will become operational in fifty states and territories and that the current service grant program will continue to be incorporated into statewide service contracts. New demonstration projects will concentrate on developing vocational rehabilitation programs specifically designed for the drug abuser, and on devising outreach techniques for polydrug abusers, women, and criminal justice clientele. In addition, prevention activities will attempt to ensure that information concerning prevention programs that prove to be effective is disseminated nationally. An effort will be made to integrate successful prevention strategies into state plans and to support a series of grants for the development of model prevention projects primarily aimed at school age children.

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)

1977 Appropriation		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$40,000,000	$45,000,000	---	$40,000,000

Purpose: Formula grants 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 1977: During 1977, formula grant funding totaled $40 million, an increase of $5 million above the 1976 level. 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. Considerable emphasis was also placed on evaluation of ongoing programs in the state. An analysis of these plans indicated that approximately 13% of the funds will be used for treatment services, with the remainder being used to fund other prevention activities.

Objectives for 1978: In FY 1978, 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.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Drug Abuse - Program Support - (Public Health Service Act, Section 301)

1977 Appropriation		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
315	$16,686,000	Indefinite	314	$16,572,000

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 headquarters and regional office personnel for planning, coordination, analysis, evaluation, and general administrative management. It supports activities which provide 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. It also provides funds for rental payments to GSA for buildings occupied by NIDA staff.

Accomplishments in 1977: During 1977, the Institute consolidated its management information system to more effectively and efficiently provide management data to Institute staff and state agencies. Activities to increase the reporting response rate proved effective; reporting increased; and errors decreased. The National Drug Abuse Treatment Utilization Survey (NDATUS) was completed with responses from over 4,000 units in 53 states and territories. Consistent with the Institute's desire to increase data utilization, technical assistance in data analysis and use of data has been provided to over 30 states. A total of $507,000 was provided for regional support activities of the Institute, and payments to GSA for building rental amounted to $415,000.

Objectives for 1978: In 1978, the NIDA staff will be reduced by one administrative position. NIDA will continue to fund various management information systems and the National Clearinghouse for Drug Abuse Information, but at a reduced level. The CODAP system, which is concerned with the monthly collection of client data from Federally funded treatment units, will receive support at a reduced level. The treatment utilization survey system will continue to provide management with necessary and timely information on drug abuse treatment units of every funding type. The 1978 estimate also includes an increase of $82,000 for rental payments to GSA for buildings occupied by NIDA staff.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Alcoholism - Research - (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, Section 503; Public Health Service Act, Section 301)

1977 Appropriation		1978 Authorization		1978 Budget Estimate	
Pos.	Amount	Act	Amount	Pos.	Amount
37	$11,808,000	1/	$24,000,000	37	$12,179,000
---	1,000,000	PHS	Indefinite	---	1,000,000
37	12,808,000			37	13,179,000

Purpose: This subactivity supports alcoholism research grants and contracts and the alcohol intramural research program located in Rockville and at the campus of NIH. The purpose of these programs 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 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 of the Institute.

Accomplishments in 1977: During 1977, the NIAAA provided support for 153 grants and contracts, including 99 continuation awards. Seven of the continuation awards were for the research scientist development program. A total of 54 new and competing renewal awards were made, of which 13 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; and 3) psychological studies on environmental, genetic and psychological factors associated with the use of alcohol.

Objectives for 1978: A program balanced between biomedical and psychosocial research will be maintained in 1978, with continued emphasis upon clinical research in both medical and psychological areas. Applied research will be directed to studies regarding the rapid clearance of alcohol from the body, blocking the intoxicating effects of alcohol, and improving

1/ Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended.

medical care of the patient during withdrawal from alcohol. Research into the moderate use of alcohol will contribute to a better definition of the alcoholic person and alcohol abuse. The Institute will also develop and maintain a system of surveillance of alcohol consumption for use in studies of the natural history and trends of alcohol use and abuse. It is expected that the eight bed intramural research program initiated by the Institute in 1977 within the NIH Clinical Center will be fully operational in 1978. Intramural studies will focus on the causes and treatment of alcoholism and related diseases, including clinical studies of the pathogenesis of alcoholism and the development of new treatment methods for the various medical complications resulting from alcohol abuse.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Alcoholism - Training - (Public Health Service Act, Sections 303 and 472)

1977 Appropriation		1978 Authorization			Budget Estimate	
Pos.	Amount	Act	Sec.	Amount	Pos.	Amount
---	$5,863,000	PHS	303	Indefinite	---	$4,934,000
---	1,337,000	PHS	472	Expired 1/	---	2,266,000
---	7,200,000				---	7,200,000

Purpose: This subactivity provides funds to 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 1977: During 1977, the NIAAA provided continuation support for 56 training grants and 18 research fellowships. Also supported were 16 new and competing training awards and 21 new research fellowships.

Objectives for 1978: In 1978, the budget request reflects the phase out of research training grants and predoctoral fellowships. The NIAAA will provide full funding support for continuation of all existing projects, and will award 39 new and competing clinical training grants. In addition, 60 new postdoctoral fellowships in the biological, psychological, and social science areas will be awarded.

1/ Authority shared with NIH; authorizing legislation to be submitted.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Alcoholism - Community Programs - Project Grants and Contracts - (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, Section 312; Community Mental Health Centers Act, Section 203(e))

1977 Appropriation		1978 Authorization			1978 Budget Estimate	
Pos.	Amount	Act	Sec.	Amount	Pos.	Amount
---	$61,322,000	1/	312	$91,000,000	---	$68,719,000
---	7,086,000	CMHC	203(e)	2/	---	---
---	68,408,000				---	68,719,000

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 1977: During 1977, the maximum Federal share of project costs was determined in accordance with rates established by the alcohol funding policy. The NIAAA made a total of 613 awards, including 192 new and competing awards. High priority areas included programs targeted to high risk, poverty and minority populations where services have traditionally been lacking. Emphasis was also placed on projects for drinking drivers, public inebriates, and employed alcoholics. In addition, continuation was provided to 21 states previously enacting the Uniform Alcoholism and Intoxication Treatment Act and 5 new states. In 1977, this activity supported the continuation of 5 evaluation contracts and provided partial support for the National Center for Alcohol Education and the National Clearinghouse for Alcohol Information.

Objectives for 1978: In 1978, the Institute will continue to fund alcoholism treatment projects, with the exception of staffing grants, according to the alcohol matching rate funding policy. Emphasis will be placed on projects

1/ Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended.
2/ Projects previously funded under the authority of the CMHC Act will be funded under the Comprehensive Alcohol Act beginning in FY 1978.

serving women, youth, Blacks, Spanish-speaking Americans, migrant workers, public inebriates and criminal justice populations. Continuation support will be provided to the 26 states previously passing the Uniform Alcoholism Intoxication and Treatment Act. In addition, approximately 10 new states will pass the Uniform Act by 1978 and will be funded. The 1978 estimate provides continuation support for Indian alcoholism treatment projects through their sixth year at full commitment levels. In 1978, 34 such projects will have reached the end of their committed support by NIAAA and will be transferred to the Indian Health Service for future funding.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Alcoholism - Community Programs - Grants to States - (Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, Section 301)

1977 Appropriation		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$55,500,000	$77,000,000	---	$55,500,000

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 1977: In 1977, an estimated 58% 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 in 1978: In 1978, a plan of utilization similar to that in 1977 is anticipated, at the same funding level. An estimated 95,000 individuals will be served by this program.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Alcoholism - Program Support - (Public Health Service Act, Section 301)

1977 Appropriation		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
158	$9,538,000	Indefinite	157	$9,468,000

Purpose: This subactivity supports the overall planning, direction, and coordination of alcoholism programs supported by the NIAAA. Also included are funds to support scientific and public information activities, program analysis and evaluation, and administrative management.

Explanation: Funding is provided for the general operation of the National Institute on Alcohol Abuse and Alcoholism, including, headquarters and regional office staff and related costs of the individual operating programs, Institute program direction, program coordination, analysis and evaluation, and administrative management. Included also is a portion of NIAAA's support for 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. These funds also provide for rental payments to GSA for buildings occupied by NIAAA Staff.

Accomplishments in 1977: 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. A total of $458,000 was provided for regional office support activities and $567,000 for building rental payments.

Objectives for 1978: In 1978, the NIAAA staff will be reduced by one position. This activity will partially support the activities carried on by the National Clearinghouse for Alcohol Information and the National Center for Alcohol Education, with the remainder funded under the community program activity, in order to provide the public with frank, accurate and up-to-date information. Included in the 1978 budget estimate is an increase of $113,000 to GSA for building rental payments (SLUC).

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Buildings and Facilities

1977 Appropriation			1978		
				Budget Estimate	
	Pos.	Amount	Authorization	Pos.	Amount
	---	$1,129,000	Indefinite	---	$350,000
(B.A.)	(---)	(---)		(---)	(350,000)

Purpose: This activity supports construction, alterations, repairs, and improvements of buildings and facilities of the Alcohol, Drug Abuse, and Mental Health Administration and Saint Elizabeths Hospital including preparation of plans and specifications.

Explanation: This account is used principally to fund construction, repairs, and improvements of Alcohol, Drug Abuse, and Mental Health Administration facilities. In addition, renovation and improvements at Saint Elizabeths Hospital may be supported from these funds. Appropriations to this activity are available until expended.

Accomplishments in 1977: No new funds were appropriated for FY 1977. The available $1,129,000 represents funds remaining from previous year appropriation for improvement and renovation at Saint Elizabeths Hospital to help remedy accreditation deficiencies cited by the Joint Commission on the Accreditation of Hospitals. These funds were utilized for areas of safety, patient privacy, and service to patients.

Objectives for 1978: In 1978, $350,000 buildings and facilities requests will allow for modernization and repairs to NIMH intramural research facility at the William A. White Building, Saint Elizabeths Hospital.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Alcohol, Drug Abuse, and Mental Health

Program Purpose and Accomplishments

Activity: Program Management - (Public Health Service Act, Section 301)

1977 Appropriation		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
201	$7,197,000	Indefinite	200	$7,119,000

Purpose: These funds provide support for the overall direction and management of the Agency staff.

Explanation: The functions carried out in this activity include planning and evaluation, program coordination, adminstrative management service, and public affairs activities. Also included are funds which provide for rental payments to GSA for buildings occupied by the Office of the Administrator staff.

Accomplishments in 1977: Particular emphasis in 1977 was given to CMHC's to increase third party payments, improve management, cost accounting and record keeping systems.

Objectives for 1978: In 1978 the Agency will reduce its staff by one position. The Agency will continue its efforts in evaluation of programs, coordination and collaboration between headquarters and regional offices, with other Federal and State agencies, and with citizens groups with regard to the delivery and the funding of alcohol, drug abuse, and mental health services. The 1978 budget estimate includes an increase of $100,000 for building rental payments to GSA.

Allocation of Funds for Drug Abuse Formula Grants

State	1976 Actual	1977 Appropriation	1978 Estimate
Alabama	$ 572,149	$ 675,757	$ 675,757
Alaska	215,471	232,317	232,317
Arizona	349,012	415,657	415,657
Arkansas	312,190	355,208	355,208
California	3,615,465	3,891,433	3,891,433
Colorado	379,347	425,706	425,706
Connecticut	567,871	589,399	589,399
Delaware	161,666	190,318	190,318
District of Columbia	572,072	677,662	677,662
Florida	1,201,390	1,376,597	1,376,597
Georgia	862,867	957,869	957,869
Hawaii	129,704	255,253	255,253
Idaho	122,272	150,000	150,000
Illinois	1,612,529	1,796,121	1,796,121
Indiana	696,248	801,742	801,742
Iowa	407,943	441,933	441,933
Kansas	290,444	356,079	356,079
Kentucky	508,636	590,990	590,990
Louisiana	609,876	701,441	701,441
Maine	158,533	195,250	195,250
Maryland	637,657	756,706	756,706
Massachusetts	854,398	962,637	962,637
Michigan	1,356,129	1,475,837	1,475,837
Minnesota	636,012	885,073	885,073
Mississippi	465,658	506,077	506,077
Missouri	661,602	810,871	810,871
Montana	127,310	150,000	150,000
Nebraska	231,578	282,708	282,708
Nevada	116,808	150,000	150,000
New Hampshire	134,796	151,973	151,973
New Jersey	1,186,619	1,443,025	1,443,025
New Mexico	229,298	239,852	239,852
New York	2,901,341	3,110,214	3,110,214
North Carolina	808,092	974,458	974,458
North Dakota	100,000	150,000	150,000
Ohio	1,462,663	1,672,558	1,672,558
Oklahoma	411,293	466,132	466,132
Oregon	459,521	586,933	586,933
Pennsylvania	1,683,256	1,924,841	1,924,841
Rhode Island	200,085	232,096	232,096
South Carolina	463,040	542,931	542,931
South Dakota	134,578	150,000	150,000
Tennesee	664,719	772,001	772,001
Texas	1,771,282	2,050,290	2,050,290
Utah	199,452	263,865	263,865
Vermont	100,000	150,000	150,000
Virginia	690,291	841,279	841,279
Washington	531,893	647,913	647,913
West Virginia	264,088	371,263	371,263
Wisconsin	715,128	812,546	812,546
Wyoming	100,000	150,000	150,000
American Samoa	8,779	7,428	7,428
Guam	29,917	29,144	29,144
Puerto Rico	1,253,556	1,155,911	1,155,911
Trust Territory	35,323	29,034	29,034
Virgin Islands	28,152	17,672	17,672
Total	$35,000,000	$40,000,000	$40,000,000

Note: Formula grants are allocated to the states based on a formula which measures the relative population, financial and program needs of each state.

Allocation of Funds for Alcohol

Formula Grants

	1976 Actual	1977 Appropriation 1/	1978 Estimate 1/
Alabama	$ 1,085,850	$ 1,085,850	$ 1,085,850
Alaska	200,000	200,000	200,000
Arizona	566,373	566,373	566,373
Arkansas	633,060	633,060	633,060
California	4,923,628	4,923,628	4,923,628
Colorado	627,287	627,287	627,287
Connecticut	695,294	695,294	695,294
Delaware	200,000	200,000	200,000
District of Columbia	200,000	200,000	200,000
Florida	2,074,445	2,074,445	2,074,445
Georgia	1,353,533	1,353,533	1,353,533
Hawaii	200,000	200,000	200,000
Idaho	226,395	226,395	226,395
Illinois	2,573,966	2,573,966	2,573,966
Indiana	1,368,101	1,368,101	1,368,101
Iowa	730,919	730,919	730,919
Kansas	567,692	567,692	567,692
Kentucky	987,606	987,606	987,606
Louisiana	1,121,860	1,121,860	1,121,860
Maine	305,067	305,067	305,067
Maryland	971,608	971,608	971,608
Massachusetts	1,405,761	1,405,761	1,405,761
Michigan	2,168,016	2,168,016	2,168,016
Minnesota	1,000,471	1,000,471	1,000,471
Mississippi	755,548	755,548	755,548
Missouri	1,241,105	1,241,105	1,241,105
Montana	200,000	200,000	200,000
Nebraska	390,391	390,391	390,391
Nevada	200,000	200,000	200,000
New Hampshire	212,211	212,211	212,211
New Jersey	1,664,097	1,664,097	1,664,097
New Mexico	338,273	338,273	338,273
New York	4,154,608	4,154,608	4,154,608
North Carolina	1,517,529	1,517,529	1,517,529
North Dakota	200,000	200,000	200,000

	1976 Actual	1977 Appropriation 1/	1978 Estimate 1/
Ohio	2,693,046	2,693,046	2,693,046
Oklahoma	761,376	761,376	761,376
Oregon	589,023	589,023	589,023
Pennsylvania	2,990,141	2,990,141	2,990,141
Rhode Island	238,710	238,710	238,710
South Carolina	842,797	842,797	842,797
South Dakota	200,000	200,000	200,000
Tennessee	1,200,642	1,200,642	1,200,642
Texas	3,260,078	3,260,078	3,260,078
Utah	339,428	339,428	339,428
Vermont	200,000	200,000	200,000
Virginia	1,268,648	1,268,648	1,268,648
Washington	867,536	867,536	867,536
West Virginia	530,308	530,308	530,308
Wisconsin	1,195,419	1,195,419	1,195,419
Wyoming	200,000	200,000	200,000
Guam	32,271	32,271	32,271
Puerto Rico	959,513	959,513	959,513
Virgin Islands	26,609	26,609	26,609
American Samoa	9,016	9,016	9,016
Trust Territory	34,745	34,745	34,745
TOTAL	55,500,000	55,500,000	55,500,000

1/ The breakout for the 1977 Appropriation and the 1978 Estimate are both estimates based on population and per capita income data used in calculating the 1976 allocation. These figures may be changed to reflect more recent population and per capita income data as well as a new index which takes into account the need for alcoholism services.

THURSDAY, MARCH 17, 1977.

SAINT ELIZABETHS HOSPITAL

WITNESSES

DR. BERTRAM S. BROWN, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH
DR. ROGER PEELE, ACTING SUPERINTENDENT, ST. ELIZABETHS HOSPITAL
JAMES E. PITTMAN, EXECUTIVE OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH
P. E. GOODY, FINANCIAL MANAGEMENT OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH
JAMES J. O'DONNELL, ACTING FINANCIAL MANAGEMENT OFFICER, ST. ELIZABETHS HOSPITAL
WILFORD FORBUSH, DEPUTY ASSISTANT SECRETARY, BUDGET, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. NATCHER. The committee will come to order.

Doctor, I have had an opportunity to examine your statement. As usual, you have made an excellent statement. With your permission, we will have it inserted in the record in its entirety and proceed with the questions.

[The complete statement follows:]

STATEMENT BY THE DIRECTOR,

NATIONAL INSTITUTE OF MENTAL HEALTH

ON

"SAINT ELIZABETHS HOSPITAL"

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 know, we are currently dealing with several issues which affect the future of the Hospital. The first is the reestablishment of full two-year accreditation status. The second is transfer to the District of Columbia. Relating to both issues has been the recent completion of a master facilities plan. This plan includes recommendations for providing a humane and therapeutic setting for the patients at the Hospital. Before any major steps on transfer can be taken with respect to the future of Saint Elizabeths, the Hospital must both regain and maintain full accreditation status. Since deficiencies in the physical plant figured so prominently in the loss of accreditation, the master facility plan is a major step toward the achievement and retention of full accreditation for many years.

Since restoration of accreditation is a key issue, a progress report on the Hospital's attempts to achieve this objective is warranted at this time. On December 18, 1976 the last stage in the appeals process resulted in con-

firmation of the disaccrediation decision by the Chairman of the Joint Commission on the Accreditation of Hospitals. Also, on December 14, 1976, the Medical and Surgical Division of the Hospital, which previously had won a one year probationary accreditation, was disaccredited. The latter event was not unexpected, since it resulted largely from the same structural defects found throughout the Hospital. We have started to initiate efforts to correct deficiencies in the physical plant such as fire and safety items, and the purchase of furnishings related to patient privacy. A master plan of the hospital site has also been completed.

The task ahead can therefore be place into three broad categories.

First, we must provide acceptable facilities which can regain full accreditation for the Hospital. Now that the master plan has been completed, strategies are being discussed within the Department as to how this can be best accomplished. This step is essential before there is any chance of regaining a one year probationary accreditation with resurvey. As part of these discussions we are evaluating options to enable the District of Columbia to plan for needed facilities to accommodate hospital patients placed in the community.

Second, we must provide for the continuity and quality of care for not only the resident patients of the Hospital, but also for the increasing numbers of patients being placed in the community. Throughout 1976 and the transition quarter, the staff at the Hospital has been making a very determined effort to outplace as many of its patients as the District's facilities can absorb. In accordance with the recent court decision in the case of Dixon v. Weinberger, we are taking steps to ensure that our patients will receive treatment in the least restrictive environment. The Hospital has been moving ahead with its efforts to reduce the inpatient population. During the past 18 months the Hospital has reduce the number of inpatients from 2,734 to approximately

2,500. At the same time, the number of outpatients has climbed to nearly 3,000. The reduction in the number of patients residing in the hospital also adds credibility to our timetable and goal of an ultimate reduction to 1,800 inpatients. In order to accomplish this objective, continue to provide quality care and treatment, and integrate our services into the D.C. mental health program, the staff and resources of the Hospital must be utilized to the fullest.

Third, Hospital staff must be deployed properly, and in sufficient numbers to completely do the job set forth by the Joint Commission on Accreditation of Hospitals. Hospital organization has already been streamlined, to allow the clinicians greater authority over those resources that affect the care of the patients. However, a manpower survey is also needed to provide a complete list of all the staffing requirements, and to assist in overcoming the personnel deficiencies cited by the Joint Commission on the Accreditation of Hospitals. Numerous contractors have been interviewed, to determine the best firm to perform this survey.

The 1978 operating budget request for Saint Elizabeths Hospital totals $90,170,000, representing an increase of $1,876,000 over the program for the current year. The additional amount provides for salary and cost of living increases. Of the $90,170,000 operating level proposed for 1978, $68,746,000 represents the estimated appropriation share, with the remainder to be derived from reimbursments. In addition, $810,000 in Buildings and Facilities funds are requested.

During 1978, it is estimated that approximately 9,350 patients will be treated. The average daily patient load for 1978 is expected to total 5,500 of which 2,400 are expected to reside in the Hospital.

I will be happy to answer any questions which the Committee might have.

JOINT PLANNING WITH DISTRICT OF COLUMBIA

Mr. NATCHER. Doctor, what joint planning has St. Elizabeths Hospital done with the District of Columbia Department of Human Resources regarding assessment of community needs such as information forecasting patient load by time of treatment required, determining resources required to meet the need including type of facilities and number and type of staff? What about it Doctor?

Dr. BROWN. Let me tell you what we have done and give the full account.

I would like to describe the process.

For the last year plus, I have been meeting regularly with the head of the Department of Human Resources of the District, Mr. Joseph Yeldell, and more recently Mr. Russo on a regular basis alternating with our staffs assigning task groups to these many problems so that we could indeed do joint planning.

As you know, Mr. Yeldell and Mr. Russo were designated by the mayor to represent him. I was designated by the Secretary to represent the Department. We have made considerable progress in defining the problem along the lines that you have described.

NONDISTRICT PATIENTS

Mr. NATCHER. What role, Doctor, should St. Elizabeths Hospital play in providing mental health care for non-District residents?

Dr. BROWN. I think that's a critical problem that has both practical and philosophical implications. Let me say practically that as the hospital, an outstanding one in the Nation's Capital, certain things will come to pass such as inaugurations, other events, people who come to Washington because it is the Nation's Capital. Certain mental health needs will have to be met.

In terms of meeting other special Federal needs, we are continuing to try to find the appropriate Federal agency to take on the responsibility. Whether or not the hospital remains a Federal resource or basically the District's institution as part of its mental health program that was not resolved in the last hundred years. It would have an impact upon an answer to that question. It it's clearly the District's institution and not so clearly the Federal institution, it would still have to do some things. That's my point.

On the other hand, it may do less not being a Federal or National hospital.

OUTPATIENT LOAD

Mr. NATCHER. Your budget shows that the hospital has more outpatients than inpatients; yet funding has traditionally been for inpatients.

How much of St. Elizabeths Hospital budget and how much of its staff are allocated by outpatients?

Dr. BROWN. Dr. Peele?

Dr. PEELE. $1.9 million was spent for outpatient care in the first quarter of this fiscal year. I would assume that that rate will continue throughout the rest of the fiscal year so it would be between $7 and $8 million of the hospital's budget that will go to outpatient services.

We do not have at this time but can obtain for you a statement of the number of staff who participate in these activities.

[The information follows:]

ALLOCATION OF FISCAL YEAR 1977 AND FISCAL YEAR 1978 STAFF AND RESOURCES FOR SEH

In fiscal year 1977, 160 equivalent positions were allocated to the hospital's community mental health center and other related outpatient activities. This figure will remain the same for fiscal year 1978. It is estimated that total costs for this activity will be about 7 million dollars in fiscal year 1977. Consistent with the modest increase of St. Elizabeths for fiscal year 1978, we anticipate these costs going up to about $7,600,000 in fiscal year 1978.

OUTPLACEMENT EFFORTS PURSUANT TO DIXON V. WEINBERGER

Mr. NATCHER. What planning has St. Elizabeths Hospital done to anticipate the final judgment in the case of *Dixon* v. *Weinberger* to outplace about 1,300 patients.

Doctor, what are your problems? What will they be when this takes place, if ever?

Dr. BROWN. I would like to just mention, namely an overall planning effort on the part of the Department of Human Resources and HEW. In the sense we have identified the community needs and problems although not the solutions in terms of what has gone on within the hospital to identify the problems of who needs to be outplaced, and who should be.

Dr. Peele and his staff have done considerable work.

Dr. PEELE. We have identified as of January of 1976 1,248 patients who, under ideal circumstances, could be served in other institutions or settings other than St. Elizabeths Hospital.

For the record, we can provide the exact breakdown of that, Generally I might say that most of them are candidates for the nursing care system, nursing homes.

Over the past 14 months, we have made progress in placing some of these 1,248 patients in the community. I believe the number is between 200 and 300. We can give you the exact breakdown for the record.

[The information follows:]

SAINT ELIZABETHS HOSPITAL OUTPLACEMENT BY TYPE OF FACILITY

	Potential outplacement [1]	Actual outplacements [2]
Skilled nursing care	229	1
Intermediate care	484	12
Foster care	300	88
Halfway house	58	6
Other type institution	94	1
Independent or family	119	128
Deceased		100
Discharged		122
Total	1,284	458

[1] January 1976 survey.
[2] As of Mar. 9, 1977.

Mr. NATCHER. Thank you, Doctor.

What evaluation has been made to determine the average number of patients needing housing outside of St. Elizabeths Hospital?

Dr. PEELE. That is very much implied in the question before in that nearly all of the 1,248 will need some kind of housing, whether it's in a nursing home, whether it's in a mental retardation institution, or whether it's in a halfway house, or foster home; but probably over 95 percent of those 1,248 patients do touch on the issue of the availability of certain types of housing or institutions.

Mr. NATCHER. The trend in outplacing patients from St. Elizabeths Hospital seems to take the form of putting the patients on convalescent leave from St. Elizabeths instead of discharging them to a community mental health center which would provide followup care.

Why is this happening and is anything being done to alleviate the situation?

Dr. PEELE. Under the hospital's original mandate of 1855 that we provide effective and humane care for the mentally ill, we feel that we are justified in continuing to see the patients after they have been placed out of the hospital on both grounds: One, the patient is more comfortable continuing to see those staff that they are already familiar with and the hospital is relatively accessible to most of them.

Second, on effectiveness of therapeutic grounds, as a rule, many of these patients do not tolerate new situations well; and to the degree you can continue to provide them with a familiar face, you will increase your effectiveness.

COORDINATION WITH DISTRICT OF COLUMBIA

Mr. NATCHER. What priority does St. Elizabeths Hospital put on outplacing new patients as soon as practicable and what coordination has taken place with the District on outplacing patients?

Dr. BROWN. I just want to make a brief comment and throw the ball back to Dr. Peele. The relationship of the hospital and its outplacing convalescent care system is the major example of the relationship to the community programs, interdependence.

I think what Dr. Peele described is because of the staff's concern and compassion and community care. If there were a more fully staffed or better community system, I am sure relationships could be worked out and they could pick up the ball.

Meanwhile, what have you done for the last issue the chairman brought up?

Dr. PEELE. Most referrals from three-fourths of the District of Columbia's areas that have community mental health centers have a zoning process by which they attempt to identify those patients who do not need inpatient care at St. Elizabeths Hospital so they themselves can follow the patients. That is, a patient from area C could initially be seen at D.C. General Hospital whether they needed inpatient care or not.

If it was outpatient care or day care that is indicated for the patient, then the area community health center would continue to follow them. Those types of patients hopefully would not come to St. Elizabeths Hospital in the first place.

The hospital, of course, has total responsibility for the area D portion of the District of Columbia.

REACCREDITATION SURVEY ISSUES

Mr. NATCHER. What is the probability of St. Elizabeths Hospital regaining accreditation, and how much will it cost?

What about that, Doctor?

Go ahead, Doctor. What about this little matter?

Dr. PEELE. The hospital will attempt to be surveyed for reaccreditation in the fall when the moneys that have already been appropriated to improve the safety of the patient have reached the level of so-called construction contracts. Until it reaches that stage, it is felt not to be useful to attempt to have a Joint Commission on Accreditation of Hospitals survey.

We would hope at that time to achieve a 1-year accreditation. How much it will cost, I gather that will be addressed in a supplemental that will be coming later according to Dr. Brown's statement.

CONSTRUCTION AND RENOVATION

Mr. NATCHER. What about major improvements now from the standpoint of accreditation? Is it necessary? Imperative before you would receive full accreditation?

Dr. BROWN. I think we have lived with this situation thoroughly and carefully enough to know that the housing, the humane housing of the patients, is the critical unmet need. As the Congress has asked, a master plan has been completed which spells out what that need, in terms of immediate replacement, and what needs to be done a few years hence.

Our estimates are fairly clear. They range between $75 and $100 million. This need will be before you in an orderly way by the Department and the new administration when it finishes looking this situation over very carefully.

I can assure you that it is being studied from every possible perspective: The GAO, OMB, the new administration, and congressional committees. I can also assure you that the patients are not in buildings that they should be in. That is the chief barrier to reaccreditation.

Mr. NATCHER. How much of the $10 million——

Mr. CONTE. Mr. Chairman, are you yielding?

Mr. NATCHER. My time is up. I will yield to you.

Mr. CONTE. You mentioned $75 to $100 million for rehabilitation. How much would it cost to build a new hospital?

Dr. BROWN. About the same.

RENOVATION VERSUS REPLACEMENT

Mr. CONTE. Wouldn't it be better to build a new one?

Dr. BROWN. You would have to find someplace to put the patients while you built the new hospital. It is a dilemma when you let a physical plant run down to this extreme. There has been almost 12 years of nothing done but absolute basic emergency fire stuff. Because of the transfer issue, and the proposal of the last administration—it has reached the point where, in essence, the whole plant needs replacement.

The question of what one would do with the 2,400 patients while razing an old facility and building a new hospital would get to be a logistic problem.

Mr. CONTE. Except you could keep the patients there, not go for accreditation, and build on a new site and have a real topnotch hospital for that money. I could see rehabilitation posing a tremendous number of problems. There are built-in problems there you will never correct.

Dr. BROWN. Well, this is where this master plan, which is really a very thorough study, looking at the buildings that can't make it, looking at the buildings that are most economically gone over, and those that should be razed, is carefully spelled out.

I think that is why the Congress wanted a master plan that looked at that in a thoughtful way.

Second, as you know, the St. Elizabeths campus would be hard to duplicate, in any way, in terms of its location, size at cost of the property within the District. However, you must say that the temptation to leave things be and build another plant that is entirely new, is an attractive one.

We would love to see it proposed by somebody.

Mr. CONTE. I am going to submit my questions, Mr. Chairman.

Mr. NATCHER. All right.

PLANNING FUNDS, 1976

Mr. NATCHER. What has been done with the $2.9 million in fiscal year 1976 funds for planning facility improvements based on St. Elizabeths' master plan?

Dr. BROWN. That $2.9 million for the planning design, for the schematics, as they call it in the trade, awaits the final outcome of the master plan and the budget proposals. It has not yet been let, not until we have approval or a plan about how to handle the situation.

MANAGEMENT STUDIES

Mr. NATCHER. What is the status of the contract to study work productivity and staffing information needs at St. Elizabeths Hospital?

Dr. PEELE. We are in consultation with NIMH and ADAMHA, the Public Health Service, and have decided to go ahead with a contract that would study the management information system and manpower needs. That was—we obtained approval for that in January of this year and we are now letting potential contractors know about that contract.

FACILITIES PLAN

Mr. NATCHER. Doctor, we have seen a draft of your master facilities plan for St. Elizabeths. Now have you developed a detailed implementation plan which lays out in increments of a 5 year or just what your priorities—what are your priorities and how much will it cost to complete this phase?

Dr. BROWN. I think the planning for implementation of the master plan, which has both a range and a set of options, has not yet been

completed. I think that—I would like to just highlight one issue, if I could take advantage of the question. I hope this will not be an overadvantage, Mr. Chairman——

Mr. NATCHER. All right.

Dr. BROWN. I refer to the reaccreditation issue, which has such practical and symbolic importance. A disaccredited Federal hospital needs a commitment of resources that one can show the accreditation committee. It does not mean that the money has to be spent all at once. It can be spent over 3 or 5 years.

Even if all the money were appropriated in 1 year, it would take 5 or 8 years to get the job done. However, the nature of the accreditation issue is such that the accreditation body wants to know that the money is available to carry out adequate housing for the patients.

We have not yet made these decisions. The new administration has it under review.

IMPLEMENTATION OF FACILITIES PLAN

Mr. NATCHER. Doctor, for the record we would like to see your detailed implementation for carrying out the goals of the master facilities plan for St. Elizabeths Hospital. Please submit that for the record.

[The information follows:]

PLAN FOR IMPLEMENTATION OF SEH FACILITY STUDY

The master facilities plan incorporated two separate schemes, including one for an inpatient population of 1,500 and another for 2,700, or any population level between, without losing physical or functional integrity and wholeness. Analysis of bed requirements at the hospital to meet District need as well as other mandated responsibilities indicates the need for the development of an 1,800 bed facility at SEH during the next 5-year period.

The master facility plan identified certain existing patient residence buildings at the hospital, renovation of which would be cost effective. It further identified which of these buildings should receive either minimum, moderate or complete renovation. Utilizing this and other information, NIMH is considering the development of 1,340 beds by renovation of existing buildings, and the construction of 460 new beds to meet the 1,800 bed goal. If future programmatic changes dictate, the 1,800 bed facility can be expanded to a considerably larger facility (2,700 beds and more) without disrupting any of the new construction or reconstruction development in the next 5 years.

The master plan, in addition, identified buildings that should be demolished because of their deteriorated condition (i.e. remodeling would not be cost effective). Many of the buildings so identified would require demolition as soon as possible to clear the grounds for new construction. Other buildings were recommended for retention because of their age and architectural excellence. Some of these will be retained as historical monuments. We have been working with the Department of the Interior regarding preservation of these buildings.

Our initial action regarding the implementation of the master plan will be the development of drawings and specifications for remodeling and for construction of new buildings.

Concurrent with developing drawings for facilities at the hospital would be the study of outplacement facility needs for the District. One possiblity under consideration is a request for authority to provide the District Government with $500,000 to develop such a study, since the outplacement of 1,100–1,200 inpatients to the District is essential if Saint Elizabeths Hospital is to be reduced to an 1,800 bed capacity. Following the determination of the District's outplacement facilities requirement, a possible followup action would be to make up to $25 million available to the District Government to develop essential outplacement facilities in the community.

Mr. NATCHER. Any additional questions?

Mr. CONTE. I will submit them.

Mr. NATCHER. Doctor, any other statement you would like to make in regard to St. Elizabeths?

Dr. BROWN. The only other statement I would like to make is that it is likely that the issue of the transfer of St. Elizabeths will be coming before the Congress in the reasonable future. I think it would be good to have as part of the record, the Department is testifying before the House District Committee, on or about March 27, on their proposal to have St. Elizabeths become a nonprofit corporation, somewhat similar to D.C. General. As a result, we have in terms of the transfer issue a new development, namely, another subcommittee or committee of the Congress, the District Committee, showing high interest and making its proposals for the final disposition.

I am hopeful that this will highlight interest and promote a solution, because while we often make light of the century of uncertainty, we are well into our second decade of uncertainty on this issue. I think it is to the harm of the patients.

Mr. NATCHER. Gentlemen, thank you very much.

That concludes the hearings at the present time and the committee will adjourn until 10 o'clock tomorrow.

[Whereupon, at 3:16 p.m., the subcommittee recessed, to reconvene at 10 a.m., Friday, March 18, 1977.]

The following questions were submitted by members of the subcommittee with the request that they be answered for the record.

IMPROVEMENTS AT ST. ELIZABETHS

Mr. CONTE. Exactly what improvements have to be made in order to bring St. Elizabeths into line with accreditation standards? How much will those specifically accreditation-related improvements cost?

ANSWER. Based upon numerous considerations, including the master facilities plan and the anticipated ability of the hospital to place patients in the community, a long-term need for an 1,800 bed hospital has been projected. Of the 1,800 beds, 1,340 can be furnished through the renovation of existing facilities. The remaining 460 would require new construction.

The development of an 1,800 bed hospital assumes the deinstitutionalization of 1,000 to 1,200 inpatients to alternative facilities in the community as directed by court action *Dixon* v. *Weinberger*. Due to the critical shortage of outplacement facilities in the District, it is necessary to study the District problem and develop an outpatient facility requirement plan in order to identify the need of facilities to receive those patients the hospital must outplace and further integrate the hospital into its community mental health program. We have established a need of $75 million to correct the deficiencies in the hospital.

BUILDINGS AND FACILITIES REQUEST

Mr. CONTE. You are proposing a major decrease in buildings and facilities for the hospital. Why is that? Aren't many of the things needed to bring the hospital up to standards covered under that item?

ANSWER. The fiscal year 1978 request of $810,000 will allow for general repairs and improvements such as replacement of steamlines and projects to improve safety and security conditions at the hospital. The administration intends to submit a separate legislative package whose goal is to transfer the hospital to the District of Columbia. This proposed legislation will contain a $100 million authorization for improvements in buildings and facilities. The recently completed master faclities plan, which has been submitted to the Congress, identifies requirements which we project will cost approximately $75 million.

ST. ELIZABETHS TRANSFER

Mr. CONTE. Why does the administration want to transfer St. Eliazbeths to the District of Columbia? Isn't this a case of simply trying to shunt a problem off on some other agency?

ANSWER. Since its establishment by Congress in 1855 as the Government Hospital for the Insane, St. Elizabeths Hospital has been located, organizationally, within the Department of Interior, the Federal Security Agency, and since 1953, within the Department of Health, Education, and Welfare. Today, St. Elizabeths Hospital serves primarily as a local facility which provides care, treatment and rehabilitation services predominantly to patients who are residents of the District of Columbia.

With the enactment of the District of Columbia Self-Government and Governmental Reorganization Act, continued Federal operation of St. Elizabeths Hospital, primarily for the benefit of the District of Columbia, seems wholly inappropriate. The hospital should be controlled and supported at the local level, serving the people of the District of Columbia as an effective and important part of a single mental health services delivery system. This would be in keeping with the modern practice of comprehensive programs for mental health care which include: inpatient services, outpatient services, day care, emergency services, and consultation and education in a unitary, community-based system.

The proposal to transfer the hospital to the District of Columbia is not a case of shunting the problem off to another agency. In fact, every effort has been made to develop a transfer document that would guarantee an accredited hospital be transferred and transfer would not occur until accreditation had been reestablished. Under "Date of Transfer of Function" in the proposed transfer bill, it states: "The transfer of function provided for in paragraph (1) shall occur on September 30, 1980, or the 120th day following accreditation of the hospital by JCAH, whichever is later."

Mr. CONTE. If St. Elizabeths were transferred to the District of Columbia, what would be the continuing relationship, if any, between the hospital and NIMH?

ANSWER. At the time of transfer of St. Elizabeths to the District of Columbia, all relationships with the hospital would be terminated except for the continuing research sponsored by the National Institute of Mental Health in the William A. White Building. This would include control of the property and personnel residing in that building, and other items as agreed to by the Secretary and the Mayor of the District of Columbia. NIMH would stand ready to provide any technical consultative support to both the hospital and the District in its role as the national mental health agency.

ST. ELIZABETHS POSITION REDUCTION

Mr. CONTE. Could you explain the proposed reduction of 10 positions for clinical and community services at St. Elizabeths Hospital?

ANSWER. The 1978 budget for all Public Health Service agencies includes a proposal to effect a reduction in the number of administrative overhead positions in order to minimize alleged duplication and overlap of administrative functions. The 10-position reduction represents the SEH proportional share of this general reduction.

IMPACT OF ACCREDIATION LOSS AT ST. ELIZABETHS

Mr. ROYBAL. You have now officially lost your accreditation. But patients still live in your facilities and life goes on. What does loss of accreditation mean in real terms?

ANSWER. The hospital was notified of its loss of accreditation by the Joint Commission on Accreditation of Hospitals in December 1975. Due to the considerable work in correcting several of the deficiencies identified by the Commission along with disagreements with interpretations made by the Commission, the hospital appealed the Commission's disaccreditation determination. The appeal process continued until December 1976 when the hospital was notified that the original disaccreditation determination was upheld by the Commission and the hospital was indeed disaccredited. During the appeal process, the hospital retained its accreditation so that in effect the hospital has been disaccredited only since December 1976. The hospital has, therefore, been without accreditation for 3 months.

However, on January 25–27, 1977, the Bureau of Health Insurance of the Social Security Administration initiated a medicare certification inspection at St. Elizabeths to determine the hospital's ability to treat medicare patients since it has been disaccredited. The medicare inspection will be completed the first week of April. In addition to the possibility of losing eligibility for medicare payments and other third party payments, there is also the increased risk in "right to treatment suits" since the lack of accreditation and/or certification of facility and program may be taken as evidence of inadequate treatment. The disaccreditation can also result in loss of certification of some 15 residency training programs at the hospital with the resulting adverse impact upon the continuation of training programs and upon the ability of graduates to enter their respective fields or professions. We also anticipate increasing difficulty in recruitment and retention of qualified personnel.

ST. ELIZABETHS MASTER FACILITIES PLAN

Mr. ROYBAL. Is your master plan for renovation completed? If so, what architectural firm developed it? What are the projected costs?

ANSWER. The master facilities plan was initiated in June 1976 and was completed on January 3, 1977. The architectural and engineering firm that developed the master plan was Dalton, Dalton, Little and Newport.

The plan, among other things, provides an architectural and engineering analysis of each patient care building with a recommendation of which buildings should be reconstructed, the level of reconstruction, which ones should be saved for historical purposes, and those that should be demolished. The level of remodeling was rated at a specific cost per square foot; the cost of new construction per square foot was estimated. Based upon the number of beds required, number of square feet per bed, level of reconstruction, patient support services requirements, and the construction of new beds, we have projected a cost of $75 million to correct the deficiencies at the hospital.

DEFICIENCY CORRECTIONS

Mr. ROYBAL. Other factors beyond structural problems caused you the loss of your accreditation. How do you plan to remedy these other problems?

ANSWER. Other factors cited by the JCAH, in addition to structural problems, that contributed to the hospital's loss of accreditation include:

Patient treatment was criticized from the standpoint of the absence of a comprehensive treatment plan recorded for each patient.

Medical records. The hospital was criticized for not having a consistent recording of all facets of the patient's activities, treatment, and progress in the medical record.

Medical staff. Commission recommended that there be a wider participation of mental health professionals other than physicians in medical staff and committee meetings.

Dietetic service. Food handling and food preparation should be improved.

Social services. The Commission criticized the frequent lack of the social work services being included in the treatment plan. This criticism was repeated for other professional services including program services, mental health workers, nursing service, patient education services, vocational rehabilitation services, psychological services, and pharmaceutical services.

A common criticism of many of the patient services was the need for appropriate staffing to meet the needs of the patients.

Since the 1975 report of the Joint Commission, the hospital has been engaged in an intensive program to correct the identified deficiencies through the formation of working committees and task forces, transmittal of policy directives, and the establishment of the Office of Quality Assurance in the Immediate Office of the Superintendent.

Immediately following the 1975 survey, during which time the personnel deficiencies were brought to the attention of the hospital, preliminary study was made to identify specific areas of deficiencies resulting in a supplemental in 1976 for 175 additional positions and $632,000. In Fiscal Year 1977 congressional action allowed $2.5 million for full year cost of 175 positions added. The 175 positions have been added to the staffing level of the hospital.

PATIENT OUTPLACEMENT

Mr. ROYBAL. Your statement makes reference to placing patients in the community. What are you talking about here?

ANSWER. It has long been the policy of St. Elizabeths Hospital to return patients to community settings as soon as it is determined that it would be advantageous to the patients, while at the same time being eligible to receive outpatient care and treatment either at the hospital or at one of the District's community mental health centers. Much time and effort is and has been expended developing and maintaining patient treatment plans on entering the hospital. Professional disciplines involved in the care of patients give full cooperation in the development of plans. During the past year, 633 eligible inpatients have been discharged and outplaced to various community settings including skilled nursing homes, intermediate nursing care facilities, halfway houses, foster care, and independent or family facilities.

Following the decision of Judge Aubrey Robinson in *Dixon* v. *Weinberger* on December 23, 1975, all patients identified as being eligible for outplacement became the responsibility of both the Hospital and the District of Columbia. Approximately 1,284 inpatients were identified as being eligible for outplacement. The District and the Department have developed an outline of a plan for compliance with the court order and presented it to the court on April 21, 1976.

Mr. ROYBAL. You are seeking to reduce your inpatient population from 2,500 to 1,800. I take it this means more people will be treated on an outpatient basis. Is that correct?

ANSWER. Reducing the inpatient population from its present level of approximately 2,500 to 1,800 would mean that there would be an increase in the number of people treated on an outpatient basis as well as an increase in the number of people discharged from care as having received all the care required.

The Hospital and the District have been working together to identify facilities existing in the District for outplacement of patients and methods of stimulating increased facility availability. There has been increasing cooperation in referral of patients to community mental health centers for outpatient care and treatment.

Mr. ROYBAL. Will your costs be going down with a lower inpatient population?

ANSWER. As the inpatient population is reduced, a certain point will be reached that will reduce Hospital operating costs. We are at the present time engaged in a study of patient costs both from the standpoint of inpatient and outpatient to identify more precisely the specific costs involved.

PERSONNEL DEFICIENCIES

Mr. ROYBAL. What specifically are the personnel deficiencies the accrediting body has cited?

ANSWER. The last survey of the hospital by the Joint Commission was made on September 8–11, 1975. The hospital was notified of its disaccreditation in December of the same year. The JCAH report, after stating that "the governing body should make available the resources necessary to recruit a sufficient number of qualified personnel to meet the needs of the facility's patients," cited specific areas it considered deficient: housekeeping, dietetic, social work, mental health workers, nursing, patient education, psychological, and pharmaceutical. Consistent with Commission policy, no indication was given of the degree of deficiency. The Commission, in its wisdom, refuses to establish a standard staff/patient ratio for a psychiatric facility on the sound basis that patient treatment and patient requirements are too variable and a standard would be meaningless. The determination of need remains the responsibility of the facility.

ST. ELIZABETHS REIMBURSEMENTS

Mr. ROYBAL. Your total budget provides for an increase of $1.8 million, but you are asking for an increase in the Federal portion of $4.2 million. This would appear to indicate a reduction in some other funds. Where does that reduction take place and why?

ANSWER. The reduction occurs in the level of reimbursement income anticipated in 1978. The District of Colubia reimburses the hospital $25.18 per day

PATIENT OUTPLACEMENT

Mr. ROYBAL. Have you noticed any positive effects on the patients since you instituted your new program of placing patients in the community?

ANSWER. The program of placing patients from the hospital into the community was instituted some 15 years ago. Due to the many advances in care and treatment of mental patients, the outplacements program has been increasing markedly in the past few years. To date we have not had the opportunity to study the special effects of outplacement. However, we are convinced that the overall result of patients taking their place in varying degrees in community

life is far more conducive to patient well being than continued hospitalization beyond the need for institutionalization.

ACCREDITATION REVIEW

Mr. ROYBAL. When do you expect to be reviewed again by the accrediting body?

ANSWER. Following JCAH disaccreditation of a hospital, the JCAH will make a return site visit when requested to do so by the hospital after the hospital believes that it has corrected the deficiencies that led to the disaccreditation. While St. Elizabeths has corrected many deficiencies, the major deficiencies relate to fire safety, patient safety, patient privacy and overall condition of buildings. Corrections in these areas require the investment of large sums for capital improvements. We have been advised by the JCAH that when commitment has been made by the administration and the Congress to provide the finances necessary to correct the major deficiencies, it would welcome an invitation to reconsider the Hospital for a yearly type accreditation until corrections are completed and the hospital would be eligible for a full 2-year accreditation. A site visit request to the JCAH prior to such commitment would be of little value as far as changing the disaccreditation decision. A specific timetable for regaining accreditation is, therefore, dependent and awaiting a commitment of the necessary funds.

Mr. ROYBAL. What are they asking you to do regarding patient privacy?

ANSWER. The last survey of the hospital by the Joint Commission on Accreditation of Hospitals was on September 8–11, 1975. The hospital was notified of its disaccreditation in December of the same year. Among the several items cited by the Commission resulting in loss of accreditation for the hospital was the problem of patient privacy. The Commission referred to one of its fundamental principles, "the psychiatric facilities should acknowledge the dignity and protect the rights of all patients," and then cited the following examples of noncompliance:

Personal articles for grooming and personal hygiene should be available in a space reserved for the patient.

Sleeping facilities should provide appropriate privacy for each patient. Allowances should be made for individual sleeping needs regarding privacy, duration of sleep, and times of retiring and rising.

Every resident should have ample closet and drawer space in which to keep his private property.

There should be places for visiting in private.

There should be areas available where a patient can be alone when this would not be in conflict with a therapeutic prescription for group activities only.

There should be areas available for a full range of social activities for two-person conversations to group activities.

Attractively furnished rooms or areas should be provided for private conversations between patients and visitors.

While remodeling and renovation to satisfy patient privacy requirements would be cost effective in certain patient care buildings, the architectural and engineering firm that developed the master facilities plan for St. Elizabeths pointed out that older buildings, while satisfactory for treatment standards at the time they were constructed, were no longer considered appropriate. They further stated that modern functional standards would require work which exceeds improvements which would be considered cost effective, that is, present

standards would require single or double rooms with showers and toilets between each room. They would also require that spaces for recreation and therapies be arranged for privacy where necessary and that noisy group activities be separated from quieter functions. Necessary modifications to the original design of the buildings including shape, volume, interior arrangement, window locations, and bearing walls would be very expensive and not cost effective.

PATIENT OUTPLACEMENT

Mr. MICHEL. Your statement makes reference to placing patients in the community. What are you talking about here?

ANSWER. It has long been the policy of St. Elizabeths Hospital to return patients to community settings as soon as it is determined that it would be advantageous to the patients, while at the same time being eligible to receive outpatient care and treatment either at the hospital or at one of the District's community mental health centers. Much time and effort is and has been expended developing and maintaining patient treatment plans on entering the hospital. Professional disciplines involved in the care of patients give full cooperation in the development of plans. During the past year, 633 eligible inpatients have been discharged and outplaced to various community settings including skilled nursing homes, intermediate nursing care facilities, halfway houses, foster care, and independent or family facilities.

Following the decision of Judge Aubrey Robinson in *Dixon* v. *Weinberger* on December 23, 1975, all patients identified as being eligible for outplacement became the responsibility of both the hospital and the District of Columbia. Approximately 1,284 inpatients were identified as being eligible for outplacement. The District and the Department have developed an outline of a plan for compliance with the court order and presented it to the court on April 21, 1976.

Mr. MICHEL. You are seeking to reduce your inpatient population from 2,500 to 1,800. I take it this means more people will be treated on an outpatient basis. Is that correct?

ANSWER. Reducing the inpatient population from its present level of approximately 2,500 to 1,800 would mean that there would be an increase in the number of people treated on an outpatient basis as well as an increase in the number of people discharged from care as having received all the care required.

The hospital and the District have been working together to identify facilities existing in the District for outplacement of patients and methods of stimulating increased facility availability. There has been increasing cooperation in referral of patients to community mental health centers for outpatient care and treatment.

Mr. MICHEL. Will your costs be going down with a lower inpatient population?

ANSWER. As the inpatient population is reduced, a certain point will be reached that will reduce hospital operating costs. We are at the present time engaged in a study of patient costs both from the standpoint of inpatient and outpatient to identify more precisely the specific costs involved.

PERSONNEL DEFICIENCIES

Mr. MICHEL. What specifically are the personnel deficiencies the accrediting body has cited?

ANSWER. The last survey of the hospital by the Joint Commission was made on September 8–11, 1975. The hospital was notified of its disaccreditation in December of the same year. The JCAH report, after stating that "the governing body should make available the resources necessary to recruit a sufficient number of qualified personnel to meet the needs of the facility's patients," cited specific areas it considered deficient: housekeeping, dietetic, social work, mental health workers, nursing, patient education, psychological, and pharmaceutical. Consistent with Commission policy, no indication was given of the degree of deficiency. The Commission, in its wisdom, refuses to establish a standard staff/patient ratio for a psychiatric facility on the sound basis that patient treatment and patient requirements are too variable and a standard would be meaningless. The determination of need remains the responsibility of the facility.

ST. ELIZABETH REIMBURSEMENTS

Mr. MICHEL. Your total budget provides for an increase of $1.8 million, but you are asking for an increase in the Federal portion of $4.2 million. This would apprear to indicate a reduction in some other funds. Where does that reduction take place and why?

ANSWER. The reduction occurs in the level of reimbursement income anticipated in 1978. The District of Columbia reimburses the hospital $25.18 per day for each District of Columbia resident treated as an inpatient. The District of Columbia day rate is constant (i.e., it does not increase in proportion to the total cost of operations) and therefore remains the same in 1978. Because there are fewer District of Columbia resident patients, and because the per diem charge for these patients remains constant, there is a decrease. Mathematically, the change is as follows:

Increase in total budget	$1,800,000
Increase in appropriation to offset loss of District of Columbia income	2,432,000
Total	4,232,000

PATIENT LOAD

Mr. MICHEL. Is your expected patient total for 1978 up or down?

ANSWER. We expect the total iumber of patients on our rolls in 1977 and 1978 to remain the same, at 5,500. Within this total, we expect a decrease of 50 inpatients (from 2,450 to 2,400) and an offsetting increase in the number of outpatients (from 3,050 to 3,100).

APPROPRIATIONS TO OVERCOME DEFICIENCIES

Mr. MICHEL. We have made some special appropriations in the past couple of years to enable you to overcome many of the deficiencies cited by the accrediting body. Yet you are telling us today that you have become totally disaccredited. What happened to that money we gave you?

ANSWER. When in June 1974 the JCAH inspected SEH facilities and subsequently granted the hospital its second provisional accreditation, several areas of noncompliance were identified. They include overcrowding, the need to improve facilities relating to patient services, and the lack of sufficient personnel in certain areas. In 1975, JCAH surveyed the hospital again and, in December of that year, notified the hospital of the disaccreditation of its psychiatric facilities. Subsequently, the hospital has pursued a vigorous appeal policy, based mainly upon the authorization of 175 additional positions and the fact that a total of $11.9 million has been made available to correct deficiencies in the physical plant. Of this total amount:

$3,025,000 has been identified for relief of overcrowding of which $125,000 has been obligated for the master facilities plan. The $2.9 million which remains unobligated in this area is for architectural and engineering design for construction of 460 patient beds and renovation of 1,047 existing patient beds. The obligations of these funds had to await completion of the master facilities plan, which has now been submitted to the Congress.

$7,440,000 has been identified for improvement of safety. Of this amount $2,343,000 has been obligated for emergency lighting, sprinkler systems, fire alarm detection and alarm systems. A total of $2,950,000 has been earmarked to eliminate the remaining life safety deficiencies to bring the buildings up to minimal standards. The remaining amount cannot be obligated until design contracts are completed. At that time, we shall use these funds for the elimination of life safety deficiencies.

$250,000 has been identified for patient privacy items. All of these funds have been obligated.

$1,145,000 has been identified for improvement of services for patients. Of this amount $977,000 has been obligated.

Despite the efforts just outlined, the JCAH on December 18, 1976, upheld its decision not to accredit the hospital. This decision exhausts the appeal process for the present time. The final decision of JCAH was not unforeseen. While the steps already taken represented material progress toward compliance, the issue of major funding for new and/or reconstructed patient facilities necessarily depended upon the development of a comprehensive facility study. The purpose of the study was to postulate a series of assumptions concerning the future patient load and role of the hospital, to insure the most efficient use of construction funds. The study has been completed and has been submitted to the Congress.

JUSTIFICATION OF THE BUDGET ESTIMATES

Appropriation Estimate

Saint Elizabeths Hospital

For expenses necessary for the maintenance and operation of the hospital, including clothing for patients, and cooperation with organizations or individuals in the scientific research into the nature, causes, prevention, and treatment of mental illness, [$60,464,000] *$68,746,000* 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 [$84,244,000] *$90,XXX,000*.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

SAINT ELIZABETHS HOSPITAL

Amounts Available for Obligation

	1977 Appropriation	1978 Estimate
Appropriation	$60,464,000	$68,746,000
Proposed supplemental	4,050,000	---
Receipts and reimbursements from:		
Federal funds	785,000	839,000
Trust funds	300,000	300,000
Non-Federal sources	22,695,000	20,285,000
Total, Obligations	88,294,000	90,170,000

Summary of Changes

1977 Estimated Obligations	$88,294,000
1978 Estimated Obligations	90,170,000
Net Change	+1,876,000

	1977 Base Pos.	1977 Base Amount	Change From Base Pos.	Change From Base Amount
Increases:				
A. Built-in:				
1. Within-grade increases	---	---	---	$1,219,000
2. Cost of living increases for food, medical supplies, utilities, equipment, contractual services, etc.	---	---	---	+1,000,000
Total increases				+2,219,000
Decreases:				
A. Built-in:				
1. Reduction on one extra day in 1978	---	---	---	-210,000
B. Program:				
1. Reduction of 10 positions	4,307	---	-10	-133,000
Total decreases			-10	-343,000
Net Change			-10	+1,876,000

Obligations by Activity

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Clinical and Community Services	4,307	$88,294,000	4,297	$90,170,000	-10	+$1,876,000
(Budget Authority)...		(64,514,000)		(68,746,000)		(+4,232,000)

Obligations by Object

	1977 Appropriation	1978 Estimate	Increase or Decrease
Total number of permanent positions	4,307	4,297	-10
Full-time equivalent of all other positions	194	194	---
Average number of all employees	4,415	4,410	- 5
Personnel compensation:			
Permanent positions	$60,592,000	$61,461,000	+$869,000
Positions other than permanent	2,908,000	2,908,000	---
Other personnel compensation	3,832,000	3,832,000	---
Special personal service payments	930,000	930,000	---
Subtotal, personnel compensation	68,262,000	69,131,000	+869,000
Personnel benefits	6,376,000	6,383,000	+7,000
Travel and transportation of persons	312,000	329,000	+17,000
Transportation of things	91,000	96,000	+5,000
Rent, communications and utilities	1,460,000	1,540,000	+80,000
Printing and reproduction	56,000	59,000	+3,000
Other services	2,124,000	2,241,000	+117,000
Supplies and materials	8,107,000	8,617,000	+510,000
Equipment	1,307,000	1,562,000	+255,000
Lands and structures	227,000	240,000	+13,000
Claims and indemnities	4,000	4,000	---
Subtotal	88,326,000	90,202,000	+1,876,000
Deduct charges for quarters	-32,000	-32,000	---
Total obligations by object	88,294,000	90,170,000	+1,876,000

Significant Items in House and Senate

Appropriations Committee Reports

Item	Action taken or to be taken
1976 Second Supplemental - House Report	
Saint Elizabeths Manpower Requirements	
1. Committee request for a copy of the report on the hospital's manpower requirements as soon as it is completed (page 49).	1. It is anticipated that the study will be completed by August, 1977. The report will be submitted as requested.

SAINT ELIZABETHS HOSPITAL

Year	Budget Estimate To Congress	House Allowance	Senate Allowance	Appropriation 1/
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	57,002,000
1977	57,964,000	60,464,000	60,464,000	60,464,000
1977 Supp.	4,050,000			
1978	68,746,000			

1/ Differences between appropriation amounts and House and Senate allowances are partially due to changes in estimated patient load.

Justification

Saint Elizabeths Hospital

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Clinical & Community Services ...	4,307	$88,294,000	4,297	$90,170,000	-10	+$1,876,000
(Budget Authority)		(64,514,000)		(68,746,000)		(+4,232,000)

General Statement

This appropriation supports the operation of the Saint Elizabeths Hospital, which provides treatment and rehabilitation of the mentally ill for approximately 2,400 inpatients and 3,100 outpatients. The Hospital operates a community mental health center which services 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 1978 Budget requests a total authorized program of $90,170,000, an increase of $1,876,000 over a current year estimated obligation level of $88,294,000.

In FY 1977 the Administration intends to submit legislation to transfer the Hospital to the District of Columbia by FY 1980. This legislation will also provide for authorization of funds for construction and renovation of the hospital.

Impact of 1978 budget:

The Hospital will treat an estimated 9,350 patients during 1978. A total of 4,000 is expected to be admitted, compared with 3,950 to be discharged from the rolls. In terms of daily averages, the inpatient load is expected to average 2,400, compared with an outpatient load of 3,100.

In its continuing effort to provide better services to its patients, the Hospital is making the following improvements:

(a) Unitization. The Hospital continues with the unitization of services to patients. Actions are being 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 44 patients. There have been 460 admissions into this program in six years. Twenty-one 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 39 patients.

(d) Intensive care units. A medical and surgical intensive care suite is being established to accomodate intensive care, post surgery and post anesthesia, and isolation units.

(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 1978, 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 1978 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 net increase of $1,876,000 will cover built-in within-grade pay increases, cost of living increases in costs of supplies such as utilities, food of patients, and fuel oil for heating, and other miscellaneous items. Further, this budget proposes a reduction of 10 administrative positions. Workload data are set forth in the following tables.

Patient Load Data

	1976 Actual	1977 Estimate	1978 Estimate
Inpatients:			
Reimbursable			
Public Health Service (Indians)	1	1	1
D.C. (Residents)	1,240	1,209	1,183
D.C. (Vol. and Non-protesting)	618	610	598
D.C. (Prisoners)	278	260	251
D.C. (Jury Trial)	19	18	15
U.S. Soldiers Home	-	-	-
Veterans Administration	1	1	1
U.S. Nationals	18	18	18
U.S. Prisoners	3	3	3
Reimbursable Totals	2,178	2,120	2,070
Nonreimbursable			
Military	47	47	47
D.C. Non-residents	190	190	190
Public Health Service	3	3	3
Virgin Islands	64	64	64
Other	24	26	26
Nonreimbursable Total	328	330	330
Total, Inpatients	2,506	2,450	2,400
Outpatients	2,897	3,050	3,100
Total on rolls (daily average)	5,403	5,500	5,500
Admissions	3,774	3,900	4,000
Discharges	3,590	3,625	3,725
Deaths	257	225	225

SAINT ELIZABETHS HOSPITAL

Reimbursement Detail

	1977 Appropriation	1978 Estimate
Reimbursements from Federal and Trust Funds:		
Veterans Administration	$33,000	$35,000
U.S. Soldiers Home	-	-
Public Health Service (Indians)	33,000	35,000
U.S. Nationals	600,000	643,000
U.S. Prisoners	100,000	105,000
Soc. Sec. (Medicare payments)	300,000	300,000
General Services Administration	19,000	21,000
Subtotal	1,085,000	1,139,000
Payment received from Non-Federal Sources:		
District of Columbia	22,515,000	20,085,000
Cafeteria sales	175,000	195,000
Sale of scrap	5,000	5,000
Subtotal	22,695,000	20,285,000
Total reimbursements	23,780,000	21,424,000
Per diem rate:		
District of Columbia	$25.18	$25.18
Other	90.60	97.48

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

SAINT ELIZABETHS HOSPITAL

Program Purpose and Accomplishements

Activity: Clinical and Community Services -(Title 24 U.S. Code, Chapter 4, Sections 161 - 222.)

1977 Appropriation		1978 Estimate		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
4,307	$88,294,000	Indefinite	4,297	$90,170,000
(B.A.)	(64,514,000)		(B.A.)	(68,746,000)

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 clinical training for professional and related personnel.

Explanation: The Hospital operates with an indefinite appropriation, which fixes a total operating ceiling and provides that direct Federal appropriations will make up the difference between the total authorized ceiling and the amount of reimbursements received during the year. Virtually all reimbursements received are for inpatient care. The principal reimbursing agency is the District of Columbia.

Accomplishments in 1977: 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 3,900; 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 3,850 patients and to achieve a slight decrease in the average daily inpatient load. It is estimated that 9,350 patients will be treated, including an average of 3,050 outpatients. The narcotic addiction program currently serves approximately 44 patients. Intensive care units are being established in the Medical and Surgical Branch.

Objectives for 1978: 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. Efforts will continue toward the goal of transferring the Hospital to the District of Columbia.

Appropriation Estimate

CONSTRUCTION AND RENOVATION SAINT ELIZABETHS HOSPITAL

For construction, alterations, extension, and equipment of buildings and facilities on the grounds of Saint Elizabeths Hospital, $810,000 to remain available until expended.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Construction and Renovation Saint Elizabeths Hospital

Amounts Available for Obligation

	1977 Appropriation	1978 Estimate
Appropriation	$---	$810,000
Unobligated balance, start of period	9,281,000	---
Total obligations	9,281,000	810,000

Summary of Changes

1977 Estimated Budget Authority	$---
1978 Estimated Budget Authority	810,000
Net Change	810,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increase:				
A. Program:				
1. Construction and Renovation Saint Elizabeths Hospital				
a. Buildings and Facilities: primarily to support general repairs and improvements	---	$---	---	+$810,000
Net Change	---	---	---	+810,000

Obligations by Activity

	1977 Estimate		1978 Estimate		Increase/ Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Construction and Renovation Saint Elizabeths Hospital						
Buildings and Facilities.....	---	$9,281,000	---	$810,000	---	-$8,471,000
Total Obligations....	---	9,281,000	---	810,000	---	-8,471,000
(Budget Authority).	---	(---)	---	(810,000)	---	(+810,000)

Obligations by Object

	1977 Estimate	1978 Estimate	Increase/ Decrease
Other Services.....	$9,281,000	$810,000	-$8,471,000
Total Obligations by Object...	9,281,000	810,000	-8,471,000

Significant Items in House and Senate
Appropriations Committee Reports

Item	Action taken or to be taken
1977 Conference Report	
Master Plan for Saint Elizabeths	
1. Committee directive that HEW submit the master facilities plan for Saint Elizabeths Hospital within 60 days after enactment of the bill (page 13).	1. The Master Plan is to be completed in late January, 1977 and will be submitted to the Committee. A draft copy of the report was submitted in early January.

Authorizing Legislation

Legislation	Authorized	1978 Budget Request
Saint Elizabeths Hospital		
Buildings and Facilities.....	Indefinite	$810,000

Construction and Renovation Saint Elizabeths Hospital

Appropriations History

Year	Budget Estimate To Congress	House Allowance	Senate Allowance	Appropriation
1976.....	$---	$7,700,000	$10,600,000	$10,600,000
1977.....	---	---	$25,000,000	---
1978.....	810,000			

Construction and Renovation Saint Elizabeths Hospital

Buildings and Facilities

	1977 Appropriation	1978 Estimate	Increase/ Decrease
Buildings and Facilities..	$9,281,000	$810,000	-$8,471,000
(Budget Authority).....	(---)	(810,000)	(-810,000)

Direct construction and facility improvement projects relating to facilities of Saint Elizabeths Hospital, including preparation of plans and specifications, are funded under this activity.

Although there is no new budget authority for FY 1977, $9,281,000 remains available from the FY 1976 appropriation for improvements and renovation at Saint Elizabeths Hospital to help remedy accreditation deficiencies cited by the Joint Commission on the Accreditation of Hospitals (JCAH). Of this unobligated balance, $2.9 million will be used for the design of facilities for new beds to relieve overcrowding, $6.0 million for the correction of fire and safety deficiencies. The remaining balance is for other improvements related to the Hospital's accreditation. Furthermore, the Administration intends to submit a separate legislative package whose goal is to transfer the hospital to the District of Columbia. This proposed legislation will contain a $100 million authorization for improvements to buildings and facilities.

Impact of 1978 Budget:

The $810,000 for FY 1978 will allow for general repairs and improvements such as replacement of steamlines and projects to improve safety and security conditions at the Hospital.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Construction and Renovation Saint Elizabeths Hospital

Program Purpose and Accomplishments

Activity: Buildings and Facilities

	1977 Appropriation			1978 Budget Estimate	
	Pos.	Amount	Authorization	Pos.	Amount
	---	$9,281,000	Indefinite	---	$810,000
(B.A.)	(---)	(---)		(---)	(810,000)

Purpose: Provides funds for direct construction and facility improvement projects relating to facilities of Saint Elizabeths Hospital (SEH), including preparation of plans and specifications.

Explanation: This activity is used primarily for construction, repairs, and improvements to bring the Hospital's facilities up to standard and maintain Joint Commission on the Accreditation of Hospitals (JCAH) standards. Appropriations to this account are available until expended.

Accomplishments in 1977: The remaining funds available from previous year's appropriation were utilized for improvements and renovation of SEH to help remedy accreditation deficiencies cited by the JCAH.

Objectives in 1978: The $810,000 for FY 1978 will allow for general repairs and improvements such as replacements of steamlines and projects to improve safety and security conditions at the Hospital.

FRIDAY, MARCH 18, 1977.

HEALTH RESOURCES ADMINISTRATION

WITNESSES

DR. HAROLD MARGULIES, DEPUTY ADMINISTRATOR
JAMES A. WALSH, ASSOCIATE ADMINISTRATOR FOR OPERATIONS AND MANAGEMENT
DR. HARRY P. CAIN, DIRECTOR, BUREAU OF HEALTH PLANNING AND RESOURCES DEVELOPMENT
DR. GERALD D. ROSENTHAL, DIRECTOR, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH
MRS. DOROTHY C. RICE, DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS
DR. DANIEL F. WHITESIDE, DIRECTOR, BUREAU OF HEALTH MANPOWER
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

Mr. Obey [presiding]. The committee will come to order.

This morning we will hear from Dr. Harold Margulies, Deputy Administrator of Health Resources Administration.

Doctor, why don't you go ahead and introduce who you have with you at the table. Then, I see you have a statement here. Perhaps you could just insert it in the record. If you do want to make a few comments before you start, fine. Then we will start with the questions.

Dr. MARGULIES. Thank you. I will be glad to do that.

I would like to introduce the other people at the table. On my far left, Dr. Jerry Rosenthal, National Center for Health Services Research. Next, Mrs. Dorothy Rice, National Center for Health Statistics. On my right is Dr. James Walsh, Associate Administrator, Operations and Management. Next to him, Dr. Harry Cain, Bureau of Health Planning and Resources Development and Dr. Daniel Whiteside, Bureau of Health Manpower, and you know Charlie Miller.

We will submit the opening statement for the record.

[The statement and biographical sketch follow:]

STATEMENT OF DR. MARGULIES, DEPUTY ADMINISTRATOR

Mr. Chairman and members of the Committee:

We are requesting $544,619,000 for programs to help assess the health of all Americans, to find better ways to help restrain our rapidly rising health costs, and to assure that an appropriate supply of health resources is available in primary care in all areas of the country.

HEALTH MANPOWER

In the past 10 years we have increased the number of medical and dental graduates and the Nation's supply of active nurses has reached 961,000. Sheer numbers are no longer the major problem: the Nation's problem is how to attract these larger numbers into direct patient care and to get them to practice in rural areas and in the inner cities. The new Health Professions Educational Act gave us some new tools to do this job.

1. Capitation for schools of medicine, osteopathy and dentistry is designed to encourage greater production of primary care specialists in residency programs.

2. About 30 percent of all physicians who have gone through family practice

residencies go on to practice in nonmetropolitan areas. This is substantially higher than those in other residency training programs. We shall support more than 3,000 such residencies and training for 200 dental students and faculty to deliver a range of services in geographically remote areas.

3. Other programs to extend the work of primary care workers are those to train physician and dental assistants, and nurse practitioners. We are requesting funds to help finance programs to train 590 nurse practitioners, 2,700 physician assistants and 1,200 dental extenders.

4. We shall support 16 area health education centers in 18 States to extend training opportunities into rural and urban communities that lack them. We hope this will encourage additional commitments by the physicians and other health professionals for service there.

5. We are asking for funds to support student aid that will be used to commit students, upon graduation, to serve in geographic areas where they are needed. Our request for National Health Service Corps scholarships will support 4,000 students in exchange for service in the National Health Service Corps or in private practice in a shortage area. A new program of federally insured loans will become effective in 1978. A minimum of 50,000 loans would be available to students in schools of the health professions and public health. The program would help asure that health professions education is open to all, not just to the wealthy. The program would also address the problem of shortages of health professionals in medically underserved areas since borrowers may enter into an agreement with the Department of Health, Education, and Welfare for repayment of the loans in exchange for service in the National Health Service Corps or for practicing in a manpower shortage area. We will fund two programs of scholarship support for 500 disadvantaged students in the health professions and 9,000 needy nursing students.

We will continue existing programs to identify, motivate and train young people from poor and disadvantaged backgrounds who may pursue training for careers in the health professions. The 100 programs to be supported by these grant funds will reach approximately 9,000 disadvantaged young people directly.

To help us plan for future health manpower needs, we expect to fund two seperate but related efforts. One is a small resource group to examine the problem of physician specialty maldistribution by looking at the influence of our present system of graduate medical education. The second effort will be through a Congressionally required program of studies on the supply, needs and distribution by specialty and geographic location of health professionals.

HEALTH PLANNING

Health planning activities contribute significantly to our effort to control the escalation of health costs while providing improved access to necessary care. There will be an operating health planning agency in each of the Nation's 212 health service areas by the end of 1977 and all State agencies will be in operation. Some of the health systems agencies (HSA's), using already existing mechanisms, are demonstrating how they can help restrain excess spending.

For example, in New York, the HSA has recommended that the New York Hospital-Cornell Medical Center turn from a $68 million, 25-story center to a 40-bed center to treat burn victims at much reduced outlays. This is an example of what can be accomplished with strong, well-informed HSA's and the backing of the [illegible] agencies.

As many of the agencies become fully designated, having developed long-term goals and an annual plan to describe how these goals are to be reached, they will concentrate on reviewing applications for certificate of need and applications for Federal funds, reviewing the appropriateness of existing institutional health services in the area, and stimulating community actions needed to implement the area's health system's plan. Our funding will permit us to continue to support HSA's at more than $0.40 per capita. We expect to provide a minimum funding of $175,000 for 38 HSA's while 174 agencies will get higher amounts.

The State agencies integrate the plans of the individual HSA's into an overall plan. They will also administer the facilities construction program and the important certificate of need programs. The State agencies and HSA's must become involved in approving new construction and taking an active role in avoiding too many beds by avoiding excess construction. With the funds we have requested, we will be able to make an average grant of $348,000 per agency. When combined with State matching of 25 percent, each State agency will average 18 staff members.

To help each HSA and State agency perform their complex and difficult jobs, we are helping to develop effective planning methods and provide the needed technical assistance for these two sets of agencies.

We plan to continue funding the ten Centers for Health Planning which were established in 1976 to provide training and orientation for staff and board members of HSAs and State agencies. We shall also operate the National Health Planning Information Center which handles between 125 and 150 requests for specific planning information from HSAs and State agencies every month.

With the Social Security Administration, we will continue to support six demonstrations on the effectiveness of regulating rates to show us effective ways to restrain the rise in health care costs.

The entire facility financing area is being examined to determine the appropriate role for loans, loan guarantees, interest subsidies, and grants, to name just a few approaches. Until these new directions become clear, we are requesting no new funds for construction of hospitals and other medical facilities.

One vital activity we have been conducting has been to encourage the people who run health facilities to make better use of and conserve energy. Together with the Energy Research Development Agency we are about to start a solar energy demonstration project for health facilities. This will contribute to the Nation's energy effort and should help health facilities control some of their energy costs.

HEALTH STATISTICS

The increased funds requested for health statistics activities will allow us to near completion of the first phase of the cooperative health statistics system. This system will help meet the expectations and hopes of the State and local governments in development of shared data systems. It also will provide funds to the States to collect uniform vital statistics, manpower and facilities data and will help State and local health planning agencies meet their basic needs in determining their health resources needs and in assessing the health status of people in their areas. For example, the Center has been able to analyze certain national data, including infant deaths, to produce some data for local planning areas.

The national surveys conducted by the National Center for Health Statistics yield data that lead to new ways to protect our health. During the past year, we published growth charts that were the result of our health and nutrition examination surveys. These charts, the most exact and extensive in the past 30 years, will allow pediatricians and family doctors to spot and treat growth abnormalities in children at very early ages.

Our national ambulatory medical care survey is the Nation's first detailed look at medical practice in physicians' offices. The first findings from this study, with which the medical profession has cooperated splendidly, are already changing some approaches to medical education. Medical schools like Harvard are using the findings to make changes in their curricula by introducing students to primary care practice early and in office practices rather than the traditional hospital setting. Medical specialty certification boards are beginning to request information from the survey on which to base questions for their examinations.

HEALTH SERVICES RESEARCH

The National Center for Health Statistics and the National Center for Health Services Research are carrying out a major study of how we as a Nation spend our money for health care. The Research Center will look at what factors influence expenditures for personnel health care and determine what impact different insurance arrangements have on costs and the use of services. They hope to get evidence on what effect items like coinsurance and deductibles have on the use of services, particularly by disadvantaged groups.

Other studies supported by the Center have shown that hospital information systems can save $3 to $5 for each patient day. These systems might reduce expenditures for inpatient care by more than $1 billion per year. As a result of another study, we found that medical malpractice costs for hospitals that used an arbitration system were 15 percent less than the costs of a comparable group that did not use this system for settling claims. This study may have significant effect on how we handle this malpractice problem.

We have also developed a more effective means for disseminating the research findings of the Center to reduce the time between discovery and getting new knowledge into the hands of the people who need it and can use it.

Emphasis in the Center is on finding reliable means for holding down the rise in health costs, but the Center is continuing to pay special attention to maintaining the quality of patient care. Several projects are evaluating the impact of national economic conditions on the health care of the disadvantaged. Research is conducted on the forces that will affect the productivity of health manpower, and the center is examining major issues in the field of health manpower and health insurance. Research projects are also examining how health planning and regulations may be made more effective.

We are funding research focused on how to find better ways of delivering long term care to a population over age 65 and more subject to chronic and disabling illnesses and conditions. We will continue this activity next year.

Seven research centers have been established to work on a number of research priorities including ways to stop the cost spiral, helping State legislatures develop State health care policy, and cost saving implications of the second opinion before undergoing surgery.

In 1978, we will establish a health services policy analysis center. Our support of these centers provide support for a limited staff and for overhead. Each center then provides the extra support for its special programs. The major job of this Agency is to find ways to provide effective access to primary care by all citizens while helping to find ways to restrain the rise in health care costs. With the funds requested, we hope to make substantial contributions to these efforts.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
HEALTH RESOURCES ADMINISTRATION

BIOGRAPHICAL SKETCH

Name: Harold Margulies, M.D.

Position: Deputy Administrator, Health Resources Administration.

Birthplace and date: Sioux Falls, S.Dak., February 13, 1918.

Education: A.B., University of Minnesota, 1938, B.S., University of South Dakota, 1940. M.D., University of Tennessee, 1942. M.S., University of Minnesota, Graduate School of Medicine, Mayo Foundation, 1948. Fellowship in Internal Med., Mayo Clinic, 1944–45/1946–49. University of South Dakota, 1972, Sc.D. (honorary).

Experience: Present Deputy Administrator, Health Resources Administration. 1971–73: Director, Regional Medical Programs Service, HSMHA. 1970–71: Acting Director, Regional Medical Programs Services, HSMHA. 1969–70: Deputy Assistant Administrator for Program Planning and Evaluation, HSMHA. 1968–69: Secretary, American Medical Association Council on Health Manpower, AMA 1967–68: Associate Director, AMA, Division of Socio-Economic Activities, Wash., D.C. 1965–67: Associate Director, Division of International Medical Education, Associate of American Medical College and Director, AAMC–AID Contract Project. 1966–67: Consultant, National Advisory Commission on Health Manpower. 1966–67: Consultant, White House Office of Science and Technology for Evaluation of Medical Programs for Pakistan. 1965–66: Advisor on Med. Educ., World Hlth. Org., Eastern Mediterranean Regional Office, Alexandria, UAR. 1961–64: Professor of Medicine and Chief of Party, Indiana University Advisory Group, AID Contract, Postgraduate Medical Center, Karachi, Pakistan. 1959–61: Principal Investigator, United Heart Station, Iowa Methodist Hospital Director of Blank Guild Heart Station, Iowa Methodist Hospital. 1949–61: Clinical Teaching Staff, Iowa Methodist Hospital, Director of Electrocardiographic Laboratory, Iowa Methodist Hospital Consultant in Internal Medicine, Veterans Administration, Private Medical Practice, Des Moines, Iowa. 1949–59: Director of Education, Iowa Methodist Hospital.

Association memberships: Sigma Xi, Fellow of the American College of Physicians, Diplomate of the American Board of Internal Medicine, Mayo Alumni Association, American Medical Association, Association of American Medical Colleges, Fellow of the American Public Health Association, Board of Trustees, Des Moines Art Center, 1958–1961.

Dr. MARGULIES. I would like to make a couple of comments.

HEALTH RESOURCES ADMINISTRATION DEVELOPMENT

The Health Resources Administration is only about 3½ years old. This is the first time we have ever testified before this committee on all parts of our program. We have not testified on the health manpower legislation for the past 3 or 4 years. This is because we have either had problems over the appropriations or more specifically because we did not have authorized legislation and we now have new, complex and rather striking legislation.

Despite those kinds of problems and uncertainties during these past 3½ years, the agency as an agency has come into full strength and I think it is functioning in ways that are more effective and less recognized than might seem appropriate. It is the only agency in the Federal Government which is dealing with the issues in health care which are providing most of the dilemmas and most of the problems that consume most of the time of people in and outside the government.

It is the only agency which is concerned simultaneously with improving delivery of health care, access to health care and dealing with the issues of uncontrollable cost, maldistribution, and distribution between specialties and primary care.

If you look through the rest of your experiences here and throughout the government, other activities are categorical, especially in dealing with single aspects of that. As a consequence of that kind of tension in this agency, we have created a sense of integrity and purpose which has made us useful in ways I am sure will not be demonstrated in these hearings.

We are turned to on policy, advice, analysis and understanding of the health delivery system by many people in and out of government. Our publications become key reference points for most thinking that is going on in these issues and we have within the agency produced a kind of cross relationship between programs and peoples which at least from my point of view is very heartwarming. It is not easy to go from a separate group of programs with its own history and purposes into a new agency and have them come together. We have done that in ways I think would be of high interest to anyone taking a look at it.

I won't consume more of your time in trying to catalog policy issues on health facilities or in looking at physician extenders or dealing with the essential problems of regulations as an instrument of public administration.

But we have done this and we continue to do it very effectively. I hope in our responses we will deal with your questions as an agency and as the components of the agency.

NATIONAL HEALTH STATISTICS

Mr. OBEY. Thank you, Doctor.

Let me ask you a few questions about health statistics. The budget for the Center for Health Statistics proposes an increase of $5,429,000. That is about a 20-percent increase. Why do you need that much of an increase for the program?

Dr. MARGULIES. Well, the National Center for Health Statistics has been undergoing a very steady change in the basic purposes and within its programs. I will ask Mrs. Rice to comment on this in a moment.

One of the major issues and functions in that center is the development of the cooperative health statistics system which allows us for the first time to have a single source between the Federal and State governments to produce essential data which are utilized for all the people in the health care system.

In addition to that, we are undertaking some new initiatives, some of which have been specifically identified by acts of Congress, which expand our programs.

Before she does comment, I would like to say that a major change which has occurred in the last several years in legislation has been the identification of data requirements in program after program, and within that process the identification of the National Center for Health Statistics as that part of the Federal Government to deal with those statistics.

MANPOWER DATA REQUIREMENTS

A good example is in the current manpower legislation, Public Law 94–484, which has a long list of data requirements, and which appropriately says that the National Center for Health Statistics will be involved. This is in addition to the core functions and the expanding functions of NCHS about which Mrs. Rice can comment on further.

COOPERATIVE HEALTH STATISTICS

Mrs. RICE. Dr. Margulies has indicated that the cooperative health statistics system provides a mechanism for collecting and processing only one time the health data that are needed by the many health programs at the local, State and national levels. Investment in this system actually reduces the need of the federally funded health programs like the health manpower and health planning activities to develop and operate independent data systems.

Savings are realized in data collection and processing costs and in the reduced reporting burden on the data provider.

In addition, high quality and comparable data are provided for the various Federal health programs. Specifically, the requested increase will allow an expansion of the CHSS into all of the 50 States in one or more of the data components.

Mr. OBEY. You say it will?

Mrs. RICE. Yes. We are in the process of development of all of the components. There are six components that comprise the cooperative health statistics system. These components are in vital statistics, health manpower, health facilities, hospital care, ambulatory care, and long-term care.

In the health manpower and health facilities components we will expand from 27 States to 42 States, in vital statistics from 34 States to 48 States and from 12 to 20 States in the hospital care data component.

Mr. OBEY. So there will be no States where you will have all components fully operational?

Mrs. RICE. Not in fiscal 1978. We are working toward this and hope to continue with additional resources in the future.

Mr. OBEY. If we were to add more money to your budget, would you be physically able to implement that system in all 50 States and if you would, what kind of dollars would you be talking about?

Mrs. RICE. We would be able to implement parts of the system in all of the States and in a few States all of the components could be at least demonstrated. For example, there are quite a few States that are ready to enter into contracts for the vital statistics health manpower and health facility components.

In the hospital care area, there are a considerable number of requests that are being made now that we cannot meet and will not even be able to meet with the increase of almost $6 million in fiscal 1978. We could use at least another $6 million in fiscal 1978. It would not be difficult to program this amount of money among the States which are technically ready to further develop the cooperative health statistics system.

MANPOWER RESOURCES

Mr. OBEY. Are there any other problems besides money?

Mrs. RICE. The main problem, besides money, in implementation of a program of this nature is the need for manpower resources in the National Center for Health Statistics. We will not be able to monitor the contracts that we have without additional positions in the Center.

DISTRIBUTION OF FUNDS

Dr. MARGULIES. There are other problems besides that, Mr. Obey. As I indicated earlier, the demands on NCHS to produce data not only for the Health Resources Administration but for those outside of it would require a very careful look at any increased funding in data to decide where in response to legislation the greatest investment ought to be made. We would have to look carefully at the use of funds for that purpose.

How much should be in manpower, for example, if we should go well beyond our present manpower investment and do what we ought to do there rather than expanding other components of the cooperative health statistics system?

I think it would be misleading to say we have a strategy that would necessarily support the health statistics system at the expense of other kinds of data requirements. We have trade-offs on that at all times.

In our budget records it shows that much of the cooperative statistics' support has come from other parts of the agency which have needs for those kinds of data. We have specific requirements in the planning activities. The HSA's will need certain kinds of data. So I think it ought to be done around a planned, orderly progression against all data needs rather than one specific activity like CHSS. We are strongly in favor of the cooperative health statistics system and I think we need to be balanced against other requirements.

Mr. OBEY. I have two or three questions to put in the record now.

DISTRIBUTION OF CHSS FUNDS BY STATES

How much will the States receive in 1978 to implement the cooperative statistics system? What is the average going to be?

Mrs. RICE. We will submit that for the record.

Mr. OBEY. You don't have that figure now?

Mrs. RICE. Not right now.

[The information follows:]

In 1978 approximately $13 million will go to the States through the cooperative health statistics system. The amount per State will vary by the number of data components implemented, the population base, and the complexity of the delivery system in each State.

COORDINATION OF HEALTH DATA

Mr. OBEY. How are you tying in the efforts of the Center for Health Statistics with the data needs of the Alcohol, Drug Abuse, and Mental Health Administration, the Bureau of Quality Assurance, et cetera? What is your process?

Dr. MARGULIES. The key process at the present time is in the Office of the Assistant Secretary for Health, a health data policy coordinating committee which has been looking not only at those kinds of data, output and utilization functions, but those that are in the National Institutes of Health and elsewhere.

We do have a problem, Mr. Obey, a very major one, in trying to coordinate data between programs. It is an issue which has been raised when I have testified before Mr. Rogers' committee as well.

As you can see, the data needs, say, in PSRO or in the Social Security Administration which does not come here, in NIH, are tied to programmatic requirements. When we meet as a policy board, we identify the conflicting or combined needs of the various parts of HEW and look at what we ought to do together.

At the present time I think there has been extremely high progress toward a common data source, common utilization which has led to probably the most effective possible use of information coming from hospitals as a primary example of health-related data. But we still do not have an effective mechanism for discriminating between the territorial wishes of one program and those of another. We are moving in that direction, but I think it requires a little better understanding than we now have.

But that central mechanism which is chaired by Mrs. Rice is one that brings the conflicting forces together with the preparation of their own protests and ideas. Out of it has come this, upon which she might like to comment, which is a health statistics program. This is the second iteration.

HEALTH STATISTICS COORDINATION PLAN

For the first time we have a health statistics plan which addresses the issue you have raised and which gives us an opportunity to lay out a program which in turn provides, I think, the beginning of a logical basis for effective appropriations.

Would you like to comment further on that?

Mrs. RICE. The health statistics plan is really hot off the press and we would like to leave a copy with you. It is, as Dr. Margulies indicated, the second iteration of the plan. It does provide an inventory of all the health statistical data activities of the department and also includes for the first time the data collection activities of the Veterans' Administration and the Department of Defense.

It is an attempt to organize the statistical activities of DHEW within a framework that I think is very useful and very meaningful. We are presenting information on the data systems in terms of health status, health resources, the use of health services and health care expenditures.

We have a 2-year action plan of the Health Data Policy Committee to address the issue of coordination.

I would like to add to the response on coordination with BQA and the Alcohol, Drug Abuse, and Mental Health Administration. NCHS is in the process of developing interagency agreements with these two agencies. We have staff coordinating committees in our agencies working on this very problem and I think we are making considerable progress in this area.

Mr. OBEY. You will leave a copy of that with the committee?

Mrs. RICE. Yes.

EPIDEMIOLOGICAL DATA

Mr. OBEY. Let me ask you a few other questions.

We have heard a lot over the last 2 years about epidemiology. Almost everywhere I turn lately there is a need for one kind or another of an epidemiological study. NCI has its own division and we have NIOSH examining it from their end and NIEHS is involved as well.

How does the data collected from the Center for Health Statistics jibe with the work of those institutes?

Mrs. RICE. To date we have done relatively little in the area of monitoring of epidemiological analyses of health data with the notable exception of special mortality analyses within our vital statistics program.

But I am happy to report that we are establishing an environmental health epidemiology program as part of our research activities next year.

One of the outcomes of this activity will be the publication of the first national atlas on mortality for all major diseases. We are also attempting to construct a system for computerized monitoring of the Nation's health to systematically detect the unusual time trends and the unusual geographic patterns of disease. When specific suspicious problems are identified through the system, the appropriate health agencies will be notified so that the merits of an investigation can be determined.

DATA GATHERING TECHNIQUES

Mr. OBEY. What is the process now? How do you go about it when you discover a potential problem? How do you go about tracking

techniques are used? How expensive is it? Why don't you describe for the record, for instance, the coke oven research.

Mrs. RICE. The follow-back research techniques that have been used in such studies are very detailed and expensive. As you mentioned, the "coke oven" project carried out in Pittsburgh is a classic example of the kind of study that was attempted to relate occupation to mortality. This was a study that took 6 people working full time for 10 years and it is my understanding that it cost about $5 million.

The researchers involved searched a great deal of personal information and they went to department stores, credit agencies, the IRS, Social Security, and friends and neighbors to try to locate and determine whether people in their study were still alive.

The findings of this particular study were very important, but I wonder whether it was worth $5 million. Certainly that question has entered into the planning for further studies by these organizations.

Mr. OBEY. They can't all cost $5 million. What is normally spent when you run into a problem like that?

Mrs. RICE. The center does not conduct those kinds of studies itself, but I understand that they are quite expensive. I understand that NIEHS feels that it is such an expensive procedure that they cannot afford to undertake this particular kind of study. NIOSH says they are spending $2½ million a year on these studies and they still have a great deal of difficulty in getting the needed information. NCI says they would do more research in this area if the follow-back procedure for determining whether study subjects was less expensive.

MORTALITY DATA

I think that the data the center receives on deaths in the country come, as you know, from the vital statistics offices of each State. Currently we use these data principally for the purpose of producing national statistics. Under the terms of our arrangements with the States, we cannot release any information which would identify an individual without written consent of the appropriate State authority. As a result, we do not index our mortality file so that the information regarding an individual can be identified.

Mr. OBEY. How are those files kept right now?

Mrs. RICE. The files are kept in the National Center on the computer tapes, but without personal identifiers on the files.

NATIONAL DEATH INDEX

Mr. OBEY. You do have some plans floating around for a national death index, don't you?

Mrs. RICE. Yes, we do. I am very pleased to report that we have made considerable progress in the past year toward the implementation of a national death index within NCHS. We are working with the representatives of the States and the users of health data such as the Institutes of Health and the Schools of Public Health and Medicine in an effort to establish this national death index within NCHS.

Such an index would greatly facilitate the efforts of an agency such as the National Cancer Institute or the National Institute of Occupa-

tional Safety and Health to conduct prospective studies of health risks of say, a group of copper smelter workers, as well as enhance the utility of mortality data generally.

The agency conducting this study would be able to determine periodically whether any members of the study group had died simply by contacting NCHS and providing us with the necessary individual identifying data.

Mr. OBEY. Would that program be separate from the cooperative health statistics program?

Mrs. RICE. Yes, it would be a completely separate program.

Mr. OBEY. If I were to explain to a budget-conscious gentleman like Mr. Michel here, for instance, what the utility would be of that kind of a system, in three or four sentences, what would it mean? What would its value be in the scheme of things?

Mrs. RICE. It would reduce the costs of conducting epidemiological studies that are needed, particularly in the area of the environmental effects on health. Heretofore a researcher who was studying a group of people over a long period of time had no easy method to determine whether particular persons in that group had died.

With the national death index, the researcher would come to the National Center for Health Statistics and we would then identify, from our files, which people were still living and those that had died. We would then tell the researcher that it appears that certain persons had died and provide the researcher with the names of the States in which the deaths occurred. Then he would contact only the States to obtain a copy of the death certificates.

Dr. MARGULIES. I think from the point of view of your question, if I understand it, Mr. Obey, the value of this would be the opportunity it provides to link together patterns of disease with the circumstances in which they appear to have occurred.

So that if there is a relationship between environmental factors, for example, and deaths which are related geographically or to industries or something of that kind, it would be more easily identified and become a subject for further analysis.

At the present time it is very difficult to do that in the absence of ready access to such information.

DEATH INDEX PRIVACY PROBLEMS

Mr. OBEY. What about privacy problems? Certainly there have to be substantial questions raised now under the way data is collected. How would that be addressed in this system?

Mrs. RICE. I am confident that the project can be designed with adequate protection for privacy. It is anticipated that the use of the index service would be strictly limited to health-related research. We are setting up a group of experts in this area to establish criteria for use of this index. I think it is anticipated that the national death index would provide greater personal privacy since it would hopefully minimize the need for researchers to resort to the use of credit agencies and other sources which often do violate privacy.

Mr. OBEY. What kind of costs are you talking about to set it up and what kind of costs would be implied after the first year or two? Would it be a constantly rising cost or not?

COST OF DEATH INDEX

Mrs. RICE. We estimate the center would require about $250,000 and four positions to maintain the minimum core activities for the death index. The costs of the minimum core activities in the center would be affected only by the change in the cost of doing business in the future years. The additional costs incurred in researching the files and providing information in response to specific requests would be borne by the agencies requesting this service.

Mr. OBEY. In the initial year of the system, would it just involve deaths which occurred in that year or would you go back a number of years?

DEATH INDEX ESTABLISHMENT

Mrs. RICE. Well, I am really unable to answer that specifically right now. We are currently working with the representatives from the States and these potential users of the service in an effort to develop the detailed plans for the index. However, even if it is not feasible to include the deaths for previous years when the system is first established, we will never be able to enhance the researcher's capability if we don't start indexing as soon as possible.

The utility may be limited early, but it will be expanded quite rapidly.

Mr. OBEY. Do you have the capability of setting it up now if you were given the money?

Mrs. RICE. Yes; we do.

Mr. OBEY. I have a number of other questions in this area which I would like to submit for the record.

Mr. Michel?

STATE HEALTH DATA CONSORTIA

Mr. MICHEL. Thank you, Mr. Chairman.

Regarding health statistics, last November, I received some very encouraging information from the Health Resources Administration relating to the support of the health data consortia at the State level to establish effective health care utilization and data systems. We have such a program currently operating in Illinois entitled The Illinois Cooperative Health Data Systems, Inc.

I understand there is consideration in the States generally to further develop and implement such activities. Can you give us a report on the number and current status of such programs in the various States?

Mrs. RICE. Yes; we are excited about this development in the Cooperative Health Statistics System. The health care utilization components of the System, particularly in the hospital statistics module, is an effort by NCHS to begin to develop shared data systems in the utilization area to meet the needs of private and public organizations at the national, State and local levels.

To date these activities are developmental in nature as they are in Illinois, and different States are designing multi-use health services utilization data systems. They are different from State to State as to the organizational structure, the manner of assuring that the systems meet local needs and the sources of shared funding. This is a high priority program in NCHS and within the Health Resources Administration.

We are encouraged by the level of excellence that is maintained by these projects. We are now financing the development of the hospital care component in 11 States. There is evidence that there is considerable interest throughout the country in the development of just such shared data systems.

SUPPORT OF SHARED DATA SYSTEMS

Mr. MICHEL. To what extent will your budget request here permit continued support of this?

Mrs. RICE. The budget request of $6 million for the cooperative health statistics system will permit us to assist the States to further develop the shared data systems. Specifically, the budget request will expand the hospital care data components into eight more States.

Mr. MICHEL. I think our Illinois group out there is applying for a second year of funding to complete their system. If we give you the money you are requesting here, will they stand a good chance of receiving the second-year funding, do you suppose?

Mrs. RICE. Yes, indeed, Mr. Michel. The Illinois Cooperative Health Data System is now directing a program which is considerably ahead of our expectations in fulfilling most of the terms and conditions of the contract. It is apparent that they are doing a very good job.

COOPERATIVE HEALTH STATISTICS SYSTEM

Dr. MARGULIES. If I may, I think it is important for the committee to know that the cooperative health statistics system is really a two-phased undertaking. We are concentrating currently on the first phase of it which has those three components which we have been addressing. The second half of it is being held under limited development, being looked at carefully, based both on budget and on what appears to be a sensible way of approaching our total data needs because the second half, and particularly those things that have to do with long-term care and ambulatory care, have a number of other people involved in their development. They are more difficult. The products are less certain and we have other demands for data resources.

So the major emphasis right now is on the completion of that large group of activities in the first three components with a continued and growing interest in developing total State capacity as well as we can. We like to have individual States doing the whole job well.

SCOPE OF COOPERATIVE HEALTH STATISTICS SYSTEM

Mr. MICHEL. During hearings on the extension of the health statistics authorizing legislation, I think you, Dr. Margulies indicated that the cooperative health statistics system would have to be reduced in scope as a result of the lack of appropriated funds. But to my recollection this subcommittee has appropriated funds at least at budget level or above during the past 3 years.

What do you say to that? Do you use the committee as a scapegoat to cover a lack of enthusiasm on your part for the Cooperative Health statistics program?

Dr. MARGULIES. No; as a matter of fact, the support we have had for it in Congress has been excellent. The problem and the issue is really not one of the funds which have been available for the cooperative system excepting in one respect.

There has not been a clearly identified commitment to this activity in legislation and in appropriations at the level of its rate of growth. What we have done, Mr. Michel, is utilize funds from elsewhere in HRA to make sure that the cooperative system can continue to grow. In fact, our enthusiasm for it has been so great that we have been pulling resources as they are appropriated and consistent with our statutory language out of other parts of HRA. With the expansion program, its continued maintenance and expansion beyond that point requires more and more funding.

We have felt that with that and with the development of other kinds of data activities which relate to it from outside, we should concentrate on completion of the first phase.

So it was not a reduction in the scope of the program but it was a reduction in the ambitions and dreams of some of the people who felt that it could expand rapidly and forever and in all directions; and like a lot of programs, it can't.

HEALTH PLANNING COORDINATING COUNCILS

Mr. MICHEL. Turning to health planning, I understand you have developed some new regulations requiring statewide planning coordinating councils to make virtually all decisions on courses of action and not allow the delegation of decisionmaking authority to a smaller executive committee of the council.

Now in Illinois this would create a problem because the council is composed of 55 members and it would be extremely costly and difficult for the council to meet frequently to make every decision.

Do you have any thoughts on this?

Dr. MARGULIES. I will ask Dr. Cain to respond to that. I am not aware of any particular problem over this. Do you want to pick up on that?

Dr. CAIN. I have not heard either of that being a particular problem. I will be happy to explore it in that instance.

Mr. MICHEL. Well, I wish you would because it is one of those things that has been mentioned to us several times. I thought I would bring it up in the hearings and see what kind of reaction we get.

Having posed the question—and there is opportunity here for you to respond in the record—I wish you would do that, Doctor, and we will save time by dropping that at this point.

[The information follows:]

Illinois has proposed structuring their executive committee in such a way that the Governor's appointees to the statewide health coordinating council would constitute a majority on the executive committee, and the by-laws would permit the committee to have final decisionmaking authority for the functions of the council. Consistent with section 1524 of Public Law 93-641, the Federal regulation on this subject will not permit the executive committee to have final decisionmaking authority, but they will permit the committee to transact necessary business of the council between regular meetings, subject to ratification of the whole council at its next regular meeting. This interpretation will be spelled out in the preamble to the final Federal regulations.

BUDGET REQUEST FOR HEALTH PLANNING

Mr. MICHEL. Now, your budget request for health planning remains at last year's level despite the fact that all 205 health systems will be in place for the first time. Isn't there a possibility for a reduction here if everything is onboard and going, or is it like every other program, just growing and growing?

Dr. MARGULIES. On the contrary. The program, as you know by the way the legislation was written, starts at an attenuated level of function for each of these planning agencies.

We ought to speak of the State agencies as well. But each of the HSA's starts with some conditional responsibilities and conditional recognition. When the agency has reached a status of full recognition and full approval, it also takes on increased responsibilities like those of review and approval of Federal grants. Consequently, the years following the initial 1 to 2 place heavier demands and require an expanded staff function for each of the HSA's rather than less.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCIES

Similarly, the State health planning and development agencies have increased responsibilities, not the least of which is the final word on certificate of need. As they increase in number and expand in function, they require added support. Some of these have utilized prior Hill-Burton funds effectively for their staff support. Those funds are withdrawn so the responsibility both at the Federal Government and State are quite marked in both these types of planning activities.

FUNDING OF HEALTH PLANNING

Mr. MICHEL. The National Association for Comprehensive Health Planning states that $196 million is the level of funding needed. What arguments can you give us on behalf of your request as against what they think is necessary?

Dr. MARGULIES. What we have tried to do in developing the funding for the health systems agencies in particular is to get as close as we can to the legislated goal of 50 cents per person and at the same time keep the funding under some kind of reasonable control.

It is not unusual for those who are in favor of a program to prefer the full authorization level rather than the appropriated level. We have tried to keep it at that point where there is a reasonable dispersement of funding, where HSA's get enough for support of their staff activities and with a reasonable rate of growth.

One can argue whether it is the appropriate sum of money, but it appeared as we went over this that this was adequate for our current purposes. It certainly is difficult, however, to maintain the position that a planning agency which is in development and has limited responsibilities does not require more money when it is in full development and has full responsbilities. So their argument has some merit.

GEOGRAPHICAL MALDISTRIBUTION

Mr. MICHEL. Let me ask you one more in this series of questions.

Can you tell us specifically how your institutional capitation grant proposal would correct the geographic maldistribution problem?

Dr. MARGULIES. To explain it briefly:

The capitation program requires that those institutions receiving capitation make sure that their graduates go into training programs in primary care. The legislation requires that there be a percentage of 35 percent for medical schools from that year on.

Osteopathic and dental schools must have approved programs training students in ambulatory care settings in remote areas or in medically underserved areas. All students will receive at least 6 weeks of this training.

Then it is also being done by a variety of other mechanisms which complement the family practice training, et cetera.

CAPITATION GRANTS

Mr. MICHEL. Now you don't have any capitation grants in here for veterinary, optometry, or podiatry schools in fiscal 1978. Why is that?

Dr. MARGULIES. Well, essentially because the problems of distribution and of other kinds of support are not as pressing in those areas as they are in medicine, in dentistry, et cetera.

VETERINARY SCHOOL CONSTRUCTION

Mr. MICHEL. I sat on the floor during the supplemental where we added $25 million in there for construction of veterinary schools. There was not a shortage of veterinarians, but under geographical distribution we had to build a new school in Massachusetts and provide some expansion.

What is the official word here? Do we have enough veterinarians, are we in short supply or what?

Dr. MARGULIES. I think that money was specifically to build some regional institutions which from my point of view is a surprising way to go about it. I don't see why you have to build a building to regionalize a function which exists.

Mr. MICHEL. I agree.

Dr. MARGULIES. I would prefer to see the concept developed, a regional approach established and somebody can look for a building. As you know, getting institutions to give up their private prerogatives for degree granting is very difficult and building a building is not going to cause them to work more rapidly to get it.

Mr. MICHEL. That was a leading question. Feel free to expand in the record.

[The information follows:]

DISTRIBUTION OF VETERINARIANS

Although there are no agreed upon figures for what constitutes an ideal number of veterinarians to meet needs, there are indications that the aggregate supply of veterinarians is currently sufficient. Like the other health professions, the number of active veterinarians has grown in recent years (a 39-percent increase between 1966 and 1975) and is expected to increase by 57 percent between 1975 and 1990, or by nearly 4 percent a year.

On the other hand, veterinarians are badly distributed. Currently over 500 counties, or 1 out of every 6, do no thave a veterinarian, and nearly an identical number of counties are officially designated as being health manpower shortage areas for purposes of loan repayment (or cancellation) under section 741(f) of the PHS Act. Veterinarians are also disproprotionately located in the West North Central, and Rocky Mountain States which have a ratio of 25 and 19 per 100,000

population, respectively. The lowest ratios per 100,000 population are in the New England, Middle Atlantic, and Pacific States (8, 8, and 13 respectively). Schools of veterinary medicine are also disproportionately located in the country.

Furthermore, recent analysis of data on numbers of farm animal veterinarians relative to number of farm animals indicates that there is a maldistribution problem on this basis also.

Mr. MILLER. I might mention for the record that we only appealed to the Senate about five of the actions of the House in the supplemental to the Center. We did appeal that one with singular lack of success.

Mr. OBEY. Mr. O'Brien?

FOREIGN MEDICAL GRADUATES

Mr. O'BRIEN. Doctor, I am a little late and maybe you touched on this, but recently in Illinois 157 physicians were disqualified for either failing or refusing to take an examination. In my district we have the Manteno State Hospital. I understand there are about 26 physicians there who could be fired. Most of these doctors are foreign medical graduates, many of whom have failed to take and pass certain tests that are rather basic.

What do you think about the possibility of restrictions on foreign medical graduates? Are we going to have to accept unqualified doctors?

Dr. MARGULIES. As you know, Public Law 94-484 has for the first time introduced some requirements on the qualifications of physicians obtaining visas to come to this country. It is the first time that those issues have been raised in health legislation. They have always been in legislation having to do with immigration and naturalization.

What that legislation attempted to do was to provide assurance to this country that a physician educated in institutions over which we exercise no control and about which we know little, has learned what he or she would have learned if educated in this country.

FOREIGN MEDICAL GRADUATE EXAMINATION

The best way to do that was to find an examination. The National Board of Medical Examiners had such an examination, which represented a level that we recognize in this country as the kind of knowledge people should have.

That has been made a requirement for visas beginning with the passage of this legislation, affecting all foreign medical graduates with a waiver in there which helps a little bit for the coming year. That is even more demanding than the prior examination which the people you are talking about either did not take or could not pass called the ECFMG which is named after the Educational Council for Foreign Medical Graduates.

That examination has been used in the past as a kind of screen for physicians coming into the country. Thousands and thousands have come in with that examination and they are serving in this country. Other thousands have come in without ever having been able to pass that examination or the English language examination and those are the ones you are talking about who for the most part are being used in phychiatric institutions where in many instances they don't know

basic English which in a psychiatric setting is abhorrent by any standard.

As a consequence, I think the action taken by Congress in passing this legislation was very good.

Now the reason they are there is because many State laws will allow someone who is not qualified otherwise to serve in a State institution because they can't get anyone else. I hope very much that no one will think that it is a wise idea to bring in people who are not qualified merely to fill the role of a doctor.

On the other hand, there is a real problem involved in this. If the State institution representing the will of the people of that State is providing psychiatric services, it must meet some kind of a standard. There have been some cases in the States and in the Federal courts which say you can't put people in a hospital which has poor fire standards, poor food or poor medical care.

So it provides a real kind of an issue for us in deciding how we get medical care there if we don't use people who are unqualified and who operate under the guise of a doctor.

SHORTAGE OF PSYCHIATRIC CARE

In all fairness I must tell you that we will have and we do have a severe shortage of psychiatric care through the hands of psychiatrists and psychologists in our State institutions. Nobody I know in the psychiatric field would defend having foreign graduates who are not qualified to come in and fill that function, but we have not found a solution up to the present time. Whether it can be helped somewhat by the scholarship program and the payback in the future years is uncertain.

But I think this issue requires very, very close attention. I would like to add one more point to it.

In the last several years the number of young men and women finishing medical school going into psychiatry has been decreasing so there is not only a relative but an absolute shortage of people trained in psychiatry. Our preference would be for more of the psychiatric needs of patients to be taken care of in the primary care delivery setting by doctors, internists, nurses, nurse clinicians and others well qualified to take care of the bulk of psychiatric problems and having psychiatrists do only those most severe cases in psychiatric case handling which comes into psychiatric institutions.

We have not reached an understanding on that issue and it is also of major national importance.

SHORTAGE OF PSYCHOLOGISTS

Mr. O'Brien. I always distinguished the psychiatrist and psychologist as identical medical training. Is there a similar shortage of psychologists?

Dr. Margulies. There is, and there is a great reluctance on the part of psychiatrists to find themselves interchangeable. That is an old professional problem. Other countries have allowed clinical psychologists to be widely used. That is improving, but there is a shortage, yes.

Mr. O'Brien. Thank you.

Thank you, Mr. Chairman.

MANPOWER BUDGET REQUEST

Mr. OBEY. Doctor, let me turn to manpower for a few questions.

The largest reduction in the manpower area is in the nursing program. Why is there such a large reduction?

Dr. MARGULIES. Well, I think the answer to that is to be found in the basic philosophy that created the Health Professions Act. The issues in nursing, like those among physicians and dentists are not quantitative, and we take a long time recognizing that.

It really is, again, a distributional problem. We felt there was not a need to continue to expand through Federal funds the number of nurses which is rising rapidly in any case, and our predictions are a continued rapid rise in the number of nurses in this country.

RATIO OF MANPOWER TO POPULATION

Mr. OBEY. What is the ratio that we are striving for per hundred thousand?

Dr. MARGULIES. We have no specific ratio that we are aiming for.

Mr. OBEY. If we don't, how do you make a judgment as to when you cut it off and when you don't?

Dr. MARGULIES. There is no absolute way of doing that for either physicians or for nurses. What does concern us is the absence of nurses in nursing homes, in rural areas, and generally underserved areas, the same as there is for physicians. We would prefer to see programs developed which guide people in that direction rather than a simple increase in quantity.

We can provide some data we have available on the number.

NURSING SPECIAL PROJECTS

Mr. OBEY. What programs are doing that now?

Dr. MARGULIES. The nursing program has stressed that through its special projects. I think the nursing activities in the Bureau of Health Manpower have been concerned with primary care, nurse practitioners in particular, for the development of physician extenders of one kind or another. The nurses have been at that before anyone else and have laid stress on primary care and care with supervision and the use of nurse clinicians in this country.

Those are the problems that I think will get the best results.

ADVANCED NURSE TRAINING

Mr. OBEY. You are proposing no funds for advanced nurse training. This really is not my area, but my understanding is that these funds are used to support the development of teachers and administrators and supervisors, et cetera. Have we saturated the market in those kinds of people?

Dr. MARGULIES. No, sir; we have not.

Mr. OBEY. Is that why you eliminated the funds?

Dr. MARGULIES. I think the reduction of those funds represent fiscal wisdom rather than programmatic judgment.

NURSE PRACTITIONER PROGRAM

Mr. OBEY. You are proposing to fund the nurse practitioner program at last year's level. Recently Newsweek magazine wrote an article on the graying of America. With more of our population getting older, shouldn't we be training more nurse practitioners to provide geriatric care? How much of the $9 million in your budget are you spending in this area and how much more should we be spending in order to prepare for future demands for nursing care by elderly citizens?

Dr. MARGULIES. We have just completed the second round of analysis of what happens with nurse practitioners, physician assistants, medex, et cetera, who work in nursing homes. They are doing quite well, but I could not argue on the basis of the data we have that there is a strong national movement toward nursing homes or geriatric care. We can provide training and we do in these areas, but they are not the most attractive vocational sites. Most of the people we are talking about are working in hospitallike institutions or clinics or on a one-on-one basis with physicians. They are more physician extenders than anything else, although nurses generally tend to serve more time linking community services together when they are nurse clinicians than in other categories.

It is a good program but I would be misleading you if I suggested it is a direct entry into the problem of the nursing for aging in this country.

NURSING FOR AGED

Mr. OBEY. How do we get more people into that field? When I was in college I spent a summer installing floor covering in our county old folks home, as we called it at the time, and also in our county mental hospital under some pretty rough conditions.

How do you get people into that field?

Dr. MARGULIES. I am not sure that we are going to get very many people into that kind of an institutional setting.

My own feeling about it is that our primary responsibility would be to keep people from being patients in such institutions. Our best bets, in my judgment, are two: One of them is in the expansion of primary care services so they are real services, so that patients don't get lost and so that someone who sees the doctor in the office or hospital and who is also in the nursing home has the same complex of medical care taking care of the individual.

DEVELOPMENT OF PRIMARY CARE DELIVERY SYSTEMS

I do not believe we can improve and expand the quality of care in nursing homes within the budgetary limit we are going to allow ourselves. I think it has to be developing much stronger primary care delivery systems which don't separate the elderly from the rest of the population and, second, by doing something we have not done in this country and that is to produce effective methods of managing the chronically ill outside of hospitals and other institutions.

We don't have legislation for this, but it could be devised. We could take care of the problems of diabetes, emphysema, arthritis, hyperten-

sion, congestive heart failure, stroke, and poststroke patients on a community-based activity using relatively few physicians and a modest number of nurses by an epidemiologic approach to medical care that would reduce dramatically the number of people going into the nursing homes.

That is a kind of revolution I am talking about in which we provide medical care in a different way than the way we have been doing it in the past. I don't see any way of getting at the problem without changing our patterns of medical care.

I have discussed this in depth with our colleagues in Western Europe who have the problem the same as we have and perhaps more so. It is the No. 1 issue in Sweden at the present time. They come to the same conclusions that trying to take care of people in institutions is not the answer for a mature society. It is a way of recognizing that we have failed to do the job and it doesn't work well.

NURSING STUDENT ASSISTANCE

Mr. OBEY. Doctor, let me ask you, what is the impact of the reduction for nursing student assistance and what other sources of supports are there for nursing students?

Dr. MARGULIES. There are the basic opportunity grants for nurses. They do participate in the National Health Service Corps scholarship program, although neither of these is an unlimited resource.

Mr. OBEY. What about nursing traineeships? If you eliminate them, is there another source of support?

Dr. MARGULIES. Do you want to comment?

Dr. WHITESIDE. No; not for nursing traineeships.

Mr. OBEY. Where do we suggest that those kids go for financial assistance?

Dr. WHITESIDE. The best we would be able to offer would be the Office of Education guaranteed student loan program.

RATIO OF MANPOWER TO POPULATION

Mr. OBEY. On the question which Mr. Michel asked earlier, again I want to ask the same question.

Is there an agreed ratio that we are striving for that we have reached in the area of veterinary medicine, optometry, podiatry, pharmacy? What is the story with that?

Dr. MARGULIES. There is no agreed-on ratio. There have been, as I am sure you know, in medicine, in dentistry and elsewhere, study after study trying to reach some conclusion about what the number ought to be. I can't give you an objective answer to that and I don't think anyone can.

So it usually is decided by whatever it is that people are willing to support and what appears to be some kind of a demand. As long as there are methods of paying for services, there will be more people available to provide them if we supply the people to do it.

NATIONAL HEALTH SERVICE SCHOLARSHIPS

Mr. OBEY. How many applications for National Health Service scholarships do you anticipate receiving in 1977 and how many will you be able to award?

Dr. MARGULIES. Do you want to respond to that, Dan?

Dr. WHITESIDE. Yes; we have been receiving about 3500 applications a year. That would be for new applications. We will be able to provide about 1,860 new awards in medicine.

Mr. OBEY. What year are you talking about, 1977 or 1978?

Dr. WHITESIDE. I am talking about 1978.

FUNDS REQUESTED FOR ALLIED AND PUBLIC HEALTH

Mr. OBEY. The budgets for Allied Health and Public Health are substantially below the level provided by the committee in the 1977 supplemental. What would be the impact of that reduction on those schools?

Dr. WHITESIDE. I think it will have considerable impact on those schools in that we have a number of projects which these funds have been supporting so we would have quite a loss in faculty support for those institutions as well as a decrease in the number of students that we will train and the number of students that will be supported.

Mr. OBEY. I understand the new Health Manpower Act provides for capitation grants to schools of public health. If this committee wanted to provide funds for that purpose, how much money would we be talking about?

Dr. WHITESIDE. For Public Health, $9.7 million.

Mr. MILLER. That is the statutory authorization.

Mr. OBEY. What is needed, in your judgment?

Dr. WHITESIDE. $9.7 million.

PHYSICIAN ASSISTANTS AND DENTAL EXTENDERS

Mr. OBEY. This committee has provided funds for several years to support the training of physician assistants and dental extenders, but we keep hearing that these individuals are not being utilized to the extent of their training because of restrictive licensure laws in the States.

What is the story on that?

Dr. MARGULIES. That has actually become a decreasing kind of an issue, although it still comes up from time to time.

Mr. OBEY. How do you deal with that in your shop?

Dr. MARGULIES. The best we can do with the State laws, we have been carrying out a number of activities around issues of credentialing, licensing, et cetera, trying to produce model legislation, trying to persuade the States that this is a thing that they would like to have.

As you know, State laws, when they have to do with licensure and credentialing in medicine, are very strongly influenced by the medical and dental societies. As there is a recognition of the advantages of physician extenders, they are used more readily.

As there is concern about the increasing number of doctors and the competition for patients, we may find a real restriction on the way in which physician extenders can be used. I think it is no minor kind of an issue. Obviously, the Federal Government can't overrule the States on an issue of licensure.

FINANCIAL DISTRESS GRANTS

Mr. OBEY. If this committee restored the cuts in capitation funds for veterinary and optometry schools, et cetera, would it still be necessary to appropriate the request for financial distress grants?

Dr. WHITESIDE. Yes.

Well, I guess it depends upon the level. Our experience has been there are institutions even with capitation who find it necessary to apply for financial distress.

Mr. MICHEL. How many are there of those these days?

Dr. WHITESIDE. We have 12 applications inhouse now.

Mr. MICHEL. Would you mind putting those in the record?

Dr. WHITESIDE. Surely.

[The information follows:]

Schools requesting health professions financial distress assistance

	Amount
Medicine:	
Meharry Medical College	$1,731,000
Creighton University	727,290
Dartmouth Medical College	750,000
Tulane University	1,071,812
Subtotal	4,280,102
Dental:	
Meharry College of Dentistry	1,545,000
Creighton University	177,201
University of Detroit	892,455
Temple University	480,675
Subtotal	3,095,331
Veterinary medicine: Tuskegee Institute	267,468
Podiatry:	
California College of Podiatric Medicine	261,100
Ohio College of Podiatric Medicine	660,000
Subtotal	921,100
Pharmacy: Xavier University	270,600
Grand total requested	8,834,601

AREA HEALTH EDUCATION CENTERS

Mr. OBEY. There have have been some favorable comments about area health education centers. Why are you holding this program at the 1977 level?

Dr. MARGULIES. Actually it is being expanded. We are going up. We went from 11 to 14 and in the next fiscal year we will go up to 16 of the area health education centers. We would probably push it at a more accelerated rate if it were not for at least two major issues.

One of them is that the area health education center is essentially a demonstration program designed around the concept which says that if you train people in communities where you would like to have them live and practice, they are more likely to remain there.

You also do some good through that kind of a service program. We have not yet had the opportunity to determine whether that is true, whether it does redistribute manpower as had been hoped.

Second, it is a fairly expensive program and can probably not be replicated all over the country. These are running around $1 million a year. They operate effectively in some circumstances.

So we have to take a look at whether they should be supported and what recommendations we will make at the end of 5 to 7 years on their future. I think they have been quite good.

IMPACT OF REORGANIZATION ON STUDENT ASSISTANCE PROGRAMS

Mr. OBEY. What impact will the reorganization of student programs have on your student assistance programs? Will all loans be administered from a central point, for instance?

Dr. MARGULIES. The recently announced reorganization moves the guaranteed Federal student loan program which has not yet been started, it is in the new legislation, into the Office of Education. So far as I know, no other change is occurring.

The direct loan programs we have are in function. They have been working for some time. They provide funds that institutions can use to make loans. That money goes back into the institution and is recirculated so it functions quite well.

The new student loan program would operate as the other ones out of the Office of Education have. A bank as a lender provides funds to a student as a borrower and there is basically a commercial arrangement with Federal guarantees.

Mr. OBEY. I will place a couple of other questions in the record on this subject.

DISSEMINATION OF RESEARCH FINDINGS

Mr. OBEY. Let me turn to health research.

According to the 1978 to 1982 forward plan for health, one of the high priority objectives for the National Center for Health Services Research is the dissemination of research findings. How would you go about that? How do you pursue that?

Dr. MARGULIES. I would like to have Dr. Rosenthal respond, if he will.

Dr. ROSENTHAL. In the past the research activities relied on what you might call traditional dissemination means for researchers, that is, professional journals and matter of that type. We have regarded this as a major deficiency and have initiated a number of vehicles which we think do a much better job of disseminating research.

We now routinely produce a very brief digest of all research studies that have been completed with the support of the center and distribute them widely.

We attempt to identify in our program development process people who are interested in issues, not as researchers but as users, and ask them to assist us in the development of the research program and even

specific projects. Then we try routinely to keep them apprised of what is going on, even before the research is completed.

We produce each year a statement of the program in health services research which describes for eight major areas of current concern the general findings of the research undertaken to date and the logic behind the particular research agenda that we have developed in each area.

We produced in the last year a summary which in one page or less describes the objectives and findings of research studies completed in the last 2 years. We plan on updating that annually. We have developed a number of summary publications. This is on emergency medical services. It attempts to summarize all the results of our concerted efforts in dealing with emergency medical service systems.

RESEARCH SYNTHESES

Second, we have also undertaken the development of a number of what we call research syntheses which are primarily directed at policy issues. One of these was embodied in testimony on national health insurance which attempted to take the question posed by the committee and put in one straightforward document a summary of all the things that we sort of knew. I say sort of knew because it is really in an accumulation of a lot of similar answers that you have some confidence.

We have recently distributed widely a paper on controlling the cost of health care which attempts to do the same thing. There is some redundancy between this paper and the national health insurance testimony, but our experience has been that you need to frame the research results in a way that is useful to the particular person who asks the question. That involves a great deal more time and effort on the part of the staff.

STAFF PARTICIPATION IN DISSEMINATION EFFORT

I think the major thing we have learned is that we have to take an active part in the dissemination effort, and also that you can't rely—you shouldn't rely—on the individuals who do the projects to perform the synthesis. They are researchers and that is what they do well. Our staff primarily takes on the responsibility for synthesizing and putting the research together in a form that is useful.

The third major area is essentially direct involvement by our staff in responding to inquires from other parts of the Department, the Legislature, and the non-Government sector. Our estimates were last year that well over a quarter of the time of our research staff was spent in direct communication with users of the research results. And that turns out to be most effective, because it's timely, it's quick, and it's responsive to their specific questions.

EFFECTIVENESS OF DISSEMINATION ACTIVITIES

Mr. OBEY. How do you measure how effective your dissemination really is? We get a lot of reports in our office every day, even about things I am personally interested in and never seem to get to them.

How do you know what you are producing is really being effective and being used?

Dr. ROSENTHAL. If I had a good answer to that these committee hearings would be easier every year.

I think I can only give you a subjective response. This year, particularly, we have had a lot of mail response to specific documents and publications that we have distributed. We have had a number of calls from people saying that they were really interested in a project and wanted more material. That hasn't really happened before.

We have had a number of calls from the Legislative Reference Service, from the Office of Technology Assessment, from the Congressional Budget Office, from staff members who said, "I saw a piece of paper that came through the office, and we need more material on that. It would be helpful."

Dr. MARGULIES. Mr. Obey. I think from my point of view there is another way of answering that question.

You have to have a special interest, and that is to begin to identify how much of what becomes the wisdom of the day, the conventional wisdom you can trace back to the origins in health services research.

I could demonstrate for you in discussions on economies in medicine, productivity, quality care, all of the debates on national health insurance, the quotations on the costs of providing services, we can run them back about 60, 70 percent of the time to the National Center for Health Services Research over the period of time during which it has turned out this work, but nobody really turns around and says this is where I got it.

They just start thinking that way, and they don't remember when they began that type of thing, and it makes it difficult for us to defend that kind of a general change.

But, what we are trying to produce is a change in thinking and in attitude, and I think that is occurring, but hard to document.

Dr. ROSENTHAL. If I could just add, this morning's discussion is probably a good case in point. I tried to listen to the discussion, particularly around manpower, and identify in my own mind how much of the substance of the interchange, both the kinds of questions and the answers, I could trace directly back to research that had been produced by investigators associated with the Center in one way or another. And certainly the material around manpower distribution and physician location and choice, the material on State licensure of foreign medical graduates, the experience we have now with nurse practitioners and quality assurance with physician extenders is all to be found in the material that has come out of the Center.

Mr. OBEY. So your people are going to get a raise.

Dr. ROSENTHAL. They deserve it.

HEALTH INFORMATION SYSTEMS

Mr. OBEY. Doctor, in your opening statement you said that studies supported by the center have shown that hospital information systems can save $3 to $5 for each patient.

These systems might reduce expenditures for inpatient care by more than $1 billion a year. That is a pretty strong statement, especially with everybody looking for ways to reduce costs.

How many hospitals have adopted that kind of a system as a way of controlling costs?

Dr. MARGULIES. That is the study which was initiated by the Center, very carefully worked out in one institution and then for the further elaboration and understanding was carried beyond that, and I am sure Dr. Rosenthal can tell you where it stands at this point.

Dr. ROSENTHAL. That is a good example of the kind of innovative impact the Center can have.

We tried about 4 or 5 years ago to put together the bits and pieces of work on hospital information systems and find out whether it really made a difference if you did the whole thing rather than buy one system for your pharmacy and another for your laboratory and so on. We initiated in a community hospital in California such a system, spent a few years to make it operational, and attempted to assess its impact.

That is where the $3 to $5 a day comes from.

As a result of that experience, there are, to my knowledge, at least four other institutions currently using that system, bought and paid for out of their own funds.

I noticed that the other hospitals that instituted the system got the press on it, while the original study and the Center's involvement somehow got lost in the shuffle. Again, a case of being absorbed in the conventional wisdom.

The sense we have is that interest in that system is burgeoning tremendously and it has not even been fully exploited.

In addition to the cost reduction, there is a significant improvement in the quality of care delivered in those institutions that comes from not having things happen, for example in the pharmacy that aren't linked somehow with what is being done to the patient many floors away.

ADOPTION OF HOSPITAL INFORMATION SYSTEM

Mr. OBEY. How do you get other hospitals to adopt this?

Dr. MARGULIES. Probably the best way to get them to adopt it is to give them a better reason to do so than they now have. The way things now stand is a hospital can run up any kind of a bill and it's going to get reimbursed.

What we need is greater fiscal pressure on them, and I suspect some of the current moves in the administration may stimulate a great many hospitals to begin to look at really effective cost saving devices so they can stay under a reasonable kind of budget.

But as long as they get paid for any kind of function at any level of efficiency, there isn't that much stimulus.

Mr. O'BRIEN. Would the gentleman yield?

Mr. OBEY. Sure.

Mr. O'BRIEN. The other day, Doctor, there was some comment made I think by Mr. Califano dealing with the fact there is no competition among hospitals, perhaps oversimplified, but I think with some merit.

On the other hand, the hospitals that are dealing with these problems you are talking about efficiently, do we do anything to really reward them? Wouldn't that supply some kind of competition, wouldn't that help your particular plan?

Dr. MARGULIES. It would considerably, and as a matter of fact, the reward system for efficiency is almost nil. It makes the increase of efficiency and the demand for it difficult to carry out.

RESEARCH IN REIMBURSEMENT STRATEGIES

Dr. ROSENTHAL. I wonder if I can speak to that again as a research issue?

There have been a number of investigations over the last 5 or 6 years really designed to look for reimbursement strategies that reward the efficient and at the same time put the squeeze on the inefficient.

We have had incentive reimbursement experiences. Prospective reimbursement is now part of the conventional logic and reflects a view that says if you give people the money limit up front and they can program within it, if they beat their target they get to keep some of the money, and if they miss they have to make it up somewhere else, then that is somewhat helpful.

We don't know how much. But my view is that that has become an accepted component of any kind of reimbursement system. Even the early discussion of the cost containment proposals for the administration, although they haven't been substantively fleshed out, imply some kind of forward budgeting reimbursement strategy. I would say that is another example of the ground work having been laid in a field where ignorance is far from blissful, where the research effort is sort of absorbed into all the discussions.

Mr. O'BRIEN. May it not be contributing to the efficiency in some of the problems now occurring in malpractice, for instance?

Dr. ROSENTHAL. Whatever happens is determined by the physician and whatever the bill it is paid for by the insurance company. There isn't much variance to that.

There are some exceptions, but not a great many. On the other hand our experience with careful attempts to control the budget isn't all that satisfactory. So, I don't want to suggest we have an answer.

We know what some of the questions are and some potential answers.

COST CONTAINMENT

I think the usual problem in the system is that the containment of costs is always a desirable objective until it meets the constraint on quality or performance. We don't yet know enough about how to make those compromises without paying too big a price.

It's easy to contain costs; all we have to do is stop paying everybody for what they do in the system, but the price for that would be dreadful, within that context we have a much tougher job.

Mr. O'BRIEN. You remind me a little bit, Doctor, of Congressman Miller's little poster which says you can cut a thousand Government programs but don't touch mine.

Thank you.

BUDGET REQUEST: IMPACT ON RESEARCH EFFORTS

Mr. OBEY. Nobody ever said that to me.

Doctor, although the 1978 budget for the Center for Health Services Research is about the same as 1977, you have a number of cuts in certain areas, such as health insurance and quality of care. Why those reductions, and what is the impact on research efforts in those areas going to be?

Dr. MARQULIES. The problem with the National Center for Health Services Research, if you look over its budgetary history, is that it has been declining regularly over the last 5 or 6 years. It hasn't even been keeping up with changes in the cost of living.

As a consequence, each year the National Center for Health Services Research has to reexamine what it can do against a set of priorities, and they have established some goals which represent the kinds of investments they would like to make in research.

When they are constricted, then they have to decide by review of researchers and policy makers where the money ought to go and where they have to hold back on it.

It's quite clear that in all of those areas that are attenuated with additional support they could expand.

Another very restrictive feature in the Center has been the lack of effective research investment in training, so that there are no training programs, no predoctorial programs in health services research, and that means the number of people who can do effective work inexpensively and then develop more effective research programs over the long haul are reduced in number.

So what the Center does is take all of that into account.

HEALTH INSURANCE RESEARCH

Mr. OBEY. If there are three prioriity areas, governmentwide, not just in the health area, that the people are getting pretty antsy about, they are energy, welfare reform, and health insurance.

You have a 50-percent reduction in your health insurance research. Does that merely reflect the fact that the Secretary's office is expending a great deal of effort in this area so you feel you don't have to?

Why that reduction?

Dr. MARGULIES. I think Dr. Rosenthal would love to respond to that question, and would be hard to control.

Dr. ROSENTHAL. I have been waiting for years to respond.

I think the point is that research is an investment effort. At the time you are putting the blade to the tree, you are using on what has already been developed and generated.

NATIONAL HEALTH INSURANCE

The immediate discussion around national health insurance reflects a decade of investment in research in that area. My guess is that there are still plenty of analyses to be done. But the marginal impact of those analyses around the structure of that program will be small.

The trick in research is to anticipate somehow what information you will need to have in the inventory when an issue becomes timely and important. We put a lot of money in national health insurance research 3 or 4 years ago.

Mr. OBEY. I understand what you are saying, but let me say if I sense the mood on that floor correctly, an awful lot of people, including myself, who have been very anxious to get moving on national health insurance, are having some second thoughts, given the cost control problems we have had in a few other areas, and I really wonder whether there is a very comfortable feeling about the fact we really do know what we are going to be doing in this area.

Dr. ROSENTHAL. I would say it's anything but comfortable. What we have learned in the last 5 years is it is not so easy as we used to think. You can't go about implementing such a program with as cavalier a general view as you used to.

SURVEY OF MEDICAL CARE EXPENDITURES

Dorothy Rice just reminded me, although it's not labeled insurance, in the budget you saw, we are undertaking an extensive program of analyses of medical care expenditures. We are working closely with the Statistics Center to do a survey of medical care expenditures, long overdue, which will provide crucial information in the development of a specific national health insurance program.

We have operated for years with limited information about expenditures on medical care. Mrs. Rice is probably more responsible for the availability of what information exists than anybody in the country, and could therefore tell you as much about the limitations as anybody.

HEW EFFORTS IN AREA OF NATIONAL HEALTH INSURANCE

Mr. OBEY. Well, how will the Health Service Research programs throughout HEW be brought together to work in a unified way on the issue of national health insurance?

Dr. ROSENTHAL. There are really three programs I think you might be referring to: the National Center for Health Services Research, the Office of Research and Statistics at SSA, and the Secretary's office.

Mr. OBEY. Do you have specific tasks assigned to people in this ball game or not?

Dr. ROSENTHAL. I suppose it works out that way.

Dr. MARGULIES. The answer is now, we don't.

Dr. ROSENTHAL. Nobody else has assigned them?

Dr. MARGULIES. No, we really don't. What we have is collaboration among professionals, but there is no central health services research function. The one place in HEW which has the responsibility for health services research is the National Center for Health Services Research. The other activities are associated with programatic intention like those in the Social Security Administration, those that may be subsdiary to the functions of that particular program.

Mr. O'BRIEN. Would the gentleman yield?

Mr. OBEY. Sure.

RESEARCH RELATING TO LONG-TERM CARE

Mr. O'BRIEN. Apropos of Dr. Rosenthal's comments about timely, and more important, I find my interest in those over 65, year by year becoming more timely and important to me. I noticed on page 7 of your comment, Doctor, your funding research focused on how to find

better ways of delivering long-term care to a population over age 65 and more subject to chronic and disabling illnesses and conditions, you will continue the activity next year.

Who makes the determination of whether or not that particular type of research should be funded at a lower level or higher level?

Dr. MARGULIES. Well, that one is a very sensitive one, and one I am deeply concerned about.

You are the only one who has happened to notice the problem for us.

We have, for investment in long-term care in HEW, virtually nothing going on. The division of long-term care is currently parked in my office because we can't really find an effective place for it. Its resources for any activities comes from other legislation, there is no legislation supporting activities of research or of training in long-term care. So some of it comes out of the health professionals and nursing programs, and some of it comes out of research.

What we do is look at the funds available and see what might be done. The National Center for Health Services Research has given very strong support to research on long-term care, but it comes out of that budget competing with such issues as productivity, quality assurance and so on, and we do it based upon what money is available.

I think there is little question about the need for a much bigger and sustained investment in long-term care, and it may very well be generated out of the new organization which has been proposed, which puts a health financing structure with long-term care interest, and I think will provide a much beter seting for sustained activities of that kind.

Mr. OBEY. Charlie, do you want to make a comment?

POLICY RESEARCH ACTIVITIES OF OFFICE OF THE SECRETARY

Mr. MILLER. Yes. I think we did not make the point that there is a coordinating office in the Office of the Secretary for these efforts, particularly as it relates to this discussion of national health insurance.

That point is the Assistant Secretary for Planning and Evaluation. A plug I would get in is that request. We have a difficult time when we come up with our appropriation for policy research in holding the line on as much as we are requesting.

Last year there was a fairly sharp cut in that request, and there is a major research effort in that account on national health insurance. This is the so-called health insurance experiment, which we tried to protect in the cut by not reducing the long-term effort, but we did have to slow it down considerably.

But this is an area where, well or poorly, there is a major effort made at the Office of the Secretary level to coordinate the research.

COST CONTAINMENT

Dr. MARGULIES. Mr. Obey, if I can just pick up on this other point, I don't want to take up too much of your time, but I think it's probably the most germane issue in today's discussion.

Almost all of the attention in this country and elsewhere in the containment of costs has been on the payment mechanism. We have

done virtually nothing to investigate what ought to be paid for. And until we pay more attention to that and mount some really major programs, we will continue to pay.

I thtink I can argue without any hesitation, without any fear of being insecure about it, that any control, any attempt to control the cost of medical care which pays attention only to the mechanism of reimbursement, of paying for fees and so forth, will fail. The costs will continue to rise.

I can also say that if one took a very careful analytical look at what we pay for, under the guise of good medical care, that anything——

Mr. OBEY. Why don't you give us some examples.

Dr. MARGULIES. We can show you some data which we have readily available which describes a distribution of common procedures like tonsillectomy, hemorrhoidectomy, hospitalization for upper respiratory infection, which in one setting to another under exactly similar conditions, there is a range of 1,000 percent in the frequency with which these are done, 1,000 percent.

These studies are well done, accepted and corroborated.

Dr. ROSENTHAL. Good research.

Dr. MARGULIES. Damn good research, that's right. I think we can go beyond that and we are beginning to do this with some of the insurance companies and demonstrate if we ever had the support to do it, a whole series of activities which the professional has for years said no longer need to be done.

SUPPORT FOR RESEARCH

Mr. O'BRIEN. Support from whom, from us or from the rest of the Congress or the country?

Dr. MARGULIES. I think we need a professional support and probably need congressional support in this direction too, and the Public Health Service is moving strongly in this direction. What I am saying is that whether you are looking at new procedures which are less important or common procedures, that we are spending billions, we are probably spending $7 billion a year on tonsillectomies.

There is serious question of whether they should ever be done, and certainly not in that number.

The same thing for a wide variety of other procedures. We are still pouring thousands and thousands and thousands vials of penicillin at people who have colds, when it's known penicillin doesn't do anything for colds. That is where the money is being wasted and as long as we have a system that pays for things which ought never to be done, we are not going to control the costs. And it's that direction we want to move in.

Mr. O'BRIEN. Would the gentleman yield?

Mr. OBEY. Sure.

Mr. O'BRIEN. When you get right into that, then you get right into the doctors, you get into the doctor's judgmental call and that means Margulies et al. is telling the doctor how he should treat the patient, is it not? Is that good?

Dr. MARGULIES. I think we have to think seriously about whether the corrections of the professional ought to be telling themselves what they are doing.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

Mr. O'BRIEN. PSRO should do something.

Dr. MARGULIES. I believe physicians can be attracted to making those kinds of judgments on subjective data.

What happens in the tonsillectomies as when the hospitals in Maine discovered what was happening, the frequency of tonsillectomies went down because the doctors looked at their own data and stopped doing it.

Mr. OBEY. Let me ask you a question: I have not had much complaint in my area on the peer review system; I frankly thought I would. I have been amazed that I have had as little as I have had in comparison with what other people have been hit with in Congress. But doctors are pretty conservative people by and large. I get the impression they don't like to waste money. Certainly a lot of them know what you are talking about in some areas is a waste of money.

How do you get them to reconcile their opposition to peer review systems with what you have just said?

Got any free advice?

Dr. MARGULIES. Yes, I have some advice on that.

Physicians do this job very well and very poorly. The perfect relationships between physicians moves new knowledge through the system at a rate which no other profession anywhere can match.

If there is an effective new concept of diagnosing or treatment, they understand how to deal with it. They listen to one another, they believe in it because they are concerned with quality. It is when something gets into practice and is either individualized or is a common kind of structure, a systemic function, that they pay no attention to it and they don't effect perfect judgment in it. What has to be done is expand some of the activities so they move from the new and attractive into the usual and ordinary, and physicians begin to pay attention to it.

We have had experience with that in some of the past programs, and doctors can be brought into making that kind of a judgment.

Furthermore, I don't think many physicians today are as unconcerned as they were in the past with the costs of medical care. What does concern me is that a number of our programs have so antagonized the professional as it relates to the Federal Government, it's very difficult to move that way. So I think I would have to say I feel as uneasy as you do about that, but I think we must undertake that kind of a movement.

EMERGENCY MEDICAL SERVICES RESEARCH

Mr. OBEY. OK. Now the administration didn't request the specific funds for the emergency medical service research. Can you give us a few examples of the EMS research which you supported and the results which have been assimilated into the operational emergency medical systems?

Dr. ROSENTHAL. For a total answer I will leave this copy of "Summary of Emergency Medical Systems Research."

There have been two or three general areas that might be of some interest. One is a cost containment strategy where a large HMO attempted to deal with the problem of great numbers of their subscribers

were using nonprovided emergency room services for matters which the plan felt it could handle on an urgent basis itself.

Members of the plan were averaging 0.45 visits per year to an emergency room, for which the county charged the plan $65 a day, by the way.

They established a small urgent care clinic that ran around the clock and reduced that 0.45 to 0.02 at a cost of about $20 a visit. Now that represents one extreme among the kinds of research that came out of the emergency services research.

There the issue was to find alternatives to the use of emergency services, first, to take the pressure off those services and, second, to take th fiscal pressure off the plan.

At the other extreme we have developed a number of what are called protocols or algorithms. These recipes for dealing with the most common emergency conditions which arrive at the emergency unit, and we have developed a few hundred of them which we are in the process of cataloging. They deal specifically with the most effective responses to burn injuries to severe trauma. Experience indicates that a tremendous reduction in morbidity and mortality can occur if the paramedics or people who initially encounter the patient respond according to these instruments.

We have supported extensive field studies of these protocols. They are used widely throughout the country in the training of emergency paramedics, in the training of ambulance attendants, and in the training of emergency room physicians. So that is something on the clinical side.

COST CONTROL MECHANISMS

Mr. OBEY. In your budget justifications, you mention cost containment in this regard, but in your budget justification for the cost containment category you say emphasis will be given to analyzing the effectiveness and impact of alternative cost control mechanisms in the hospital sector.

Specifically, what mechanism will you be looking at, or are you prepared to recommend the implementation of any particular cost control mechanisms?

Dr. ROSENTHAL. I think to answer the second half first, that it's important from the research side to make sure that the properties of those instruments of cost containment are well understood long before any recommendations are made. Any recommendations will be based on a number of concerns which we probably are not competent to assess, but knowing the potential consequences is important. What we have tried to do is to identify all cost containment instruments ranging from shared services to certificate-of-need, to rate review, to the use of deductibles and coinsurance.

That is, we have just made a cookbook list of these instruments and tried to identify those about which we really didn't know as much as we thought, that is, where the impact on other aspects of hospital industry performance was uncertain. We have asked individuals to prepare syntheses of existing research with respect to each of these cost containment instruments.

For example, we have recently distributed the report of a major study of the impact of certificate of need legislation. The results indicate certificate-of-need reduces the expansion of the bed supply, but encourages an offsetting increase in other types of capital investment in the institutions. On balance cost increases seem to be about the same, with or without a certificate of need program, although the shape of the investment is quite different.

Now, that is one finding. Well done, very meticulous, not the last word but clearly indicative of the need to understand thoroughly the consequences of various cost containment strategies.

Mr. OBEY. Would you say the last sentence again?

Dr. ROSENTHAL. Sure. The study indicated quite clearly that under an active certificate-of-need program, the rate of bed supply increase was reduced, but the rate of investment in the hospital sector was not. That is, the nature of the investment changed but the level did not. More CAT scanners, more radiological equipment.

Dr. MARGULIES. Intensive care treatment.

Dr. ROSENTHAL. That is right, the institutions modified their capital intensity without expanding the number of beds. There is some indication that this is a general trend, by the way. Therefore, a certificate of need, to be effective, is really going to have to deal with these kinds of pressures, which are now very strong in the hospital system.

Mr. OBEY. I have a number of other questions I would like to ask, but we are running out of time, so I will submit them for the record.

Mr. OBEY. I would like to turn to health planning and also submit some additional questions for the record and just ask a few now.

CERTIFICATE OF NEED

You mentioned certificate of need programs. One of the functions of the new State health planning and development agencies is to administer that program.

How many States now have certificate of need laws which conform to that planning act?

Dr. CAIN. Well, there are now 30 States that have the certificate of need programs. But it's our best estimate that probably all will require some changes to come up to or exceed the floor in the regulations that were just issued by HEW on this subject.

Mr. OBEY. You say all of them will have to make some changes?

Dr. CAIN. We think so, in substantial degree because there are quite a number of procedural requirements that flow out of the Planning Act, as well as out of the regulatory specification regarding such things as scope of coverage and required findings, that will require some changes, we think, in every case to comply.

Dr. MARGULIES. The regulations have come out in time so that the current round of State legislatures meeting will have an opportunity to address this, and the program has made all of the States aware of it, and there is a high likelihood they will make those changes in time to be effective.

EXCESS HOSPITAL BEDS

Mr. OBEY. Again I would rather put a couple of questions in the record here and then ask you—as you know, the Institute of Medicine published a report on controlling the supply of hospital beds and they recommended a national policy to reduce the existing number of beds by 10 percent.

What do you think of that policy and what kind of guidelines are you issuing to planning bodies with regard to reducing the excess hospital beds?

Dr. MARGULIES. We haven't produced national guidelines yet, but we have drafted some which would certainly move in the same direction, and we are—they have been circulating for general comment among our colleagues and in the public.

We would agree that there is a need to reduce the number of hospital beds in ratio to the population. It's an uneven kind of thing. There are so many areas where there are too many beds and there are still some that have requirements for additional numbers. But it seems to be a basically sensible policy. And the planning agencies already are well aware of that, and the approach to certificate of need and to planning is to bring the hospital beds down to the number which is reasonable for managing the needs of the community.

HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT

Mr. OBEY. Where are you with regard to publishing your final regulations on all of the provisions of that act?

Dr. CAIN. On all of the provisions, we have out now quite a few, but still have to issue the final regulations on State agencies, and on the State-wide Health Coordinating Councils, which should be out in about five weeks. On the Area Health Services Development Fund, we don't expect to have out the proposed rules until September. We haven't hurried on that one because there aren't any appropriations under that heading.

We are also close now, several weeks, to the proposed rules on the review and approval functions that HSA's are to perform.

Another of the charges which require regulations is the review of all existing institutional health services for their appropriateness. We intend to have out proposed rules on that in June.

There are several sets of regulations still to be issued under title XVI pertaining to the medical facilities program, and either as proposed or final, we will have them all out by mid 1978.

IMPLEMENTATION OF LAW

Mr. OBEY. Will there be any problem with the length of time it's going to take on regulation in terms of slowing the implementation of the law?

Dr. CAIN. Yes. We have up to this point taken more time than anyone would have wanted, and that has been primarily a function of

the complexity of the issues. You can tell from what I just referred to, we have a ton of "regs" to issue.

Mr. OBEY. What I am getting at is this. We have run into this a lot before when we face a law, you have effective dates and then "regs" seem to take forever. How do we get better judgments made as to when you can reasonably expect "regs" to be out, and how do you get a better planning operation going on both ends of the street, on Pennsylvania Avenue, so that we aren't in this position?

Dr. CAIN. Well, that is a very tough issue. In the case of the programs with which I have had some acquaintance, I think you are right, that it has to start with a better coordinated review in the legislative process between the Executive and the Congress. In the Planning Act, as a prime example, there were several changes in it in the few hours before it was passed at the end of 1974, and a host of issues came out of that rather hasty action that haven't been well resolved.

Mr. MARGULIES. I think, Mr. Obey, this particular issue is one that the Health Resources Administration has been looking at very carefully. We are about to enter into a contractual arrangement with the Kennedy School of Government which has initiated some earlier studies with the Department of Labor to take a look at the fundamentals.

It sounds like a hard way around the question, but I don't think we have examined in this country, in our Government the way in which we are trying to do public administration through regulations. We come up with simplistic questions and simplistic answers. It certainly gains with a better understanding between Congress and the Executive on what it is we are trying to do when we write legislation, not just the reasonable timing, but reasonable language.

More and more what Congress writes in its laws is perceptive and regulatory in itself, which limits the rank of discretion of the Executive. I understand why that has occurred but it continues to be a serious kind of problem.

IMPLEMENTATION OF LAW

Further, we use the same regulatory processes for issues that are big and small, and become very cumbersome. We use the Office of General Counsel frequently, and this throws us into the mode of briefing that we should write regulations to make ourselves immune from effective lawsuits, and I am not exaggerating, a good bit of what the Office of General Counsel does is try to make sure that the regulations will keep us from losing when we get sued.

At one time, as I remember, Secretary Weinberger had something like 18,000 lawsuits against him. I don't know how many of them he won, but the score wasn't very big.

OGC would like to lower that a little.

But we have not addressed it. I went around to the major resources of public administrative thinking in this country, in Washington, and around the country, and I found practically no place where there has been serious consideration of what is probably one of the half dozen major issues in the country, the business of using regulations as a tool of public administration, and probably it is worse in the field of health than anywhere else.

I think we learned something from the Planning Bureau. We do it better than we did before.

Mr. MICHEL. But the President said he is going to make you read all of those regulations, and that will take even longer.

Dr. MARGULIES. He said the Secretary was going to.

Mr. OBEY. How many hours is he going to have in his day?

Mr. MILLER. One other point needs to be added.

I think they have hit the principal ones, but I don't know any internal management subject that has gotten more attention from recent Secretaries of HEW than this one has. It's the toughest nut to crack, and we sure haven't cracked it, but there is enormous effort not to make reviews sequential and, somehow or another, to collapse time. But the complexity of the work is enormous. Have you ever looked at the Health Planning Act, have you ever held it in your hands? It's over 100 pages—and issuing regulations for it is a fearsome job.

Mr. OBEY. I don't recall how long it took to pass it, but usually I think you can bet that the length of time you spend debating it on the floor is in inverse proportion to its complication and length.

Mr. MILLER. Of course, one couldn't say that of the committee process in that instance.

Mr. OBEY. But I have two or three other questions which I will submit for the record.

Mr. OBEY. Mr. Michel, do you have any questions?

SUPPLY OF NURSES

Mr. MICHEL. I left off with a question with respect to the supply of veterinarians. What does your review show with respect to the supply of nurses in the country today? Is there a shortage, an abundance, or what?

Dr. MARGULIES. As I indicated earlier, I think the rate of increase in the number of nurses is very promising. The total number is, if you want to use a point of reference of Western Europe, or Sweden, England, France, West Germany, we are at that level or ahead of them in total number.

The problem is still distribution and trying to have nurses, as physicians, where you would most like to have them, and this is not just a professional problem, it's the fact that the population tends to be skewed, and in addition to that, the problems of the chronically ill and elderly make it even more troublesome.

INSURED LOAN DEFAULT

Mr. MICHEL. When the new federally insured loan program gets under way, will you have in place a strong administrative mechanism to assure against the default problem that we have had in the regular guaranteed student loan programs?

Dr. MARGULIES. I would think so. Our experience thus far with the loan programs for the health professionals has been very good. The defaults have been minor. And the people I have talked with in the student loan marketing association, called Sally Mae, think their experience with this will be very, very good.

Mr. MICHEL. I would hope so.

Dr. MARGULIES. It's a different group of clients.

Mr. MICHEL. Will this new program enable us really to reduce funding for any of the other health manpower programs, do you think?

Dr. MARGULIES. You mean the increased support for students?

Mr. MICHEL. Yes; the insured loan program.

Dr. MARGULIES. I think it may. My own feeling is that the insured student loan program may prove to be one of the most costwise of the investments we are making.

Mr. MICHEL. Cost efficient, do you mean?

Dr. MARGULIES. Yes; I think it will be costwise efficient.

If a student borrows $40,000 or $50,000 to go to medical school, it's a reasonable debt load for the kind of income he or she is going to get after going into practice. It can be utilized in a way to offset the costs of medical education, dental education, whatever it may be effectively.

The likelihood of it being paid back is very good. They have to return their taxes, and there is a prescription on declaring bankruptcy as a method of getting around it, so I think it could easily change the whole pattern of Federal support. But I do believe we are going to need to have a secure method of supporting students if we are not going to have it for the institutions.

SPECIALTY DISTRIBUTION

Mr. MICHEL. I am reminded of our earlier exchange or the one that Mr. O'Brien had about our problems out in Illinois, and your response with respect to the shortage of psychiatrists. You know, after everything we did in the early days of this committee here for fellowships, traineeships, and so on, we found, doggone it, that we were training all of the psychiatrists, but a greater percentage didn't move into the State institutions where they were most needed, but hung out their own shingles for private practice, and we thus didn't really meet the problem that was being discussed here earlier.

I don't know exactly how you get at that, unless whenever the Federal Government gets involved in an incentive sort of way it exacts a quid pro quo by mandating a series or a period of years or something. I would agree with you that while we certainly have changed, we don't institutionalize, and don't like to anymore. With so much more being targeted on ambulatory care in that field, there ought to be the first-class professionals, but how many times have I had people think they are being shortchanged because the doctor with whom they are dealing at that institution is some foreign doctor who has an accent of some kind.

They think right away, look what you have done to me, and how they have been discriminated against.

We included money in the supplemental for this study on the need and distribution, et cetera, of health professionals. Now it appears as though you are requesting additional funds. How long is this study going to go on and what will the ultimate cost really be?

Dr. MARGULIES. Initially, the proposal was to have a study set up over a period of about a year and a half. I think it will take longer. The purpose is to analyze through the use of people from all over the

country in a committee structure the potentialities for laying out for the country the number of specialists we need, where we need to train them, where they need to be located, and I would say that we can give you a full report on that within 18 months.

But I suspect that if it is set up and makes good recommendations which are acceptable and reasonable, that there will be continued need to support that function.

MEDICAL CARE EXPENDITURE SURVEY

Mr. MICHEL. Is there any information available as yet from that study on expenditures for health care and the impact of different insurance arrangements on costs in use of services?

Dr. MARGULIES. You are talking about the survey. It's just been initiated, and it's just under way, and as you heard, it's the first major study of this kind. It will produce that kind of information.

Mr. MICHEL. Now is that being coordinated with the Office of Policy Research, so that there isn't any duplication?

Dr. MARGULIES. Yes, as a matter of fact, this is being looked at with great eagerness by a number of people.

MALPRACTICE INSURANCE

Mr. MICHEL. As a matter of fact, in this area you are speaking, of the area of malpractice, and the validity of insurance premiums comes to mind. I got to looking into statistics in my own State and the number of cases that were filed that actually come to some kind of remuneration compensation, and they were relatively few, and at just a fraction of the original suit. When you add up those awards as distinguished from those that don't end up in any kind of payment whatsoever, you say for heavens sake, the premiums are outlandish. What do your figures show, if anything?

Have you done any research?

Dr. ROSENTHAL. The problem with malpractice insurance is that claim related to this year's premium can occur decades later. Although some of the States have initiated statutes of limitation, there aren't many courts that will stand there, look at a mentally retarded 18-year-old, and not go back to the obstetrician on a malpractice charge. So there is a need for tremendous reserves out of those premiums.

Now, it's really hard because of the long lead time to deal with that expense. A number of companies have moved to what they call a current claims basis, where you insure yourself only for claims laid against you this year. The problem is that when an individual retires, he has to keep carrying insurance, because he doesn't know when a claim is going to show up.

There probably isn't any easy way to deal with the issue. We have, however, had some interesting research indicating that a program of arbitration and adjudication of disputes between patients and physicians over malpractice claims can reduce the claims paid by well over 50 percent.

What that means in the long run is very, very hard to tell. Data are not easily obtainable.

Mr. MICHEL. I am going to submit some questions for the record, but just one final thing, Doctor, and you touched on it here in one of these exchanges.

My father turned 88 a few weeks ago. About a year and a half ago he had a stroke. Up to that point he was in good health, did yard work, walked a lot and everything, very sharp.

The stroke was just that little thing that affected right to left and left to right, and he can't read, just can't watch television. There is enough wobbliness in walking that Mom doesn't want to let him out of her sight. And he feels like a prisoner. Of course, we wouldn't send him to a nursing home, and Mom wants to give him that day-to-day care. I know in a community like ours, 130,000, there ought to be a number of those similar stroke victims. If you had enough daily activity oriented toward these people, which would be enough to keep their attention alive in the absence of their being able to read or watch television or something, it would help give them something to do and help avoid a situation where they get to drifting off to sleep too frequently during the day that night isn't night anymore and they can't sleep at night. Is it possible to have a centrally located point where a number of people with maybe similar kinds of conditions could be engaged in enough activity to make life more interesting?

Dr. MARGULIES. I think out communities could easily do that much more than they have. We could have an expansion of home health care, but you are really talking about something which allows him to have an activity that makes him feel that he is a part of what is going on in this world.

Of course, if your mother got ill, then his problem is even worse. We don't really have effective mechanisms for dealing with it, and it's more than a medical problem.

We keep looking for those kinds of solutions. But to say we have an answer to that would be untrue.

Dr. ROSENTHAL. I think, if I may, when we had our earlier discussion about long term care, the situation you describe points up one of the reasons why it's so hard to deal with it. Whatever solution there is to that problem is not to be found within what we think of as the medical care system.

That is, the problems of long term care are problems that involve all of the human services activities, and that is one of the things that makes them so difficult to deal with.

Dr. CAIN. Can I add on that? That if the health planning agencies are doing their jobs well, that is one of their responsibilities, to detect that kind of a problem and begin to orchestrate whatever that community has to answer that.

Mr. MICHEL. Because there would be an opportunity with some kind of local aegis to have shared costs that would make it a very practical kind of thing for the most modest of families, without getting into these monumental costs that really scare people.

Dr. MARGULIES. It requires some consistency, some attention, and some people who are willing to be involved in it.

Mr. MICHEL. Thank you. That is all. I will submit some questions.
Mr. OBEY. Thank you very much for coming.
The hearing is adjourned.
We shall reconvene Monday at 2 o'clock.

MR. CONTE

NEW HEALTH PRACTITIONERS

Mr. CONTE. Would you explain how your programs work to train nurse practitioners and physician and dental extenders.

ANSWER. In the Nurse Practitioner program, grants are awarded to schools of nursing, medicine, and public health and to hospitals and other private, nonprofit entities to plan, develop, and operate, or significantly expand, or maintain existing programs to train nurse practitioners. The program must be at least one academic year and combine classroom instruction with supervised clinical practice. Emphasis is placed on training to provide primary care in homes, ambulatory facilities, long-term care facilities, and other health care institutions. Special consideration is given to programs which emphasize training respecting the special problems of geriatric patients or training to meet the particular needs of nursing home patients.

The physician assistants program also makes grant awards supporting the planning, development, operation, or maintenance of physician assistant training programs or faculty training programs. Physician assistant training equips graduates to provide many primary care services under the supervision of a physician.

In 1978, the expanded function dental auxiliaries program becomes a grant program providing support to various educational entities for the planning, development and operation, or maintenance of programs to train dental extenders. Didactic and clinical preparation of dental extenders is accomplished largely through curriculum modification of accredited dental auxiliary education programs so that the curriculum includes expanded function training. Other projects train the practicing dental auxiliary workforce in expanded functions or train faculty to teach expanded functions.

NURSE TRAINING FUNDS

Mr. CONTE. You are essentially proposing to eliminate all assistance for nurse training. Would you explain why, particularly with regard to the elimination of capitation grants and student assistance loans and traineeships? What evidence do you have to support a contention that this money is unnecessary?

ANSWER. The elimination of support for these programs is based upon our determination that the current supply of active registered nurses in the country, 961,000, is sufficient.

MANPOWER INITIATIVES

Mr. CONTE. On page 126 of your justification you are requesting no funds for manpower initiatives. Would you tell me more about that program? Why are no funds being requested?

ANSWER. In the past, manpower initiatives projects have supported interdisciplinary efforts to provide high quality health care in a cost-effective manner, training health professions students in the use of the team approach to the delivery of primary health care, and innovative projects in humanistic medicine. In 1978, a separate request of $2.1 million would fund the team approach training projects. Because the authority for the manpower initiatives program expires at the end of 1977, and because other programs address more directly the priority issues of specialty and geographic maldistribution, no funds are requested.

HEALTH PROFESSIONS SPECIAL PROJECTS

Mr. CONTE. Why are you proposing to eliminate the health professions special projects program? What was done in that program during the past year?

ANSWER. The authority for the health professions special projects program expires at the end of fiscal year 1977. Projects have assisted schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, and podiatry

to conduct special projects encompassing a variety of efforts. These include curriculum development, interdisciplinary training, improvement of geographic and specialty distribution, efficient utilization of health personnel, and increased admissions of minorities and disadvantaged students to health professions schools. Other projects concern competency measurement and more effective delivery of health care. Many programs for which funds are requested for 1978 focus on these same issues.

STUDENT LOAN PROGRAM

Mr. CONTE. Why are you proposing to eliminate the student loan program?

ANSWER. There is ample provision for student assistance in other loan and scholarship programs. The federally insured loan program should be fully operational in fiscal year 1978. This program maximizes the benefits from Federal dollars since direct loans are replaced with private source loans guaranteed by the Federal Government.

In addition, 296 health profession schools and 1,195 nursing schools have substantial loan funds, derived from our direct loan program, from which they can make new loans. In 1978, we estimate 10,667 health professions loans and 10,625 nursing loans could be made from these loan funds held by the schools. The nursing scholarship program, the new scholarship program for the exceptionally needy, and the NHSC scholarship program should help assure that students with significant need and minimal resources receive student assistance.

EFFECT OF REORGANIZATION

Mr. CONTE. What will be the effect on your operations of the HEW reorganization recently announced by Secretary Califano?

ANSWER. As a result of reorganization, the new health professions Federally insured loan program has been transferred to the Office of Education. At present, this is the only change about which we have been notified.

PUBLIC HEALTH AND ALLIED HEALTH

Mr. CONTE. What are the current manpower needs in allied health and public health? Aren't there still many more positions available than qualified people to fill them?

ANSWER. The most recent compilations of supply and requirements for Public Health personnel with graduate degrees in such fields as biostatistics and epidemiology, Public Health nutrition, environmental health, health education, and health and hospital administration indicated the following requirements in selected fields:

	1970 supply	1980 supply [1]	1980 requirements
Environmental health	2,200	4,300	5,000
Epidemiology	1,000	1,800	2,000
Health education	2,000	3,600	6,000
Health administration	8,500	18,200	25,200
Public health nutrition	1,000	1,800	2,600

[1] Assuming constant school output.

The above chart which compares projected supplies with projected needs for public health professionals in 1980 is based on the assumption that public health schools will produce a constant output of students. Because of the record of expansion in the fields of allied and public health, and because of the present attractive job market in these areas, the 1980 supply will almost certainly exceed the projections in the chart, bringing the 1980 supply of allied and public health personnel close to the projected 1980 requirements.

While detailed data on personnel supply and requirements are not available, the most recent survey of hospital personnel (1973) indicated an overall shortage as measured by vacancies in budgeted positions, of about 4 percent. The professions in which vacancies were greatest include such fields as occupational therapy (11.7 percent), physical therapy (8 percent), medical records administration (6.4 percent), respiratory therapy (5.1 percent), dietitians (4.9 percent), and clinical laboratory technologists (4.6 percent).

Mr. CONTE. Your justifications are fairly deceptive, so far as they are comparing your 1978 estimate to the 1977 continuing resolution levels of funding. With regard to public health education and allied health, would you compare your request to the amount provided in 1976.

ANSWER. The amount provided for public health activities in 1976 was the continuing resolution level of $20,520,000, compared to the fiscal year 1978 request of $8,000,000. The amount provided for allied health activities in 1976 was the continuing resolution level of $28,321,000, compared to the $8,000,000 request for fiscal year 1978. The 1978 request reflects our belief that, given fiscal constraints, we should direct our public health and allied health funding support into project-oriented programs where priority goals in those fields can be addressed through grant and contract awards.

RATE REGULATION

Mr. CONTE. Would you explain the elements of your demonstration projects on the effectiveness of rate regulation to restrain health care costs?

ANSWER. The Social Security Administration has been delegated authority to implement section 1526 of the Health Planning Act. The SSA currently has eight rate regulation projects operating under section 222 of the Social Security Act in the States of Connecticut, Massachusetts, New York, Pennsylvania, Washington, Maryland, New Jersey, and California. We expect that some of these section 222 projects will also receive grants for rate regulation under our section 1526 authority.

In terms of the 1526 experiments, the State rate regulation programs set rates prospectively, that is, before the period for which rates will be paid, for the entire State. These programs must be legislatively authorized, and must be administered by a fully designated State health planning and development agency. Past experience has indicated that important elements of a rate regulation program include the method of determining rates, appeals mechanisms, coverage of institutions, third party payer participation, and the mandatory or voluntary nature of participation.

Mr. CONTE. Where are those six demonstrations being conducted?

ANSWER. We have not yet awarded any demonstration grants because none of the State agencies have been fully designated. We are hopeful that some of the States that are interested in receiving rate regulation grants this year will also be eligible for full designation so that the $2 million available can be utilized.

FACILITIES CONSTRUCTION

Mr. CONTE. In your opening statement, you mentioned that the entire facility financing arena is being examined to determine the appropriate role for various funding mechanisms. What form is that examination taking?

ANSWER. Within the Public Health Service, we are examining the issue of capital financing, particularly as it relates to the various funding mechanisms that currently exist for facilities construction.

Mr. CONTE. Do you have a special task force, committee, or something else?

ANSWER. A work group has been set up involving components of the Health Resources Administration, particularly the Bureau of Health Planning and Resources Development, and the Office of the Assistant Secretary for Health. The work group is looking at questions on the current supply of hospital beds, trends in the sources of financing for construction, current methods of Federal intervention in financing construction, and some recommendations for the future.

Mr. CONTE. When do you expect to have a final study or conclusions available in this area?

ANSWER. We expect to have this report completed by June of this year.

Mr. CONTE. And might we then expect some recommendations as to new funds for facility construction?

ANSWER. We expect to have some recommendations on how to finance high priority construction needs when we submit our legislative proposal for extension of the National Health Planning and Resources Development Act. This legislative proposal will probably be sent to Congress sometime during the summer, depending on when hearings are scheduled for extending this program.

Mr. CONTE. It often seems that the need is not for the construction of new facilities, but for the expansion or renovation/rehabilitation of existing ones. What programs are available for such work?

ANSWER. Our medical facilities construction program under title XVI of the Health Planning law provides for the construction, modernization, and conversion of medical facilities which would include expansion and renovation of existing facilities. The Department of Housing and Urban Development also has programs which support the expansion and renovation of both hospitals and nursing homes. Other agencies which I am aware of that have such programs for facility construction include the Farmers Home Administration, the Appalachian Regional Commission, and the Economic Development Administration. I understand that the Veterans' Administration and the U.S. Armed Forces Service also spend a good deal of money each year for such work.

Also, title XVI provides that each State, as a part of its State health plan, develop a State medical facilities plan based upon the needs for expansion, conversion, or renovation/rehabilitation as well as new facilities, growing out of the detailed planning and priorities of the several health systems agencies within the State. This means that States will be fully responsible for the development of their medical facilities plans but will work closely with both the heath systems agencies and the State health coordinating council at appropriate stages throughout the process.

The State medical facilities plan will serve as a basis for allocating loans and grants under title XVI, and hopefully under other Federal construction authorities as well. It may have additional uses at the option of the State, particularly in administering certificate of need programs. It is expected that the States, as they develop their SMFP's, will examine all possible alternatives to inpatient care facilities before determining their requirements for any sort of costly changes in the physical plant portion of their health care structure.

Mr. CONTE. How much is requested in this budget for this purpose?

ANSWER. We have not requested any funds in this budget for this purpose. There is a great deal of controversy right now over how such funds should be channelled in order to do the most good, and, in fact, whether the facilities market has already been saturated to the point where there may no longer be a need to continue pouring Federal funds into such programs. We are currently examining these questions from a policy standpoint and feel that it would not be reasonable to put additional funds into this activity until these new directions become clear.

HEALTH PLANNING

Mr. CONTE. You are requesting $125 million for health planning, the same amount as last year. Will this be an adequate amount to provide the level and sophistication of health care planning that is necessary in order to meet the mandates of the authorizing legislation?

ANSWER. As you probably know, Mr. Conte, the legislation puts quite a burden on the State and local health planning agencies as far as all the things they must do in accomplishing the objectives of the legislation. The complexities of these numerous activities will require highly skilled staff, a broad array of technical assistance to the agencies, and the development and refinement of planning methods and technologies which will, of course, all require a good deal of money. The $125 million request is the minimum amount which would be necessary to comply with the mandates of the authorizing legislation, although better program implementation might result from a higher funding level.

FACILITIES CONSTRUCTION

Mr. CONTE. Last year you had $51.5 million for medical facilities construction. Was all of that obligated?

ANSWER. As of right now, none of those funds has been obligated. However, we are in the process of reviewing about 136 applications for project grants under section 1625 and we will be obligating the $11.5 million available for such projects in May of this year.

With respect to the formula grants, the $40.1 million available cannot be obligated until there are State health plans—largely comprised of health systems agencies—and State medical facilities plans, the criteria for which are now under development. In addition, there will have to be final regulations on construction standards, assurances, allotments, and application procedures, the last of which will not be published until late in fiscal year 1978. We will then begin to utilize the funds available for this activity.

Mr. CONTE. Could you provide a listing of the projects funded by that account?

ANSWER. As I stated previously, none of the projects have yet been funded. A listing of section 1625 projects will be available in May of this year, and we will not know until late in fiscal 1978 just what projects will be funded with the formula grants.

PLANNING METHODS DEVELOPMENT/TECHNICAL ASSISTANCE

Mr. CONTE. What forms of planning method development and technical assistance will you be providing for HSA's and State planning agencies?

ANSWER. We will be providing a broad array of assistance to the planning agencies in this regard. First, there is a major need in the area of health planning development to improve the methodology and expand the scope of the collection of health statistics needed by the planning agencies as a basis for developing their health systems plans and annual implementation plans. Second, there is a need for special projects aimed at providing to the HSA's and State health planning agencies technical assistance materials of various types. These projects would include such things as developing approaches and criteria to be used by planning agencies in assesing the adequacy, appropriateness, costs, quality and other factors involved in the review of capital expenditure projects; developing economic analysis methodology applicable to various problems of planning, review, and plan implementation faced by the planning agencies; and developing financial, physical, and other requirements that must be considered in planning and reviewing projects for health resources development.

In addition, the ten centers for health planning will provide training, consultation, and other technical assistance to health systems agencies, State health planning and development agencies, and statewide health coordinating councils. Their major aims are to assure that the governing bodies of HSA's have a good understanding of how the health care industry works, what the major problems are, and so forth; and to provide technical assistance to planning agency staff to assure that they have access to the best planning techniques available.

Another form of assistance will be rendered through the national health planning information center which provides clearinghouse and related information exchange and dissemination services to the HSA's and State agencies. The center has become a mainstay of our activities in providing technical assistance to the planning agencies in the form of publications, announcements, bibliographies, and various other activities. The information collected by NHPIC grows continuously and, along with this growth, the opportunities for its service to the planning agencies continue to expand as shown by the steady rise in requests for information pouring into the Center.

MR. O'BRIEN

RELATIONSHIP OF CHSS TO THE HEALTH PROFESSIONS TRAINING ACT

Mr. O'BRIEN. What is the relationship of the cooperative health statistics system program to the recently enacted health professions training act?

ANSWER. The cooperative health statistics system (CHSS) is expected to meet a major portion of the data needs of the Health Professions Educational Assistance Act of 1976. The manpower and facility components of the CHSS are operating in more than half of the States. The remaining States will be added as rapidly as resources are made available to provide manpower data for local, State, and national needs. The manpower component provides data on the thirteen occupations currently licensed in every State. In addition, data concerning health professionals employed by health care institutions are provided through the facility component of CHSS. Until the CHSS is fully operational in all States it will be necessary to conduct surveys in the non-CHSS States to obtain complete national manpower data. This is a cumbersome procedure, tends to divert funds, delays full implementation of the CHSS, and does not provide for shared data for local-State purposes in the non-CHSS State. It is well to recognize that the data concerning manpower, as specified by this act, is viewed as essential to local/State health planning and manpower training functions. Therefore, when the system is fully implemented, it will meet some of the data requirements specified or implied by the authorities contained in the Health Planning and Resource Development Act and Public Law 94–484, as well as be of value to many other programs and interests.

Not all of the data requirements for Public Law 94–484 will be met through this system, however. Programmatic data, such as student supply information, will be provided by the activities of the Bureau of Health Manpower collaborating on surveys with the National Center for Health Statistics. The Health Resources Administration has facilitated the planning of such activities on a cooperative basis between the two Bureaus.

BUDGET REQUEST VERSUS ENACTMENT OF P.L. 94–484

Mr. O'BRIEN. Is the current budget request for health statistics adequate to provide for the cooperative system to expand its health manpower statistics modules to meet the needs of the act? Or should we consider an increased level of appropriations to the national center for health statistics for that purpose? We do not want to see the very important data broker or health care utilization module receive inadequate support.

ANSWER. The budget includes a request for an additional $6 million for the cooperative health statistics system, bringing the total for that program to approximately $14 million. The budget request would enable expansion of the facilities and manpower components of the system from 27 to 42 States. These components are necessary to establish various inventories, including those for allied and unlicensed health manpower, which are essential to the conduct of many of the activities established by the Health Professions Training Act. This expansion of activity can take place within the budget request without disrupting implementation of the other data activities. We have also requested $2 million for manpower supply and distribution reports, under the health professions programs, for manpower data gathering. This request would support a program to generate statistics and evaluate programs. Studies will be made for physicians, dentists, VOPP's, and Allied and Public Health manpower.

COST FOR SUPPORT OF DUPLICATE SYSTEMS

Mr. O'BRIEN. If you are not able to continue the previously planned rate and scope of implementation of the cooperative health statistics system, what will be the ultimate cost to the public for support of duplicate systems at the State level for such Federal health initiatives as health planning, quality assurance, rate review, certificate of need and other programs both with respect to the burden on providers and the associated dollar cost?

ANSWER. The most serious effects of a reduction in rate and scope of growth of the Cooperative Health Statistics System will be felt by those segments of the economy that must have timely, accurate, and complete data on the utilization of hospitals, nursing homes, clinics and other health care resources.

Congressional action has created a strong demand for health utilization data at the local level for professional standards review organizations, health systems agencies, rate setting agencies, certificate-of-need programs, and health manpower utilization. The legislatively defined functions of the Cooperative Health Statistics System, in relation to these programs, are to assist and coordinate the activities of other Federal agencies collecting Federal, State, and local statistics; to undertake and support the development and evaluation of such systems; to provide the Federal share of data collection costs of such systems; and to review the statistical activities of the Department to assure that they are consistent with the cooperative system. In addition, the Cooperative Health Statistics System is specifically referenced in other legislation, such as National Health Planning and Resource Development Act and the Health Professions Educational Assistance Act, and has delegated responsibilities under other laws. The effectiveness of the center in carrying out these responsibilities is dependent on the rate of growth and scope of the Cooperative Health Statistics System.

The inability to perform these functions will result in the continued proliferation of single-purpose data collection systems serving the needs of a particular user and covering only some special class of persons such as the beneficiaries of a particular program. These redundant requests for data from physicians, hospitals, nursing homes, clinics, and other health care providers will increase the reporting burden on the respondents and increase the costs of collecting processing, and distributing data. Not only will there be no mechanism for insuring that these disparate pieces of data be comparable, but they will likely be biased depending on the purposes for which they were supplied, and will be incomplete in that large segments of the population served will not be included. It

will not be possible for the Congress, the Department, or State and local agencies to obtain a comprehensive picture of the utilization of health care resources across the Nation. As a result, everyone will be planning and budgeting with inadequate and incomplete data which could result in major waste of both Federal and State health dollars. The true cost of a reduction in the Cooperative Health Statistics System may be a continued inability to control escalating costs, ineffective utilization of scarce resources, and a continued lack of a solid base for planning our system of health care.

CHSS AS A LINE ITEM IN THE BUDGET

Mr. O'BRIEN. What is your feeling about making the Cooperative Health Statistics System a separate line item in the budget?

ANSWER. As you know, we currently present our budget to Congress in three lines, the Cooperative Health Statistics System, the National Health Surveys and Analysis, and our program management requirements. This certainly seems to serve the needs of the National Center for Health Statistics to provide adequate information to the Congress with regard to the purposes, accomplishments, and budget needs of our programs.

However, if the question is directed at my feelings with respect to a separate appropriations authority for the Cooperative Health Statistics System I would view that somewhat differently. In order to manage an activity the size and scope of the National Center for Health Statistics, some degree of flexibility in allocating resources among competing statistical responsibilities is necessary.

Dichotomizing the small budget authority into a Cooperative Health Statistics System and another National Center for Health Statistics activity split is fraught with management problems. For example, the inability to shift resources during certain periods of time when needs of one program outweigh needs of another activity is very limiting in a management sense. Another example is the inherent fallacy in such a split between the national surveys and the complete reporting systems in the Cooperative Health Statistics System, since a survey such as the hospital discharge survey can be greatly improved by the development of the Cooperative Health Statistics System. On the other hand, a national survey such as the health interview survey may best meet the needs of local areas by selected oversampling, et cetera, so that both mechanisms should be able to exchange resource support in order to develop as a total national statistical system dedicated to meeting needs at all levels of government.

I do not believe that any change in authority is needed, with the possible exception of an increase in the level of authorization in order to accommodate the 1978 President's budget request.

CHSS AND PRIVATE INDUSTRY

Mr. O'BRIEN. Why do you think it is that private industry is so excited about the cooperative system?

ANSWER. We cannot respond regarding the attitudes of "private industry" as a whole, but we are aware of the reactions of certain groups within such areas as private health insurors, corporate pension and welfare plans, labor unions, and hospitals. While each type of industry has its unique needs for data, many of which are stimulated by Federal laws and regulations, there are certain advantages to the Cooperative Health Statistics System that all of these groups recognize as beneficial to them.

First, all of the major parties in industry—labor, management, health insurance, and health providers—are experiencing the spiraling costs for health care services, are being pressed to provide more and better care for their constituents, and are being held increasingly accountable by the Federal Government for the quality and cost of the health benefits or services being provided. A statement that is being widely circulated, attributed to General Motors, is that they are spending more for healh care benefits for their employees than for the steel used in production. It is clear that the health services delivery system will command increasing attention from all parties.

Given this situation, there is an increasing demand for data on the utilization of health services which cannot be met by existing reporting and survey mechanisms. All of the available data refer to special classes of patients such as those insured by a particular company or Federal plan, or hospitals that sub-

scribe to a particular data processing service. Most of these data are proprietary in that they cannot be freely accessed even to obtain aggregated data needed for actuarial calculations. Little of the data is comparable in terms of uniform data items and definitions across the various systems.

Those representatives of private industry with whom we have had contract, have expressed strong support for the Cooperative Health Statistics System as the primary mechanism for collecting and disseminating health resources utilization statistics because it offers a way to overcome many of the major difficulties. First, it reduces the burden and costs of reporting on hospitals, nursing homes, and physicians by collecting the information only once and distributing the results to a wide variety of users. Second, it assures that data will be collected in a uniform and comparable manner regardless of the source of payment, the ownership of the facility, or other factors related to single purpose reporting systems. Third, it provides for a consortium of major data users including private industry and providers which will serve as an open forum where all interested parties can have a voice in determining the flow of data, the problems of access and confidentiality, the quality of the data, and the potential uses of the data. In effect, it becomes a meeting ground for management, labor, insurance, medicine, and government. Fourth, the cooperative system is devoted to meeting data needs at all levels, particularly the local health service areas where decisions must be made.

This growing interest of private industry in health statistics can only be viewed as a very healthy development since it will mean more involvement in the planning and allocation of health resources, quality of care, cost containment, and other critical problems. Such efforts as rate setting, prospective reimbursement of hospitals, allocation of scarce personnel and equipment resources, and review of the necessity and quality of care, can only be done with timely, accurate, and complete data at the local level. Private industry has come to recognize its need for such data and is willing to invest funds and resources to achieve it in a cooperative mode.

I would like to submit for the record a document recently released by the Association of Private Pension and Welfare Plans which addresses these concerns and expresses industry's support of shared data systems. The document relays industry's position on a "national health system" and in several areas describes the requisite data support systems.

COST OF EXTENDING THE PROGRAMS

Mr. O'BRIEN. How much money would be required to extend this program to every State?

ANSWER. Our original estimates were that the direct Federal share of this system would be $60 million when all States were implemented in all the data components. However, we are finding that in many cases the contract costs are lower than anticipated. This is especially true in the data components on utilization of services. For example, in the hospital care component some of the State systems have established consortiums of data users and many of these systems are becoming almost self supporting as they receive funds from PSRO's, health planning agencies, hospitals, and others.

These developments make it difficult to estimate the total Federal cost once the Cooperative Health Statistics System is fully operational, but the amount should be below our initial estimate of $60 million.

MR. ROYBAL

EVALUATION OF HIS AND HANES OUTPUT

Mr. ROYBAL. I understand that the Office of Management and Budget has asked the National Center on Health Statistics to perform an evaluation of the health interview survey (HIS) output to determine its usefulness to users and the need for future data on an annual basis. Has the evaluation been completed? Does it include an assessment of the need for data about groups within the population such as the Hispanic American population? Do you plan to do a similar evaluation of the health and nutrition examination survey (HANES)?

ANSWER. Funds have been requested for the evaluation of the health interview survey. The proposal requesting them includes a component which would involve examination by a national committee of experts to determine the degree to

which the health interview survey is meeting the data needs of health professionals and administrators. The issue of the need for health data on groups within the population is implictly included in the charge to the national committee.

The health interview survey has been working on the problem of collecting data on Hispanic Americans for over 2 years. During 1976 the health interview survey began to collect data on the ethnic and national origins of its respondents. A paper on the results of this work has been prepared and data are now available for tabulations on the various subgroups, including Hispanic Americans.

This type of data is also being collected during 1977. The pretest of the 1978 questionnaire contains a revised form of the type of question needed to produce health data for Hispanic Americans.

While the funds necessary for the overall evaluation are awaited, work which will have major implications for making the health interview survey data more timely has begun using already allocated services and personnel. The Division of Health Interview Statistics is experimenting with procedures which, if successful, will reduce the amount of time and resources necessary for the core component of its questionnaire. This will allow for an expanded use of timely supplements which can be added to each year's questionnaire to meet current data needs as they arise.

The Division of Health Examination Statistics initiated a proposal to evaluate the HANES mechanism in June 1976. The proposal was funded under HEW 1 percent evaluation funds in the fall of 1976. The contract will be awarded in May 1977. The purpose of the contract is comprehensive.

"To evaluate HANES and possible modifications thereof in answering the principal questions necessary to solve present and future health problems as related to nutrition. The scope of the evaluation includes all of HANES activities to identify essential characteristics of data to meet specified needs. This entails identifying specified needs and requirements for satisfying those needs, recommending modifications to the current data collection mechanism, reviewing necessary resources to adequately meet needs, and reviewing data collected and identifying priority analyses in terms of major public policy questions." (Quoted from request for proposal.)

TIMELINESS OF HIS AND HANES DATA

Mr. ROYBAL. In a recent draft report, the Office of Management and Budget stated that the data produced from HIS and HANES are "not being analyzed or disseminated in a timely fashion." What steps has the Center for Health Statistics taken to remedy this situation?

ANSWER. The Center has taken a number of steps to improve the timeliness of the data. One of these has been the establishment of a new report series, "Advance Data From Vital and Health Statistics of the National Center for Health Statistics." This has resulted in the early release of findings from the health and nutrition examination survey, the health interview survey, and our other data-collection activities. For example, data on serum cholesterol levels, height and weight data, dietary intake patterns, dermatological examination findings, and other topics, appear many months before the more detailed reports could be distributed in the vital and health statistics series. In addition, we are collaborating in data analysis and report writing with outside experts and are contracting for report editing to save time. Other steps taken include implementing new methods for editing the raw data concurrently with the data collection to reduce the total time involved. We have instituted a "user's tape release program" which makes the computer tape available for analysis by outside research agencies, and we make these tapes available more quickly.

FIXED SITE EXAMINATION CENTERS FOR HANES

Mr. ROYBAL. The Office of Management and Budget suggested that the Center switch from exclusive use of a few mobile examination centers to fixed site examination centers to improve the timeliness of its reporting of HANES results. What impact would this change have on the ability of the Center to report HANES results on a more timely basis? What impact would this change have for increasing the HANES sample to a size adequate for making reliable estimates of the health needs of the Hispanic American population?

ANSWER. Having a greater number of examination centers conducting examinations simultaneously would reduce the time for data collection in a specific survey or enable a survey to include more locations in the study over the same period of time. However, data collected using fixed site examination centers with contract personnel may not be comparable to data produced through the mobile examination centers staffed by NCHS personnel. A study designed to test this question was completed in April 1976 and indicated a somewhat different approach to contract examinations would have to be developed. A second project has been proposed to improve and develop the contract examination potential and, hopefully, to make possible some use of this method. If this study, which will probably be conducted in fiscal year 1978, shows this method can be used, we will use it in combination with mobile examination centers if resources permit, since the methodology results in some increased costs.

More detailed and timely HANES studies of the Hispanic American population would result from use of the combined operational modes—fixed and mobile—if the fixed sites prove feasible.

HEALTH DATA ON HISPANIC AMERICANS

Mr. ROYBAL. What are the Center's plans for improving the regular collection, analysis, and publication of health data on Hispanic Americans as mandated under Public Law 94-311? Under these plans, what health issues or conditions would be examined? Would you please report on what the Center has done to expand its surveys and studies to include sufficient sample sizes for covering this population? At how detailed a level of aggregation would the data be available? For instance, would the data be available on the basis of age, sex, education, income, and geography—that is, urban, rural, State, or region?

ANSWER. The Center had begun to identify Hispanic Americans in some of its surveys several years prior to the enactment of Public Law 94-311. Thus, data have already been collected by both the 1973 and 1976 national surveys of family growth, by the health and nutrition examination survey (HANES), 1971-74, by the 1973-74 national nursing home survey, and by the national reporting system on family planning services since 1972. Within the past 18 months, the Center has added a specific Hispanic identifier to its health manpower inventory/survey activities, to the health interview survey (HIS), and has worked with all States to persuade them to include an Hispanic identifier on their new registration certificates for births and deaths beginning January 1978.

The same data will be collected about the health of Hispanic Americans that is collected about the rest of the population. It will be possible to make national estimates for this group by sex, age, education, and income. From the HANES we should be able to make national estimates on the nutritional status of Hispanic Americans and on the prevalence of such chronic conditions as hypertension and diabetes. Using data aggregated from 2 years of the HIS, we can make national estimates on the utilization of health care services, disability, several acute conditions (e.g., upper respiratory infections, injuries), high-prevalence chronic conditions (e.g., heart conditions, hypertensive disease, and visual and hearing impairments), and a number of other health variables. We have specific plans to publish reports with data on the health of Hispanic Americans from both the HANES and the HIS.

At this point in time we have not made specific plans to expand the sample size of our principal surveys which would, among other benefits, allow even more detailed data about Hispanic Americans. Before investing a significant amount of staff and financial resources in immediate redesign of our samples we plan to analyze our existing data, especially that from the health interview survey, in order to assess the ways and extent to which health measures for Hispanic Americans differ from measures for other components of the population. This analysis will then be the basis for planning any sample redesigns or for other modifications of our activities.

Mr. ROYBAL. What efforts has the Center made to seek the cooperation of State agencies collecting vital statistics information on the basis of reliable idenification of the Hispanic American population? What form have these efforts taken in the State?

ANSWER. During the past year the NCHS has had repeated contacts with all States to discuss the need for birth and death data for the Hispanic population and to encourage them to add an item to their birth and death certificates to obtain these data.

Early in 1976, we telephoned those States with large Hispanic populations encouraging them to add an item on their certificates when they were revised for implementation in 1978.

At the Public Health Conference on Records and Statistics during the week of June 14, 1976, which was attended by representatives from almost all State vital statistics offices, the need for data on the Hispanic population was presented and discussed.

In October 1976, we met with representatives from four Southwestern States to discuss ways of wording a question on birth and death certificates to obtain data for the Hispanic population.

In December 1976, a letter was sent to the State registrar of vital stastistics in each State reemphasizing the need for data on the Hispanic population and encouraging them to add an appropriate item to their birth and death certificates.

Presently we are conducting a telephone survey of each State to determine their plans for revising 1978 certificates. Again, the possibility of adding an Hispanic origin question is being discussed with each State during this survey.

A letter will be sent to each State registrar within the next 2 to 3 weeks indicating the recommended wording of such a question.

Mr. ROYBAL. Has the Center considered conducting a special survey focused on the health problems of the Hispanic population? Would you please provide an estimate of the cost of such a survey, including information about the number of people who would be examined and the length of time it would take to conduct the survey?

ANSWER. The Center has considered a special survey of the health, and particularly the nutritional problems, of the Hispanic population. How to design such a survey can be better determined after data from the first health and nutrition examination survey and data on the Hispanic population from the health interview surveys of 1976 and 1977 are analyzed. Both of these will have some information relating to health problems of the Hispanic population. Then it will be possible to determine whether, and to what extent, their health problems differ from those of other persons who are in a comparable position with respect to such variables as age, sex, income, and education. On the basis of this analysis we will determine what kinds of modifications of our survey program, if any, are needed to better define the special health problems of the Hispanic population. Since the nature and content of a survey determines the cost, size, and time factors, we can give only a very gross indication of these. For a special survey of several thousand persons to be examined and interviewed, the time required would be about 1 year, and the cost about $2 million. Once the data on the Hispanic population have been analyzed from the health interview survey and the health and nutrition examination survey programs referred to above, it will be possible to formulate more precise estimates, and to recommend the best procedures to use.

MR. OBEY

EXISTING NEW HEALTH DATA SYSTEMS

Mr. OBEY. Doctor, we have received your report—all 156 pages—on the existing new health data systems. Since this is a rather lengthy report—we will not insert it in the record—however, can you now summarize your findings—in terms of any duplication that may exist?

(*a*) How much do we spend, as a nation, in gathering health statistics?

(*b*) Having submitted your 156 page report to the committee, which lists quite an inventory of data gathering activities what specific steps are you and the Office of the Secretary taking to better coordinate the health data collecting efforts throughout HEW?

ANSWER. The report referred to, Health Statistics Plan, Fiscal Years 1978–1982, is a description of the Department's current health data systems and the anticipated new reporting systems planned for the next 2 years.

We are very much aware and concerned about the duplication that exists among current reporting systems and are attempting, through the Health Data Policy Committee, to resolve these and to avoid future overlaps. The 2-year action plan as outlined in chapter III is primarily focused on these problems and the procedures proposed to resolve them. The issues that will be addressed in the coming 2 years are:

The organizational locus of health statistics activities within the Department.

The mechanisms available for coordinating these activities to conform with a national health data policy.

The roles of the various agencies and offices of the Department with relation to general purpose and program specific health data.

The roles and relationships among various external advisory groups to the Department.

The roles, responsibilities, and relationships of various departmental programs to the cooperative health statistics system.

These activities will identify the duplications that exist, the data gaps that are apparent, and inconsistencies in health data policies and procedures. As it proceeds, the Health Data Policy Committee will make recommendations to the Assistant Secretary for Health to remedy the problems identified by this process.

We recognize that neither the Health Data Policy Committee nor the National Center for Health Statistics can resolve those issues that cut across Departmental programs or can determine the level of resources necessary to accomplish stated objectives within the Department.

The Office of Management and Budget estimates that the Federal Government will spend approximately $114 million for health statistics in fiscal year 1978. Based upon our experience in computing the Federal share of health data costs we believe that this figure represents only about 20 percent of the total national expenditures for health data. While no accurate estimates are available, our most informed guess would be that all Federal, State, and local governmental health statistics activities account for approximately $500 million each year. This does not include moneys spent by private industry which may very nearly equal governmental expenditures.

MINIMIZING THE REPORTING BURDEN

Mr. OBEY. Doctor, will the cooperative health statistics system result in minimizing the reporting burden on health care institutions and health professionals?

ANSWER. Yes: specific examples are available. Data on health manpower which is required by Public Law 93-641 and Public Law 94-484, are collected by the cooperative health statistics system (CHSS) for members of the nursing profession and the pharmacists. This information will be used by the National Center for Health Statistics (NCHS), and be made available to other Federal agencies, the American Nurses Association, health systems agencies, local jurisdictions, and other uses of health manpower statistics. In prior years the health professionals would have been asked to respond to questionnaires by local jurisdictions, national associations, NCHS and others for the same or similar information.

Health facility data has been requested for the Federal Government by NCHS, the Hill-Burton program, State licensing authorities, and others. As in the manpower example, the States supported by the CHSS transmit a data tape to the NCHS for its use and the use of other Federal agencies and then disseminates the same data to users at the State and local levels, thereby eliminating the need for multiple reports by the facilities.

In States being supported by the CHSS for the development of hospital care data activities, duplication of reporting by the hospitals to several Federal and State agencies has been eliminated. In some instances information collected from hospitals by abstracting services, is combined with information collected by the cooperative health statistics system from those hospitals not being serviced by the national abstracting service, thereby reducing the reporting burden on institutions for meeting Federal requests.

Mr. OBEY. Can you provide us with any evidence showing that in some areas of the country—the cooperative system has actually minimized the reporting burden?

ANSWER. In 20 or more of the States having operating cooperative health statistics system manpower systems, the basic information is being collected once and distributed to a wide variety of users who formerly generated questionnaires specific to their own requirements. The same situation applies to the health facility component of the cooperative health statistics system as well as those being supported in the hospital component. For example, Rhode Island and Wisconsin are collecting information from hospitals which they are then making available to the American Hospital Association (AHA), making it unnecessary for the individual hospitals to report on the questionnaire distributed by the AHA to collect the data.

REDUCING REPORTING COSTS

Mr. OBEY. What impact will the cooperative system have in reducing reporting costs?

ANSWER. It is difficult to estimate the actual dollar savings that will result from the system. The savings will, to a large extent, be in the reduction of duplicative collection and processing. In the past in many States data preparation and processing was done three times: by the local jurisdictions, by the State organization, and finally by the National Center for Health Statistics. In the States supported by the cooperative health statistics system this activity is now being accomplished at the State level only and the data is made available to the local and Federal partners on tape, which results in substantial savings in dollars, as well as manpower. A specific example is in New York State where the six largest counties, which together account for 40 percent of upstate New York's vital events, no longer process their own vital events but receive monthly data tapes from the State office. Missouri provides a similar service for both St. Louis City and County and is working on a similar agreement with Kansas City.

Similar economies are inherent in the manpower, facility, and hospital care components. A position paper produced by the Commission on Federal Paperwork estimates as follows:

"Federally funded, multiple, uncoordinated data collection activities create an ever increasing paperwork burden without maximizing State or national data use. Each year health manpower and health facility data activities alone cost the Federal Government more than $200,000 in each State. Florida, Illinois, and Wyoming estimate that under the CHSS system these Federal expenditures would be cut in half at a minimum. A more impressive measure of cost savings is in the area of hospital patient data. In the State of Illinois the same information is obtained from hospital patient records no less than four times—three times directly by Federal agencies. Using an estimated low figure of $3 per record for data collection, processing, tabulation and analysis of the 2.1 million annual discharges, multiple data activities in the State of Illinois cost the Federal Government more than $18 million each year."

CHSS IMPACT ON THE OVERALL COST OF REPORTING

Mr. OBEY. For the record, can you show the committee the impact this system has had to date on the overall cost of reporting.

ANSWER. It is extremely difficult to estimate the impact the cooperative health statistics system has had on the overall cost of reporting by health care providers in the Nation.

Most of the Federal information reporting requests are generated within the health financing claims processing, cost accounting, and systems directed at determining benefit eligibility rather than through a statistical system. There are inherent in each of these so-called "program statistical systems" duplication of data items required. We have demonstrated in several States (Missouri, Iowa, Maryland, and New Jersey) that the cooperative health statistics system hospital care component can collect, process, and distribute most of these data items one time and meet these multiple needs without burdening the institution with four or five reporting forms to complete. If these other Federal programs accept using these systems for their purposes, the system can continue to impact on reducing the overall cost of reporting from institutions. As indicated earlier, the Commission on Federal Paperwork estimates that a savings of $3 per record can be realized for each user that agrees to share a system rather than developing their own. This has been estimated at a total savings of approximately $200 million in the hospital care statistics area alone.

RESEARCH AUTHORIZED BY SECTION 222

Mr. OBEY. Section 222 of the Social Security Amendments of 1972 authorized the Secretary to conduct experiments and demonstrations in various methods of reimbursements to health care providers. What type of coordination exists between your center and the experiments authorized under section 222? Is there any joint planning or funding of such projects?

ANSWER. With regard to the research authorized by section 222, the National Center for Health Services Research, together with the Division of Long-Term Care in the Office of the Administrator, has taken the lead in conducting experi-

ments concerned with long-term care. The purpose of this research is to test the effectiveness and the cost-efficiency of providing benefits not currently covered by medicare and medicaid. We have been particularly concerned with developing and evaluating community alternatives to nursing home care.

Funding for the research costs of these projects is provided by the National Center. The Division of Direct Reimbursement in the Social Security Administration's Bureau of Health Insurance provides and bears the cost of the fiscal intermediary services. Reimbursement for the services themselves is provided, as permitted by the provisions of section 222, from the medicare trust funds.

The planning and management of these projects involves extensive collaboration with the Social Security Administration and the Medical Services Administration of the Social and Rehabilitation Service. In addition, a DHEW coordinating committee was established which also included representatives from the Office of Long-Term Care, the Office of the Assistant Secretary for Health, the National Institute of Mental Health, and the Health Services Administration.

HEALTH SERVICES RESEARCH CENTERS

Mr. OBEY. I believe the National Center for Health Services Research supports a number of special research centers. How many centers are there and specifically what kind of work are they doing? (*a*) Now, is the research conducted by the centers designed to address a particular problem in the health care industry? (*b*) Doctor, how much are you spending in support of the centers?

ANSWER. The Health Services Research Centers program is a major programmatic undertaking of the National Center for Health Services Research. The program currently provides support to five general health services research centers and two national special emphasis centers. In fiscal year 1977, the National Center has allocated a total of $3,500,000 to the support of the program. This figure represents about 14.5 percent of the National Center's total appropriation. Public Law 94–460, the HMO Amendments of 1976, calls for the establishment of a third special emphasis center to be known as the Health Services Policy Analysis Center. Subject to the availability of resources, it is anticipated that an award to support such a center will be made early in fiscal year 1978. It is estimated that the National Center will allocate approximately $650,000 per year for the support of this center, bringing the total annual cost of the program to approximately $4,200,000 in fiscal year 1978.

In February 1976 five institutions were awarded grants to support the establishment and operation of general health services research centers. These institutions and the level of first year funding are identified in the table below. In October 1976, grants to support the establishment and operation of two special emphasis centers dealing with management and technology were awarded to the University of Pennsylvania and the University of Missouri, respectively. Levels of funding for special emphasis centers are also displayed in the table.

HEALTH SERVICES RESEARCH CENTERS, BY TYPE AND LEVEL OF 1ST-YEAR FUNDING

	Direct costs	Indirect costs	Total award
Core centers:			
University of Michigan	$250,000	$106,408	$356,408
University of Washington	250,000	63,817	313,817
UCLA	250,000	84,498	334,498
Johns Hopkins University	250,000	120,000	370,000
University of North Carolina	250,000	84,709	334,709
Special emphasis centers: [1]			
University of Missouri (technology)	650,000	243,223	893,223
University of Pennsylvania (management)	650,000	324,054	974,054
Total	2,550,000	1,026,709	3,576,709

[1] A solicitation inviting proposals to establish a Health Services Policy Analysis Center will be issued in the spring of 1977.

University of Washington Health Services Research Center, Stephen M. Shortell, Ph.D., director

To date, center activities have focused on issues related to health manpower, planning and regulation, and public payments for health services. The center has

provided a policy analysis capability for the Washington State Legislature and consultative services for other state agencies in the region.

Johns Hopkins Health Services Research and Development Center, Sam Shapiro, B.S., director

The center at Johns Hopkins has undertaken research in a variety of settings (e.g., HMO's, ambulatory facilities of community and teaching hospitals, etc.) that focuses on issues related to the organization and delivery of primary health care services. The center is, for example, now engaged in studies to develop procedures for cost-effectiveness comparisons of ambulatory care provided by alternative manpower configurations.

University of Michigan Health Services Research Center, Beverly C. Payne, M.D., director

The initial emphasis of research activities is the study of organizational determinants of the quality and cost of professional health services. A major study of the impact of second surgical opinions is about to be initiated.

UCLA Health Services Research Center, Charles E. Lewis, M.D., director

The UCLA center is concerned with examining the impact of individual and aggregate consumer behavior and participation in the delivery of health care. The focus of their studies is the stimulation and development of consumer initiated approaches to make more effective and efficient use of health care resources.

University of North Carolina Health Services Research Center Gordon DeFriese, Ph.D., director

With the assistance of its advisory bodies, eight major areas have been identified as the targets of center attention. These include: health services utilization; new practitioners in primary care; supply and distribution of health care resources; quality assurance; impact of technology; health planning; and cost containment.

Health Care Technology Center, University of Missouri Donald A. B. Lindberg, M.D., director

The Health Care Technology Center plans to involve itself in studies dealing with various aspects of technology as they relate to health care delivery. Emphasis will be placed on studies of the role and utility of computers and information systems in the delivery of health care. Attention will also be given to examination of applications of technology as they relate to the support of the private practitioner, and to improving the quality of and access to health care in rural areas.

Health Care Management Center—University of Pennsylvania Samuel P. Martin, M.D., director

The initial focus of the Health Care Management Center is on developing programs oriented toward improving the management of resources within and among health care-related organizations. Efforts here will include research, training, and technical assistance activities.

HEALTH SERVICES RESEARCH TRAINING

Mr. OBEY. Now, Doctor, your budget has totally phased out training support for health services researchers. Now, as I understand it, the National Research Council in its report recommended continued support for health services research training. Is there currently a shortage of individuals in this area?

(*a*) What will be the impact of discontinuing the training support in this area?

(*b*) Do you have any data on how many people are needed and how many are being trained in health services research?

ANSWER. As Federal health care program proliferate and as more programs are proposed, issues such as access to health care, quality of care, and cost containment need increasingly to be addressed. Effective planning tools, reliable evaluation methods, ways of accurately monitoring the use and misuse of health care resources, and systems for measuring and maintaining the quality of services need to be improved or to be developed. While the demand for such research is evident, data on the supply of health services researchers are not available.

We do know that research in health care requires researchers from such fields as economics, sociology, statistics, and political science. From the Bureau of

Labor Statistics, data are available which indicate that economists, political scientists, and sociologists may face keen competition for jobs. Employment opportunities for statisticians appear more favorable. It is the administration's view that market forces, the keen demand for health researchers and limited opportunities elsewhere for such professionals, will attract an adequate number of professionals into the field of health research without expensive Federal training programs. The impact of discontinuing Federal training support, then, should be minor.

The National Research Council of the National Academy of Sciences is currently conducting a market survey of the health services research manpower pool and will have a report prepared by early summer 1977. The National Center for Health Services Research has supported between 600–700 health service research trainees since 1969 and these figures will be included in the report.

Prediction of future personnel requirements in the various disciplines making up the complex field of health services research is uncertain. The National Research Council's 1976 report "Personnel Needs and Training for Biomedical and Behavioral Research" includes an estimate that as many as 1,200 to 1,500 Ph.D. trained health services researchers may be required by the year 1980.

HEALTH PLANNING

Mr. OBEY. Doctor, will all 212 designated planning areas and the 50 States receive planning support under this budget?

ANSWER. Yes that is almost certain. Even today only six areas do not have designated local or State agencies performing planning functions.

Mr. OBEY. How many of the health systems agencies HSA's will be fully designated in 1978?

ANSWER. By the end of fiscal year 1978 I expect most of the HSA's will be fully designated. By then, each of the first 199 designated agencies will have either achieved full designation or will have been terminated under a requirement in the law. We expect most will pass the test.

Mr. OBEY. Now, full designation requires greater responsibilities, such as review and approval of applications for Federal funds. How have you satisfied yourself that the HSA's can actually perform these additional functions?

ANSWER. There are at least two aspects to the answer. One, we are developing a thorough review and evaluation system, involving both onsite inspections and quarterly reports, which will assess the agencies' performance and potential against a set of performance standards and program requirements and, two, we will be carefully reviewing the health systems plans and annual implementation plans for their utility in guiding HSA decisions in all of their project review activities.

Mr. OBEY. How do you intend to monitor and evaluate the performance of all 212 health systems agencies?

ANSWER. Let me elaborate on the previous answer. Recently we issued performance standards to guide the work of the health systems agencies. We are going to review the performance of all of them before they achieve full designation, on the basis of the law and the standards. A full review also is required each 3 years by the statute.

In our reviews we are going to begin with a self-review by the agency itself, followed by regional office assessment. Then we will emphasize corrective action by the agency, with the help of the regional office and the appropriate center for health planning, to correct deficiencies.

To summarize, we believe—very strongly—that it is our responsibility to monitor and evaluate HSA performance, and to provide assistance to agencies so they will become more effective, and we are hard at work at this task.

Mr. OBEY. Doctor, how much per capita will each health systems agency receive in 1978?

ANSWER. The request would provide for the 174 agencies above the minimum population of 450,000 to receive about $0.40 per capita. The 38 agencies that receive the minimum grant of $175,000 would be at about $0.63 per capita.

Mr. OBEY. The planning law provides for additional matching funds to be awarded to HSA's for locally generated funds. What dollar level of matching awards do you anticipate making to the HSA's in 1978.

ANSWER. It is too early to make a particularly reliable estimate, but in fiscal 1976 the agencies raised about $5 million in local contributions. This year we expect them to raise about $8 million and around $10 million in 1978. If we are

correct, the present budget request would allow us to match about $8 million of that in 1978.

Mr. OBEY. For the record, list the amount of local contributions received by the HSA's in 1977 and the anticipated level for 1978.

ANSWER. We do not have those figures yet. The reporting for this will not be complete until September of this year. I will, however, provide you with a State-by-State listing of local contributions received by the HSA's in 1976.

[The information follows:]

Fiscal year 1976 local contributions received by the HSA's

Region I:	
Connecticut	$145,040
Maine	34,050
Massachusetts	115,124
Rhode Island	50,000
Region II:	
New Jersey	248,990
New York	486,344
Region III:	
Maryland	342,867
Pennsylvania	310,004
Virginia	228,851
West Virginia	3,000
Region IV:	
Alabama	24,845
Florida	334,125
North Carolina	189,762
South Carolina	58,333
Tennessee	47,005
Region V:	
Illinois	132,880
Indiana	163,556
Michigan	425,561
Ohio	537,706
Wisconsin	132,218
Region VI	
Region VII:	
Iowa	95,000
Kansas	20,989
Missouri	18,734
Nebraska	62,147
Region VIII	
Region IX:	
Arizona	170,727
California	269,482
Hawaii	191,936
Region X:	
Oregon	36,505
Washington	43,500
Total all States	4,919,281

CENTERS FOR HEALTH PLANNING

Mr. OBEY. Now, you are requesting funds for 10 Centers for Health Planning. What have been the accomplishments of these Centers so far?

ANSWER. Each of the 10 Centers provide training, consultation, and other technical assistance to health systems agencies, State Health Planning and Development Agencies, and Statewide Health Coordinating Councils. Their major aims are to assure that the governing bodies of HSA's have a good understanding of how the health care industry works, what the major problems are, and so forth; and to provide technical assistance to planning agency staff to assure that they have access to the best available planning techniques.

In their short period of existence and with their client agencies only recently organized and developed to carry out the mandates of Public Law 93-641, the

Centers have convened numerous sessions with the agencies to cover the essential elements in developing Health Systems Plans, State Medical Facility Plans, the procedures and processes in reviewing proposals for the development of new health care resources, and methods of increasing community participation in the health planning process. Other Center activities include the review of draft State certificate of need laws, the conduct of training sessions on the selection and analysis of health status indicators used in the planning process, and assisting State and areawide agencies in the development of cost containment strategies.

Additionally, the Centers have been instrumental in convening sessions that permit diversified interchange between agencies that foster increased communication and understanding of Public Law 93-641. The decentralized nature of the Centers' operations has proved to be of great value in responding to the needs of agencies that exist in the different Federal regions. The experience of the Centers is also of great value in helping the Bureau's central office target its methods development activities on products that will be of the most use to the State and local planning agencies.

PLANNING METHODS DEVELOPMENT

Mr. OBEY. You are also requesting $2,100,000 for planning methods development. How much have you spent in the last 2 years in this area?

ANSWER. In fiscal year 1976, which was the first full year of this program, $3,100,000 was spent for planning methods development and in fiscal year 1977 about $5,900,000 will be expended. The wide disparity in spending for these 2 years results from the fact that 4 of the 10 Centers for Health Planning were funded from Fiscal Year 1976 funds, while none of them will have to be funded in fiscal year 1977, thus freeing up a larger amount of funds that can be spent for planning methods development in this year. As you can see, the amount for planning methods development drops again in fiscal year 1978. This is due to the fact that the contracts for all 10 Centers for Health Planning will have to be renewed.

Mr. OBEY. On what kinds of activities will you spend the $2,100,000 in 1978?

ANSWER. These funds will be used primarily to support two principal needs. First, there is a major need in the area of health planning development to improve the methodology and expand the scope of the collection of health statistics needed by the planning agencies as a basis for developing their Health Systems Plans and Annual Implementation Plans. Secondly, there is a need for special projects aimed at providing to the HSA's and State health planning agencies technical assistance materials of various types. These projects would include such things as developing approaches and criteria to be used by planning agencies in assessing the adequacy, appropriateness, costs, quality and other factors involved in the review of capital expenditure projects; developing economic analysis methodology applicable to various problems of planning, review, and plan implementation faced by the planning agencies; and developing financial, physical, and other requirements that must be considered in planning and reviewing projects for health resources development.

FACILITIES CONSTRUCTION

Mr. OBEY. Doctor, how much of the funds appropriated to date for medical facilities construction has been obligated?

ANSWER. Of the $51.7 million appropriated in 1976, none yet has been obligated. However, we are in the process of reviewing about 136 applications for project grants under section 1625 and we will be obligating the $11.4 million available for such projects in May of this year.

With respect to the formula grants, the $40.3 million appropriated in fiscal year 1976 cannot be obligated until there are State health plans—largely comprised of health systems plans now being developed by the health systems agencies—and State medical facilities plans, the criteria for which are now under development. In addition, there will have to be final regulations on construction standards, assurances, allotments, and application procedures, the last of which will not be published until late in fiscal year 1978. We will then begin to utilize the grant funds and the $250 million in loan authority already made available by previous congressional action.

Mr. OBEY. Will all of the States have their medical facilities plans developed and submitted to HEW in fiscal 1978?

ANSWER. The notice of proposed rulemaking on the State medical facilities plan is scheduled for publication this summer. This will allow enough time for us to issue final regulations and for the States to develop and submit their plans before the end of fiscal year 1978.

Mr. OBEY. Why are you not requesting medical facilities construction funds in this budget?

ANSWER. Evidence of overbidding is one of the primary reasons that medical facilities construction funds have not been requested in this budget. Also, the entire facility financing arena is undergoing a policy reexamination to determine the directions in which construction funds should be channeled. It is prudent to wait to put funds into construction activities until these new directions become clear.

MR. STOKES

SUPPLY OF DOCTORS AND DENTISTS

Mr. STOKES. Dr. Margulies, you indicated on page 1 of your written testimony that, "In the past 10 years we have increased the number of medical and dental graduates and the Nation's supply of active nurses has reached 961,000." Dr. Margulies, how many doctors and dentists are there in the United States?

ANSWER. At the end of 1975, there were an estimated 375,000 active physicians (M.D.'s and D.O.'s) and 112,000 active dentists in the United States.

RATIO OF DOCTORS TO POPULATION

Mr. STOKES. What is the ratio of doctors to the general population?

ANSWER. The ratio of physicians to general population is approximately 176 physicians per 100,000 population, or 1 physician for every 569 persons.

Mr. STOKES. Do you consider this an adequate ratio?

ANSWER. Overall, this could be considered an adequate population ratio for the aggregate number of physicians, although this average, like any average tends to conceal wide differences within the averages. Among other things, the U.S. average for all physicians is inadequate to measure either the medical specialty and primary care manpower situation or the situation in particular geographic areas. For example, the U.S. average includes a smaller portion of primary care physicians than is usually considered adequate, and covers ratios in geographic areas, ranging from 80 physicians per 100,000 in non-metropolitan areas, to 185 per 100,000 in metro areas.

Mr. STOKES. If not, what would the adequate ratio be?

ANSWER. There is no single U.S. ratio of physicians to population that would be generally accepted as representing an adequate ratio in all circumstances, since each geographic or health service area in the Nation would require a different ratio. The precise ratio would depend on such factors as size, age, sex, and health status of the population and their health insurance coverage and specialty distribution, productivity, and practice characteristics of an area's physicians, all of which vary from area to area. Although a substantial amount of work is going on within HRA that is aimed at addressing different aspects of adequacy, it is likely that no single number of ratio will ever be developed that could be agreed upon or could cover all situations.

RATIO OF MINORITY PHYSICIANS AND DENTISTS TO MINORITY POPULATION

Mr. STOKES. Dr. Margulies, what is the ratio of minority physicians and dentists to the minority population in the United States?

ANSWER. In 1970, the latest year for which comprehensive and detailed information on minority practitioners is available, there were approximately 19,400 minority physicians and 3,700 minority dentists in the United States. In this case, minorities include total races other than white, i.e., American Indians, Japanese, Chinese, etc. The ratio of minority practitioners to minority population was 77 per 100,000 for physicians and 15 per 100,000 for dentists.

Mr. STOKES. Do you consider this an adequate ratio? If not, what would be an adequate ratio?

ANSWER. It is clear that the number of minority physicians and dentists is less than proportional to the total numbers of these minorities in the population. However, as with adequacy ratios for physicians and dentists in general, there are no commonly accepted ratios for minority health manpower. In addition,

the major minority issues in health manpower in reality are tied more to making certain that minorities have an equal opportunity to enter the health professions and that the minority population has equal access to quality health care, no matter who provides it.

MINORITIES IN NURSING PROFESSION

Mr. STOKES. Dr. Margulies, how many (what percentage) of the 961,000 active nurses are black/minorities?

ANSWER. Our best estimate is that about 1 in 10 active registered nurses are minorities, and about 1 in 12 are black. These estimates draw heavily on the figures cited in the 1970 Decennial Census.

NUMBERS OF HEALTH PROFESSIONALS

Mr. STOKES. Dr. Margulies, do you still claim that "sheer numbers are no longer the major problem * * * ?"

ANSWER. Sheer numbers of physicians are indeed no longer the problem. Not only have recent increases in the number of health professionals outpaced population growth by a substantial margin, but a significantly expanded educational pipeline is now in place and operating near capacity, so that the aggregate supply of health professionals will continue to rise substantially over the next decade. We see our major manpower concerns, currently and in the year ahead, as providing adequately trained manpower to resolve geographic and specialty maldistribution problems and as the unavailability of primary care.

MINORITY PHYSICIAN SHORTAGES

Mr. STOKES. Dr. Margulies, on page 3, you further indicate that you plan to examine the problem of "physician specialty maldistribution." Dr. Margulies, a study being prepared by the National Center for Health Statistics reveals that 9 out of 10 visits to black doctors are by black patients while 1 out of 10 visits to a white doctor's office are made by black people. Dr. Margulies, don't these findings suggest to you that the problem is one of severe minority shortages as opposed to mere "maldistribution?"

ANSWER. Although these figures may be interpreted as reflecting a shortage of minority practitioners, the major issue, when we discuss maldistribution, is not whether there are enough black doctors to service the black population, but whether the black population is receiving adequate medical and dental care. Of course, one of the major objectives of the Health Resources Administration has been and is to increase the number of minorities in the health professions and to provide improved opportunities for minorities to attend health professions schools.

PRIMARY CARE MANPOWER IN GEOGRAPHICALLY REMOTE AREAS

Mr. STOKES. Dr. Margulies, on page 1 you claim that you "* * * shall support more than 3,000 such residencies and training for 200 dental students and faculty to deliver a range of services in geographically remote areas." Dr. Margulies, name with specificity these "geographically remote areas."

ANSWER. The two programs training residents and faculty to which this statement refers are national competing awards subjected to review and prioritizing. Therefore, we can not predict what geographically remote areas might be served by projects under these family medicine/general dentistry and general internal medicine/general pediatrics residencies and training programs. Studies do suggest that a number of these primary care graduates do locate in nonmetropolitan areas.

MINORITIES IN PRIMARY CARE PROGRAMS

Mr. STOKES. Of the inner city areas mentioned, how many of the 3,000 residencies and 200 dental students and faculty will be minority, black?

ANSWER. As previously indicated, these programs training residents and faculty operate through national competing awards. Therefore, we can not predict what segments of the general population will be participating in those projects which ultimately receive funding.

MINORITIES IN NEW PRACTITIONER PROGRAMS

Mr. STOKES. Dr. Margulies, on page 2 of your testimony, you have indicated that you "* * * are requesting funds to help finance programs to train 590 nurse practitioners, 2,700 physician assistants and 1,200 dental extenders." How many of these 590 nurse practitioners, 2,700 physician assistants and 1,200 dental extenders will be black/minorities?

ANSWER. These programs are also operated through national competing awards. Therefore, we can not predict what segments of the population will be participating in funded projects.

AREA HEALTH EDUCATION CENTERS LOCATIONS

Mr. STOKES. Dr. Margulies, in which 18 States will the 16 area health education centers that you have mentioned be located?

ANSWER. The 11 area health education centers presently being funded are located in California, Illinois, Massachusetts, Minnesota, New Mexico, North Carolina, North Dakota, South Carolina, Texas, and West Virginia. It is not possible at this time to predict the locations of the additional AHECS since they are competitive contracts yet to be awarded.

DISADVANTAGED ASSISTANCE

Mr STOKES. Dr. Margulies, on page 2 you state that you will provide grant support to 100 programs which will reach 9,000 disadvantaged young people. Dr. Margulies, provide me with specific examples of these 100 programs and what are you requesting as the average level of funding for each program?

ANSWER. The average grant amount is $190,000, while the average contract award is $90,000. Some typical projects are the Harvard Summer School project, the Chinatown Action for Progress project, the academic reinforcement project at Mississippi Valley State University, and a project with the Cherokee Nation of Oklahoma. Participants in the Harvard Summer School project include Black Americans, Spanish-heritage Americans, American Indians, Asian Americans, educationally disadvantaged whites, and women. The project is an admissions and retention effort in which participants take competitive pre-medical courses, receive tutoring and counseling, and share a clinical experience. The Chinatown Health Clinic operates a program for undergraduate Asian Americans providing lectures, seminars, tutoring, counseling and experience in a health facility. The project aims to identify, recruit, motivate, and give admission assistance to Asian Americans interested in pursuing health careers. A similar program linked to the University of California is operated for Spanish-heritage students by the Federación Rural de Salud de California. The academic reinforcement project at Mississippi Valley State University provides to Black Americans curriculum to motivate undergraduate students to enter health careers as well as academic assistance in basic sciences. The Cherokee Nation of Oklahoma project includes a summer program for high school seniors and college undergraduates and tutoring and counseling services.

SCHOLARSHIPS FOR FIRST YEAR EXCEPTIONALLY NEEDY STUDENTS

Mr. STOKES. Dr. Margulies, on page 2 you indicate that you "* * * will find two programs of scholarship support for 500 disadvantaged students in the health professions." Of the $16 million authorized, you have requested but $5 million to provide financial assistance for these 500 disadvantaged students. Dr. Margulies, considering the fact that 67 percent of the families of minority students earn $10,000 a year and 20 percent make $5,000 or less a year, why is such a small amount being requested?

ANSWER. Since this scholarship program for the first-year exceptionally needy is newly authorized in 1978, we felt to request the full authorization amount might not be wise. Some time and experience may be necessary to develop an effective program. Given this consideration and general fiscal constraints, we believe the $5,000,000 request is a reasonable one. The Office of Education guaranteed loan program, the new health professions federally insured loan program, and the National Health Service Corps scholarship program will also serve as sources of financial assistance for those in financial need.

SPECIAL HEALTH CAREER OPPORTUNITY GRANTS

Mr. STOKES. Dr. Margulies, how much have you spent on the Special Health Career Opportunity Grants Program since 1972?

ANSWER. From 1972 through the transition quarter, 1976, $31,641,000 had been obligated for "Special health career opportunity grants program."

Mr. STOKES. How much in new funds are you requesting in fiscal year 1977? If not, why are you requesting no new funds?

ANSWER. For fiscal year 1977, we requested $8 million as we have also done for fiscal year 1978.

Mr. STOKES. Dr. Margulies, you state on page 7 that, "Several projects are evaluating the impact of national economic conditions on the health of the disadvantaged." Dr. Margulies, name these projects and provide me with some insight into the methodolgy to be utilized?

ASWER. There are eight contracts being supported by the National Center for Health Services Research which are evaluating the impact of national economic conditions on health care of the poor. They are:

"Impact of National Economic Conditions on Health Care of the Poor—Public Finance." This contract analyzes trends in Medicaid eligibility participation rates and expenditures, and evaluates recent changes in State fiscal positions and related changes in Medicaid and non-Medicaid outlays. Aside from developing a model to assess the relative changes in eligibility participation rates under Medicaid, the study will be classifying States by degree of financial strain (ranked according to changes in personal income, per capita outlays, unemployment and tax revenues) in order to analyze the differential response to economic conditions which State and local governments have made with respect to the financing of health care programs.

"Impact of National Economic Conditions on Health Care of the Poor—Insurance Coverage." This contract research effort will determine the aggregate impact of unemployment on loss of health insurance coverage. Information from the April 1972 Survey of Pension Plans and Health Insurance and the Annual Data File, along with the 1971 Survey of Health Care Expenditures and Health Insurance, will be used to develop estimates of the coverage of both employed and that portion of the employed population who, because of selected characteristics, are at risk in terms of job loss. A survey will be mounted to interview unemployed individuals in order to assess their present health insurance coverage. The difference in insurance coverage for the at risk employed and coverage for those actually unemployed will provide a measure of the impact of unemployment on health insurance coverage.

"Impact of National Economic Conditions on Health Care of the Poor—Insurance Coverage." This study will analyze the nature and extent of impact which an accelerated rate of unemployment has on the health insurance coverage of the U.S. labor force. It will complement a coterminous study (see above, "Insurance Coverage") by focusing more on the institutional characteristics of health insurance coverage and on the blue collar worker. The study will review a number of the plans of the International Foundation of Employee Benefit Plans in order to highlight differences in available health insurance packages. These will include the various options available in terms of extension of benefits after layoff, self-pay provisions and portability. Approximately 1,500 enrollees or former enrollees under these plans will be interviewed in order to assess their response to layoff with respect to health insurance coverage. Early stages of this contract research indicate that at least in the construction industry, insurance eligibility rules, self-pay options, and the use of an "hours bank" may, in many cases, provide more than 30 days coverage after layoff.

"Impact of National Economic Conditions on Health Care of the Poor—Facility Use." This research will investigate the effect of adverse economic conditions and the implacations for ability to pay on the use of publicly owned health care facilities compared to that of voluntary and proprietary facilities. Observed changes in the utilization of such facilities will be subject to a multivariate analysis (at a disaggregated level) and the relative implications for possible policy intervention will be outlined. The data will be from the American Hospital Association and will cover the periods of 1966 through 1974. Both time series and cross sectional analyses will be made relating hospital utilization to various socio-economic characteristics by SMSA, institutional characteristics (such as beds per capita, and physicians per capita), and inflation and unemployment rates.

"Impact of National Economic Conditions on Health Care of the Poor—Health Status." The study will be a comparative analysis of information on incidence of acute and chronic conditions and other health status related measures for periods of relative economic stability and for similar information recorded during more recent periods of economic instability. The study will take into account differences in population characteristics, such as family income, employment status, occupation, age, location, race, sources of health care payment, and the degree and duration of poverty. The basic data will be derived from an unmet needs study which interviewed 3,893 low- and moderate-income people in the Nashville area during 1972. Similar information will be secured for 1976. In addition, the available health interview survey will be analyzed to capture health status measures such as the limits of activity and limits of mobility.

"Impact of National Economic Conditions on Health Care of the Poor—Utilization." This study will analyze the direction and extent of change in hospital outpatient clinic use and "nonemergency" use of emergency rooms by income class and other population variables, in relatively high and low unemployment areas. It involves a two-stage approach. First, an aggregate analysis will be done comparing total outpatient visits over time and unemployment levels in 147 major labor areas as defined by the Department of Labor. A second component of the study will be a survey of approximately 1,380 hospitals and extension of the national community hospital ambulatory care survey originally prepared by Columbia. Questions will address the number and type of visits, visit characteristics (socio-demographic variables plus the relative of urgency of each visit), fiscal characteristics (in terms of the charges and sources of payment within the hospital setting) and, finally, the organization and delivery of care characteristics (i.e., the survey will attempt to denote any observable changes in clinic organization, staffing, hours, etc. in response to perverse economic conditions).

"Impact of National Economic Conditions on Health Care of the Poor—Access." The study will document and evaluate changes in access to primary care in terms of changes in patient wait at site of visit, delay in receiving appointments, patient's choice of provider, and the relationship between travel time and waiting time cost to out-of-pocket prices for physician services. It will be based upon a survey which piggybacks on the Michigan omnibus survey and will deal with approximately 1,500 adults selected on a national probability basis.

"Impact of National Economic Conditions on Health Care of the Poor—Provider Rationing." The study will look at the differential hospital experience of various socioeconomic groups during a period of adverse economic conditions. An analysis of hospital admissions by selected socioeconomic characteristics of the patient mix, diagnostic mix, and source of payment will be done in order to partially assess the possibility of increased rationing of admissions in terms of patient ability to pay. The data will be over a period of 1972 to 1974, using patients from acute care voluntary hospitals in Rhode Island and accounting for approximately 95 percent of all hospital admissions in Rhode Island. It will look at the frequency and distribution of discharges, patient days and length of stay, arrayed by age and payment modes, primary and secondary diagnosis, and socioeconomic characteristics.

RESEARCH PROJECTS IN AREA OF LONG-TERM CARE

Mr. STOKES. Also, what specific research projects are being funded "* * * to find better ways of delivering long-term care to the population over 65 * * *?"

ANSWER. Let me give you an idea of what we have done in the past, what research we are supporting now, and the kinds of problems that we hope to explore in the future.

The National Center is currently sponsoring several projects to evaluate evaluation and placement services for aged and chronically ill patients that give more careful consideration to the possibility of maintaining a person in the community rather than putting him or her in a nursing home. "Project Triage" is providing a central entry and referral system for people over 65 in central Connecticut who need long-term care services. The evaluation has been designed to test both the efficiency, in terms of cost, and the effectiveness of providing a comprehensive, coordinated package of health and social services that is carefully tailored to the needs of the particular patient. Another evaluation-place-

ment service, developed at the University of Rochester, has already been shown to be effective in increasing the rate of appropriate placements both in institutions and at home with supportive services.

The predominance of nursing homes as suppliers of long-term care in this country stems largely from the structure of existing long-term care financing mechanisms. Their position is not a function of proven superiority in clinical efficacy, efficiency, or attractiveness. The National Center has therefore devoted substantial resources to the exploration of strategies for noninstitutional long-term care programs. Particular emphasis has been given to home care not only because it represents a potentially useful alternative to institutionalization, but also because home health services after hospitalization may have substantial rehabilitative impact in some types of cases.

This contention is supported partially by the findings of one carefully controlled study which examined the effect of visiting nurse services on patient functioning and health services utilization among elderly patients discharged from a rehabilitation hospital. The study revealed that continued nursing had statistically significant beneficial effects on physical or mental functioning for patients with certain specific conditions.

Another important form of home care is general homemaker/home aide services. One study found that intensive daily assistance by home aides seemed to be an acceptable alternative to institutionalization for all clients other than stroke patients. The service was associated with significantly reduced institutionalization for study patients who had a friend or family member in the household capable of providing evening or overnight care.

The National Center is continuing to study the effectiveness of diverse long-term care strategies particularly as alternatives to institutionalization. One important set of current projects are a set of service demonstrations and an evaluation of homemaker, adult day care, and day hospital services for medicare and medicaid beneficiaries. These studies were mandated by section 222 of Public Law 93–603. They involve the cooperation of the Social Security Administration in reimbursing providers for the experimental benefits and processing related claims. The National Center is also conducting experiments in the use of home alarm systems and medically oriented housing as substitutes to institutionalization for elderly and disabled persons who do not require intensive levels of care.

In the area of planning, the National Center intends to encourage the development of a conceptual framework for assessing long-term care problems and the adequacy of existing services. Such a framework is critical to the improvement of planning capabilities in long-term care, particularly since multiple human service delivery systems are involved. The National Center will also support research to examine consumer preferences and other factors affecting demand for a variety of long-term care programs. To improve our ability to allocate scarce resources effectively, researchers will be encouraged to identify realistic health and social objectives of long-term care for people with various chronic health conditions, to study the mix of services required to efficiently meet these objectives and to evaluate the social acceptability of innovative service options. Finally, studies regarding the effects of current Government policies on the nature and supply of long-term care programs and historical analyses of the roles of Government, the health sector, families and communities in providing long-term care are also viewed by the National Center as priority research needs.

In relation to health insurance, further studies are needed that will examine the access problems, demand distortions and inefficiencies associated with the current structure of medicare and medicaid. A more fundamental issue is the question of whether insurance and assistance schemes keyed to acute medical care needs are consistent with the health and social requirements for long-term care in this society. Another major concern currently is the problem of how to structure catastrophic health insurance in a noninflationary manner. To prepare for the possibility that disease-specific cost controls may be required, the National Center will encourage systematic analyses of the health service and family costs associated with chronic health conditions known to frequently entail devastating personal expenditures.

The unique characteristics of long-term care pose some special challenges in quality assurance. From a medical perspective, quality assessment tools are needed that will take into account the limited patient outcome goals and complex treatment processes characteristic of much long-term care. From a broader perspective the National Center has also identified the need to develop quality assessment techniques and quality assurance mechanisms which bring a com-

munity perspective to issues of the adequacy of services and cooperative arrangements among programs and providers of the nursing, social, and custodial service components of long-term care. In this regard, one important element of the quality assurance mechanism is a community-based monitoring system for patient evaluation. In addition, special investigations are warranted in the area of long-term care to address the problems of continuity of care, protection of individual dignity in the care process, and prevention of social isolation for people whose activities are restricted.

SOLAR ENERGY

Mr. CONTE. Would you tell me more about your solar energy demonstration project for health facilities? How much are you devoting to that project? Where is it going to be?

ANSWER. The solar demonstration program is a Health Resources Administration-Energy Research and Development Administration joint effort under a 4-year agreement established in September 1976. The program plans to fund solar demonstration projects in 5 separate types of health facilities in each of the 12 climatic zones established by ERDA (ERDA/GE phase "O" study). The facility types are large and small hospitals, long-term care facilities, health clinics, and hospital laundries. Laundries are selected as a separate category as they are high consumers of hot water (applicable to solar energy) and other energy sources. These projects will be established in all areas of the United States and will study the economic feasibility for the use of solar energy to heat water and for heating and cooling of space for the delivery of health care. In the event that the results of these demonstration activities show that solar energy is economically feasible for health institutions, efforts will be made to promote a transition from a total dependence on conventional energy sources to at least a partial dependence on solar.

ERDA has agreed to provide the funding for this effort—approximately $1,500,000 for the first year with about $500,000 earmarked for Public Health Service and Indian Health Service facilities. In the private sector the remaining $1 million will be used to fund from six to eight demonstration projects the first year. Each project is required to be established on a cost-share basis with the health facility contributing a minimum of 25 percent of the total project cost. Maximum Federal funding for a single project is $300,000 for the first year. It is anticipated that funding for fiscal year 1978 will be approximately $2,500,000.

Mr. CONTE. Would you tell me what some of the projects of the National Center for Health Services Research have been over the past year?

ANSWER. The following projects are illustrative of the types of research supported by the National Center for Health Services Research over the past year.

"Evaluation of the Implementation of a Medical Information System in a General Community Hospital." The National Center has assisted in the development and has undertaken an evaluation of an automated technicon medical information system (MIS) at the El Camino Hospital in Mountain View, Calif. The system has permitted the nursing staff to reduce the amount of time spent on clerical tasks, helped to improve communications among nurses and with ancillary departments, and facilitated better planning of patient care. In some areas (direct patient care), MIS has reduced or contained staff levels at a time when hospital growth has increased administrative burdens. The evaluation strongly suggests that this type of information system in a community hospital might reduce the cost per patient day by as much as $5. Were such a system available in all hospitals, the net savings would amount to $1 billion annually.

"Determinants of Hospital Wage Inflation." The purpose of this research is to further understand the determinants of change in the size and composition of the hospital labor force, and the growth in wage rates paid to hospital employees. With this information, the effects of alternative public policies (as well as the effects of factors beyond the control of Government) on the three labor market variables can be predicted. The principal policies of interest relate to third-party reimbursement and direct and indirect regulation of hospitals, including prospective budgeting and wage-price controls.

"Impact and Diffusion of a Technological Innovation for Health Care—A Study of Automated EKG Systems." Within the past four years automated EKG systems have grown from an instrument for research to an acceptable clinical procedure accounting for approximately ten percent of the over 40,000,000 EKGs

processed annually. The purpose of this project is to: (1) gain a better understanding of the forces that effected the diffusion of this technological innovation; (2) determine the socio-economic benefits as observed by health care providers who have adopted automated systems; (3) provide an assessment of the impact such system would have on the accessibility, costs, and manpower requirements given various rates (speed) of adoption; and (4) develop guidelines applicable to technical assistance or adoption incentive programs for consideration by the National Center for Health Services Research.

"Provider Response and Cost of Dentistry for the Elderly." This project is designed to estimate the cost of providing dental care for the elderly on the basis of an evaluation of their oral health needs. The results of a clinical examination of a sample of elderly people will be provided to a group of dentists for the formulation of appropriate treatment plans. The cost of treatment will be estimated under various types of insurance coverage, and the results will be projected to the population sampled. In this way, the cost implications of expanding current Government programs to include dental benefits for the elderly can be assessed.

The legislation which established the National Center for Health Services Research also directed that 25 percent of its annual appropriation be used for intramural research. In fiscal year 1977, this amounted to $6 million and 38 positions. One of the three major initiatives developed by the intramural research staff during the past year is a large-scale analysis of health care expenditures. A survey of medical expenditures was initiated in cooperation with the National Center for Health Statistics during fiscal year 1977. This national panel survey of some 10,000 households will provide a data base for several sets of analyses. Of particular importance are the analyses designed to inform the policy debates on national health insurance.

The health expenditures survey will provide extensive data on the utilization of various kinds of health services by people with specified economic and demographic characteristics who are facing known and specified health systems. With this data, it will be possible to calculate "who" defined in terms of income, family size, age and sex of family head, region of country, and so forth, is receiving various dollar values of health services. It will also be possible to estimate the factors which influence how many health services people with various characteristics are likely to utilize. This information can then be used to simulate the costs and particularly the distributional effects of various kinds of national health insurance programs, as well as the effects of other major policy changes such as changes in the tax treatment of medical expenditures. With the use of a detailed model, it will be possible to estimate the dollar value of medical services which will be received by various groups under alternative financial arrangements (such as the usage of coinsurance, deductibles, various kinds of taxes, and so forth). The survey has been developed to facilitate specific research studies. These studies will be initiated in fiscal year 1978 or sooner, depending on when the data become available.

Mr. CONTE. What are you doing to reduce the time it takes to get research discoveries into widespread practice?

ANSWER. In the past, the National Center depended on what might be called the traditional dissemination mechanisms employed by the research field to inform others of research activities and findings. We have regarded this approach as an ineffective means of keeping a diverse audience of users aware of information that might be critical to their activities. The National Center, has, therefore, initiated a series of publications to provide rapid and wide dissemination of the results of research programs. Executive summaries which are brief and written in nontechnical language are now required for every grant and contract supported by the National Center. These summaries are reproduced and mailed to groups that have been identified as potential users of information. The National Center has recently published and will publish on a regular basis summaries of recent studies in health services research. These summaries are one page in length and identify the principal findings of each project as well as journal articles that resulted from the project.

A series of publications, called "research digests," consists of separate reports that bring essential findings and applications to the attention of the public. These reports are somewhat more detailed than an executive summary but are written in nontechnical language. All final reports are now sent to the National Technical Information Service and can be obtained by those individuals who wish to

have the complete and often lengthy investigator's description of a project. Finally, the National Center is producing syntheses of the research literature on issues of immediate relevance. A recent example is the discussion paper entitled "Controlling the Cost of Health Care," which attempts to frame the research results in a manner that is useful to those in the policy arena who are asking questions dealing with such issues.

Mr. CONTE. What is the purpose of your Health Services Policy Analysis Center? What will be done there? Where will it be? With what level of financial support?

ANSWER. The Health Maintenance Organization Amendments of 1976 (Public Law 94–640) amends the authorities of the National Center for Health Services Research to require support for a Health Services Policy Analysis Center. This new special emphasis center will focus on the development and evaluation of national policies relating to health services, including the development of health maintenance organizations and other forms of group practice, with a view toward improving the efficiency of the health services delivery system. A solicitation for proposals was issued by the National Center for Health Services Research in February 1977. Grant applications have been invited from established academic and other nonprofit institutions. The Health Services Policy Analysis Center will receive up to $400,000 in direct costs for a 5-year period. It is anticipated that at least one award will be made on or about October 1, 1977.

Mr. CONTE. This year you are proposing no grants or funding for EMS research. Would you explain why not?

ANSWER. The research program authorized by section 1205 of the Emergency Medical Services System Act of 1976 (Public Law 94–573) is being administered by the National Center for Health Services Research. Through coordination with the designated lead agency, research continues to focus on the development and testing of methods to evaluate the effectiveness and efficiency of EMS systems, and the dissemination and utilization of the findings of these research efforts.

Five of the research projects now underway will require funding for at least 1 additional year to produce valid final results which can be accepted and used by EMS system managers and evalutors. The National Center for Health Services Research is requesting $976,000 in the 1978 budget to meet the estimated continuation commitments for these research projects.

The following questions were submitted by members of the subcommittee with the request that they be answered for the record.

JUSTIFICATION OF THE BUDGET ESTIMATES

Appropriation Estimate

Health Resources

For carrying out [, to the extent otherwise provided,] 1/ titles III, *VII* 2/, VIII and XV [and section 472] 3/ of the Public Health Service Act, section 1122 of the Social Security Act and section 222 of the Social Security Amendments of 1972, [$359,008,000] *$544,619,000* of which [$9,000,000] *$2,000,000* shall remain available until expended for [carrying out section 305 (b) (3) of the Public Health Service Act, without regard to the requirements of section 308 of said Act] 4/ *loan guarantees and interest subsidies under part B of title VII.* 5/ *(Departments of Labor and Health, Education, and Welfare Appropriation Act 1977: additional authorizing legislation to be proposed for $161,087,000.)*

Explanation of Language Changes

1/ This language is superfluous and therefore should be deleted.

2/ Title VII has been added to include programs under the recently passed Health Professions Educational Assistance Act of 1976.

3/ Reference to section 472 of the Nursing Research Training and Fellowship awards has been deleted because funds are not requested in 1978 for these activities.

4/ Language has been deleted because no funds are requested for this activity in 1978.

5/ Language has been added to include authority to fund Health Professions Construction Interest Subsidies program, with extended availability requested.

Analysis of Appropriation Language

Language Provision	Explanation
"...of which $2,000,000 shall be available for loan guarantees and interest subsidies under part B of title VII and shall remain available until expended..."	This provision changes the basic law for Health Professions Construction Interest Subsidies program by extending the availability of funds without fiscal year limitation. The construction cycle takes from two to three years to completion. Certain requirements, such as matching funds by States through their legislature, and environmental impact statements involve long lead time. Funds during this time must remain available to insure our commitment to these institutions.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Amounts Available for Obligation 1/

	1977	1978
Appropriation	$359,008,000	$544,619,000
Proposed supplemental	304,970,000	---
Subtotal, appropriations	663,978,000	544,619,000
Comparative transfer to:		
"Office of the Assistant Secretary for Health" for one position in the Regional Office	-50,000	---
Subtotal, budget authority	663,928,000	544,619,000
Unobligated balance, start of year	85,748,219	9,224,599
Unobligated balance, end of year	-9,224,599	-9,224,599
Total, obligations	740,451,620	544,619,000

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1977 - $600,000 and 34 positions; 1978 - $1,100,000 and 34 positions.

Summary of Changes

1977 Estimated Obligations	$740,451,620
1978 Estimated Obligations	544,619,000
Net Change	-195,832,620

	1977 Base Pos.	1977 Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Annualization of positions new in 1977	70		---	+$750,000
2. Federal Employees Compensation cost increase	---		---	+12,000
3. Increase in payments to Working Capital Fund	---	$543,000	---	+166,000
4. Increase in payments to NIH Management Fund	---	702,000	---	+53,000
5. Increase of FTS, postage and telephone costs	---		---	+110,000
6. Increase of payments to Service and Supply Fund	---	945,000	---	+170,000
7. Cost of positions restored in 1977	34		---	+833,000
8. Increase in costs of reimbursable agreements with Bureau of the Census	---		---	+100,000
9. Within grades	---		---	+665,000
Subtotal			---	+2,859,000
B. Program:				
(National Health Statistics)				
1. Support of the Federal share of costs of the Cooperative Health Statistics Systems	69	8,350,000	---	+4,887,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
(Health Services Research)				
2. Additional support for grants and contracts.....	---	17,900,000	---	+100,000
3. Health Professions Capitation Basic support to 186 schools tied to specialty and geographic initiatives.....	---	97,700,000	---	+16,800,000
4. National Health Service Scholarships To provide 500 additional scholarships in exchange for service in the National Health Service Corps in shortage areas...	---	35,000,000	---	+5,000,000
5. Exceptional Need Scholarships To provide financial assistance to 500 needy students in their first year of post-baccalaureate study in health professions schools.....	---	---	---	+5,000,000
6. Nurse Scholarships To assure financial access to nurse education for an additional 2,500 disadvantaged students.....	---	6,500,000	---	+2,500,000
7. Family Medicine Residencies and Training To address the specialty distribution problem by supporting 360 more family medicine and general dentistry residents in training.....	---	39,000,000	---	+6,000,000
8. Physician/Dental Extenders To address the specialty distribution problem by supporting six additional projects training physicians assistants and dental extenders and faculty.....	---	10,500,000	---	+600,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
9. Area Health Education Centers To address the geographic maldistribution problem by supporting 2 additional AHEC training health professionals in underserved areas.....	---	14,000,000	---	+1,500,000
10. Foreign Medical Graduates To support seven additional projects to integrate foreign medical transfers into U.S. medical schools..	---	1,000,000	---	+1,000,000
11. Manpower Supply and Distribution Reports To continue and expand the baseline data and analytical activities of the comprehensive health professions data system.....	---	1,000,000	---	+1,000,000
(Program Management) 12. To increase direct operation costs such as dissemination of program information and management of grants and contracts in support of the Office of Resources Opportunity, Energy Action Staff, Division of Long Term Care and Health Professions.....	---	33,524,000	---	+142,000
Subtotal.....			---	+46,529,000
Total, increases.....			---	+47,388,000
Decreases:				
A. Built-in:				
1. One less day of pay.....	---		---	-170,000

	1977 Base Pos.	1977 Base Amount	Change from Base Pos.	Change from Base Amount
2. Non-recurring costs....	---	549,000	---	-727,000
Subtotal....			---	-897,000
B. Program: (Health Planning and Resources Development) 1. Medical Health Facilities No funds requested in 1978 budget request.....	---	51,545,000	---	-51,545,000
2. Special Medical Facilities No funds requested in 1978 budget request.....	---	23,000,000	---	-23,000,000
(Health Services Research) 3. No funds are requested in 1978 for research training as program is being phased out.....	---	100,000	---	-100,000
(Health Professions Education) 4. Health Professions Loans Funding discontinued in favor of Federally Insured Loan Program.	---	20,000,000	---	-20,000,000
5. Health Professions Loan Repayments Reflects decreasing participation due to eligibility limitation to direct loan recipients.....	---	2,000,000	---	-500,000
6. Shortage Area Scholarships Program phased out as prior recipients received final funding in 1977. Similar scholarships available under NHSS program.....	---	400,000	---	-400,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
7. Health Professions Scholarships Program phased out as prior recipients received final funding in 1977. Scholarships available under NHSS and exceptional need programs.....	---	1,000,000	---	-1,000,000
8. Dental Health Some TEAM project support is retained while continuing education and education development programs are phased out. Funds have been directed toward higher priority areas.....	---	6,200,000	---	-4,100,000
9. Nursing Capitation The supply of nurses is adequate without additional Federal financial support...	---	40,000,000	---	-40,000,000
10. Advanced Nurse Training The Supply of nurses is adequate without additional Federal financial support...	---	9,000,000	---	-9,000,000
11. Nursing Special Projects The supply of nurses is adequate without additional Federal financial support...	---	15,000,000	---	-9,000,000
12. Nursing Loans Phase-out of program. The supply of nurses is adequate without additional Federal financial support; schools may make loans from funds on hand.....	---	22,500,000	---	-22,500,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
13. Nurse Traineeships The supply of nurses is adequate without additional Federal financial support...	---	13,000,000	---	-13,000,000
14. Nurse Loan Repayments The supply of nurses is adequate without additional Federal financial support...	---	3,000,000	---	-3,000,000
15. Nurse Research Grants and Contracts The supply of nurses is adequate without additional Federal financial support...	---	5,000,000	---	-5,000,000
16. Nurse Fellowships The supply of nurses is adequate without additional Federal financial support...	---	1,000,000	---	-1,000,000
17. Health Professions Special Projects Authority Ends-Capitation, the National Health Service Scholarship program, the Federally insured loan program, and other special education programs are sufficient for addressing problems of geographic and speciality maldistribution.....	---	20,200,000	---	-20,200,000
18. Health Professions Start-up Assistance Reflects reduced continuation costs to honor previous commitments.....	---	3,000,000	---	-2,000,000
19. Financial Distress Capitation funds provide support to assist most schools in maintaining financial stability; only schools in dire financial straits would participate in this program.....	---	3,000,000	---	-1,000,000

	1977 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
20. Manpower Initiatives Authority for this program has expired.....	---	7,000,000	---	-7,000,000
21. Health Teaching Facilities Construction Grants Direct funding of construction is not a high priority..	---	8,695,453	---	-8,695,453
22. Health Teaching Facilities Interest Subsidies Reflects decreased need for subsidies on previously guaranteed loans.....	---	2,283,167	---	-283,167
Subtotal.....	---		---	-242,323,620
Total, decreases.....			---	-243,220,620
Total, net change.....			---	-195,832,620

Obligations by Activity

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
National Health Statistics:						
(a) National health surveys and analysis	429	$19,961,000	429	$19,364,000	---	-$597,000
(b) Cooperative health statistics	69	8,350,000	69	14,272,000	---	+5,922,000
(c) Program support.	44	1,038,000	44	1,142,000	---	+104,000
Standard Level User Charge	---	(1,016,000)	---	(1,016,000)	---	(---)
Subtotal, National Health Statistics	542	29,349,000	542	34,778,000	---	+5,429,000
Health Planning and Resources Development:						
(a) Health Planning:						
(1) Local planning agencies	---	97,000,000	---	97,000,000	---	---
(2) State agencies	---	19,500,000	---	19,500,000	---	---
(3) Planning methods development/ centers	---	6,500,000	---	6,500,000	---	---
(4) Rate regulation	---	2,000,000	---	2,000,000	---	---
Subtotal, Health Planning	---	125,000,000	---	125,000,000	---	---
(b) Medical Facilities Construction:						
(1) Formula grants	---	40,373,000	---	---	---	-40,373,000
(2) Project grants	---	11,172,000	---	---	---	-11,172,000
Subtotal, Medical Facilities.	---	51,545,000	---	---	---	-51,545,000
(Budget Authority).	---	(---)	---	(---)	---	(---)

Obligations by Activity

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
(c) Special Medical Facilities	---	23,000,000	---	---	---	-23,000,000
(Budget Authority)	---	(9,000,000)	---	(---)	---	(-9,000,000)
(d) Program Support.	406	11,921,000	406	11,924,000	---	+3,000
Standard Level User Charge	---	(866,000)	---	(866,000)	---	---
Subtotal, Health Planning and Resources Development	406	211,466,000	406	136,924,000	---	-74,542,000
(Budget Authority)	---	(145,921,000)	---	(136,924,000)	---	(-8,997,000)
Health Services Research	38	24,039,000	38	24,000,000	---	-39,000
Program support	188	6,095,000	188	6,442,000	---	+347,000
Standard Level User Charge	---	(502,000)	---	(502,000)	---	(---)
Subtotal, Health Services Research	226	30,134,000	226	30,442,000	---	+308,000
Health Professions Education:						
(a) Health Professions:						
(1) Institutional Assistance	---	97,700,000	---	114,500,000	---	+16,800,000
(2) Student Assistance:						
National Health Service Scholarships	---	35,000,000	---	40,000,000	---	+5,000,000
Loans	---	20,000,000	---	---	---	-20,000,000
Loan Repayments	---	2,000,000	---	1,500,000	---	-500,000
Exceptional need scholarships	---	---	---	5,000,000	---	+5,000,000
Shortage Area Scholarships	---	400,000	---	---	---	-400,000

Obligations by Activity

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Health Professions Scholarships.	---	1,000,000	---	---	---	-1,000,000
Subtotal....	---	156,100,000	---	161,000,000	---	+4,900,000
(b) Dental Health Education:						
(1) TEAM grants..	---	5,500,000	---	2,100,000	---	-3,400,000
(2) Continuing education...	---	200,000	---	---	---	-200,000
(3) Education development & application..	---	500,000	---	---	---	-500,000
Subtotal...	---	6,200,000	---	2,100,000	---	-4,100,000
(c) Nursing:						
(1) Institutional Assistance: Capitation grants.....	---	40,000,000	---	---	---	-40,000,000
Advanced Nurse Training.....	---	9,000,000	---	---	---	-9,000,000
Nurse Practitioner.....	---	9,000,000	---	9,000,000	---	---
Special Projects.....	---	15,000,000	---	6,000,000	---	-9,000,000
Subtotal....	---	73,000,000	---	15,000,000		-58,000,000
(2) Student Assistance:						
Loans.....	---	22,500,000	---	---	---	-22,500,000
Scholarships	---	6,500,000	---	9,000,000	---	+2,500,000
Traineeships	---	13,000,000	---	---	---	-13,000,000
Loan Repayments.....	---	3,000,000	---	---	---	-3,000,000
Fellowships..	---	1,000,000	---	---	---	-1,000,000
Subtotal....	---	46,000,000	---	9,000,000	---	-37,000,000
(3) Educational Assistance: Research Grants.....	---	5,000,000	---	---	---	-5,000,000
Subtotal, Nursing....	---	124,000,000	---	24,000,000	---	-100,000,000

Obligations by Activity

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
(d) Public Health-education.....	---	8,000,000	---	8,000,000	---	---
(e) Allied Health.....	---	8,000,000	---	8,000,000	---	---
(f) Special Educational programs:						
(1) Family Medical Residencies and Training.....	---	39,000,000	---	45,000,000	---	+6,000,000
(2) Primary Care Residencies and Training.....	---	15,000,000	---	15,000,000	---	---
(3) Health Professions Special Projects	---	20,200,000	---	---	---	-20,200,000
(4) Physician/ Dental Extenders.....	---	10,500,000	---	11,100,000	---	+600,000
(5) Area Health Education Centers.....	---	14,000,000	---	15,500,000	---	+1,500,000
(6) Disadvantaged Assistance...	---	8,000,000	---	8,000,000	---	---
(7) Foreign Medical Graduates.....	---	1,000,000	---	2,000,000	---	+1,000,000
(8) Graduate Medical Education National Advisory Committee....	---	1,000,000	---	1,000,000	---	---
(9) Financial Distress.....	---	3,000,000	---	2,000,000	---	-1,000,000
(10) Health Professions Start-up.....	---	3,000,000	---	1,000,000	---	-2,000,000
(11) Manpower Initiatives..	---	7,000,000	---	---	---	-7,000,000
(12) Manpower Supply & Distribution Reports.....	---	1,000,000	---	2,000,000	---	+1,000,000
Subtotal, Special Educational Programs....	---	122,700,000	---	102,600,000	---	-20,100,000

Obligations by Activity

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
(g) Health teaching facilities:						
(1) Construction grants	---	8,695,453	---	---	---	-8,695,453
(2) Interest subsidies	---	2,283,167	---	2,000,000	---	-283,167
Subtotal, Health Teaching Facilities	---	10,978,620	---	2,000,000	---	-8,978,620
(Budget Authority)	---	(---)	---	(2,000,000)	---	(+2,000,000)
(h) Program Support	674	22,577,000	668	23,020,000	-6	+443,000
Standard Level User Charge	---	(302,000)	---	(302,000)	---	(---)
Subtotal, Health Professions Education	674	458,555,620	668	330,720,000	-6	-127,835,620
(Budget Authority)	---	447,577,000	---	330,720,000	--	-116,857,000
Program Management	300	10,947,000	300	11,755,000	---	+808,000
Standard Level User Charge	---	(627,000)	---	(627,000)	---	---
Total Obligations	2148	740,451,620	2142	544,619,000	-6	-195,832,620
(Budget Authority)		(663,928,000)		(544,619,000)		(-119,309,000)

Obligations by Object

	1977 Estimate	1978 Estimate	Increase or Decrease
Total number of permanent positions..	2,148	2,142	-6
Full-time equivalent of all other positions.....	171	165	-6
Average number of all employees.....	2,225	2,220	-5
Personnel compensation:			
Permanent positions.....	$41,825,000	$42,282,000	+$457,000
Positions other than permanent....	2,883,000	2,857,000	-26,000
Other personnel compensation.....	593,000	574,000	-19,000
Subtotal, personnel compensation.	45,301,000	45,713,000	+412,000
Personnel benefits.....	5,199,000	5,110,000	-89,000
Travel and transportation of persons.	3,165,000	3,414,000	+249,000
Transportation of things.....	203,000	208,000	+5,000
Rent, communications and utilities..	4,963,000	5,673,000	+710,000
(Standard Level User Charge).....	(3,313,000)	(3,313,000)	(---)
Printing and reproduction.....	1,337,000	1,319,000	-18,000
Other services.....	12,985,000	13,191,000	+206,000
Project Contracts.....	26,761,000	37,019,000	+10,258,000
Supplies and materials.....	884,000	869,000	-15,000
Equipment.....	630,000	603,000	-27,000
Investment and loans.....	42,500,000	---	-42,500,000
Grants, subsidies & contributions...	596,523,620	431,500,000	-165,023,620
Total obligations by object.....	740,451,620	544,619,000	-195,832,620

Significant Items in House and Senate
Appropriations Committee Reports

Item	Action Taken or to be Taken
1977 House Report	
Health Data Systems	
1. Report on all existing health systems especially those where a health agency has contracted outside the Government for Health Statistics (page 54)	1. The Office of the Assistant Secretary for Health has prepared a Health Statistics plan which includes an inventory for data collection systems. This report will be provided to the committee prior to hearings on the 1978 budget.
1977 Senate Report	
Dental Health Activities	
2. Committee directive that future budget submissions for the Division of Dentistry be specifically earmarked in all budget justification material (page 74)	2. This budget justification includes the detailed dental health budget material requested.
Foreign Medical Graduates	
3. Committee directive that HRA submit a report prior to the 1978 hearings reviewing the current foreign medical graduate debate (page 74)	3. The report has been completed and will be forwarded to the Congress prior to formal Congressional review of the 1978 budget.

Significant Items in House and Senate
Appropriations Committee Reports

Item	Action taken or to be taken
1977 Senate Report	
Medical Facilities Construction Grants	
4. Committee directive that the Secretary of HEW use the previously appropriated funds for public hospital projects pursuant to section 1625 of the Health Planning Act (page 76)	4. From the 1976 appropriation there remains $11.38 million for grants to public and quasi-public medical facilities to prevent or correct life safety code violations and accreditation and licensure problems. On November 26, 1976, a notice appeared in the Federal Register announcing that the program was operational and asking for applications. Guidelines were submitted to all those agencies requesting application kits. To date, some 200 application kits have been sent out and the application deadline was established as January 25, 1977. It is expected that the applications will be reviewed and initial approval of those projects funded should occur on or before May 18, 1977.

Significant Items in House and Senate
Appropriations Committee Reports

Item	Action Taken or to be Taken
1976 Supplemental-Senate Report	
Special Medical Facilities	
5. Report on medical care program at Rogers Memorial Hospital (page 35)	5. The report requested by the Committee was provided under cover letter to Senator Warren G. Magnuson dated March 4, 1976. The 1976 Supplemental Appropriation made available $4 million in construction funds to Rogers Memorial Hospital. On October 14, 1976, the project was approved by DHEW and construction is now underway to complete the sixth floor, add some new equipment, and provide for adequate parking.

Authorizing Legislation

Health Resources	Amount Authorized	1978 Budget Request
1. National health statistics:		
(a) National health survey and analysis		
PHS Act - Sec. 308(1)(2).....	1/	$19,364,000
(b) Cooperative Health Statistics		
PHS Act - Sec. 308(1)(2).....	1/	14,272,000
(c) Program Support		
PHS Act, various sections.....	Indefinite	1,142,000
2. Health planning and resources development:		
(a) Health Planning		
(1) Local planning agencies		
PHS Act - Sec. 1516.....	1/	97,000,000
(2) State agencies		
PHS Act - Sec. 1525.....	1/	19,500,000
(3) Planning Methods Development/Centers		
PHS Act - Sec. 1534.....	1/	6,500,000
(4) Resources Development Fund		
PHS Act - Sec. 1640.....	1/	---
(5) Rate Regulation		
PHS Act - 1526.....	1/	2,000,000
(b) Medical facilities construction:		
(1) Medical Facilities		
PHS Act - Sec. 1613.....	1/	---
(c) Program support		
PHS Act, various sections.....	Indefinite	11,924,000
3. Health services research		
PHS Act - Sec. 308(1)(1).....	1/	24,000,000
(a) Program support		
PHS Act, various sections.....	Indefinite	6,442,000
4. Health professions education		
(a) Health professions		
(1) Institutional assistance:		
Capitation grants		
PHS Act - Sec. 770.....	219,083,000	114,500,000
Capitation bonus students		
PHS Act - Sec. 770.....	Such sums as necessary	---
(2) Student assistance:		
National Health Service Scholarships		
PHS Act - Sec. 756.....	75,000,000	40,000,000

	Amount Authorized	1978 Budget Request
Loans		
PHS Act - Sec. 742	$26,000,000	---
Loan repayments		
PHS Act - Sec. 741	Such sums as necessary	$1,500,000
Scholarships		
PHS Act - Sec. 780	Such sums as necessary	---
Scholarships - First Year Financially Needy		
PHS Act - Sec. 758	16,000,000	5,000,000
Lister Hill Medical Scholarships		
PHS Act - Sec. 759	160,000	---
Scholarships - U.S. Students in Foreign Medical Schools		
PHS Act - Sec. 785	Such sums as necessary-prior recipients	---
Physician Shortage Area Scholarships		
PHS Act - Sec. 786	Such sums as necessary-prior recipients	---
(b) Dental Health Educational Assistance:		
(1) Continuing Education Grants		
PHS Act - Sec.788	2/	---
(2) Education Development and Application grants and contracts		
PHS Act - Sec. 301	Such sums as necessary	---
(c) Nursing:		
(1) Institutional assistance:		
Capitation		
PHS Act - Sec. 810	55,000,000	---
Financial Distress		
PHS Act - Sec. 815	5,000,000	---
Advanced nurse training		
PHS Act - Sec. 821	25,000,000	---
Nurse Practitioner		
PHS Act - Sec. 822	25,000,000	9,000,000
Nursing Special Projects		
PHS Act - Sec. 820	15,000,000	6,000,000 3/

	Amount Authorized	1978 Budget Request
(2) Student Assistance:		
Loans		
PHS Act - Sec. 837.....	$35,000,000	---
Scholarships		
PHS Act - Sec. 845.....	Such sums as necessary	$9,000,000
Traineeships		
PHS Act - Sec. 830.....	25,000,000	---
Loan repayments		
PHS Act - Sec. 836.....	Such sums as necessary	---
Fellowships		
PHS Act - Sec. 472.....	Such sums as necessary	---
(3) Educational assistance		
PHS Act - Sec. 301.....	Such sums as necessary	---
(4) Congressional reports		
PHS Act - P.L. 94-63 various sections.....	Such sums as necessary	---
(d) Public Health:		
(1) Institutional assistance:		
Graduate Programs in Health Administration		
PHS Act - Sec. 791.....	3,250,000	3,000,000
Special Projects - Public Health and Health Administration		
PHS Act - Sec. 792.....	5,000,000	5,000,000
(2) Student assistance:		
Public Health Traineeships		
PHS Act - 748.....	7,500,000	---
Traineeships -- Other Graduate Programs in Health Administration		
PHS Act - Sec. 749.....	2,500,000	---
(e) Allied Health:		
(1) Institutional assistance:		
Allied Health Special Projects grants and contracts		
PHS Act - Sec. 796.....	22,000,000	8,000,000
(2) Student Assistance:		
Allied Health Advanced Training		
PHS Act - Sec. 797.....	4,500,000	---
(3) Educational Assistance:		
Allied Health Educational Assistance to Disadvantaged		
PHS Act - Sec. 798.....	1,000,000	---

	Amount Authorized	1978 Budget Request
(f) Special educational programs:		
(1) Family Medicine/General Dentistry Residencies		
PHS Act - Sec. 786.....	$45,000,000	$45,000,000 4/
(2) Family Medicine Departments		
PHS Act - Sec. 780.....	10,000,000	---
(3) Internal Medicine & General Pediatrics		
PHS Act - Sec. 784.....	15,000,000	15,000,000
(4) Interdisciplinary Training and Curriculum Development		
PHS Act - Sec. 788.....At least	15,000,000 6/	---
(5) Physician Assistants/Dental Extenders/TEAM		
PHS Act - Sec. 783.....	25,000,000	13,200,000
(6) Area Health Education Centers		
PHS Act - Sec. 781.....	20,000,000 3/	15,500,000
(7) Disadvantaged Assistance		
PHS Act - Sec. 787.....	20,000,000	8,000,000
(8) U.S. Foreign Medical Transfers		
PHS Act - Sec. 782.....	2,000,000	2,000,000
(9) Graduate Medical Education National Advisory Committee		
PHS Act - Sec. 222.....	Such sums as necessary	1,000,000
(10) Manpower Supply and Distribution Reports		
PHS Act - Sec. 708.....	Such sums as necessary	2,000,000
(11) Medical School Start-Up Development Costs		
PHS Act - Sec. 788.....	1,500,000	---
(12) Start-Up		
PHS Act - Sec. 788.....Up to	5,000,000 6/	1,000,000
(13) Financial Distress		
PHS Act - Sec. 788..... Up to	5,000,000 6/	2,000,000
(14) Congressional Directives		
PHS Act - P.L. 94-484.....	Such sums as necessary	---
(g) Medical and Dental Manpower Act of D.C.	expired	---
(h) Health teaching facilities:		
(1) Construction:		
Health professions		
PHS Act - Sec. 720.....	40,000,000	---
Nursing		
PHS Act - Sec. 801.....	20,000,000	---
(2) Interest Subsidies:		
Health professions		
PHS Act - Sec. 726.....	2,000,000	2,000,000
Nursing		
PHS Act - Sec. 805.....	1,000,000	---

	Amount Authorized	1978 Budget Request
(i) Program Support		
(1) Graduate Student Insured Loans		
PHS Act - Sec. 727.....	$ 1,500,000 plus further sums as necessary	---
(2) All Other.....	Indefinite	$23,020,000
Other unfunded authorizations:		
Sec. 301 - PHS Act Educational Development and Application.....	Such sums as necessary	---
Sec. 789 - PHS Act Emergency Medical Services Training.....	10,000,000	---
5. Program Management		
PHS Act, various sections.....	Indefinite	11,755,000
Total.....		544,619,000

1/ Authorization expires September 30, 1977.

2/ Authorization is included under Section 788 - Interdisciplinary Training and Curriculum Development.

3/ Not less than 10% for educational opportunities for the disadvantaged.

4/ Not less than 10% for General Dentistry Residencies.

5/ Also includes such sums as necessary to complete prior projects.

6/ Combined authorization total must not exceed $25 million.

Health Resources Administration

Year	Budget Estimate To Congress	House Allowance	Senate Allowance	Appropriation
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	307,650,000
1977	223,300,000	351,896,000	363,120,000	358,958,000
1977 Supplemental	304,970,000			
1978	544,619,000			

Justification

HEALTH RESOURCES

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
National Health Statistics.....	542	$29,349,000	542	$34,778,000	---	+$5,429,000
Health Planning and Resources Development.....	406	211,466,000	406	136,924,000	---	-74,542,000
(Budget Authority)	---	(145,921,000)	---	(136,924,000)	---	(-8,997,000)
Health Services Research.....	226	30,134,000	226	30,442,000	---	+308,000
Health Professions Education.....	674	458,555,620	668	330,720,000	-6	-127,835,620
(Budget Authority)	---	(447,577,000)	---	(330,720,000)	---	(-116,857,000)
Program Management.	300	10,947,000	300	11,755,000	---	+808,000
Standard Level User Charge.....	---	(3,313,000)	---	(3,135,000)	---	(-178,000)
Total, Health Resources.....	2,148	740,451,620	2142	544,619,000	-6	-195,832,620
(Budget Authority)		(663,928,000)		(544,619,000)		(-119,309,000)

General Statement

The mission of the Health Resources Administration is to identify health care resource problems and maintain or strengthen the distribution, supply, utilization, quality and cost effectiveness of these resources to improve the health care system and individual health status.

Major thrusts include the measurement and analysis of trends in health status, health care and other indicators, research and testing of alternative approaches to an effective health care system; development of a national health planning capability geared to promoting equal access to quality health care at a reasonable cost; and promotion of innovative strategies and targeted development of such resources as manpower, facilities and technological advances aimed at developing a more effective health care system. The proposed budget of $544,619,000 is distributed among the activities described below.

The focus of the National Center for Health Statistics is to provide reliable national descriptive baseline health statistics; to identify and measure problems and trends in health status; to provide data on the distribution, supply, utilization, and costs of health care resources and services; and to further implement the cooperative system of data collection with States and local areas for producing comparable and reliable health data at the National, State and local levels without duplication of effort.

One of the most significant needs in the field of health statistics is the development of data systems that are capable of satisfying the multiple requirements for data at the State and sub-State levels and which provide the types of data needed for evaluation of the impact of major Federal health programs. A major thrust in the 1978 request is expanded implementation of Phase I (vital statistics, manpower, and facilities components) of the Cooperative Health Statistics System, aiming toward eventual implementation of these three components in all 50 States. In addition, further developmental work will be done on the three data components of Phase II (hospital care, long-term care, and ambulatory care components) of the Cooperative System. The system is designed to permit State and local health planning agencies to meet basic planning requirements with regard to determining health resources needs and assessing health status, as well as helping to meet the data needs of such other health programs as Professional Standards Review Organizations. A total of $34,778,000 is requested for these activities.

The Health Planning and Resources Development Act of 1974 calls for the creation of a nationwide network of health systems agencies (HSAs) and State Health Planning and Development Agencies (SHPDAs) 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.

Control over capital investments and health facilities is critical to the control of health costs. Increased numbers of hospital beds as well as costly new technology are generally agreed upon as principal contributors to the rise in the cost of health care. The newly established health planning activities represent our only major systematic effort at local, State, and Federal levels to control future capital investments in health.

By the end of 1977, 205 health systems agencies, 7 Section 1536 waiver States (combined HSA-State agency), and 49 State Agencies will have been designated covering every designated area and State in the Nation. During 1978, nearly all of the HSAs and State Agencies will move to full designation agreements, rather than conditional designation agreements. Accordingly, they are required to perform the full range of functions provided for in the legislation. Additional functions for the HSAs include the review and approval or disapproval of proposals for use of Federal funds, and review of all institutional health services for appropriateness. In addition, once the HSAs complete their Health Systems Plans, they will be participating more fully in the State certificate-of-need process as they review the need for proposed new institutional health services or facilities.

Funds are also requested for the development of more effective planning methods, including continued support for the ten Centers for Health Planning established during 1976, and which are designed to provide training and consultation for local governing board members, HSAs and SHPDA staff, and members of the Statewide Health Coordinating Councils. In addition, rate review demonstrations will be supported in up to six States. A funding level of $136,924,000 is requested for this range of activities under the health planning and resources development program.

The National Center for Health Services Research is the principal source of support for research on problems in the delivery of health services. The research program of the National Center is determined by the need for information to develop health policy, define delivery problems, and identify alternative approaches to organizing, producing, distributing and financing health services. Major areas of focus include research on health insurance, quality of care, health manpower, ambulatory care and emergency medical services. In addition to the program of grants and contracts, a program of intramural research is designed to develop in-house capability to deal with a broad range of research issues. The 1978 request provides for continuation of the program of Health Services Research Centers, of which seven have been funded and permits the establishment of the newly mandated Health Services Policy Analysis Center. It also permits new awards to be made in such research areas as health manpower and inflation, productivity and costs. The budget request for these activities is $30,442,000.

The 1978 request of $330,720,000 for health manpower is based upon the recently enacted Health Professions Educational Assistance Act of 1976 (P.L. 94-484). This Act identifies as priorities the improvement of the geographic distribution of health manpower and the production of more primary care practitioners. This is a shift from earlier legislation which focused on expanding enrollment. The budget provides for the program of capitation grants - institutional support awarded on a formula basis - to those health professions schools agreeing to undertake special efforts to address problems of specialty distribution and other legislative requirements. Medical schools, for example, must have specified percentages of filled first-year residency positions in training programs in primary care, such as family medicine, general internal medicine, or general pediatrics.

The National Health Service and the Exceptional Need Scholarship programs are designed to address the shortage of health professionals in certain manpower shortage areas. Scholarships are awarded to medical, osteopathic, dental, nursing, and potentially other students in exchange for service in a health manpower shortage area. Participants are required to perform obligated service either as a commissioned or civilian member of the Corps, or, under specified conditions, in private practice in a shortage area. Funds are also included for costs of the new program of Federally insured loans to health professions students.

A variety of special project grant and contract activities is proposed, designed particularly to address the problems of specialty and geographic maldistribution. These include support for family medicine residencies and training, training in the general practice of dentistry, and for medical residency programs in internal medicine and pediatrics emphasizing primary care. Support is continued for the Area Health Education Center (AHEC) program, which is designed to provide educational experience in rural and remote areas, with linkage back to major medical centers. Special project funds are also requested to support training programs for physicians' assistants and dental extenders, promoting the concept that certain health services can be provided adequately by persons receiving shorter and less costly training than physicians and dentists. An additional area of special project assistance is designed to recruit disadvantaged students into health professions training through identifying disadvantaged students and providing counseling and preliminary education.

The program management activity, funded for $11,755,000, provides funding for the Agency Administrator and his immediate staff. 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 1978. Also included within this activity is funding for budget and fiscal direction as well as Agency planning and evaluation, policy coordination, legislative liaison and general administrative support.

National Health Statistics

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
National Health Surveys and Analysis.....	429	$19,961,000	429	$19,364,000	---	-$597,000
Standard Level User Charge.....		(1,016,000)		(1,016,000)		(---)
Cooperative Health Statistics System	69	8,350,000	69	14,272,000	---	+5,922,000
Program Support..	44	1,038,000	44	1,142,000	---	+104,000
Total.....	542	29,349,000	542	34,778,000	---	+5,429,000

The National Center for Health Statistics develops and maintains reliable general purpose, national health statistical data collection systems; performs studies to improve health survey methods; and provides technical advice on the application of statistical methods. The Center also provides 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 National, State, and local levels.

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
National Health Surveys and Analysis.....	429	$19,961,000	429	$19,364,000	---	-$597,000
Standard Level User Charge.....		(1,016,000)		(1,016,000)		(---)

This activity provides for collection, analysis and publication of national, descriptive, baseline health statistics. Data are provided on vital events; the health status of the population including physical, nutritional, mental, and physiological characteristics; illness; injury; impairment; the supply and utilization of health facilities; family planning practices; family planning services; and on other health related matters.

The data described above are collected through a variety of continuous and periodic centrally operated national health and vital statistics surveys. In 1977 data collection was begun in the second round of two major surveys: the Health and Nutrition Examination Survey II will update data on nutritional status and provide more information in problem areas identified in the earlier study; the second National Survey of Family Growth will provide a time series on the dynamics of population change and maternal and child health. Also in 1977 supplemental questions were added to the continuing Health Interview Survey in order to obtain data to identify and describe the extent and pattern of any flu epidemic this year. The 1978 budget provides for continuing the surveys and analysis at the 1977 level. Data collected in previous years will be analyzed and published and the 1978 cycle of data collection will be initiated.

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Cooperative Health Statistics System..	69	$8,350,000	69	$14,272,000	---	+$5,922,000

The purpose of this activity is to (1) assist Federal, State, and local agencies involved in matters relating to health, in the design and implementation of a cooperative system for producing comparable and uniform health information at the National, State, and local levels; (2) coordinate the activities of Federal agencies respecting the design and implementation of such a system; (3) undertake and support by contract, research, development, demonstration, and evaluation respecting such a system; (4) provide the Federal share of the data collection costs under such a system; and (5) review statistical activities of DHEW to assure they are consistent with such a system.

Initial efforts in the system have resulted in the combining of data collection for statistical, administrative, management, and regulatory purposes for local, State, and national organizations and in the decentralization of data collection and processing with responsibility placed at the operational level for quality control, initial processing, and distribution of data. The $6 million increase will permit further implementation of the system as indicated below.

Number of State Projects by Year

Data Component	Fiscal Year 1976	1977	1978
Vital Statistics	29	38	48
Health Manpower Statistics	27	30	42
Health Facilities Statistics	24	30	42
Hospital Care Statistics	10	15	20

In 1978 particular emphasis will be to (1) develop in several States total health information systems which will demonstrate the importance and usefulness of health care utilization data, (2) bring States with manpower and facilities developmental contracts up to full implementation level, (3) expand research and demonstration projects regarding methods of data use, and (4) continue research into data collection methods for hospital care, long-term care, and ambulatory care data.

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program Support	44	$1,038,000	44	$1,142,000	---	+$104,000

This activity participates fully in planning and coordination Center activities in developing goals and objectives, and in developing the Center's policies and procedures. This also includes the direction of the Center's personnel management and administrative management functions.

The proposed budget for 1978 for this activity will provide continued assistance and guidance in the establishment of a reimbursable work program.

The increase of $104,000 would be used to (1) purchase approximately 12,000 copies of the Ninth Revision, International Classification of Diseases from the World Health Organization for use in the classification of causes of death during 1978-1987; (2) contract with WHO for the development of special supplementary International Classification of Diseases for use in classifying symptoms and patient complaints; and (3) fund within grade raises. This increase is partially offset by a $3,000 decrease for one less day of pay.

Health Planning and Resources Development

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Health Planning:						
Local Planning Agencies.....	---	$ 97,000,000	---	$ 97,000,000	---	---
State Agencies..	---	19,500,000	---	19,500,000	---	---
Planning Methods Development/ Center.....	---	6,500,000	---	6,500,000	---	---
Rate Regulation.	---	2,000,000	---	2,000,000	---	---
Medical Facilities Construction:						
Formula Grants..	---	40,373,000	---	---	---	$-40,373,000
(Budget Authority)		(---)		(---)		(---)
Project Grants..	---	11,172,000	---	---	---	-11,172,000
(Budget Authority)		(---)		(---)		(---)
Special Medical Facilities.....	---	23,000,000	---	---	---	-23,000,000
(Budget Authority)		(9,000,000)		(---)		(-9,000,000)
Program Support...	406	11,921,000	406	11,924,000	---	+3,000
(Standard Level User Charge)		(866,000)		(859,000)		(-7,000)
Total.....	406	211,466,000	406	136,924,000	---	-74,542,000
(Budget Authority)		(145,921,000)		(136,924,000)		(-8,997,000)

The Bureau of Health Planning and Resources Development provides national leadership and administration of a program of Federal, State, and local health planning and health delivery systems development. The Health Planning and Resources Development programs 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.

The 1978 budget request for health planning and resources development activities maintains the 1977 level of support. However, in 1978 all of the 49 regular State Health Planning and Development Agencies, 205 Health Systems Agencies, and 7 section 1536 waiver States will be required to attain full designation status and assume the full range of planning functions provided in the legislation. In addition, the ten Centers for Health Planning will be funded for their third year of operation and up to six rate regulation demonstration projects will be continued. No funds are requested for the Facilities Construction program in 1978. The carry-over activities from Title VI such as monitoring of assurances given and payments on construction will be continued during 1978.

Health Planning and Resources Development

	1977 Estimate	1978 Estimate	Increase or Decrease
Local planning agencies.....	97,000,000	97,000,000	---
State agencies.....	19,500,000	19,500,000	---
Planning methods development/ centers.....	6,500,000	6,500,000	---
Rate regulation.....	2,000,000	2,000,000	---
Total.....	125,000,000	125,000,000	---

The Health Planning and Resources Development Act of 1974 calls for the creation of a nationwide network of health systems agencies (HSAs) and State Health Planning and Development Agencies (SHPDAs) 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.

Control over capital investments and health facilities is critical to the control of health costs. Increased numbers of hospital beds as well as costly new technology are generally agreed upon as principal contributors to the rise in the cost of health care. The newly established health planning activities represent our only systematic effort, at local, State, and Federal levels to control future capital investments in health.

The Law authorizes that fully designated HSAs be funded on a $.50 per capita basis with additional funding made available through matching grants up to $.25 per capita; that SHPDAs receive Federal grant support of up to 75 percent of their operating costs. Projects assisted under planning methods development activity are funded through contracts, and rate regulation demonstrations are funded on a project grant basis with a maximum of six States participating.

Currently 196 HSAs, five Section 1536 waivers States and 44 regular SPHDAs have been designated. By the end of 1977, 205 HSAs, seven Section 1536 waiver States and 49 regular SHPDAs will have been designated covering every designated area and State in the Nation. Each of these agencies will operate under conditional designated status for at least a 12 month period, after which time they may apply for full designation status. The period of conditional designation has a statutory limitation of 24 months, at which time the agencies must either become fully designated or terminate. Less than a third of the HSAs and approximately

one half of the SHPDAs are expected to become fully designated in 1977, with the remaining HSAs and SHPDAs being required to attain full designation status in 1978. Full designation carries with it additional functions and greater responsibilities, including review and approval of applications for Federal funds and review for appropriateness of existing institutional health services.

The 1978 budget request maintains the 1977 level of operations.

	1977 Estimate	1978 Estimate	Increase or Decrease
Local planning agencies.....	97,000,000	97,000,000	---

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 met in achieving the goals. The request would allow for a minimum funding level of $175,000 and an overall average of $.45 per capita. Approximately 38 agencies will receive the $175,000 minimum, resulting in an average of $61 per capita for the minimum agencies, and 174 agencies will receive grants above the minimum, for an average of $.42 per capita excluding matching funds, $.08 per capita below the level provided for in the statute. It is estimated that matching funds can be provided at about $.05 per capita, $.20 per capita below the statute provision. An average staff of 18 can be supported at an average level of $455,000 per agency.

	1977 Estimate	1978 Estimate	Increase or Decrease
State agencies.....	19,500,000	19,500,000	---

The functions of the SHPDA include organization development, establishment of procedures and criteria for review of health changes, integration of the health plans of the HSAs into a State health plan, administering the facilities construction program, administering the certificate-of-need program, and providing staff support to the Statewide Health Coordinating Council. The SHPDA is also required to make findings as to the need for all new institutional services proposed to be offered in the States, and the appropriateness of existing services. The requested level of funding would allow for an average grant of approximately $348,000 per agency, up to 75 percent of the total of each agency's operating budget. Given State matching of 25 percent, the average total agency budget would be approximately $464,000 which would provide for an average staff of 18 per agency.

	1977 Estimate	1978 Estimate	Increase or Decrease
Planning methods development/ centers.....	6,500,000	6,500,000	---

The purpose of this activity is to develop effective planning methods and to provide technical assistance to HSAs and SHPDAs in evaluating, adapting, and utilizing new planning methods.

Approximately $3,900,000 of the request would be used to fund the ten Centers for Health Planning which were established during 1976 and funded for a two-year period. The functions of the Centers include the provision of training, including training of Board members, HSA and SHPDA staff, and members of the State Health Coordinating Council (SHCC), provision of consultative services to the agencies and the SHCC, and the development of materials, e.g., orientation materials, guides, models, and health planning manuals. Approximately $2,100,000 of the request would be used to develop planning methods designed to determine the need and demand for health services and improved capital expenditures, and about $500,000 would be used to continue the operation of the National Health Planning Information Center which facilitates the exchange of information concerning health services, health resources, and health planning and resources development practice and methodology.

	1977 Estimate	1978 Estimate	Increase or Decrease
Rate regulation.....	2,000,000	2,000,000	---

The purpose of this activity is to demonstrate the effectiveness of regulating rates for the provision of health care. In addition to containing costs, these demonstration efforts are designed to improve overall cost consciousness among hospital and medical staff by promoting improved budgeting practices, and detailed justification of capital expenditure requests.

This activity is coordinated with the Social Security Administration and is carried out in conjunction with Section 222 of the Social Security Admendments of 1972, which has to do with testing prospective reimbursement programs.

Approximately six rate review demonstration projects will be developed during 1977 and jointly funded with the Social Security Administration. The budget request would allow for the continued support of these projects and/or for the funding of new projects up to a total of six.

Medical Facilities Construction

	1977 Estimate	1978 Estimate	Increase or Decrease
Formula Grants.....	$40,373,000	---	$-40,373,000
(Budget Authority).....	(---)	(---)	(---)
Project Grants.....	11,172,000	---	-11,172,000
(Budget Authority)	(---)	(---)	(---)
Total.....	51,545,000	---	-51,545,000
(Budget Authority)	(---)	(---)	(---)

The Health Planning and Resources Development Act of 1974 established the Health Facilities Construction program, replacing the Hill-Burton Medical Facilities Construction program. 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.

Formula grants to States are determined on the basis of population, financial need, and the need for medical facilities projects. Of the total funds appropriated, 22 percent must be made available for direct Federal project grant assistance.

Funds appropriated in 1976 are available through 1978. Carryover activities from the Hill-Burton program such as monitoring of assurances given and payments on construction will be continued during 1978. Assistance to facilities programs outside the Department (e.g., HUD, FHA) will also continue.

The entire facility financing arena, including Medical Facilities Construction, is undergoing re-examination from a policy standpoint (considering the appropriate role(s) for loans, loan guarantees, interest subsidies, grants, funding depreciation through medicare reimbursements, regional pooling of depreciation funds, etc) to determine the directions in which these programs should be channelled. Until these new directions become clear, no new funds will be requested for the Medical Facilities Construction program.

Special Medical Facilities

	1977 Estimate	1978 Estimate	Increase or Decrease
Special Medical Facilities.....	$23,000,000	---	$-23,000,000
(Budget Authority).....	(9,000,000)		(-9,000,000)

The Bureau of Health Planning and Resources Development administers this activity authorized by Sections 305(b)(3) and 308 of the Public Health Service Act which provides for research and demonstration projects respecting the design, construction, utilization, organization, and cost of facilities and equipment. Grants and Contracts are used to fund projects under this activity.

Of the total funds appropriated in 1977, $2,000,000 was provided to the Children's Hospital in the District of Columbia and $2,000,000 to the Georgetown University Concentrated Care Center for the purchase of equipment to make the new facilities at these medical institutions completely operational. The remaining $5,000,000 is for the construction of a health facility in Nome, Alaska.

No funds are requested for this activity in 1978.

Program Support

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program Support....	406	$11,921,000	406	$11,924,000	---	+3,000
(Standard Level User Charge).....		(866,000)		(866,000)		(---)

This activity provides for the salaries and expenses to support the personnel and management operations of the Bureau of Health Planning and Resources Development and the operations and staff of the ten Regional Office Bureau related components.

The proposed budget for 1978 will provide continued support in administering the Bureau's programs as set forth in the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) and administration of the Loan and Loan Guarantee program. Activities include site visits, monitoring and evaluation, consultation, guidance, and technical assistance to the State and local agencies. In addition, administration of Title VI activities such as monitoring of assurances and subsidy payments on construction and the Loan and Loan Guarantee program including monitoring and loan financial analysis will be continued.

The net increase of $3,000 represents mandatory items such as within grade increases; increased costs for FTS, Postage and Telephone, Working Capital Fund, and Service and Supply Fund; cost of positions restored in 1977; and less one day of pay and non-recurring costs.

Health Services Research

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Health Services Research.....	38	$24,039,000	38	$24,000,000	---	-$39,000
Standard Level User Charge.....		(100,000)		(100,000)		(---)
Program Support.....	188	6,095,000	188	6,442,000	---	+347,000
Standard Level User Charge.....		(402,000)		(402,000)		(---)
Total.....	226	30,134,000	226	30,442,000	---	+308,000

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. This legislation authorizes the Secretary, acting through the National Center, to undertake a broad range of research, demonstration, and evaluation activities respecting virtually all aspects of health services delivery in this country. The new law resulted from a growing recognition that substantial improvement in the efficiency and effectiveness of health services is most likely to be achieved by expanding our knowledge of provider and consumer behavior and through testing and evaluating new approaches to producing, financing, organizing, and delivering health services.

In response to the provisions of P.L. 93-353 and to the concerns expressed by the Congress, the National Center is giving particular emphasis to the formulation of an issue-oriented research agenda, the establishment of an extramural research center program, and the development of an effective system for disseminating the results of the research effort.

There are relatively few sources of broad support for research in health services. As a result, the decisions made by the National Center on what kinds of research to support are likely to have a greater impact on future policy and the course of events than might otherwise be the case. To date, the National Center has identified eight priority issues for intensive research. The areas currently identified are broadly labeled: Quality of care; Cost containment; Health care and the disadvantaged; Health manpower; Health insurance; Planning and regulation; Ambulatory care and emergency medical services; and Long-term care.

The 1978 budget request of $30,442,000, provides $24,000,000 for health services research which will permit the National Center to support continuation projects, including those in the area of EMS research, and to award several new starts in the high priority areas of Health Manpower and Cost Containment.

HEALTH SERVICES RESEARCH: WORKLOAD ESTIMATES

	1977 Estimate		1978 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
(1) Research Grants and Contracts:						
Research, demonstration and evaluation awards:						
Non-competing continuations	40	$8,000,000	45	$8,900,000	+5	+$900,000
Renewals	8	1,500,000	8	1,500,000	--	---
New grants	24	4,500,000	17	3,700,000	-7	-800,000
Supplementals	(15)	900,000	(15)	900,000	(--)	---
Subtotal	72	14,900,000	70	15,000,000	-2	+100,000
Contracts:						
Continuations	10	2,700,000	9	1,300,000	-1	-1,400,000
New contracts	5	300,000	10	1,700,000	+5	+1,400,000
Subtotal	15	3,000,000	19	3,000,000	+4	---
TOTAL	87	17,900,000	89	18,000,000	+2	+100,000
(2) Intramural Research:						
Staff Support	--	1,559,000	--	1,529,000	--	-30,000
Positions		38		38		--
Contracts/Inter-agency agreements	15	4,480,000	15	4,471,000	--	-9,000
TOTAL	15	6,039,000	15	6,000,000	--	-39,000
(3) Research Training:						
Continuations	12	100,000	--	---	-12	-100,000
TOTAL, Program	114	24,039,000	104	24,000,000	-10	-39,000
(4) Program Support	--	6,095,000	--	6,442,000	--	+347,000
TOTAL, Health Services Research	114	30,134,000	104	30,442,000	-10	+308,000

Distribution of Research Projects by Program Areas

	1977 Estimate	1978 Estimate	Increase or Decrease
A. Health Services Research:			
(1) Quality of Care	$6,284,000	$3,600,000	-$2,684,000
(2) Cost Containment	2,700,000	2,800,000	+100,000
(3) Health Care and the Disadvantaged	1,800,000	1,171,000	-629,000
(4) Health Manpower	1,000,000	2,000,000	+1,000,000
(5) Health Insurance	2,600,000	1,250,000	-1,350,000
(6) Planning and Regulation	1,400,000	2,400,000	+1,000,000
(7) Ambulatory Care and Emergency Medical Services	275,000	2,600,000	+2,325,000
(8) Long-Term Care	1,600,000	1,300,000	-300,000
(9) Exploratory, Developmental, and Special Projects	1,121,000	1,100,000	-21,000
Subtotal	18,780,000	18,221,000	-559,000
B. Health Services Research Centers Program	3,600,000	4,250,000	+650,000
Subtotal	22,380,000	22,471,000	+91,000
C. Intramural Staff Support and Research Training Program	1,659,000	1,529,000	-130,000
Total, Programs	24,039,000	24,000,000	-39,000
D. Program Support	6,095,000	6,442,000	+347,000
Total, Health Services Research	30,134,000	30,442,000	+308,000

A. Health Services Research

The research program of the National Center is determined by the need for general information to inform health policy, define delivery problems, and identify alternative approaches to organizing, producing, distributing and financing health services.

The National Center carries out its research program both internally using the staff of the agency and externally through grants and contracts. The research program does not distinguish where proposed research will be undertaken. The allocation of research projects between the intramural and extramural programs is determined by such factors as the availability of relevant expertise and the urgency for information.

The 1978 request of $24,000,000 includes $6,000,000 for intramural research and $6,900,000 for new and renewal extramural projects. The annual cost, on the average, of a project supported by the National Center is now close to $200,000 per year. Some typical or proposed research studies by the eight issue areas to be supported in 1978, are listed below:

1) Quality of Care - Ultimately the value of a quality assurance system depends on its ability to effect more appropriate patterns of provider behavior and resource utilization. Evaluation of the Emergency Medical Care Review Organization program did not provide definitive evidence of changes in the performance of the delivery system resulting from the implementation of quality review and quality assurance mechanisms. Staff of the National Center have designed, and will implement in 1977-1978 in collaboration with the Public Health Service Hospitals, a study to evaluate the impact of prototype review mechanisms on the process, outcomes, and utilization of medical care. Specifically, the study will attempt to assess the effect of concurrent review and retrospective review mechanisms, separately and in combined applications.

In 1978, the National Center intends to undertake a set of studies to assess the relationship between medical education and physician performance. Also proposed is a study, which will examine the patients' role in determining the nature and content of the health services provided.

2) Cost Containment - Research in this area would focus on analyses of industry wage/cost dynamics, studies of hospital investment, price deflators, and strategies to reduce the rate of increase of health care costs such as alternative schemes for reimbursement and novel approaches to organizing the production process. Emphasis will be given to analyzing the effectiveness and impact of alternative cost-control mechanisms in the hospital sector.

The National Center would also propose to undertake a set of studies to develop a medical price index which takes into account technological changes, quality changes, and population-based variations in price. Current indices do not permit one to monitor effectively either the behavior of the health industry prices or changes in the resource-intensity of medical practices.

3) Health Care and the Disadvantaged - The National Center is currently supporting studies which investigate the impact of national economic conditions on the health care available to and used by the disadvantaged. As a result of a grant program solicitation, the National Center is supporting studies which address such issues as, a) the use of preventive and ambulatory public health services, b) the impact of unemployment on health services utilization and health status, and c) the demand for dental care in low-income families. The results of the research funded to date will be available in 1978 and will help determine the focus of future research on this issue.

4) Health Manpower - Relatively few studies have been undertaken to identify and analyze opportunities for structural innovations that might improve the way health manpower is trained, deployed, or utilized. In 1978, the National Center would focus research on the implications of collective bargaining for the health care industry and on an analysis of industry employment career patterns/upward mobility.

5) Health Insurance - In 1978, studies would focus on national health insurance-related analyses and on catastrophic care. Staff of the National Center will analyze the data obtained from the Medical Care Expenditure Survey initiated in 1977. The planned analyses will focus on the factors which influence expenditures for personal health services and the impact of alternative insurance arrangements on costs, public and private expenditures, the utilization of services, and the distribution of benefits and costs among different elements of the population. The effects of coinsurance, deductibles, and other arrangements designed to encourage reduced utilization will also be studied, with attention to costs, utilization, and the impact on disadvantaged groups.

Further analysis of last dollar insurance coverage will be undertaken, using the results of the catastrophic illness studies initiated in 1975 and data from the Medical Care Expenditure Survey.

6) Planning and Regulation - In 1978, the research program will emphasize the following: 1. Research on the establishment of standards for the performance of the health industry and the implementation of these standards by means of regulation. Such studies would assess the impact of certificate-of-need programs on investment and costs and would evaluate the effectiveness of hospital rate regulation; and 2. Research on market-structural changes to improve the health care delivery system, such as the studies of the impact of Federal policy on the growth of HMOs and the impact of HMO development on expenditure patterns.

7) Ambulatory Care and Emergency Medical Services - As one aspect of research on ambulatory care, the National Center supports research on the adequacy and 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, with approved proposals funded in 1976 and 1977.

In 1975-1977, 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 new budget authority for this program in 1978. The National Center is, therefore, requesting funds to meet estimated continuation commitments.

8) Long-term Care - The National Center has soliciated research proposals that focus on the problems of long-term care. Studies that result from this solicitation will be funded in 1977. The research program in 1978 will emphasize the same issues proposed in the solicitation: Planning, health insurance, assessment of performance, and the relationships between poverty and chronic health conditions.

B. Health Services Research Centers

A major component of the National Center's research effort is the Health Service Research Centers program, which was established in 1976. The National Center currently is supporting five basic health services research centers and two special emphasis centers. The grants to these centers provide support for a limited amount of staff and for overhead, but do not support the cost of actual research projects to be undertaken by the centers. The average award for each basic center is $341,886 per year for five years. The special emphasis centers cost approximately $1,000,000 per center. In 1978, the National Center would expand the program to establish the newly mandated Health Services Policy Analysis Center, which is estimated to cost $650,000. The total cost of the Research Centers program in 1978 is $4,250,000.

C. Health Services Research Training Programs

Phase out of the National Center's research training activities was begun in 1973. In 1977, the National Center will support only grants and fellowships for which support was committed in an earlier year. It is expected that these projects will not require additional funding in 1978, therefore no funds are being requested.

D. Dissemination of Research Findings

Of critical concern to the Congress, Administration and the public in general, is the rapid and effective dissemination of the results of the research effort. The National Center has made substantial progress in dealing with this problem. One-page summaries of the findings of each individual project are published regularly. Executive summaries written in non-technical language are now required of all grants and contracts and are disseminated as soon as the final report is received. A publication series entitled, "Research Digest" which provides in more extensive detail the scope and findings of significant projects is being distributed widely. Finally, a formal system for snythesizing and analyzing the research findings on policy issues of immediate concern is now being established.

Health Services Research

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program Support.....	188	$6,095,000	188	$6,442,000	---	+$347,000
Standard Level User Charge....		(402,000)		(402,000)		(---)

The National Center for Health Services Research is responsible for the appraisal and evaluation of the effectiveness of health services operations and for developing a research, demonstration and evaluation program that is geared to improving health care nationally.

The staff of the National Center devotes major effort to designing and directing the strategic program of research. The staff obtains high-level evaluation of all proposals, provides technical support for advisory bodies responsible for reviewing grants and contracts for scientific merit, monitors the research studies supported by grant or contract, reviews results, and publishes and disseminates the findings and the data obtained from the research. The staff provides technical assistance and consultation to organizations and individuals within and outside the Department engaged in or concerned with the results of health services research, evaluations and demonstrations.

The National Center regularly calls upon policymakers, consumers, health care providers, and program administrators to identify the current and emerging health care issues which they believe to be most pressing. The National Center intends to continue and expand its efforts to arrange conferences and to initiate extensive discussions with public and private authorities in order to specify the nature and magnitude of, and possible approaches to, the problems such groups identify as being of major importance. The purpose of these meetings is to identify and establish the importance of a particular research issue.

The National Center request shows an increase of $347,000 for 1978. This includes $210,000 for built-in costs, which is partially offset by a $15,000 decrease for one less day of pay and $78,000 for other non-recurring costs. An additional $230,000 will provide support for the restoration of 1977 positions and the increase in administrative costs to support the intramural research program and expanded project review process.

Health Professions Education

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Health Professions...	---	$156,100,000	---	$161,000,000	---	+$4,900,000
Dental Health Education.....	---	6,200,000	---	2,100,000	---	-4,100,000
Nursing.....	---	124,000,000	---	24,000,000	---	-100,000,000
Public Health..	---	8,000,000	---	8,000,000	---	---
Allied Health..	---	8,000,000	---	8,000,000	---	---
Special Educational Programs.....	---	122,700,000	---	102,600,000	---	-20,100,000
Health Teaching Facilities.....	---	10,978,620	---	2,000,000	---	-8,978,620
(Budget Authority)	---	(---)	---	(2,000,000)	---	(+2,000,000)
Program Support.....	674	22,577,000	668	23,020,000	-6	+443,000
Standard Level User Charge...	---	(302,000)	---	302,000	---	---
TOTAL.....	674	458,555,620	668	330,720,000	-6	-127,835,620
Budget Authority		(447,577,000)		(330,720,000)		(-116,857,000)

The 1978 budget for health manpower activities is directed toward providing available high quality health care to all Americans. Support is targeted toward alleviating the specialty maldistribution of health professionals by increasing the supply of primary care physicians and auxiliary personnel; redressing the problem of geographic maldistribution through scholarships tied to service commitments and programs to regionalize health professions education in medically underserved areas; assuring opportunities for the disadvantaged to pursue health careers; and increasing productivity and containing costs through more efficient use of personnel. Through the Public Health, Allied Health, and Nursing programs, emphasis is placed on the maintenance of health and on improving the efficiency and competence of health care personnel.

	1977 Estimate	1978 Estimate	Increase or Decrease
Health Professions			
Institutional Assistance:			
Capitation.....	$97,700,000	$114,500,000	+$16,800,000
Student Assistance:			
National Health Service Scholarships.....	35,000,000	40,000,000	+5,000,000
Loans.....	20,000,000	---	-20,000,000
Scholarships.....	1,000,000	---	-1,000,000
Shortage Area Scholarships.....	400,000	---	-400,000
Loan Repayments.....	2,000,000	1,500,000	-500,000
Exceptional need Scholarships.....	---	5,000,000	+5,000,000
TOTAL	156,100,000	161,000,000	+4,900,000

Support is provided for: basic financial assistance to health professions education institutions and student assistance to health professions students. This support addresses the critical health manpower problems of geographic and specialty maldistribution and health professions education to needy students.

	1977 Estimate	1978 Estimate	Increase or Decrease
Capitation.....	$ 97,700,000	$ 114,500,000	+$ 16,800,000

Capitation grants provide a base of Federal financial support to health professions schools to assist them in meeting the costs of their educational programs in return for efforts to meet identified national health manpower needs. These include the maintenance or expansion of training capacity, increased emphasis on training for the delivery of primary care, training in medically underserved areas, and altering specialty and geographic distribution patterns.

These financial incentive grants are awarded according to a formula established in legislation of schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy and podiatry and now, to schools of public health. To qualify for capitation support medical schools must have specified percentages of filled first-year residency positions in direct or affiliated residency training programs in primary care. The required percentages are: 35% in 1978; 40% in 1979; and 50% in 1980. Medical schools must also reserve an "equitable number" of positions in their classes for U.S. citizens who were students in foreign medical schools before October 12, 1976.

The request of $114,500,000 in 1978 will support 186 schools in the disciplines and amounts represented below:

Type of School	Enrollment	X	Average Amt Per Student	Total
1977				
Medicine				
Allopathic.....	57,627	X	$1,102	$63,500,000
Osteopathic.....	3,684	X	1,221	4,500,000
Dentistry.....	20,965	X	1,101	23,100,000
Veterinary Medicine...	6,556	X	671	4,400,000
Optometry.....	4,094	X	317	1,300,000
Podiatry.....	2,286	X	394	900,000
	95,212			97,700,000
1978				
Medicine				
Allopathic.....	59,388	X	$1,350	$80,200,000
Osteopathic.....	3,898	X	1,350	5,300,000
Dentistry.....	21,470	X	1,350	29,000,000
	84,756			114,500,000

	1977 Estimate	1978 Estimate	Increase or Decrease
National Health Services Scholarships.....	$35,000,000	$40,000,000	+$5,000,000

The NHS Scholarship program will substantially influence the distribution of physicians practicing in rural or inner-city shortage areas by requiring one year of service in return for each year of scholarship support received. A minimum of two-years service is required. The program awards financial assistance for educational and living expenses in exchange for equivalent years of service in the National Health Service Corps, the Indian Health Service or private practice in a health manpower shortage area. Implementation of this program will address the acknowledged problems of specialty and geographic maldistribution of doctors, dentists, and certain other health professions personnel.

Tuition and fees are paid directly to the school and the student receives 12 monthly stipends of $400 per month. Eighty-one percent of the awards must go to students of medicine and osteopathy; 9% to students of dentistry; and 10% may go to other health professionals designated by the Secretary as in short supply in the National Health Service Corps. The minimum obligation is two years.

The NHS Scholarship program increases access to quality health care for citizens in medically underserved areas. We estimate over 1,000 doctors or dentists will have been assigned to shortage areas by 1978. The budget request of $40,000,000 will provide support for approximately 4,000 participants.

	1977		1978	
	No.	Amount	No.	Amount
New Awards.....	1,703	$18,025,000	2,540	$25,400,000
Continuations....	1,630	16,975,000	1,460	14,600,000
Total.....	3,333	35,000,000	4,000	40,000,000

Discipline	New Awards	Continuations	Total	Graduating	Recipients Available for Service
1977					
Medicine...	1,380	1,680	3,060	1,361	482
Dentistry..	50	23	73	55	55
Nursing....	144 1/	---	144	102	102
Other.....	56	---	56	18	18
Total..	1,630	1,703	3,333	1,536	657

1/ Includes: Clinical nurses - 40; nurse anesthetists - 20; nurse midwives - 14; nurse practitioners - 28; and public health nurses - 42.

1978					
Medicine...	1,860	1,380	3,240	982	933
Dentistry..	360	---	360	9	18
Nursing....	---1/	52	52	52	52
Other.....	320 2/	28	348	188	188
Total...	2,540	1,460	4,000	1,231	1,191

1/ In 1978 all nursing personnel included under "other" category.
2/ To be determined by DHEW Secretary, depending upon needs.

	1977 Estimate	1978 Estimate	Increase or Decrease
Loans.....	$20,000,000	---	-$20,000,000

In 1977, loans were 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 phased out, the Federally Insured Loan program is a source of funds for these students. In addition, students may apply for Health Service Scholarships. In 1978, schools may provide student loans from their replenished loan funds on hand.

	1977 Estimate	1978 Estimate	Increase or Decrease
Scholarships.....	$1,000,000	---	-$1,000,000

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 1978, the Health Professions Scholarship program has been terminated in favor of a conditional scholarship program requiring the recipient to serve in designated shortage areas of various public health programs for a specific period of time. For this reason, no funds have been requested for this program.

	1977 Estimate	1978 Estimate	Increase or Decrease
Physician Shortage Area Scholarships.....	$400,000	---	-$400,000

The final year of scholarship support (1977) provided funds to approximately 100 recipients. This program is being phased-out in favor of the National Health Service Scholarship program.

	1977 Estimate	1978 Estimate	Increase or Decrease
Loan Repayments.....	$2,000,000	$1,500,000	-$500,000

This program serves as an additional mechanism for attracting health professionals to medically underserved areas by providing for service agreements in exchange for repayment of up to 85% of educational loans incurred by health professions students. Individuals with degrees from accredited schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry and veterinary medicine, who obtained direct health professions student loans, are eligible to enter into an agreement with the Secretary for repayment of a part of these loans for practice in a shortage area.

For the minimum period of two years of service in a shortage area, 60 percent of the outstanding principal will be repaid (plus interest as it falls due). For a third year of service, an additional 25 percent of the principal will be repaid (plus interest as it falls due).

Three hundred health professionals practicing in shortage areas would have loans repaid under this request of $1,500,000.

	1977 Estimate	1978 Estimate	Increase or Decrease
Exceptional Need Scholarships.....	---	$5,000,000	+$5,000,000

This program is intended to encourage persons with limited resources to enter a career in the seven health professions (MOD, VOPP) and thereby assure that such education is accessible, not only to the wealthy, but also to students from ~~low-income~~ or disadvantaged backgrounds.

These scholarships assist full-time students with exceptional financial need in their first year of post-baccalaureate study at a health professions school. Scholarship recipients will receive a stipend of $400 a month for living expenses, plus tuition and other reasonable educational expenses without incurring a service obligation. Hopefully after a successful first-year of receiving scholarship support, recipients will seek out and qualify for other types of financial assistance in order to continue their education. The request of $5,000,000 would support 500 financially needy students.

	1977 Estimate	1978 Estimate	Increase or Decrease
Dental Health Education			
Educational Assistance:			
Continuing Education.....	$ 200,000	--	$ -200,000
Educational Development & Application.....	500,000	--	-500,000
Special Projects:			
Expanded Function Dental Auxiliaries 1/.....	($2,000,000)	($2,000,000)	--
TEAM grants.....	5,500,000	2,100,000	-3,400,000
General Dentistry Residencies 1/.....	--	(4,500,000)	(+4,500,000)
Total.....	$6,200,000	$2,100,000	-$4,100,000

1/ Discussed under Special Educational Programs

	1977 Estimate	1978 Estimate	Increase or Decrease
Continuing Education.....	$200,000	---	-$200,000

In previous years, the Dental Continuing Education program supported projects which trained personnel to update their knowledge and skills in current dental concepts, techniques and management. No funds are requested for this program in 1978.

	1977 Estimate	1978 Estimate	Increase or Decrease
Educational Development and Application.....	$500,000	---	-$500,000

In 1977, contracts totalling $500,000 were awarded to analyze, develop and apply new concepts in areas such as dental education and curriculum, dental manpower requirements, and dental delivery systems. No funds are requested in 1978.

	1977 Estimate	1978 Estimate	Increase or Decrease
Training in Expanded Auxilary Management (TEAM)..	$5,500,000	$2,100,000	-$3,400,000

The Training in Expanded Auxiliary Management program provides support to dental schools for the development and implementation of didactic and clinical training experiences which prepare dental students to organize and manage multiple-auxiliary dental practices, including the utilization of dental extenders. TEAM trained dentists operate at the patients chair utilizing dentistry assistants while traditionally trained dentists do not delegate direct patient care tasks to others. This training will enable graduates to improve the efficiency of dental practice and the increased productivity resulting from greater efficiency should make more dental services available to more people, and be a significant factor in cost-containment.

The request of $2,100,000 would support 12 TEAM programs for approximately 800 students.

TEAM Projects	1977	1978
Number of projects.....	27	12
Students in training projects.....	1,725	800

	1977 Estimate	1978 Estimate	Increase or Decrease
Nursing			
Institutional Assistance:			
Capitation	$40,000,000	---	-$40,000,000
Advanced Nurse Training	9,000,000	---	-9,000,000
Nurse Practitioners	9,000,000	$9,000,000	---
Special Projects	15,000,000	6,000,000	-9,000,000
Student Assistance:			
Loans	22,500,000	---	-22,500,000
Scholarships	6,500,000	9,000,000	+2,500,000
Traineeships	13,000,000	---	-13,000,000
Loan Repayments	3,000,000	---	-3,000,000
Fellowships	1,000,000	---	-1,000,000
Educational Assistance:			
Research Grants	5,000,000	---	-5,000,000
TOTAL	124,000,000	24,000,000	-100,000,000

These activities have provided support to programs included in the Nurse Training Act of 1975 through institutional support, student assistance, and research and development projects. Since the supply of nurses is adequate, additional Federal financial support for most programs is not needed. Undergraduates have access to the Basic Education Opportunity Grants, and graduate students to the Guaranteed Loan program, in the Office of Education.

	1977 Estimate	1978 Estimate	Increase or Decrease
Capitation	$ 40,000,000	---	-$40,000,000

The Nurse Training Act of 1975 authorized a new formula for capitation grants to support educational programs in nursing schools of all types. Schools were to either increase first-year enrollments or carry out programs dealing with the preparation of nurse practitioners, continuing education, recruitment of disadvantaged students, and clinical training in community health centers. In 1977, capitation awards were issued to 1,090 nursing programs. No funds are requested for this program in 1978.

	1977 Estimate	1978 Estimate	Increase or Decrease
Advanced Nurse Training..	$9,000,000	---	-$9,000,000

The advanced nurse training program supported grants and contracts to collegiate schools of nursing to plan, develop, and operate, or significantly expand or maintain programs for the advanced training of professional nurses to be teachers, administrators, supervisors, or nursing specialists. In 1977, 61 projects were supported at a cost of $6,800,000 and 18 continuations from prior years were funded for $2,200,000. No funds are requested for this program in 1978.

	1977 Estimate	1978 Estimate	Increase or Decrease
Nurse Practitioner.....	$9,000,000	$9,000,000	---

This activity provides support to programs which train nurse practitioners. The overall impact is improved accessability, availability, and quality health care, especially in medically underserved areas. The nurse practitioner instructs and counsels individuals, families and groups in health promotion and maintenance. The graduate is qualified to take health histories, perform physical examinations, assess and define health problems, initiate some treatments under medical protocols, and recognizes when to refer a patient to a physician or other health provider. The nurse practitioner works in collaboration with other health care providers and agencies. They are employed in ambulatory care settings such as clinics, neighborhood health centers, health departments, solo or group practices in both urban and rural settings. Programs must be one academic year in length with a minimum of four months didactic instruction and clinical supervision, enroll at least eight full-time students per class, and meet guidelines and regulations. Some emphasis will be placed on problems of geriatric and nursing home patients.

Both shortage and the maldistribution of primary care health professionals are addressed by this program since nurse practitioners provide primary care in community and ambulatory care settings. They thus improve access to quality primary health care and contribute to cost efficient delivery of health services by assuming some roles formerly performed only by physicians.

Presently there are about 8,000 nurse practitioners. The request of $9,000,000 would support 45 nursing programs which have approximately 590 students in training as nurse practitioners. Support includes funds for helping to organize and establish programs.

	1977	1978
Amount	$9,000,000	$9,000,000
Number of Projects	45	45

	1977 Estimate	1978 Estimate	Increase or Decrease
Special Projects	$15,000,000	$6,000,000	-$9,000,000

The Special Project program is directed at improving the nursing education process and the product. This program aims to improve access to quality health care, to strengthen the nursing workforce's competencies, and to assure nursing opportunities for the disadvantaged.

Grants and contracts are awarded for the following project purposes: to increase nursing education opportunities for individuals from disadvantaged backgrounds; to help improve the distribution of nurses by geographic area; to develop continuing education and retraining programs; to assist in developing curricula and training programs in primary and specialized care in pediatrics and geriatrics; to plan, develop, or establish new nurse training programs, to upgrade the skills of licensed practical nurses and auxiliary nursing personnel; and to assist in cooperative merger efforts between hospital training programs and academic institutions.

Not less than ten percent of the money appropriated for this program is used for projects which increase nursing education opportunities for individuals from disadvantaged backgrounds.

The request of $6,000,000 would support 65 projects in the aforementioned targeted areas.

	1977	1978
Career Development and Mobility	$5,350,000	$2,140,000
Curriculum Revision	3,300,000	1,320,000
Expanded Clinical Roles	900,000	360,000
Faculty Development	150,000	60,000
Instructional Technology	1,200,000	480,000
New Program	1,700,000	680,000
Program Evaluation	300,000	120,000
Planning Grants	300,000	120,000
Remedial Services	300,000	120,000
Disadvantaged Assistance	1,500,000	600,000
Total	15,000,000	6,000,000

	1977 Estimate	1978 Estimate	Increase or Decrease
Loans.....	$22,500,000	---	-$22,500,000

This program provided long-term low interest loans up to $2,500 per academic year to assist students having need for financial assistance to undertake the course of study leading to a diploma, an associate degree, a bachelor's degree, or a graduate degree in nursing. Funds were allocated by a legislative formula to participating accredited schools of nursing located in the United States, Puerto Rico, Guam, and the Virgin Islands. The participating schools administered these funds. In 1978 no funds are requested for this program. Schools may provide student loans from their replenished loan funds on hand.

	1977	1978
Total amount awarded.....	$22,500,000	---
Number of Schools.....	1,195	---
Number of Students Assisted..	28,125	---
Average Per Student.....	$800	---

	1977 Estimate	1978 Estimate	Increase or Decrease
Scholarships.....	$6,500,000	$9,000,000	+$2,500,000

The Nursing Scholarship program provides scholarships up to $2,000 per academic year to assist students having exceptional financial need so that they might undertake a course of study leading to a diploma in nursing, an associate degree in nursing, a bachelor's degree in nursing or its equivalent, or a graduate degree in nursing. Funds are allocated according to a legislative formula to participating schools of nursing education which in turn make scholarship awards to those in need.

This program contributes to opportunities for the disadvantaged to pursue nursing careers and to provide quality health care to all Americans.

The request of $9,000,000 would support 9,000 nursing students at 1,350 schools.

	1977	1978
Number of Schools.....	1,297	1,350
Number of Students receiving Scholarships.....	6,500	9,000
Average Scholarship Amount.....	$1,000	$1,000

	1977 Estimate	1978 Estimate	Increase or Decrease
Traineeships.....	$13,000,000	---	-$13,000,000

The Traineeships program provided financial assistance to registered nurses undertaking advanced education preparation for leadership positions. Traineeships provided stipend, tuition, and dependence allowances which enabled nurses to preapre for positions as teachers, administrators, or supervisors for nursing services in institutional and community settings. In 1977, $13,000,000 supported 3,300 trainees. No funds are requested for this program in 1978.

	1977 Estimate	1978 Estimate	Increase or Decrease
Loan Repayments.....	$3,000,000	---	-$3,000,000

The Nursing Loan Repayment program for service in a shortage area provided for the Secretary of DHEW to repay a portion of an individual's education loan incurred for the cost of education at a school of nursing when the individual entered into an agreement to practice his profession (including practice as a member of the Public Health Commission Corps or National Health Service Corps) for a specified period in an area determined by the Secretary to have a shortage of and need for such nurses. No funds are requested for this program in 1978. Similar needs can be met through the NHS scholarship program.

	1977 Estimate	1978 Estimate	Increase or Decrease
Fellowships.....	$1,000,000	---	-$1,000,000

In 1977, National Research Awards for predoctoral and postdoctoral nurse fellowships were made to individuals for specified research training for several purposes: (1) to increase the opportunities for qualified nurses to engage in full-time graduate study and research training; (2) to prepare professional nurses to conduct independent research, collaborate interdisciplinary research, and stimulate and guide others in nursing research; (3) to promote the availability and utilization of nurses with research training as faculty in schools of nursing, and (4) to prepare nurses to conduct scientific inquiry in disciplines that have significance for nursing theory and practice. No funds are requested in 1978.

	1977	1978
Total amount	$1,000,000	--
Applications received	2,000	--
Estimated number of awards	110 to 120	--

	1977 Estimate	1978 Estimate	Increase or Decrease
Research Grants	$5,000,000	---	-$5,000,000

This program supported research projects throughout the country. Particular emphasis had been in the area of clinical therapy, which centered around psychosocial management aspects of patient care. No funds are requested in 1978.

	1977 Estimate	1978 Estimate	Increase or Decrease
Public Health:			
Institutional Assistance:			
Grants to Graduate Programs in Health Administration....	--	$3,000,000	+$3,000,000
Special Projects-Public Health and Health Administration...	--	5,000,000	+5,000,000
Formula Grants.....	$2,000,000	--	-2,000,000
Graduate Training Grants.....	6,000,000		-6,000,000
Total.....	$8,000,000	$8,000,000	--

	1977 Estimate	1978 Estimate	Increase or Decrease
Grants to Graduate Programs in Health Administration.....	---	$3,000,000	+$3,000,000

A number of current problems in the health delivery system, including high costs, inadequate access and inefficiency have been attributed in part to the lack of effective planning and management. Recognizing the need for increased numbers of appropriately trained managers in all segments of the health system, this new program of grants for graduate programs in Health Administration will support the expansion and improvement of graduate programs in health administration, hospital administration and health planning.

Under the request of $3,000,000, an estimated 30 public or non-profit private educational entities, including schools of social work, would receive grant awards.

	1977 Estimate	1978 Estimate	Increase or Decrease
Special Projects-Public Health and Health Administration.....	---	$5,000,000	+$5,000,000

The request of $5,000,000 would support approximately 100 projects in these high priority areas training about 7,000 students.

	1977 a/		1978	
	Projects	Amount	Projects	Amount
Preventive medicine and dentistry	26	$1,300,000	--	---
Biostatistics and epidemiology	10	500,000	10	$500,000
Health administration, planning and policy analysis	64	3,200,000	70	3,500,000
Environmental and occupational health	10	500,000	10	500,000
Dietetics and nutrition	6	300,000	10	500,000
Other	4	200,000	--	---
Total	120	6,000,000	100	5,000,000

a/ In 1977, these categories of projects were funded under the Graduate Training Grants program; authorization for that program expired in 1977. The new authority for Special Projects in Graduate Training in Public Health and Health Administration can fund similar projects as detailed above.

	1977 Estimate	1978 Estimate	Increase or Decrease
Formula Grants	$2,000,000	--	-$2,000,000

This program is not authorized in 1978, so no funds are requested.

	1977 Estimate	1978 Estimate	Increase or Decrease
Graduate Training Grants	$6,000,000	--	-$6,000,000

In 1978 this authority is replaced by the grants to graduate Programs in Health Administration and the Special Projects for Public Health and Health Administration.

In the field of public health, there is a recognized need to increase the emphasis on preventing illness, while at the same time attempting to deal with currently prevalent public health problems, such as environmental hazards, chronic diseases, alcoholism and drug abuse. Emphasis in health administration is based on the need for improved management of the health system through better health planning and cost containment as well as providing trained administrators for new or expanding delivery systems such as HMO's, long term care facilities, group practices, ambulatory care, etc.

This program provides support for projects in accredited Schools of Public Health and to other public or non-profit private educational entities for support of new or expansion of existing programs in biostatistics or epidemiology; health administration, health planning or health policy analysis; environmental or occupational health; and dietetics and nutrition.

	1977 Estimate	1978 Estimate	Increase or Decrease
Allied Health			
Institutional Assistance:			
Special Projects Grants and Contracts.....	$ 8,000,000	$ 8,000,000	--

This allied health program help assure the availability of qualified health professionals through its credentialing and continuing education efforts. It influences the efficiency of health care services through role definition and career development projects. The program contributes to improved geographic distribution through regional systems of coordination and management.

Grants and contracts are awarded to eligible entities to assist in planning, developing, demonstrating, operating, and evaluating projects to establish:

-- a regional or State system for the coordination and management of education and training at various levels for allied health personnel and nurses in educational institutions and their clinical affiliates.
-- new roles and functions for allied health personnel and methods for increasing their efficiency.
-- new or improved methods of credentialing allied health personnel.
-- methods of recruitment, training and retraining.
-- career ladders and programs of advancement for practicing allied health personnel.

The law stipulates that of the amounts appropriated for special project grants and contracts, 50% is to be reserved for awards to training centers for allied health professions. Priority would be given to programs training allied health professionals in specialties crucial to the support of primary care practitioners and in specialties with critical manpower shortages.

The request of $8,000,000 would support an estimated 150 projects.

	1977		1978	
	Projects	Amount	Projects	Amount
Regional/State system to coordinate education and training programs	2	$200,000	12	$1,000,000
New roles and functions, efficient methods	2	250,000	6	500,000
Credentialing	8	1,500,000	8	1,500,000
Recruitment, training, and retraining	136	6,000,000	80	4,000,000
Career ladders and advancement programs	2	50,000	44	1,000,000
Total	150	8,000,000	150	8,000,000

Special Educational Programs

	1977 Estimate	1978 Estimate	Increase or Decrease
Family Medical Residencies and Training..	$ 39,000,000	$ 45,000,000	+$ 6,000,000
Primary Care Residencies and Training.....	15,000,000	15,000,000	---
Health Professions Special Projects.....	20,200,000	---	-20,200,000
Physician/Dental Extenders.	10,500,000	11,100,000	+600,000
Area Health Education Centers.....	14,000,000	15,500,000	+1,500,000
Disadvantaged Assistance...	8,000,000	8,000,000	---
Foreign Medical Graduates..	1,000,000	2,000,000	+1,000,000
Graduate Medical Education National Advisory Committee.....	1,000,000	1,000,000	---
Financial Distress.....	3,000,000	2,000,000	-1,000,000
Health Professions Start-up Assistance.....	3,000,000	1,000,000	-2,000,000
Manpower Initiatives.....	7,000,000	---	-7,000,000
Manpower Supply and Distribution Reports.....	1,000,000	2,000,000	+1,000,000
TOTAL.....	122,700,000	102,600,000	-20,100,000

	1977 Estimate	1978 Estimate	Increase or Decrease
Family Medical Residencies and Training:			
Family Medicine.....	$39,000,000	$40,500,000	+$1,500,000
General Dentistry.....	---	4,500,000	+4,500,000
Total.....	39,000,000	45,000,000	+6,000,000

	1977 Estimate	1978 Estimate	Increase or Decrease
Family Medical Residencies and Training.....	$39,000,000	$40,500,000	+$1,500,000

This program supports development of family medicine faculty and family medicine training programs so that more family medicine practitioners will enter the health care delivery system where they are needed. It also supports efforts to increase the portion of training occurring in an ambulatory environment instead of in-patient hospital settings to assure that family medicine training occurs in a community setting.

The program is directed at making comprehensive personal health care available and accessible to medically underserved areas, an effort which must be considered a key part of a national goal of quality health care for all Americans. An adequate supply of such comprehensive personal health care practitioners is essential for any national health care program since such practitioners can and should handle the vast majority of patient complaints and illnesses. It will help to stabilize and reverse the significant downward trend in the number of family physicians which has occurred in the last 30 years and help assure the continued availability of needed family care to many communities.

Of special concern, the program directly addresses the recognized specialty maldistribution problem of a lack of primary care practitioners. These primary care practitioners usually disperse in rough proportion to the population; thus, the family medicine training program will also help alleviate the geographic maldistribution problem.

A combination of allopathic residencies, osteopathic internships, faculty development and predoctoral training are supported under the family medicine residencies and training program.

The request of $40,500,000 would support 236 projects and approximately 3,150 residencies and faculty. Also 1,260 new first-year places annually would be assisted with these funds.

	1977	1978
Types of Projects:		
Faculty Development	30	30
Residency Training	143	146
Family Medicine:		
Pre-doctoral and Preceptorships	60	60
Total	233	236
Total Faculty Trained	300	300
First Year Residencies	1,100	1,260
Total Residencies	2,580	2,850

	1977 Estimate	1978 Estimate	Increase or Decrease
General Dentistry Residency Training Program.....	---	$4,500,000	+$4,500,000

The General Dentistry Residency program will support the planning, development and implementation of didactic and clinical experiences that enable dental students to acquire the advanced skills and competencies that characterize primary care general dentistry. The program is intended to counteract the trend toward dental over specialization and fragmentation of care and should lead to a reduced need for referring patients, resulting in reduced costs and improved quality of care. In addition, graduates of these programs will be more adequately prepared to deliver a broad range of dental services in geographically remote areas.

Program support will be provided for establishing new residencies, for expanding and improving existing residencies, and for stipends to those residents who are in need of financial assistance.

The request of $4,500,000 would support 20 grants, providing training and experience for approximately 200 students and faculty.

	1977 Estimate	1978 Estimate	Increase or Decrease
Primary Care Residencies and Training.....	$15,000,000	$15,000,000	---

The major purposes of this program are: (1) the development of first-year residency positions and conversion of existing internal medicine and pediatric residency positions with emphasis on ambulatory care; (2) the development of remote, plus, non-hospital sites of education; and (3) the development of additional osteopathic general internal medicine and pediatric residency positions, again with emphasis on ambulatory care.

By promoting the training of many primary care doctors in fields of general internal medicine and general pediatrics, this program will directly address the specialty maldistribution problem.

Indirectly, the program may help alleviate the geographic maldistribution problem since primary care practitioners tend to distribute themselves in more equitable proportion to the population. Also, by creating residency opportunities in ambulatory primary care, this program helps assure future access to quality health care, certainly a prerequisite for any national health insurance system.

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The 1978 request of $15,000,000 would support an estimated 104 projects training 450 residents and 200 faculty and would help move the manpower force toward the goal of 5,900 first-year primary care residencies in these specialties by the early 1980's.

Types of Projects:	1977	1978
Faculty Development	20	20
Residency Training	64	64
Predoctoral and Clerkships	20	20
Total	104	104
Total Faculty Trained	200	200
Residents Trained	450	450

	1977 Estimate	1978 Estimate	Increase or Decrease
Health Professions Special Projects	$20,200,000	---	-$20,200,000

This program assisted MOD/VOPP schools to meet the costs of projects such as: curriculum improvement, interdisciplinary training, more efficient utilization of health personnel, more effective approaches to the organization and delivery of health services and improvement of geographic and specialty distribution of health professionals. In 1977, the $20,200,000 supported approximately 229 continuation projects. No funds are requested in 1978 since authorizing legislation has expired. Similar types of projects would be funded under other activities within this budget request.

	1977 Estimate	1978 Estimate	Increase or Decrease
Physicians/Dental Extenders:			
Physicians Assistants	$8,500,000	$9,100,000	+$600,000
Dental Extenders	2,000,000	2,000,000	---
Total	10,500,000	11,100,000	+600,000
Physician Assistants	$8,500,000	$9,100,000	+$600,000

This program supports the planning, development, operation, or maintenance of physician assistant training programs and the training of faculty to serve in such P.A. programs. The educational programs supported by these grants must have an orientation in the curriculum and a deployment mechanism which encourages the graduates to work in Health Manpower Shortage Areas.

The Physician's Assistants graduating from Federally funded programs directly impact on the primary care shortages recognized by Congress. Research has shown that primary care physicians' practices can be augmented by 40% to 70% by the introduction of appropriately trained Physician's assistants. Physician assistants deliver those primary care services for which they have been trained to function at the same competency as the physician, including: complete physical examination; analyses of patient complaints; performing attendant examinations; ordering laboratory tests; recording medical data and outlining treatment regimes within physician specified parameters. Research also demonstrates that 44% of P.A.'s are located in non-metropolitan areas, while only 14% of non-federal physicians are located in the same areas. Thus, we expect the P.A. programs to impact on the geographic maldistribution of health service problems.

The request of $9,100,000 would help sustain 40 programs training 2,700 physician assistants and 6 faculty development projects supporting 60 faculty students.

	1977	1978
Number of Projects.....	40	40
Number of Students Trained.....	2,700	2,700
Number of Faculty Training Projects....	---	6
Number of Faculty Trained.....	---	60

	1977 Estimate	1978 Estimate	Increase or Decrease
Dental Extenders.....	$ 2,000,000	$ 2,000,000	---

The purpose of the Dental Extender program is to upgrade the training of dental hygienists and dental assistants to qualify them to assume expanded functions under the supervision of the dentist as members of the dental care team. The degree of task responsibility allowed dental extenders varies from state to state. Duties can include administering certain types of anesthesia, applying cavity liners and bases and placing and removing periodontal dressings. The use of dental auxiliaries increases the amount of services a dentist is able to provide, and potentially extends the mix of primary dental services. This contributes to cost-containment, alleviation of health manpower shortages, and broader accessibility to health care.

Didactic and clinical preparation of dental extenders is accomplished through curriculum modification to include expanded functions; supplementary education for practicing auxiliaries; and training of faculty members to teach expanded functions.

The request of $2,000,000 would support approximately 24 programs, benefitting an estimated 1,200 students and faculty.

	1977	1978
Number of Projects.....	24	24
Number of Students and Faculty Trained.	1,200	1,200

	1977 Estimate	1978 Estimate	Increase or Decrease
Area Health Education Centers.....	$14,000,000	$15,500,000	+$1,500,000

The AHEC program is especially designed to alleviate the geographic maldistribution of health manpower and, to a lesser extent, specialty maldistribution. By supporting projects linking schools of medicine or osteopathy, and other health institutions to rural and urban communities, practitioners in training may develop commitments to serving in such underserved areas. Continuing education is provided to practicing health professions and basic training is afforded to students.

The AHEC program is a university-based system which calls upon participating schools to significantly change existing patterns of education and to form partnerships with local communities. All AHEC contracts are cost-shared with state and local resources contributing approximately 25% of the total cost of the program. This program assists in assuring quality health care to those Americans in urban and rural areas which lack adequate primary care health manpower.

In 1977, the $14,000,000 funded 14 centers serving 16 states and 300 counties. The 1978 request of $15,500,000 would support 16 centers serving 18 states and 325 counties.

	1977	1978
Number of Projects.....	14	16
Health Professionals in Training.....	8,000	9,000
Graduate Medical and Dental Trainees...	700	800
Hours of Continuing Education Provided to Rural Health Practitioners.....	57,000	62,500

	1977 Estimate	1978 Estimate	Increase or Decrease
Disadvantaged Assistance...	$8,000,000	$8,000,000	---

This program is one of the few training programs exclusively for individuals from socioeconomic backgrounds who are educationally or financially disadvantaged, and who are interested in pursuing a health career. This program can help assure that opportunity for health professions education is open to the poor or less privileged, not just to the rich. Thus, the program represents an effort to assure equal opportunity to the less fortunate.

The types of programs supported are motivation, recruitment, admissions, retention and placement of these students. Funds are awarded directly to public, nonprofit private health or educational entities not to individuals. A limited stipend, however, is allowed for students participating in these programs.

The Program assists in meeting the cost of projects to identify, recruit and offer secondary and post secondary education and training for increased enrollment and retention of disadvantaged individuals already enrolled in health prefassions schools.

This program has the potential to impact on the geographic maldistribution problem since minority or rural students might be more likely to return to areas medically underserved. The request of $8,000,000 would support 100 projects benefiting 9,000 students, the same as in 1977.

	1977 Estimate	1978 Estimate	Increase or Decrease
Foreign Medical Graduates...	$1,000,000	$2,000,000	+$1,000,000

This program supports grants to schools of medicine and osteopathy to plan, develop and operate programs to assist U.S. citizens enrolled in foreign medical schools before October 12, 1976 in transferring to U.S. medical or osteopathic schools with advanced standing. A major objective of this program is to identify the deficiencies that exist in the medical education of the transferring U.S. foreign medical students and to develop materials and methodologies for correcting these deficiencies. Eventually, such students may be integrated into the U.S. health workforce as highly qualified practitioners. This stimulation for U.S. schools to assist these students is intended to remedy an unfortunate situation which currently exists--namely, the foreign enrollment of U.S. citizens in schools where the teaching is not done in English and the education is inferior to that in the U.S. However, it is not intended to establish an alternative route to a medical career in the U.S. and therefore, students enrolled after the enactment of P.L. 94-484 will not be able to participate.

The 1978 request of $2,000,000 would support 14 projects benefiting 600 students.

	1977	1978
Number of Projects.....	7	14
Students Benefiting.....	350	600

	1977 Estimate	1978 Estimate	Increase or Decrease
Graduate Medical Education National Advisory Committee..	$1,000,000	$1,000,000	---

This Committee provides the Secretary of HEW with a resource group to address the problem of physician specialty maldistribution through the analysis of specialty requirements, the examination of the characteristics and outputs of the current specialty education system, and analysis of the effects which patterns of reimbursement and support for specialty education have upon the numbers and types of physician specialists being trained.

The request of $1,000,000 would allow the Committee to examine issues, review analyses, and advise on data requirements and research needed to permit the GMENAC to fulfill its task of proposing national goals and recommending Federal policies, strategies and plans to achieve the established goals. It would also fund three analytic contracts required to support the Committee's mission and charter functions.

	1977 Estimate	1978 Estimate	Increase or Decrease
Health Professions Start-up Assistance.....	$3,000,000	$1,000,000	-$2,000,000

This program provides grants to new MOD, VOPP and public health schools so that they may begin instruction earlier or substantially increase their enrollments over what would otherwise be possible. The program may help alleviate the geographic maldistribution problem because preference is given to schools in areas where those health professionals are in short supply. In addition, a portion of the start-up funding is earmarked in legislation to a particular institution emphasizing training in family medicine.

By increasing training opportunities for health professionals, particularly in underserved areas, better access to quality health care should be attained.

The $1,000,000 requested will meet prior-year commitments to seven schools in six states.

	1977	1978
Number of Schools.....	10	7

	1977 Estimate	1978 Estimate	Increase or Decrease
Financial Distress.....	$3,000,000	$2,000,000	-$1,000,000

This program provides financial assistance to MOD, VOPP, or public health schools to meet costs of operation if in dire financial distress, to meet pressing accreditation requirements, or to carry out operational, managerial or financial reforms in response to a cost analysis study. A school may, in return for financial distress assistance, be required to reform its operation.

Financial Distress grants are intended to provide interim assistance to schools in serious financial straits. The amount of the grant to a school is limited to 75 percent of the financial distress grant to that school in the preceding year.

This program is helpful in maintaining quality training of sufficient numbers of health professionals to assure access to quality health care in the future. In addition, many of the hard-pressed schools benefitting from this program are oriented to minority needs.

An estimated five schools would receive funds under this request of $2,000,000.

	1977	1978
Number of Schools.....	8-9	5

	1977 Estimate	1978 Estimate	Increase or Decrease
Manpower Initiatives.....	$7,000,000	---	-$7,000,000

In 1977, $7,000,000 supported projects for: the recruitment and retention of individuals from disadvantaged backgrounds as health professions students; interdisciplinary efforts to provide cost-effective, high quality health care; training health professions students in the use of the team approach for delivering primary care; and teaching the humanistic medicine technique to all types of health professionals. Authority has expired for this program, therefore no funds are requested in 1978.

	1977 Estimate	1978 Estimate	Increase or Decrease
Manpower Supply and Distribution Reports.....	$1,000,000	$2,000,000	+$1,000,000

These funds will provide a Congressionally mandated comprehensive program of studies on supply, requirements, and distribution by specialty and geographic location of health professionals such as physicians, dentists, optometrists, physical therapists, etc. Information on health profession personnel will be collected, compiled and analyzed on a regular basis, and analytic and descriptive studies prepared on health manpower developments and issues of importance to the economical and equitable delivery of health care services. In addition, these studies are essential to health planners at local, State and Federal levels to analyze the health needs of the nation for the future.

The request of $2,000,000 would support a program to generate the statistics and develop the analyses needed to design effective health manpower legislation, develop policy, and plan, develop and evaluate programs. Studies will be made for physicians, dentists, VOPP's, Allied Health manpower, and Public Health manpower.

	1977 Estimate	1978 Estimate	Increase or Decrease
Health Teaching Facilities: Interest Subsidies.....	---	$2,000,000	+$2,000,000

The Federal Government will continue to support construction for health professions education through loan guarantees for private non-profit schools. The Government also has the authority to guarantee the full amount of any losses in case of loan defaults.

The Interest Subsidies program provides assistance to eligible health professions schools or affiliated hospitals and out-patient clinics which did not receive construction grant support.

In 1978, $2,000,000 is needed to pay the 3% interest subsidies on prior guaranteed loans of $75 million for health professions teaching facilities awarded in 1972. Payment of these subsidies is a continuing commitment during the life of the 30 year loans. This assistance program provided expansion of training facilities at five institutions with an increase of 92 first year enrollment places, 369 new teaching inpatient beds and the replacement of 1,156 obsolete teaching beds.

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program Support.....	674	22,577,000	668	$23,020,000	-6	+443,000
Standard Level User Charge..	---	(302,000)	---	(302,000)	---	(---)

The Bureau of Health Manpower is responsible for the development, implementation, and operation of programs authorized under the newly enacted Health Professions Education Assistance Act of 1976, P.L. 94-484 and the Nurse Training Act of 1975, P.L. 94-63.

During 1978, major emphasis will be placed on (1) the H.P. Capitation programs, with increased eligibility requirements in primary care, (2) the National Health Service Scholarship program with expanded eligibility and hence additional application processing, (3) a revised Family Medicine Residencies program open to hospitals and medical and dental schools, (4) the newly authorized General Dentistry Residencies and Exceptional Financial Need Scholarship programs, and (5) administration of the Federally Insured Loan program.

The 1978 request of $23,020,000 and 668 positions is needed to carry out new initiatives directed in the health manpower legislation and also to provide for the orderly completion of activities supported in previous years. Both the new and continued programs require grant and contract reviews, consultation and technical assistance, monitoring of projects, program direction, and administration of active and new grants and contracts. The decrease of six positions is part of an effort to eliminate the potential of overlapping administrative functions at the various organizational levels within the PHS. The reduction affects resource levels throughout various programs but can be achieved without impacting on Agency accomplishments.

Office of the Administrator

	1977 Estimate		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program Management.....	300	$10,947,000	300	$11,755,000		+$808,000
Standard Level User Charge.....		(627,000)		(627,000)		(---)

The staff of the Office of the Administrator is responsible for overall direction and management of HRA. Functions include administrative management, program planning and evaluation, program coordination, and public affairs activities. Efforts are under way in the areas of energy conservation for hospitals and other health facilities, and implementation of the Health Professions Educational Assistance Act of 1976. Efforts are continuing for implementation of the Health Planning and Resources Development Act of 1974.

Program offices located in the Office of the Administrator are: (1) the Energy Action Staff whose activities are referred to above; (2) the Division of Long Term Care whose main concern is to provide leadership and training to improve the quality of health care and social services available to those in long term care institutions, particularly the elderly; and (3) the Office of Health Resources Opportunity, which operates to promote the ability of disadvantaged Americans to receive benefits from all HRA programs.

DENTAL ACTIVITIES[1/]
($ in thousands)

	1977 Estimate	1978 Estimate
Funds Budgeted Under Dental Health:		
Continuing education	$,200	---
Education, Development and application	500	---
TEAM	5,500	$2,100
Subtotal	6,200	2,100
Funds Supporting But Not Budgeted Under Dental Health		
Capitation/Basic	23,100	29,000
National Health Service Scholarships	766	3,600
Loans	3,416	---
Expanded Function Dental Auxiliary	2,000	2,000
General Dentistry (Family Medicine)	---	4,500
Special Projects	2,465	---
Start-Up	250	250
Subtotal	31,997	39,350
Program funds	38,197	41,450
Program Support funds	3,474	3,669
Total, Dental Activities	41,671	45,119
Positions As of End-Of-Year	94	94

The increase in program support funds in 1978 results from anticipated increases in mandatory items.

1/ Does not include funds for dental functions conducted in other parts of the Public Health Service including: Dental prevention activities transferred to the Center for Disease Control; HEADSTART activities transferred to the Health Services Administration; and the functions of the Special Assistant for Dental Affairs in the Office of the Assistant Secretary for Health.

NURSING ACTIVITIES[1/]
($ in thousands)

	1977 Estimate	1978 Estimate
Institutional Assistance:		
Capitation	$40,000	---
Advanced Nurse Training	9,000	---
Nurse Practitioner	9,000	$9,000
Special Projects	15,000	6,000
Student Assistance:		
Loans	22,500	---
Scholarships	6,500	9,000
Traineeships	13,000	---
Loan Repayments	3,000	---
Fellowships	1,000	---
Educational Assistance:		
Research Grants, Contracts, and Fellowships	5,000	---
Program funds	124,000	24,000
NHS Scholarships	1,532[2/]	520
Program Support funds	3,139	3,277
Total, Nursing Activities	128,671	27,797
Positions As Of End-Of-Year	67	67

1/ Does not include funds for the Chief Nurse Officer's staff in the Office of the Assistant Secretary for Health.

2/ Included in 1977 Supplemental Request.

HEALTH RESOURCES ADMINISTRATION

National Center for Health Statistics

Program Purpose and Accomplishments

Activity: National Health Surveys and Analysis (Public Health Service Act, Section 308)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
429	$19,961,000	1/	429	$19,364,000

1/ Authorization expired September 30, 1977.

Purpose: This activity provides for the collection, analysis, and publication of national, descriptive, baseline health statistics; an annual collection of vital statistics on births, deaths, fetal deaths and marriage and divorces; a continuing nationwide health interview survey of households; and a series of national surveys based on physical examinations of samples of the population, including data on nutritional status. Other periodic surveys secure data on health institutions and their patients, diagnosis and treatment provided by physicians, family planning services, and data on child-bearing patterns and population growth.

Explanation: The information developed deals primarily with the provision of accurate, timely, and quality national baseline statistics on vital events; the health status of the population including physical, mental, and physiological characteristics; illness; injury; impairment; and on supply and utilization of health facilities. These data are made available to a wide range of users.

Accomplishments in 1977: The Center operated the activities described above. Data collection was begun in the second round of two major surveys, while findings from the first round were published. The Health and Nutrition Examination Survey II updated the data on physical and nutritional status gathered in 1971 - 74. The second National Survey of Family Growth began a time-series on information concerned with the dynamics of population change, family planning, and maternal and child health. New activities included questions about flu-like illnesses. The data, which are reported weekly, complemented information from the Center for Disease Control in describing the extent and pattern of any flu epidemic this year.

Objectives for 1978: The 1978 budget provides for operating the continuous and periodic health and vital statistics projects at the 1977 level. Data collected in 1976 and 1977 will be analyzed and published and the 1978 cycle of data collection will be initiated. The Cooperative Health Statistics System will develop in several States total health information systems, bring States with manpower and facilities developmental contracts to full implementation, and expand research and demonstration projects.

HEALTH RESOURCES ADMINISTRATION

National Center for Health Statistics

Program Purpose and Accomplishments

Activity: Cooperative Health Statistics (Public Health Service Act, Section 308)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
69	$8,350,000	1/	69	$14,272,000

1/ Authorization expired September 30, 1977

Purpose: To (1) assist Federal, State, and local health agencies in the design and implementation of a cooperative system for producing comparable and uniform health information at the National, State and local levels; (2) coordinate the activities of Federal agencies respecting the design and implementation of such a system; (3) undertake and support by contract: research, development, demonstration, and evaluation respecting such a system; (4) provide the Federal share of the data collection costs under such a system, and (5) review statistical activities of the Department of Health, Education, and Welfare to assure that they are consistent with such a system.

Explanation: The primary goal is the development of shared health data systems among data users and producers at local, State, and National levels. The Center has the responsibility for National leadership in coordinating the efforts among Federal agencies and between the Federal government and the States, and in assuring the quality and comparability of data collected.

Accomplishment in 1977: Data collection activities were continued in 45 States, the District of Columbia, and Puerto Rico. There was major growth in the output of the CHSS, namely, published statistics at the State and local level for use in the development, planning, and monitoring of Federal and State health programs. The consolidation of contracts for vital statistics, health manpower, and facilities components was extended into six additional States, making a total of 16 States having a nucleus for a coordinated health information system within a center for health statistics. There were an additional 19 States with vital statistics components, 13 with health manpower contracts, and 11 with health facilities contracts. Developmental and demonstration projects were conducted in 15 States with respect to obtaining data on the utilization of health care.

Objective for 1978: To (1) develop in several States total health information systems demonstrating the importance of health care utilization components, (2) bring all States with manpower and facilities developmental contracts up to the full implementation level, (3) expand the number of States with vital statistics, health manpower, and health facilities contracts, and (4) expand data applications and statistical activities.

HEALTH RESOURCES ADMINISTRATION

National Center for Health Statistics

Program Purpose and Accomplishments

Activity: Program Support (Public Health Service Act, various sections)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
44	$1,038,000	Indefinite	44	$1,142,000

Purpose: This activity supports the salaries and expenses of the management operations of the National Center for Health Statistics, including the direction, planning, and administrative functions of the Center.

Explanation: This activity provides for the planning and coordination of Center activities in developing goals and objectives, and in developing and implementing Center policies and procedures. This activity directs the Center's administrative management programs including personnel management and management analysis, and also provides administrative services for the Center.

Accomplishments in 1977: This activity supported the expansion of the Cooperative Health Statistics System, the Medical Care Expenditure Survey, and the reimbursable work program through direction, planning, and administration of these programs.

Objectives in 1978: This activity will provide continued direction of the Center's ongoing activities as well as the continued development of the reimbursable work program. In addition, it will provide major direction and support for the expansion of the Cooperative Health Statistics System.

This budget requests 44 positions and $1,142,000 for carrying out the activities associated with program support. This amount includes a $104,000 increase for (1) the purchase of approximately 12,000 copies of the Ninth Revision, International Classification of Diseases from the World Health Organization for use in the classification of causes of death during 1978-1987; (2) a contract with WHO for the development of a special supplementary International Classification of Diseases for use in classifying symptoms and patient complaints; and (3) the funding of within grade increases. This increase is partially offset by a $3,000 decrease for one less day of pay.

HEALTH RESOURCES ADMINISTRATION

Health Planning and Resources Development

Program Purpose and Accomplishments

Activity: Health Planning and Resources Development (Public Health Service Act, Title XV and XVI, Social Security Act, Section 1122)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$125,000,000	1/	---	$125,000,000

1/ Authorization expires September 30, 1977.

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 improve the quality and delivery of health services throughout the Nation, contain health care cost, and prevent unnecessary duplication of health resources.

Explanation: The law authorizes that fully designated health systems agencies (HSAs) be funded on a $.50 per capita basis, with additional funding made available through matching grants up to $.25 per capita; that State health planning and development agencies (SHPDAs) receive Federal financial participation of up to 75 percent of their operating costs. Projects for Planning Methods Development/Centers are funded through contracts, and Rate Regulation demonstrations are funded on a project grant basis with a maximum of six states participating.

Accomplishments in 1977: By the end of 1977, 49 regular SHPDAs, 205 HSAs and seven Section 1536 waiver States will have been designated, of which less than a third of the agencies are expected to be fully designated. The remaining agencies will continue under conditional designation status. Six rate review demonstration projects are expected to be developed and funded jointly with the Social Security Administration.

Objectives for 1978: Nearly all of the 49 regular SHPDAs, 205 HSAs, and seven Section 1536 waiver States will attain full designation status during 1978. The 10 Centers for Health Planning will be funded for their third year of operation and up to six rate review demonstration projects will be funded.

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HEALTH RESOURCES ADMINISTRATION

Medical Facilities Construction

Program Purpose and Accomplishments

Activity: Medical Facilities Construction (Public Health Service Act, Title XVI)

1977 Estimate		1978 Authorization	1978 Budget Estimate	
Pos.	Amount		Pos.	Amount
---	$51,545,000	1/	---	---

(---) (Budget Authority)

1/ Authorization expires September 30, 1977.

Purpose: Medical Facilities Construction is authorized under Title XVI of the Public Health Service Act. 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.

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% 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 costs of the project, except that there may be 100% Federal funding if the project is located in an urban or poverty level area.

Of the $51,760,000 appropriated in 1976, $40,372,800 was allotted to the States and territories for new construction and modernization of medical facilities and $11,387,200 was awarded to fund approximately 5 special medical facility projects.

Objectives for 1978: Carry-over activities from Title VI such as monitoring of assurance given and payments on construction will be continued during 1978. 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)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$23,000,000 (9,000,000) (Budget Authority)	1/	---	---

1/ Included in overall health services research authorization.

Purpose: Special medical facilities construction is authorized by sections 305(b)(3) and 308 of the Public Health Service Act which provides for research and demonstration projects respecting the design, construction, utilization, organization, and cost of facilities 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 1977: During 1977, $2,000,000 was provided to the Children's Hospital in the District of Columbia and $2,000,000 to the Georgetown University Concentrated Care Center for the purpose of equipment to make the new facilities at these institutions completely operational. The remaining $5,000,000 is for the construction of a health facility in Nome, Alaska.

Objectives for 1978: No funds are requested for this activity in 1978.

HEALTH RESOURCES ADMINISTRATION

Health Planning and Resources Development

Program Purpose and Accomplishments

Activity: Program Support (Public Health Service Act, various sections and Social Security Act, Section 1122)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
406	11,921,000	Indefinite	406	11,924,000

Purpose: This activity provides for the salaries and expenses to support the personnel and management operations of the Bureau of Health Planning and Resources Development (BHPRD).

Explanation: This activity provides the funds for maintaining the operations and staff of the Health Planning and Resources Development programs and the operations and staff of the ten Regional Office Bureau related components.

Accomplishments in 1977: Technical assistance to, and consultation with the Health Systems Agencies (HSAs), the State Health Planning and Development Agencies (SHPDAs), the ten Centers for health planning and the National Health Planning Information Center will be provided. Regulations will be developed and published on the development of Health Systems Plans and Annual Implementation Plans, Certificate of Need, HSA Review and Approval of funds function, assurances of service, and Federal Assistance for medical facilities under Title XVI. Guidelines will be developed and issued on the administration, organization, and operation of the HSAs, SHPDAs, and State Health Coordinating Councils.

Objectives for 1978: BHPRD will continue to provide technical assistance to, and consultation with the HSAs, SHPDAs, Health Planning Centers, and the National Health Planning Information Center. Regulations will be developed and published on the State Health Plan, the State Medical Facilities Plan, the Area Health Services Development Fund, and appropriateness review. In addition, there will be a major emphasis on reducing costly duplication, the rising cost of health care, and reaching the medically underserved.

HEALTH RESOURCES ADMINISTRATION

Health Services Research

Program Purpose and Accomplishments

Activity: Health Services Research (Public Health Service Act, Sections 304, 305 and 308)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
38	$24,039,000	1/	38	$24,000,000

1/ Authorization expires September 30, 1977

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 1977: From program solicitations issued in 1976, the National Center awarded research projects in the areas of Long-Term Care, Emergency Medical Services and Health Care and the Disadvantaged. Awards were made to establish two Health Services Research Special Emphasis Centers.

Objectives for 1978: The budget request of $24,000,000 will provide $6,000,000 for the intramural research program and $18,000,000 for grants and contracts. The request will support continuation commitments, including those for the Health Service Research Centers program, will permit establishment of the newly mandated Health Services Policy Analysis Center, and will permit for several new awards to be made in such research areas as Health Manpower, and Inflation, Productivity, and Costs.

HEALTH RESOURCES ADMINISTRATION

Health Services Research

Program Purpose and Accomplishments

Activity: Program Support (Public Health Service Act, various sections)

1977 Estimate		1978	Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
188	$6,095,000	Indefinite	188	$6,442,000

Purpose: This activity supports the salaries and expenses of the National Center for Health Services Research extramural operations and management personnel.

Explanation: The National Center for Health Services Research is responsible for the appraisal and evaluation of effectiveness of health services operations and for developing a research demonstration and evaluation program geared to improving health care.

Accomplishments in 1977: The staff of the Center devoted major effort to designing and directing strategic research. The staff obtained high-level evaluation of all proposals, closely monitored contracts, reviewed results, informed the professional community of significant progress and identified the next steps. Considerable time and effort was devoted to close collaboration with the investigators, providers, payers and major national organizations.

Objectives for 1978: The Center will continue to prepare special studies, analysis, and reports, to provide technical assistance, to design and develop research components for other programs, and to design and conduct evaluations of its own and other programs. The Center will continue to expand its efforts to arrange conferences and to initiate extensive discussions with public and private authorities in order to specify the nature and magnitude of, and possible approaches to, problems identified as being of major importance. This activity requests 188 positions and $6,442,000. This amount includes a $210,000 for mandatory costs, partially offset by a $15,000 decrease for one less day of pay and $78,000 for other non-recurring costs. An additional $230,000 will provide support for restoration of 1977 positions and the increase in administrative costs to support the intramural research program and expanded project review process.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Health Professions Support -- institutional assistance (Public Health Service Act, Title VII, Part E)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$97,700,000	$176,660,000	---	$114,500,000

Purpose: The capitation program provides basic operating support to schools of medicine, osteopathy, and dentistry in return for efforts to increase primary care specialization to provide remote site training.

Explanation: Capitation--A formula grant which includes in its computation a school's enrollment and all participating schools' total enrollments. Participating schools must meet conditions for filled primary-care residencies and remote site training in ambulatory care facilities.

Accomplishments in 1977: 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 1978: The capitation request of $114,500,000 would support approximately 186 schools of medicine, osteopathy and dentistry. By 1978 35% of medical school's filled first year residencies must be in primary care, while dental schools must increase by 70% filled-first year residencies in general dentistry or pedodontics.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Health Professions--student assistance (Public Health Service Act. Title VII, Part C)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$ 58,400,000	$ 91,000,000	---	$ 46,500,000

Purpose: All student assistance programs help assure financial access to health professions education, particularly to the needy. In addition, the Loan Repayment program and the National Health Service Corps Scholarship program tie loan repayment and financial assistance to future service in designated health manpower shortage areas, thus helping to remedy the geographic maldistribution problem.

Explanation: Loan Repayments: Students enter into 2 or 3 year agreements for service in a shortage area in exchange for repayment of 60% and 25% of their outstanding direct student loan principal and interest due. Exceptional Financial Need Scholarship: Student with exceptional financial need in their first year of post-baccalaureate study in a health professions school receive scholarship awards for tuition, fees and $400 monthly stipends.

National Health Service Scholarships: Medical, osteopathic, dental and, if needed, other health professions students are awarded scholarships for tuition, educational fees, and $400 monthly stipends. For each year of assistance they are obligated to serve in the National Health Service Corps, or in private practice in a health manpower shortage area. Minimum service is for two years and maximum is for four.

Accomplishments in 1977: The National Health Service Scholarship program supported 3,333 students of medicine, osteopathy, dentistry, nursing, and other health professions. Student loans assisted 16,600 health professions students. Scholarships for 1,145 prior recipients and Physician Shortage Area Scholarships for 400 prior recipients represented final year funding. 600 students participated in the Loan Repayment program.

Objectives for 1978: The Exceptional Financial Need Scholarship request of $5,000,000 would support an estimated 500 students. The $1,500,000 requested for Loan Repayments would fund 300 participants.

The National Health Service Scholarship request of $40,000,000 would support an estimated 4,000 students.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Health Professions - dental health activities (Public Health Service Act, Title VII, Part F)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$ 6,200,000	$ 25,000,000 1/	---	$ 2,100,000

1/ Included in this amount are authorizations for physician assistants and dental extenders which are part of a broader authority, which also includes TEAM, under Special Educational Programs.

Purpose: This activity continues to be the focus of Federal initiatives in dental education, practice and manpower 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 service which heretofore have been performed solely by the dentist.

Accomplishments in 1977: Twenty-seven 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. Five continuing Education projects and seven Education Development and Application projects in research, development, demonstration or evaluation were supported from the $700,000 request.

Objectives in 1978: The request of $2,100,000 would support an estimated 12 projects training 800 dental students in TEAM programs.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Nursing Support - institutional assistance (Public Health Service Act, Title VIII, Part A)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$73,000,000	$40,000,000	--	$15,000,000

Purpose: These programs support efforts to train nurses prepared to deliver substantial primary care health services and to improve the education, distribution, and practice of nurses.

Explanation: Nurse Practitioners -- Grants and contracts to academic institutions, hospitals, and other entities to plan, develop and operate programs emphasizing problems of geriatric and nursing home patients, primary health care in the home, ambulatory and community settings to improve the accessability of health professionals.

Special Projects -- Grants and contracts to nursing schools and other public or non-profit private agencies to plan or develop new nurse t.aining programs, increase educational opportunities for the disadvantaged, improve geographic or specialty distribution and implement training programs for primary care in pediatrics and geriatrics.

Accomplishments in 1977: Approximately 1,090 capitation awards were made to support an enrollment or more than 210,000 nurses. Advanced nurse training supported an estimated 79 projects benefiting approximately 1,100 students. Approximately 54 nurse practitioner projects were awarded benefiting about 900 students. 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 1978: The Nurse Practitioner request of $9,000,000 would support approximately 45 projects benefiting 590 students. The request of $6,000,000 for Special Projects would continue to support 65 projects. Funds are not requested for the Capitation and Advanced Nurse Training programs because the supply of nurses is adequate without additional Federal financial support.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Nursing - student assistance (Public Health Service Act, Title III, Title IV, Part I, and Title VIII, Part B)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$ 46,000,000	Indefinite 1/	---	$ 9,000,000

1/ No amount specified; authorized level determined by formula based on enrollments.

Purpose: The nursing student assistance programs provide financial aid to needy students particularly those from disadvantaged and minority groups.

Explanation: Scholarship funds are awarded to participating schools of nursing on the basis of statutory formulas. The schools in turn award funds to students on the basis of individual needs and resources.

Accomplishments in 1977: The nursing loan program assisted 28,125 students. Continued assistance was provided to 6,500 scholarship recipients. Nurse traineeships supported approximately 3,300 trainees ($4,000 per trainee) at about 109 schools. The nurse loan repayment program assisted approximately 300 students. Nursing fellowships were awarded to approximately 110-120 individuals.

Objectives for 1978: The request of $9,000,000 for Nursing Scholarships would assist 9,000 students at 1,350 schools. Funds are not requested for the Nursing Student Loan program since schools may make a substantial number of loans from their loan funds on hand. Federal financial support is not requested for traineeships, fellowships, or loan repayments in 1978 due to the adequate supply of nurses.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Nursing - educational assistance (Public Health Service Act, Title III, Section 301)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$5,000,000	Indefinite	---	---

Purpose: The nursing research program provides a federal focus for clinical nursing research, research application and development and testing of research instrumentation and developments in nursing science and primary care.

Explanation: Nursing Research grants and contracts are awarded on a competitive basis and reviewed by the National Advisory Council. These grants and contracts will provide a better understanding of health problems, health behavior, and health care providers and the application of new methods in order to attain better nursing care.

Accomplishments in 1977: In 1977 fifty awards were made for nursing research.

Objectives for 1978: The supply of nurses is adequate without additional Federal financial support in 1978.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Health professions - Public Health (Public Health Service Act, Title VII, Part C and G)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$8,000,000	$8,250,000	--	$8,000,000

Purpose: Grants for graduate programs in Health Administration provide for the expansion and improvement of these programs to assure that managers will be appropriately trained to meet the current demands in delivery of health care. The special projects in public health and health administration program was designed to promote program and curriculum initiatives in areas of special concern in the public health field.

Explanation: (1) Grants for graduate programs in health and hospital administration and health planning are awarded to public and nonprofit private educational entities (including schools of social work) to support graduate educational programs. These programs must meet requirements concerning first-year enrollments increases, 25 graduates per year and $100,000 in funds from non-Federal sources. (2) Under the special projects in public health and health administration programs, schools of public health and other eligible educational entities are awarded grants or contracts to develop new programs and curriculum or expand existing ones in fields of special concern in public health. Among the concerns addressed are: preventive medicine and dentistry, health planning and administration, epidemiology, nutrition, and environmental health.

Accomplishments in 1977: In 1977, approximately 19 awards were awarded to schools of public health under the formula grant program. An estimated 80 projects were awarded for projects in preventive medicine, dentistry, health planning and administration, environmental health, and nutrition under the public health graduate training program.

Objectives for 1978: In 1978, the $3,000,000 requested for graduate programs in health administration would support about 30 projects and 1,800 graduate students. The request of $5,000,000 would support approximately 100 special projects in public health and health administration benefitting 7,000 students.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Health Professions - Allied Health (Public Health Service Act, Title VII, Part G)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$8,000,000	$22,000,000	--	$8,000,000

Purpose: The allied health special projects program was designed to promote projects in identified areas of special concern in training and educational programs, modes of practice, credentialing, and career orientation for allied health professionals.

Explanation: To address some key allied health needs, the allied health special projects program awards grants and contracts addressing the planning, development and operation of a regional or State system for coordination and management of education and training, to improve competence and credentialing mechanisms, to develop new, more effective and efficient allied health roles and to provide needed continuing education. Fifty percent of funds appropriated will be awarded to training centers.

Accomplishments in 1977: An estimated 150 grants and contracts were awarded, some for interdisciplinary projects but most for projects with discreet allied health professions disciplines such as emergency medical technologists, various types of therapists, dietitians, and medical technologists.

Objectives for 1978: The 1978 request of $8,000,000 would support 150 projects.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Special Educational Programs (Public Health Service Act, Title VII, Part F)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$122,700,000	$137,000,000 1/	--	$102,600,000

1/ Included in this figure is authorization for the TEAM program which is part of a broader authority.

Purpose: These programs are designed to increase the supply of primary care health professionals and extenders and, in the case of Area Health Education Centers and Physician Assistants, to help alleviate the geographic maldistribution problem as well. Programs addressed to recruit and retain individuals from socio-economic backgrounds in health careers are also supported.

Explanation: Grants support both family medicine and primary care residencies training programs and physician assistant training programs. The general dental residencies program supports the development and implementation of programs that enable students to acquire skills in advanced level general dentistry. Area Health Education Center contracts support remote site training of new and practicing health professionals in underserved areas. Grants and contracts are also used to recruit and provide supportive services to the disadvantaged as they pursue health careers. Institutions that are in financial distress and other new health professions schools starting health professions programs receive grant support. The Expanded Function Dental Auxiliaries (EFDA) program supports the development of the programs to train students to become dental hygienists and dental assistants to be efficient members of the dental health care team. The Foreign Medical Transfers program supports projects aimed at integrating U.S. foreign medical transfer students into U.S. medical schools. Support is also given the Graduate Medical Education National Advisory Committee which addresses the problem of specialty maldistribution. The Manpower Supply and Distribution Reports program will support expanded base-line data and analytical activities of the Comprehensive Health Professions Data System.

Accomplishments in 1977: Family medicine grants supported 236 programs benefiting 2,580 residents. General internal medicine and general pediatrics primary care grants supported 64 residency and 40 faculty development and undergraduate programs training an estimated 450 residents and 200 faculty. Grants under physician assistants programs supported training of 2,700 physician assistants. The area health education centers program supported 14 centers training approximately 8,700 health professionals.

Eight-nine health professions schools received financial distress assistance while ten received start-up assistance. About 9,000 disadvantaged students participated in the disadvantaged assistance program. The expanded function dental auxiliaries program trained 1200 dental extenders and faculty. The Foreign Medical Transfer program supported 7 projects benefiting 350 U.S. citizen foreign medical transfer students. Three projects were supported under the Graduate Medical Education National Advisory Committee. The Comprehensive Health Professions Data System was implemented. The Manpower Initiatives program supported 36 previous commitments. The Health Professions Special Projects program supported 229 continuation projects.

Objectives for 1978:
With the $40,500,000 requested for family medicine residencies, 236 projects and an estimated 2,850 family medicine residencies and 300 faculty would be supported. Approximately 450 general internal medicine and general pediatrics residencies and 200 faculty in 104 projects would receive support from the $15,000,000 requested as would about 46 projects training approximately 2,700 physician assistants, 60 faculty students from the $9,100,000 requested. Sixteen area health education centers would receive funding under the $15,500,000 request. The $2,000,000 for the dental extenders program would train approximately 1,200 students and faculty and the general dentistry residencies program of $4,500,000 would assist about 200 students and faculty. The $8,000,000 requested for the disadvantaged assistance program would support 100 projects benefitting 9000 students. Approximately 14 Foreign Medical Transfer projects benefiting 600 students would be supported. Three projects would be supported with funds allocated for the Graduate Medical Education National Advisory Committee. Further analytical studies would be conducted which phase in other health professions areas for the Comprehensive Health Professions Data System. Five health professions schools would receive financial distress assistance while seven schools would receive start-up assistance.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Health teaching facilities -- construction grants (Public Health Service Act, Title VII, Part B, and Title VIII, Part A)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$8,695,453	$60,000,000	---	---
	(---)	(Budget Authority)		

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: Matching grants are made with the participating institutions public or other non-profit medical, osteopathy, dental, veterinary, pharmacy, and podiatry schools.

Accomplishments in 1977: Three grants were awarded for construction of health teaching facilities. These awards created 68 new first-year places in health professions schools and 45 new first-year places in nursing schools.

Objectives for 1978: Support of construction grants is no longer a high priority since additional health teaching facilities are not needed. Therefore, no funds are requested in 1978.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Activity: Health teaching facilities -- interest subsidies (Public Health Service Act, Title VII, Part B, Title VIII, Part A)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$2,283,167	$3,000,000	---	$2,000,000
	(---) (Budget Authority)			

Purpose: This program serves as a means of helping to finance additional health teaching facilities at institutions which do not receive direct construction grant support.

Explanation: Non-profit private entities constructing health teaching facilities receive interest subsidies of up to 3% for construction loans.

Accomplishments in 1977: Five institutions received interest subsidy funds in 1977 to support construction of health professional schools. Funds were available from prior years.

Objectives for 1978: To provide 3% interest subsidy to five institutions to which prior loan guarantee commitments of $75,000,000 have been made.

HEALTH RESOURCES ADMINISTRATION

Health Professions

Program Purpose and Accomplishments

Actitity: Program Support (Public Health Service Act, Various sections)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
674	$22,577,000	Indefinite	668	$ 23,020,000

Purpose: This activity supports the salaries and expenses of management operations and personnel associated with Bureau of Health Manpower programs.

Explanation: This activity funds maintenance of operations and staff of the Bureau of Health Manpower's extramural programs as well as the Bureau director's office.

Accomplishments in 1977: Major efforts supported were grant and contract review, consultative and technical assistance, project monitoring, grant and contract administration, and program direction for a wide range of health manpower programs. 50 positions for implementing and administering the new Federally Insured Loan program were included.

Objectives for 1978: During 1978, funds will primarily support these same functions, as well as implementation of programs under the new Health Professions Education Act, new manpower analysis efforts, and continuations of some other, slightly modified programs. The decrease of six positions is part of an effort to eliminate the potential of overlapping administrative functions at the various organizational levels throughout the PHS. The reduction affects resource levels throughout various programs but can be achieved without impacting on Agency accomplishments.

HEALTH RESOURCES ADMINISTRATION

Office of the Administrator

Program Purpose and Accomplishments

Activity: Program Management (Public Health Service Act, various sections)

1977 Estimate		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
300	$10,947,000	Indefinite	300	$11,755,000

Purpose: This activity provides staff support for the Office of the Administrator, for guidance, leadership, and direction to the agency programs. This office is responsible for determining and implementing health policies, priorities, goals, and objectives which will improve areas of health cost and health service inefficiencies.

Explanation: To provide funding for program direction and support services for the Office of the Administrator.

Accomplishments in 1977: The Agency recentralized from 10 regional offices activities concerned with award of health manpower education grants and contracts. Additionally the Agency began the installation of a tactical work plan system coupled with manpower management surveys to study the allocation of personnel required for the administration of agency programs. A new agency management information system was begun in 1977 to develop and administer improvements in reports and records management. Organization of the National Council on Health Planning and Development, mandated by P.L. 93-641 (The National Health Planning and Resources Development Act of 1974), took place in collaboration with several other elements of the Public Health Service. Gains were made in the process of implementing an Executive Management Development program including the identification of all managerial positions and the establishment of their requirements; identification of new managers and persons with high potential for managerial positions; and systematic training of all new managers and persons with high potential.

Objectives in 1978: The Office of the Administrator will complete the formulation of its own internal management system, which will lend vital support to improving communication between central and regional offices by clearly identifying the agency's long and short term goals and objectives. The agency will complete the installation and implementation of the tactical work plan system, and will advance the implementation and application of the management information system.

TENTATIVE HEALTH FACILITIES CONSTRUCTION GRANT ALLOCATIONS
FOR FISCAL YEARS 1976, 1977, AND 1978 UNDER P.L.--93-641

States	FY 1976	FY 1977	FY 1978
	$40,372,800	---	---
Alabama	747,458	---	---
Alaska	747,458	---	---
Arizona	747,458	---	---
Arkansas	747,458	---	---
California	747,458	---	---
Colorado	747,458	---	---
Connecticut	747,458	---	---
Delaware	747,457	---	---
Dist. of Columbia	747,457	---	---
Florida	747,458	---	---
Georgia	747,458	---	---
Hawaii	747,457	---	---
Idaho	747,457	---	---
Illinois	747,458	---	---
Indiana	747,458	---	---
Iowa	747,457	---	---
Kansas	747,457	---	---
Kentucky	747,458	---	---
Louisiana	747,458	---	---
Maine	747,457	---	---
Maryland	747,458	---	---
Massachusetts	747,458	---	---
Michigan	747,458	---	---
Minnesota	747,458	---	---
Mississippi	747,458	---	---
Missouri	747,458	---	---
Montana	747,458	---	---
Nebraska	747,457	---	---
Nevada	747,457	---	---
New Hampshire	747,457	---	---
New Jersey	747,458	---	---
New Mexico	747,458	---	---
New York	747,458	---	---
North Carolina	747,458	---	---
North Dakota	747,458	---	---

TENTATIVE HEALTH FACILITIES CONSTRUCTION GRANT ALLOCATIONS
FOR FISCAL YEARS 1976, 1977, AND 1978 UNDER P.L.-93-641 (Cont.)

States	FY 1976	FY 1977	FY 1978
Ohio	747,458	---	---
Oklahoma	747,458	---	---
Oregon	747,458	---	---
Pennsylvania	747,458	---	---
Rhode Island	747,457	---	---
South Carolina	747,458	---	---
South Dakota	747,458	---	---
Tennessee	747,458	---	---
Texas	747,458	---	---
Utah	747,457	---	---
Vermont	747,457	---	---
Virginia	747,458	---	---
Washington	747,458	---	---
West Virginia	747,458	---	---
Wisconsin	747,457	---	---
Wyoming	747,457	---	---
American Somoa	376,250	---	---
Guam	376,250	---	---
Puerto Rico	747,457	---	---
Trust Territory	376,250		
Virgin Islands	376,250	---	---

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] *$111,000*, 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] *$2,481,000: Provided*, That the amounts appropriated herein shall remain available until expended. *(Departments of Labor and Health, Education, and Welfare Appropriation Act, 1977.)*

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.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Payment of Sales Insufficiencies and Interest Losses

Amounts Available for Obligation

	1977	1978
Appropriation	$4,000,000	$2,592,000
Estimated transfer to other accounts 1/	4,000,000	2,592,000
Health Professions Education Funds	(2,727,000)	(1,814,000)
Nurses Training Fund	(1,273,000)	(778,000)

1/ Distribution between Health Professions Education Fund and Nurse Training Fund may vary due to changing interest rate.

Summary of Changes

1977 Appropriation	$4,000,000
1978 Request	2,592,000
Net change	-1,408,000

	1977 Base Pos.	1977 Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Payment to Treasury - The increase in interest owed to the Treasury results from estimated increase in interest rate	---	$1,777,000	---	+$184,000
Total, increases	---	1,777,000	---	+184,000
Decreases:				
A. Built-in:				
1. Payment to Government National Mortgage Association - The decrease in insufficiency payments results from a decrease in participation certificates outstanding	---	164,000	---	-53,000
2. Payment to Government National Mortgage Association - The decrease in interest losses to Government National Mortgage Association results from reductions in pledged notes held by the Government National Mortgage Association	---	765,000	---	-245,000

3. Cancellations - The decrease related to the undisbursed cash balance plus current collections which will provide sufficient funds for this category for 1978....	---	1,294,000	---	-1,294,000
Total, decreases.....	---	---	---	-1,592,000
Total, net change.....	---	---	---	-1,408,000

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Health Professions Education Fund

Amounts Available for Obligation

	1977	1978
Receipts and reimbursements from non-Federal sources	$1,735,000	$2,425,000
Transferred from other accounts (estimate)	2,727,000	1,814,000
Transferred to participation Sales Fund	-1,312,000	-1,350,000
Unobligated balance, start of year	36,006,000	34,694,000
Transferred from Participation Sales Fund	---	3,684,000
Other unobligated balances, end of year	-34,694,000	-37,028,000
Total, obligations	4,462,000	4,239,000

Obligations by Activity and Object

	1977	1978	Increase or Decrease
Cancellations	$ 841,000	---	-841,000
Interest	3,621,000	$4,239,000	+618,000
Total, obligations	4,462,000	4,239,000	-223,000

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Nursing Training Fund

Amounts Available for Obligation

	1977	1978
Receipts and reimbursements from non-Federal sources	960,000	$1,090,000
Transferred from other accounts (estimate)	1,273,000	778,000
Transferred to participation sales fund	---	---
Transferred from participation sales fund	---	997,000
Unobligated balance, start of year	23,855,000	23,855,000
Other unobligated balances, end of year	-23,855,000	-24,852,000
Total, obligations	2,233,000	1,868,000

Obligations by Activity and Object

	1977	1978	Increase or Decrease
Cancellations	$ 453,000	---	-$453,000
Interest	1,780,000	$1,868,000	+88,000
Total obligations	2,233,000	1,868,000	-365,000

Authorizing Legislation

	Amount Authorized	1978 Budget Request
Public Health Service Act:		
Payments to Schools to Cover Certain Costs Incurred in Making Student Loans from Borrowed Fund:		
Health Professions Sc. (Sec. 744(b))	Indefinite	$1,814,000
Schools of Nursing (Sec. 827(b))	Indefinite	778,000

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	4,000,000
1977	4,000,000	4,000,000	4,000,000	4,000,000
1978	2,592,000			

Payment of Sales Insufficiencies and Interest Losses

	1977 Estimate	1978 Estimate	Increase or Decrease
Total	$4,000,000	$2,592,000	-$1,408,000

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 1977

The appropriation for 1977 for sales insufficiencies and interest losses is $4,000,000. Included is $1,772,000 for payment of interest to the Treasury Department on $28,434,000 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, $1,294,000 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 1978

In 1978, 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.

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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 1978 request of $2,592,000 will provide the following Federal Payments:

$2,481,000 -- Payment of Interest Differential
($1,726,000)-- Health Professions Education Fund
($755,000)-- Nurse Training Fund

$111,000 -- Payment of Insufficiencies
($88,000)-- Health Professions Education Fund
($23,000)-- Nurse Training Fund

Payment of Interest 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 $27,043,000 (Health Professions Education Fund, $18,159,000 and Nurse Training Fund, $8,884,000) loaned to schools.

$1,961,000 -- Payment of Interest Differential to Treasury
($1,317,000)-- Health Professions Education Fund
($644,000)-- Nurse Training Fund

(2) This category provides for Federal payment to the Government National Mortgage Association representing the 5.25 percent interest rate on $9,888,000 ($7,782,000, Health Professions Education Fund, and $2,106,000, Nurse Training Fund) worth of paper (pledge notes) held by the Government National Mortgage Association as collateral for participation certificates sold to private investors.

$520,000 -- Payment of Int. to Govt. National Mortgage Assn.
($409,000)-- Health Professions Education Fund
($111,000)-- Nurse Training Fund

Payment of Insufficiencies

This category provides for Federal payment to the Government National Mortgage Association representing the difference between 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 $9,888,000 worth of paper (participation certificates) held by the public.

$111,000	--	Payment of Insufficiencies
($88,000)	--	Health Professions Education Fund
($23,000)	--	Nurse Training Fund

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Medical Facilities Guarantee and Loan Fund

FY 1978 Budget

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APPROPRIATION ESTIMATE

Medical Facilities Guarantee and Loan Fund

For carrying out title XVI of the Public Health Service Act, [$31,000,000] *$41,000,000* shall be available without fiscal year limitation for the payment of interest subsidies. The total principal amount of loans to be guaranteed or directly made, which may be allotted among the States, pursuant to titles VI and XVI of the Public Health Service Act shall not exceed a cumulative amount of $1,750,000,000. *(Departments of Labor and Health, Education, and Welfare Appropriation Act, 1977.)*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH RESOURCES ADMINISTRATION

Medical Facilities Guarantee and Loan Fund

Amounts Available for Obligation

	1977	1978
Appropriation	$31,000,000	$41,000,000
Receipts and reimbursements from:		
Non-Federal sources	32,071,000	28,120,000
Unobligated balance, start of year	71,160,000	64,223,000
Unobligated balance, end of year	-64,223,000	-59,347,000
Total, obligation	70,008,000	73,996,000

Summary of Changes

1977 Estimated Obligations	$70,008,000
1978 Estimated Obligations	73,996,000
Net change	+3,988,000

	1977 Base Pos.	1977 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	---	$35,883,000	---	$+17,463,000
Total increases	---	---	---	17,463,000
Decreases:				
B. Program:				
1. Direct loans - The decrease in direct loans is the result of commitments under Title VI authority being closed out in 1977, and loan closings under Title XVI authority just beginning to get underway in 1978.	---	34,125,000		-13,475,000
Total decreases		---	---	-13,475,000
Net change	---	---	---	+ 3,988,000

Summary of Changes

1977 Budget Authority	$31,000,000
1978 Budget Authority	41,000,000
Net change	+10,000,000

	1977 Base Pos.	1977 Base Amount	Change from Base Pos.	Change from Base 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	--	$31,000,000	--	+$10,000,000
Net change	--	---	--	+10,000,000

Obligations by Activity

	1977 Estimate	1978 Estimate	Increase or Decrease
Interest subsidies.....	$35,883,000 (31,000,000)	$53,346,000 (41,000,000)	+$17,463,000 (+10,000,000)
Direct loans.....	34,125,000 (---)	20,650,000 (---)	-13,475,000 (---)
Total obligations.....	70,008,000 (31,000,000)	73,996,000 (41,000,000)	+ 3,988,000 (+10,000,000)

Obligation by Object

	1977 Estimate	1978 Estimate	Increase or Decrease
Investments and loans.....	$34,125,000	$20,650,000	-$13,475,000
Grants, subsidies, and Contributions.....	35,883,000	53,346,000	+17,463,000
Total obligations by object.....	70,008,000	73,996,000	+ 3,988,000

Authorizing Legislation

	Amount Authorized	1978 Budget Request
1. Interest subsidies:		
(a) Public Health Service Act (Sec. 1622).....	Indefinite	$41,000,000

Medical Facilities Guarantee and Loan Fund

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1971	$ 5,000,000	$ 5,000,000	$ 5,000,000	$ 5,000,000
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	10,000,000
1977	31,000,000	31,000,000	31,000,000	31,000,000
1978	41,000,000			

Medical Facilities Guarantee and Loan Fund

	1977 Estimate	1978 Estimate	Increase or Decrease
Interest Subsidies	$31,000,000	$41,000,000	+$10,000,000

General Statement

The Medical Facilities Loan and Loan Guarantee Fund has existed since 1972 under the 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 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 the year in which the funds are authorized and for two subsequent fiscal years.

The fund consist 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 guaranteed loans and direct loans which are sold and guaranteed.

Interest Subsidies

The purpose of the interest subsidy activity is to honor commitments entered into for subsidizing loan guarantees and direct loans made for modernization, construction, and conversion of hospitals and other medical facilities. Interest subsidies are paid on guaranteed loans made to private nonprofit agencies and on the instruments supporting direct loans to public and private nonprofit agencies. In the case of guaranteed loans, financing is obtained through normal commercial channels. The Government contributes 3 percent of the interest, and guarantees the loan. Direct loans 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.

The budget policy for 1978 is to honor the commitment for interest subsidy payments for loans already committed under the $1.5 billion authorization. Interest on the additional $250 million authorized in 1977 will not begin to accrue before 1979.

The interest subsidy activity is currently assisting in the funding of 314 loan and loan guarantee construction and modernization projects, of which 72 are direct loans and 242 are loan guarantees. By the end of 1978, it is expected that approximately 380 such projects will be ongoing -- 95 direct and 285 guaranteed -- of which 367 will be receiving interest subsidy payments. The 1978 request for $41 million is required to pay interest subsidies on these projects.

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 XVI)

1977 Estimate	1978 Authorization	1978 Budget Estimate
31,000,000	Indefinite	41,000,000

Purpose: The purpose of this program is to stimulate and support an increased volume of capital project for health facilities through the guarantee of loans to private nonprofit agencies, the making of direct loans to public and private nonprofit agencies, the payment of interest on both guaranteed and direct loans, and the repurchasing of direct loans which have been sold and guaranteed.

Explanation: The loan principal authorizations are made available to 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 public and private nonprofit hospitals. Guaranteed loan financing is obtained through normal commercial channels. The Government contributes 3% of the interest, and guarantees the loan. Direct loans are made 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, 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. Loan principal authorizations are available for the year in which the authorization is made and for two subsequent years.

Accomplishments in 1977: The fund assisted approximately 367 projects in 300 communities with a total of $1,470,000,000 in loan principal authorization commitments. $1,263,000,000 was for loan guarantees and $207,000,000 was for direct loans. Commitments made under the $1.5 billion authorization, which expired at the end of the TQ, were closed in 1977.

Objectives for 1978: Total obligations of $73,996,000 for 1978 include $53,346,000 for interest subsidies and $20,650,000 for direct loans. Approximately 380 loan and loan guarantee construction and modernization projects will be underway, of which about 367 will require interest subsidy payments. The $41,000,000 requested for 1978 is required to pay interest subsidies on loans made.

MONDAY, MARCH 21, 1977.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Assistant Secretary for Health

WITNESSES

DR. JAMES F. DICKSON III, M.D., ACTING ASSISTANT SECRETARY FOR HEALTH
ACCOMPANIED BY:
RUPERT MOURE, EXECUTIVE OFFICER, PUBLIC HEALTH SERVICE
DR. JAMES C. KING, DEPUTY DIRECTOR, OFFICER OF INTERNATIONAL HEALTH, PUBLIC HEALTH SERVICE
JOHN L. ELSBREE, 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
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER, OFFICE OF THE SECRETARY

ASSISTANT SECRETARY FOR HEALTH

Mr. FLOOD. We will continue with the Public Health Service.

This is the office of the Assistant Secretary of Health, what we call the salaries and expenses account.

Dr. Dickson, we will insert your biographical sketch and prepared statement in the record at this point.

[The biographical sketch and statement follow:]

BIOGRAPHICAL SKETCH

NAME: James F. Dickson III, M.D.

POSITION: Acting Assistant Secretary for Health

BIRTHPLACE AND DATE: Boston, Massachusetts, May 4, 1924

EDUCATION: B.S. - Dartmouth College, 1944
M.D. - Harvard Medical School, 1947

EXPERIENCE:

Jan. 21, 1977 - Present: Acting Assistant Secretary for Health, Department of Health, Education, and Welfare

1976 - 1977: Deputy Assistant Secretary for Health

1970 - 1976: Director of Health for the President's Advisory Council on Management Improvement

1965 - 1970: Director for Engineering in Biology and Medicine at the National Institutes of Health

1961 - 1965: Special Fellow of the Electronic Systems Laboratory at Massachusetts Institute of Technology. There he engaged in the application of Communication and control theory for the study of biological systems and in the development of computer-oriented engineering systems for biomedical research and health care. During this period he was active in engineering and medical societies, was a member of national committees concerned with science, technology and health, and served as Senior Consultant for Health with the President's Commission on Technology, Automation and Economic Progress.

1954 - 1960: Engaged in cardiovascular research and in the practice of thoracic and cardiovascular surgery in Boston and New York City.

He was trained as a general and thoracic surgeon on the Harvard Surgical Service at the Boston City Hospital. During the Korean War, he was Chief of Surgery at the 8055 Mobile Army Surgical Hospital in Korea.

PROFESSIONAL ORGANIZATIONS: Dr. Dickson is a member of the Institute of Medicine of the National Academy of Sciences, past President of the Biomedical Engineering Society, a Diplomate of the American Board of Surgery, and a member of the American Physical Society and the Institute of Electrical and Electronics Engineers.

PUBLICATIONS: Author of some fifty professional papers and the editor of five books dealing with science, technology and medicine.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Statement by the Assistant Secretary for Health

on

"Assistant Secretary for Health"

Mr. Chairman and Members of the Committee:

I am pleased to be here today to request funds for three Public Health Service appropriations. The first, the Assistant Secretary for Health, finances the overall management activities of the Public Health Service and several specific health programs. The second, Scientific Activities Overseas, supports health research in foreign countries with special foreign currency funds. And the third, Retired Pay and Medical Benefits for Commissioned Officers, provides payments to retired Commissioned Officers and contract medical care expenses of dependents of uniform services personnel.

Assistant Secretary for Health

For this appropriation, $23.2 million is requested to continue the same level of activities carried on in 1977. Although the 1978 budget request does not reflect any position changes compared to 1977, 35 positions were eliminated in 1977 providing savings to fund the October 1976 pay raise.

Included in this request is $5.6 million to support the Public Health Service's management staff in the 10 regional offices, and the headquarters staff of the Office of Regional Operations which advises the Assistant Secretary for Health on matters pertaining to operations in the regional offices. These offices are an important segment of the

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Public Health Service since they are responsible for awarding and administering some 6,400 grants totalling $1.6 billion as well as providing technical assistance to state and local health agencies.

The personnel to carry out the Assistant Secretary's managerial responsibilities and to provide him with staff advice on health matters is funded through the Program Direction and Support Services activity, for which we are requesting $14.5 million. In 1977, as required by the new National Consumer Health Information and Health Promotion Act of 1976, an Office of Health Information and Health Promotion was established. This new office is responsible for developing national goals and strategies and promoting public and private educational activities so that the American people can make the best use of the health care system and take advantage of current knowledge to prevent and control disease. The 5 positions to support this new office were provided within our available 1977 resources.

We are requesting $2.3 million for activities that provide leadership in the development and enforcement of health care standards to assure the delivery of high quality health care. The budget reflects the transfer into this activity of the Health Maintenance Organizations qualification and compliance function as required by the Health Maintenance Organization Amendments of 1976. This function was formerly funded in the Health Services Appropriation.

Also included in this appropriation is $790,000 for the support of the program of the President's Council on Physical Fitness and Sports. Through this program, we promote private support of physical fitness and participatory sports for youth and adults, including special programs

for women and the elderly. Our goal is to effectively integrate regular exercise into the daily lives of the American people.

Scientific Activities Overseas

Through the use of special foreign currency credits received from the sale of surplus agricultural commodities, we support health research in selected foreign countries. In 1978 we are requesting $11.4 million in new budget authority, a decrease of $6 million from the 1977 operating level for the Scientific Activities Overseas appropriation. Projects to be supported are selected on the basis of scientific merit and relevance to our domestic health responsibilities. Examples of current projects are studies on chest diseases of coal miners, the screening of indigenous herbal drugs for anti-cancer properties, and the role of arthopods in the transmission of leprosy.

Retired Pay and Medical Benefits for Commissioned Officers

We are requesting $56.9 million for this appropriation, an increase of $4.6 million over the 1977 level. A total of $30.5 million is required for payments to retired Public Health Service Commissioned Officers and for benefits paid to survivors of deceased retired officers. The remaining $26.4 million provides for the payment of contract medical care furnished to dependents and retirees authorized by the Dependent's Medical Care Act. Dependents of Coast Guardsmen and commissioned officers of the Public Health Service and of the National Oceanic and Atmospheric Administration are covered.

Mr. Chairman, I will be pleased to answer any questions you may have.

Mr. FLOOD. Doctor, your budget for salaries and expenses calls for $1,000 increase. How did you manage to hold your increase to only $1,000? We like to get budget requests like this. We like to hear this. It certainly appears you are a little frugal when you want to be.

Mr. BERSANO. That is a net figure. Actually there is a decrease of about $527,000 that is related to the reduction of 35 positions in 1977 and the reduction due to one less day of pay in 1978. We do have some offsetting mandatory increases for rental charges that are due to GSA of $146,000, and other mandatory increases amounting to $528,000.

Mr. FLOOD. You say in your budget justification you are going to reduce your staff by 35 positions in 1977.

Mr. BERSANO. Right.

STAFF REDUCTION

Mr. FLOOD. In what areas are you going to make that cut? What kind of impact, if any, is that going to have on the effective operation of your shop?

Dr. DICKSON. For those positions that we were told to cut?

Mr. FLOOD. I just want to say we certainly hope you are not going to make these in the regional offices because we get all kinds of complaints from grantees and everybody else that the regional offices are understaffed.

Dr. DICKSON. Yes.

Mr. FLOOD. What do you mean "yes"?

Dr. DICKSON. Ten of the 35 being reduced are in the regional offices. The rest of the reduction were pretty much prorated among the headquarters offices. There was one that related to physical fitness and so forth.

Mr. FLOOD. What do you mean "so forth"?

Dr. DICKSON. I have the distribution of how the remaining 24 positions were applied among the headquarters offices.

IMPACT OF STAFF REDUCTION

Mr. FLOOD. You are going to cut 35 jobs. What kind of impact will that have?

Dr. DICKSON. We tried to spread them out in such a way that we can get by and get on with the things we are supposed to do. Totally from the regional office staff and the office of regional operations in headquarters there were 13 removed, 15 from program direction and support services and 6 from health care assurances. And, as I said before, 1 from physical fitness.

Mr. FLOOD. Still talking about those 35 jobs, how are they going to affect your office's ability to carry out all these additional responsibilities in the area of HMO qualification, the health promotion activities?

Dr. DICKSON. I think there are two main areas that give us difficulty.

Mr. FLOOD. What about HMO qualifications?

Dr. DICKSON. The HMO qualifications and compliance functions and the Health Education Office are the two which are mainly affected.

Mr. FLOOD. Health promotion?

Dr. DICKSON. Yes. It is felt the most in those 2 offices.

Mr. FLOOD. Is that good or bad or what?

Dr. DICKSON. I think in the health education area we are prepared to go ahead and do the things we must do. We are in the process of relating and coordinating the health education activities found across all the agencies of the Public Health Service.

In the HMO area we do have a backlog at the moment with respect to qualification of some 40-odd applications. We are in the process of trying to get on and clear that backlog up. It does present a problem for us since we are continuing to receive new applications.

COORDINATION OF HEALTH EDUCATION ACTIVITIES

Mr. FLOOD. Do you have what we call a master plan to coordinate all these various health education activities that are currently being carried out by the health agencies?

Dr. DICKSON. We are in the process through the new office of working on four areas: first, the development of policy with respect to the Public Health Service health information functions; second, setting of priorities for these agency activities; the third, has to do with providing guidance for coordinating these functions; and fourth, we are identifying unmet needs in the area of health information. We are in the process of bringing that material together so it does constitute a plan. The plan hasn't been developed at this time.

Mr. FLOOD. You don't have any so-called master plan right now?

Dr. DICKSON. No, sir.

TRANSFER OF STAFF TO REGIONAL OFFICES

Mr. FLOOD. Last year Dr. Cooper was here and testified before the committee that he was in the process of transferring additional responsibilities for the HMO, for the PSRO, and the health emergency programs to the regional offices. Has that been accomplished?

What is the nature of responsibility that you are transferring to the regional offices?

Dr. DICKSON. It has not been accomplished at this time.

Mr. FLOOD. What is the status? Dr. Cooper told us he was in the process of transferring. So where are we?

Mr. MOURE. We have not transferred positions and dollars for HMO's to the regions.

Mr. FLOOD. What about the PSRO?

Mr. MOURE. We have transferred a number of positions to the regions in the PSRO area; 30 additional positions have been transferred.

Mr. FLOOD. What about this emergency medical; that is becoming a big deal?

Mr. MOURE. No additional positions have been transferred.

Mr. FLOOD. Why would you transfer things like emergency medical to the regions?

Mr. MOURE. The immediacy of the location is important in terms of emergency medical services but the numbers of positions and other resources available in that small program make it difficult to transfer positions.

Mr. FLOOD. Do you have any plans now to further decentralize these PHS programs?

Mr. MOURE. No, sir.

NURSING HOME PROGRAM

Mr. FLOOD. What is the status of your nursing home program. This isn't the first time you have heard about that, that part which is supposed to be determining the quality of the care being provided. It is very much in front now.

Dr. DICKSON. I think it is very difficult at this time to assess the degree to which the quality of care in the nursing homes in the country is actually being improved. The difficulty we have largely has to do with measuring the quality of care. The reason there are difficulties in measuring the quality of care is that we just don't have any specifically defined objective criteria to use.

Mr. FLOOD. You have this program. What is the impact of this program today up until right now on improving the quality of care of the nursing homes? You told us about the program. What is its impact?

Dr. DICKSON. We are moving into phase II of the overall program. We have started in a number of sites, and I don't think we know the impact at this time.

Faye, do you want to comment.

Dr. ABDELLA. Mr. Chairman, I think there are several indications of the way phase II is going. By June of this year we hope to have a revised patient appraisal and care evaluation instrument that will bring together measurements of patient status, common terminology and core data that can be used by the administrators as a management and by PSRO and other utilization review groups as the measuring tool for quality of care.

Mr. FLOOD. Are the nursing home operators cooperating with you?

Dr. ABDELLA. Yes, sir.

The various industry, as we call them, representatives, and consumer groups are on our advisory committee as well as State and regional people.

The nursing home operators are actually being trained in 146 facilities. We have trained some 500 nursing home operators in this effort and we hope by June this can be doubled.

Mr. FLOOD. Is this a national effort or is it being done just in certain areas?

Dr. ABDELLA. We are starting by involving some 20 States. The reason we didn't want to include all the others is because we wanted to be sure that all affected States would be participating with us and the regional personnel. The main affort is a training job.

Mr. FLOOD. How much are you going to spend in 1977 and 1978 on this?

Dr. ABDELLA. We had projected a need of $483,000 for 1977.

Mr. FLOOD. That will cover both years?

Dr. ABDELLA. That would be for 1977 only.

Mr. FLOOD. What about 1978?

Mr. BERSANO. In 1978 we anticipate a need of $448,500.

LINKAGE OF NURSING HOME PROGRAM WITH OTHER PROGRAMS

Mr. FLOOD. Also on the nursing home program, how does that tie in with the PSRO's, the Professional Standards Review Organization?

Dr. ABDELLA. As you may know, Mr. Chairman, there are 15 demonstration PSRO long-term care and about half of those are now participating in this experimental program. We are building on experience in States such as Pennsylvania and Utah in this effort.

Mr. FLOOD. You obviously have a lot of material. Suppose you place in the record this information describing in more detail what you are doing in this entire area of reviewing these nursing home operations.

Dr. ABDELLA. Yes, sir, be glad to.

[The information follows:]

PATIENT APPRAISAL AND CARE EVALUATION OF LONG-TERM CARE FACILITIES

BACKGROUND

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 factfinding 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 care. One specific findings, namely that the survey/certification process focuses on the institutional framework within which care is provided rather than on the patient, led to phase II of the Long-Term Care Improvement Campaign.

Phase II introduces, on a demonstration basis, a Patient Appraisal and Care Evaluation (PACE) instrument in selected long-term care facilities in order to assure a systematic and uniform assessment of patients' needs and outcomes of care.

PHASE II PROGRESS TO DATE

Since the announcement of phase II of the Long-Term Care Facility Improvement Campaign by the Under Secretary in February 1976, the accomplishments have been as follows:

(1) A preliminary Patient Appraisal and Care Evaluation (PACE) instrument with uniform terminology has been developed and is now being field tested in 146 facilities in 19 States. All 10 HEW regional offices are involved.

(2) Training of nearly 500 persons, including provider personnel (appraisers, directors of nursing, administrators) and State and Regional Office monitors has been carried out using a standard short-term course and training manual.

(3) Preliminary collection of data is now being completed which consists of at least 3 patient appraisals and 2 care evaluations carried out by provider personnel on each of the approximately 2,000 patients/residents in the study.

(4) State-Federal monitoring team visits are being completed to each facility in the study to determine problems encountered and progress made in the application of PACE.

PLANS FOR FISCAL YEARS 1977 AND 1978

There are five major phase II activties planned for the remainder for fiscal years 1977 and 1978:

Projects I and II—Evaluation and revision of PACE

Since November 1976, in each of the selected facilities, appraisers have applied the PACE instrument monthly to selected patients who are receiving

care under medicare and/or medicaid reimbursement; and Regional and State personnel have made monitoring visits to all facilities.

A continuous evaluation of the data obtained both directly from the participating providers using the instrument as well as from the Federal-State monitoring visits is being carried out. In addition to this analysis of data, five PACE debriefing training workshops will be conducted in the late spring of 1977 to review, analyze, and evaluate the feasibility study of the PACE portion of phase II.

As an outcome of these activities, collection and analysis of data, monitoring visits, and debriefing workshops, the PACE instrument will be revised. Such revision will be directed toward reduction in length, simplificaton of format, and ease of application. Following this revision, the 19 States presently involved and six additional States will be invited to participate in a program using the revised PACE instrument during calendar year 1978.

Project III—PACE program of instruction

A contract will be awarded to develop a "packaged" program of instruction on how to use the PACE instrument that with a minimum of formal training and personnel time, can be used by appraisers, monitors, and other persons involved in the PACE program. The instruction "package" will be designed for direct use in the facility and with a flexible scheduling of personnel time.

Project IV—Instrument to measure cost of services rendered

Following a review of PACE to determine which elements are useful in terms of cost of care to that individual, a contract will be awarded which will examine existing cost instruments and prepare a preliminary instrument compatible with PACE. This instrument will be field tested in a selected sample of long-term care facilities and following revision and OMB clearance, will be ready for use in facilities using PACE.

Project V—Review of survey/certification process

An ad hoc workgroup is beginning a review of existing Federal regulations for SNFs and ICFs to determine which relate to patient care and which to facility attributes concerned with administrative, and health and safety matters. Following this the group will then develop and implement a plan for necessary revision of the Federal regulations in order to implement the PACE process in long-term care facilities. Also planned is a review of the applicability of present survey and certification requirements to the use of PACE, to determine areas where modification or additional procedures are needed, and then to develop such procedures.

POTENTIAL IMPACT OF PACE

Once evaluation is complete and PACE is revised, the goal of a nationwide approach to the quality of care in long term care facilities can begin.

The possible benefits of this program to the patients/residents and providers could be: A reduction and revision of the present survey form so that it would certify the actual patient care delivered rather than only the facility's capability of rendering the care; Uniformity of the facility's patient care record keeping which would enable other professional quality of care reviewers to utilize this same documentation, that is, PSRO, Utilization Review Committees, and Medical Review and Independent Professional Review teams; The greater efficiency and effectiveness in developing patient care plans and in evaluating care given; Use as a management tool by providers for better resource utilization.

The potential impact on the survey/certification process could be: Better utilization of manpower time thus enabling the survey teams to provide more technical assistance; More sophisticated monitoring procedures State-wide; Increased Federal impact on nursing homes by direct verification of quality of care; Increased volume of validation surveys; Implementation of a system utilizing State-by-State comparisons of quality of patient care rendered.

MULTILATERAL HEALTH ACTIVITIES

Mr. FLOOD. Here is a phrase. How is the multilateral approach to international health reflected in the budget that we have before us?

Dr. KING. The multilateral approach, Mr. Chairman, is simply our attempt to channel as many of those constructive international health programs as we can to be in accord with the activities of the World Health Organization and its priorities where they fit our priorities. It is not reflected per se in our budget.

Mr. FLOOD. It is not?

Dr. KING. No, sir.

Mr. FLOOD. It is not in your forward plan for the health budget?

Dr. KING. It is in the forward plan for health but not in our budget.

Mr. FLOOD. If your are going to use your people and all your things to be identified with the WHO, what do you mean it is not in your budget? Why isn't it?

Dr. KING. The international activities, Mr. Chairman, in which we are involved bring us into close connection with WHO but they have an impact on the health of the American people. Our prime function is to work toward improving that health. Anything we do in collaboration with WHO is in part reflected on us.

Mr. FLOOD. That is fine for the authorization committee but what we are trying to find out is, how is that reflected in this budget? This is the Appropriations Committee. How is it reflected in the budget? Did you think about that?

Dr. DICKSON. You mean the total amount, sir, and the positions?

Mr. FLOOD. In what way? How is it reflected? You don't have it in earmarked dollars, so how is it reflected in the budget?

Dr. DICKSON. It is reflected within the budget for the Office of International Health which is some $800,000 and 22 positions.

DEPENDENTS' MEDICAL CARE

Mr. FLOOD. How much of the increase in the dependents medical care is due to inflation?

Dr. DICKSON. A total of about a million dollars.

Mr. FLOOD. What percentage do you assume for fiscal year 1978?

Dr. DICKSON. 4.3 percent.

COAST GUARD DEPENDENTS' CARE COST

Mr. FLOOD. Last year we talked about the Coast Guard, the possibility of other agencies as well, paying their share of these costs of these dependent care costs. You pay for the Coast Guard, you pay for the PHS and National Oceanic.

Mr. BERSANO. There is no change in the way the cost of care for Coast Guard dependents are reflected in the budget. We are still paying for those costs.

Mr. FLOOD. To whom did you talk, the Air Force or what? There was a lot of talk last year about the Coast Guard.

Mr. BERSANO. The only thing that has been changed, Mr. Chairman, is that the funds to pay for the medical care activities provided on the Coast Guard bases are now in the Department of Transportation's budget. That is, the cost of operating hospitals and clinics located on Coast Guard bases.

Mr. FLOOD. Those are under Coast Guard jurisdiction. For the record, suppose you break out the amount now attributable to all of the non-PHS dependents and personnel.

[The information follows:]

MEDICAL BENEFITS FOR NON-PHS PERSONNEL

In 1978, the anticipated dependent's medical care costs will amount to $22,783,000 for dependents of eligible personnel of the U.S. Coast Guard, the National Oceanic and Atmospheric Administration, and to retired personnel of these services. Specifically, medical care costs for dependents of Coast Guard personnel will amount to $22,308,000 while medical care for the National Oceanic and Atmospheric Administration's dependents will cost $475,000.

Mr. FLOOD [continuing]. Mr. O'Brien.

PSRO AND HMO PROGRAMS

Mr. O'BRIEN. Doctor, I have a hard time keeping terms, organizations, and responsibilities separate. Just before I came to this committee I came to the personal conclusion that PSRO is a profoundly good institution and probably should be used in the legal profession. I am not so sure about the HMO's. I have the feeling that if I had a dollar to spend from this committee, and I had to choose between the two, I would go the PSRO route. Do you have any comments on that?

Dr. DICKSON. No; I think they serve a different function. I am not sure how you would weigh the developing of some innovative form of delivery of care as opposed to trying to get a more satisfactory way to assure the quality of care. I think it is a little bit like comparing apples and oranges. I really don't know myself, if I had to choose between one or the other, which I would rate the most important.

I think basically if I were forced to choose I would be looking more to innovative forms of care that you could then measure and see what you were doing in terms of cost, quality, and access of medical care. But in a sense it is a difficult question for me to answer since the purposes of the two organizations are different. Both are needed.

Mr. O'BRIEN. I had one experience with an HMO in my area where I concluded that the people who participated in it got shortchanged, because the care provided wasn't quite as comprehensive as it should be.

Dr. DICKSON. That is one of the reasons we have in the Office of the Assistant Secretary of Health an HMO qualification function. Around the country there are probably 180 groups that might refer to themselves as health maintenance organizations. However, in subjecting that group to qualification inquiry, we have only been successful to date in finding 29 out of some 200 that actually come up to speed in a satisfactory way in terms of their performance and plans. I believe, of the ones that are qualified, it will be interesting over the next several years to see what their impact is, particularly on the quality and cost aspects of the delivery of care.

Mr. O'BRIEN. Is it a part of your responsibility to monitor the performance?

Dr. DICKSON. Yes, it is.

Mr. O'BRIEN. Would that also include the performance of the PSRO?

Dr. DICKSON. Yes, sir.

Mr. O'BRIEN. Do you just minister to them or do you take what they give you and tell the others about it?

Dr. DICKSON. I am not sure exactly what you are asking me.

PROFESSIONAL STANDARD REVIEW ORGANIZATIONS

Mr. O'BRIEN. Occasionally I have a feeling that the PSRO, in my own area, the first in Illinois—I think it is a good one and is underrated. I sometimes have the notion that the Washington scene tends to tell my doctors what to do, and I am not so sure that my doctors are all that wrong.

Dr. DICKSON. I understand there have been comments about heavy-handedness with respect to activities here in Washington as far as the actvities of individuals and physicians in different groups are concerned. It is a problem to see that this doesn't occur.

In the Professional Standards Review Organization I think it is a very difficult task to get these groups organized, even over an extended period of time. Also, to be successful it is necessary that the physicians, who participate in making the reviews, must want to be a part of that operation. I think to date it has been successful and that physicians are cooperating to make this enterprise a successful one.

I believe some 120,000 out of the 240,000 active physicians in the United States relate in a positive way to the PSRO program.

However, I believe if intrusions are made in that program with respect to PSRO relationships to ambulatory care facilities it may prove to be a considerable problem to private physicians. The Professional Standards Review Organizations have to conduct themselves with a great deal of care or else the physicians will be disenchanted.

Mr. O'BRIEN. Thank you, Doctor.

Thank you, Mr. Chairman.

Mr. FLOOD. Mr. Natcher.

Mr. NATCHER. Not at this point, Mr. Chairman.

Mr. FLOOD. Mr. Michel.

SCIENTIFIC ACTIVITIES OVERSEAS PROJECTS

Mr. MICHEL. Thank you, Mr. Chairman.

Where are most of the scientific activities, overseas projects, currently located?

Dr. KING. They are in four principal countries: Egypt, Pakistan, India, and some in Tunisia. And, of course, we have many ongoing from earlier days in Poland, Yugoslavia,

Mr. MICHEL. The reason of course being the surplus of foreign currencies in those countries; right?

Dr. KING. That is correct, sir.

Mr. MICHEL. Do scientists in these countries apply for this funding on their own or do we seek them out?

Dr. KING. A combination of both situations occur.

Mr. MICHEL. Do we have listed any place what specifically we have learned from the money we spend for research activities in those countries or on those projects?

Dr. KING. Yes, sir.

We have descriptions of the activities, the accomplishments, in each of the principal countries.

Mr. MICHEL. In the interest of time, why don't you give me some good examples of that in the record.

Dr. KING. Very good sir.

[The information follows:]

SCIENTIFIC ACTIVITIES OVERSEAS RESEARCH ACCOMPLISHMENTS

Examples of the many projects funded through this appropriation which benefit the people of the United States include:

Egypt

In Egypt, a study of the "Distribution and Inactivation of Parasites and Bacterial Pathogens in Edible Fish" has revealed infective parasites and potentially pathogenic bacteria in edible fish from the Nile and from brackish water lakes. Both the United States and Egypt will benefit from methods developed through this study for detection and inactivation of parasites and bacterial pathogens. Some of the methods developed will be directly applicable to the Food and Drug Administration's work with our domestic fishing industry. Additionally, the study is providing HEW with information on the public health danger of fish and fish products imported into the United States from the Mediterranean basin.

India

India has provided a number of unusual research opportunities which this appropriation has enabled the United States to utilize. A study of "The Role of Arthropods in Transmission of Leprosy" has shown conclusively that a number of arthropods carry acid fast bacteria. The microbacterium laprae was identified in the culex mosquito, and this insect was found capable of taking up leprosy bacilli from lepromatous lepers. These findings supported the hypothesis that biting arthropods could transfer microbacterium laprae from one individual to another.

Yugoslavia

The program of cooperation with Yugoslavia, which has spanned 15 years, has included productive research in many areas of mutual interest. Among these are studies of the effects of parental alcoholism on psychosomatic development of children, with particular attention to learning abilities and deviant behavior. Preliminary analysis of the data from these studies suggest that children of alcoholic parents are smaller, more neurotic, and less capable. Indepth analysis of the data is in process. In the area of disease control, a study of the protective value of a live oral, lyophilized vaccine against bacillary dysentery in children has demonstrated that an oral attenuated streptomycin-dependent vaccine is both effective and safe in protecting children against infection with homologous strains.

Poland

A study of the "Effect of Diet on Health of Workers Exposed to Cadmium" promises to be of considerable benefit to the United States. Cadmium is a toxic mineral that slowly accumulates in the body, and it is known that vitamin C reduces its toxicity in animals. The subjects of the study in Poland work in a metal-cadmium battery factory where exposure to cadmium oxide dust is high compared to other populations in Poland and the United States. This study should tell us whether vitamin C will protect humans against excess cadmium intake. This is important for the whole U.S. population because cadmium intake from U.S. food is nearing the Food and Agricultural Organization of the United Nations and World Health Organization's recommended tolerable intakes.

Mr. FLOOD. Thank you very much.

[The following questions were submitted by members of the subcommittee with the request that they be answered for the record.]

POSITION REDUCTIONS

Mr. MICHEL. Whenever we try to cut positions in the Department, we always seem to hear cries of anguish and an argument that every position is a vital one. Yet we see from your statement that 35 positions have been eliminated in order to help fund the pay increase. Is there more "fat" in the Public Health Service than you like to let on?

ANSWER. There was no "fat" that made it easy to eliminate positions. A concerted effort is being made to reduce manpower requirements in the Public Health Service. Part of this effort has been an overall reduction in administrative positions throughout the Public Health Service. These 35 positions in the Office of the Assistant Secretary for Health and an additional 126 administrative positions from the six health agencies are being eliminated in 1977 and 1978. The loss of these 35 positions will make it much more difficult for us to cope with the new responsibilities being delegated to the Office of the Assistant Secretary for Health.

Mr. MICHEL. Where did these 35 positions come from?

ANSWER. The 35 positions were eliminated from the following activities: regional management, —13, of which 10 were in the regional offices; program direction and support services, —15; health care assurance, —6; and for the President's Council on Physical Fitness and Sports, —1.

HEALTH INFORMATION AND HEALTH PROMOTION

Mr. MICHEL. Is this new office entitled "Office of Health Information and Health Promotion" still just gearing up, or does it have an ongoing program?

ANSWER. In the brief period that has elapsed since the Office of Health Information and Health Promotion was established, the staff primarily has been engaged in the formation of plans for implementing the National Consumer Health Information and Health Promotion Act of 1976.

It is not envisioned that OHIHP will conduct directly a major grant or contract program: rather, the preferred strategy will be to encourage others in the Public Health Service, the Department, and the public and private sectors to fund more prevention, preventive health services, health promotion, and health education and information activities. Most of the relevant agencies have ample legislative authority but have done little research or evaluation in these areas. The OHIHP strategy would include providing monies, on a joint-funding basis, to Federal agencies, as a practical means of implementing the mandate of the National Consumer Health Information and Health Promotion Act of 1976 to make maximum use of existing authorities and resources of the Department in implementing the act.

Mr. MICHEL. What kind of "national goals and strategies" is OHIHP expected to develop?

ANSWER. The need for complementary national policies, goals, and strategies has been underscored by the President's Committee on Health Education, the National Conference on Preventive Medicine, and more recently by the Expert Panel on Consumer Health Education of the Fogarty International Center of NIH. However, accompanying the pressures for the immediate development of national goals and strategies are a number of countervailing forces, including: incomplete understanding of the nature and causes of health risks; lack of a systematic review of the broad range of experience and experimentation in health promotion and prevention and health education and information; questionable effectiveness of many educational principles, techniques, and methodologies when applied to some very common problems (e.g., obesity, alcoholism and drug abuse); the fact that development of national goals and strategies is an activity that necessarily cuts across departmental lines; differing opinions within the scientific community regarding the major correlates of health and disease; and questions related to the appropriateness of Federal involvement in a variety of possible initiatives in these areas.

The approach to implementing the National Consumer Health Information and Health Promotion Act of 1976 proposed by the Office of Health Information and Health Promotion, which emphasizes research and evaluation, would enable the Department to move quickly with the development of national goals and strategies for those areas where the evidence is most solid. At the same time, it would identify gaps in our knowledge, suggest short- and long-term research

and evaluation priorities, and provide greater assurance of a firm relationship between the national goals, policies, and strategies formulated and the health of the Nation's citizens.

The areas in which national goals and strategies might be developed initially include: childhood immunizations, selected aspects of nutrition (e.g., obesity, salt intake), school health, new directions in smoking prevention and cessation, and impact of the media (both advertising and programing) on health.

Mr. MICHEL. Will the Office of Health Information and Health Promotion be working closely with NIH and the NIH dissemination program?

ANSWER. Yes, the Office of Health Information and Health Promotion will work closely with the National Institutes of Health and the other five Public Health Service agencies to improve dissemination of health information to the public.

In recent years, the National Institutes of Health has made substantial improvements in the dissemination of research information, and plans to further improve its activities through the efforts of the task force on communications, as reported to this committee.

Mr. MICHEL. Will this new office ultimately be responsible for coordinating all of the Public Health Service's public information programs?

ANSWER. The Office of Public Affairs in the Office of the Assistant Secretary for Health is responsible for directing and coordinating the information activities of the health agencies, particularly those public information activities which cross agency lines. While the National Consumer Health Information and Health Promotion Act of 1976 requires the Office of Health Information and Health Promotion to coordinate all activities within the Department which relate to health information, health promotion, preventive health services, and health education, this requirement is not interpreted to mean that the Office will assume direct responsibility for activities already assigned to other PHS programs and staff offices. To the extent possible, the Office of Health Information and Health Promotion will meet the legislative requirement by working with the Office of Public Affairs in the Office of the Assistant Secretary for Health, the public affairs staffs within the PHS agencies, and staff in other Departmental programs which impact on health information and health promotion. In general, OHIHP will be concerned with enhancing the capability of the public information programs to provide information and technical assistance to the public consistent with the overall objectives of the legislation.

HEALTH STANDARDS

Mr. MICHEL. What does that activity entail which provides leadership in the development and enforcement of health care standards? Can you give us some specifics as to what exactly this leadship involves?

ANSWER. In announcing the reorganization, Secretary Califano made it clear that the Assistant Secretary for Health will continue to set health standards policy. Health standards generally involve professional judgments relevant to the structure and process of medical care. For example, health standards deal with manpower training, medical facilities, equipment, and criteria related to what constitutes the appropriate provision of services. The details regarding what specific program elements are to be covered under the term "health standards" are currently being worked out by a high-level Department task force.

INDIRECT COSTS

Mr. MICHEL. Last year I asked this question, and I'd like to get an update this year. What is the total amount of the Public Health Service budget that is going toward indirect costs?

ANSWER. We estimate that a total of $605,942,000 will be spent for indirect costs in fiscal year 1977.

Mr. MICHEL. What is the current average indirect cost rate for Public Health Service as a whole?

ANSWER. The current projected average indirect cost rate for fiscal year 1977 is 13.4 percent.

SCIENTIFIC ACTIVITIES OVERSEAS PROJECTS

Mr. MICHEL. Where are most of the scientific activities overseas projects currently located?

ANSWER. Most of the currently active projects are located in India, Egypt, Yugoslavia, and Poland. There are also a few projects in Tunisia, Pakistan, Morocco, and Israel.

Mr. MICHEL. How many projects are being funded, and how many countries are involved?

ANSWER. During fiscal year 1977, approximately 200 projects in eight countries will receive funds from this appropriation. This includes expenditures for projects for which funds were obligated in earlier years as well as new obligations for some 75 new and ongoing projects in fiscal year 1977.

Mr. MICHEL. Do scientists in these countries actively apply for this funding on their own, or do you have to seek them out?

ANSWER. Both situations occur. We receive many totally unsolicited proposals from foreign scientists. For areas of special concern to the PHS Agencies, however, we may actively seek scientific collaborators in the participating countries.

Mr. MICHEL. Has this program ever really provided anything of great value to us?

ANSWER. Yes, it has. A good example is the work done in Israel, with financing from this appropriation, on the lipid-storage disease—Tay Sachs disease, Gaucher's disease, and Niemann-Pick disease, all of which are characterized by an accumulation of chemically complex fatty substances due to inborn metabolic errors. These disease, which result in organ dysfunction, mental retardation and even early death, were the subject of unsuccessful investigation for more than 50 years.

The Israeli studies have, among other things, made possible the monitoring of pregnancies for early detection of these diseases and thereby made accurate genetic counseling a practical reality.

REGIONAL MANAGEMENT

Mr. CONTE. You are requesting $5.6 million for your regional management staff. I have received a number of reports of problems in the regional setup, largely because the agencies are responsible for the funding and accountability of their programs to Congress, but the regional offices which actually administer the programs report to your office of regional operations. Are you aware of these problems, and do you have any suggestions for improving the lines of control and accountability for such programs?

ANSWER. We are aware of the various concerns expressed by some Public Health Service Agency's headquarters staff concerning their preference to exercise direct control over regional office programs. These views are not surprising. However, there has been no definite evidence brought to our attention that programs are being adversely affected because of the administrative relationship of the Regional Health Administrators to my office through the Office of Regional Operations is working with both regional central office program cut lines of authority and responsibility at all levels in the Public Health Service commensurate with overall accountability and stewardship. In our efforts to strengthen these management capabilities, we are continually reviewing and improving the regional work planning system through our management by objectives initiative and our manpower management analysis. For instance, the Office of Regional Operations is working with both regional and central office program staffs to identify priority program outputs to be achieved in the regions. I believe that headquarters and regional office staffs must continue to work in a cooperative and mutually satisfying and rewarding manner to address the health needs of the country. Specifically, to improve control, we intend to improve headquarters offices' understanding and use of work program guidance as the mechanism by which they define their expectations of regional office staff. The regional offices can be, and are, held accountable for carrying out the activities identified in their work plans much as contractors are accountable for meeting the specifications of contracts. ORO and the Bureau of Community Health Services (BCHS) in the Health Services Administration have proven that this mechanism is viable, and responsive to program objectives. We, therefore, intend to emulate the BCHS experience throughout other Public Health Service decentralized program activities.

In terms of accountability, headquarter offices are accountable to the Assistant Secretary for Health for effective administration of programs. Regional Health Administrators are also accountable to the Assistant Secretary for Health for carrying out the activities identified in their work plans based upon headquarters

guidance and for carrying out PHS and HEW policy and initiatives which cross program, bureau and/or agency lines.

Mr. CONTE. You mentioned your office's awesome responsibility for the awarding and administration of some $1.6 billion worth of grants. With the reduction of 35 positions to cover pay increases, does your office have adequate staff to effectively oversee the grants under your jurisdiction?

ANSWER. The reduction of 35 positions was not made entirely from the regional office staff. The regional management activity was reduced by a total of 13 positions, 3 from the headquarters office of the office of regional operations and 10 from the regional offices. That left a total of 124 management positions in the regions and 23 in the office of regional operations. Positions for the administration and awarding of grants are included as part of program resources which are appropriated through Public Health Service agency budgets. Therefore, the monitoring of grants was not affected by the reductions. Through the use of the manpower management program we identify the number of personnel needed to manage the grant programs. Further, we use the budget process for long range plans with respect to future staffing needs. Having the Regional Health Administrators control regional resources provides some flexibility for handling short range problems.

IMPACT OF HEW'S REORGANIZATION

Mr. CONTE. What changes do you see in your office as a result of the recent reorganization of certain DHEW activities and offices—in particular, how has administration of the health care assurance program been affected?

ANSWER. There are three points of impact on the health care assurance activity resulting from Secretary Califano's March 8 reorganization establishing the Health Care Financing Administration. The policy-setting function related to the maximum allowable drug costs activity will be transferred to the new Administration. A portion of the long-term care activity now funded in the health care assurance activity will also be transferred to the new Administration. While the operational aspects of the professional standards review organizations are being transferred to the new Health Care Financing Administration, the Office of Quality Standards will still be responsible for developing quality assurance and standards of health care.

The Secretary, in announcing his reorganization, indicated that the Assistant Secretary for Health will continue to oversee health systems planning and to set health care policy. The ability of the Assistant Secretary for Health to shape health policy will be increased by this reorganization since policy direction will be provided to a single person responsible for health care financing, the Administrator, Health Care Financing Administration.

TECHNICAL ASSISTANCE

Mr. CONTE. What sorts of technical assistance to State and local agencies does your office provide?

ANSWER. Staff of the regional offices provide technical assistance to State and local agencies in several ways. They interpret PHS and program policy for these organizations, they aid them in identifying and applying for needed funds, they disseminate information about technical and professional advances for specific program areas, and they actively assist grantees in overcoming planning and operational problems. Relative to specific grants, regional office personnel provide technical assistance in needs assessment, program and project planning, proposal development, and implementation methods. Regional health administrators, because of their continuing interaction with State and local agencies, provide the Assistant Secretary for Health with a perspective of the needs and views of these important health care providers.

DISSEMINATION ACTIVITIES OF HEALTH AGENCIES

Mr. CONTE. I believe your office is currently compiling a report on the dissemination activities of the health agencies. When will that report be completed?

ANSWER. Advance copies of this report had been submitted to the committee prior to its formal transmission on March 30.

DECENTRALIZED HEALTH PROGRAMS

Mr. CONTE. What programs are currently decentralized and administered through regional offices?

ANSWER. The following programs are decentralized to the regional offices:

Comprehensive public health services—Formula grants.
Crippled hildren's services—Formula and project grants.
Family planning projects.
Community health centers.
Maternal and child health services—Formula and project grants.
Migrant health grants.
Health maintenance organization development.
Emergency medical services.
Appalachian health programs.
Health underserved rural areas program.
Disease control—Project grants.
Childhood lead-based paint poisoning control.
Urban rat control.
Mental health—Hospital improvement grants.
Mental health—Hospital staff development grants.
Community mental health centers—Comprehensive services support.
Alcohol formula grants.
Health facilities construction grants and loans.
State health planning and development agencies.
Health planning—Health systems agencies.
Short-term training grants.
Dental—Training in expanded auxiliary management.
Continuing dental education.
Health professions loans.
Health professions scholarships.
Nurse Training improvement—Special projects.
Nursing scholarships.
Nursing loans.
Nursing school construction.
Family medicine—Training grants.
Health manpower education initiative awards.
Health professions—Special project.
Health professions—Start-up assistance.
Emergency medical services training grants.
Health professions school construction.
National health service corps.
Provider standards and certification.
End-stage renal disease.
Occupational safety and health technical assistance.

PHS REGULATIONS PROCESS

Mr. CONTE. What are you doing to encourage greater public participation in your regulations development process?

ANSWER. A notice of intent, a document describing questions the Secretary wishes to address through regulations, is issued whenever our consideration of important policy issues will be aided by public comment at an early stage. The notice of intent is used liberally to permit interested outside groups and other members of the public to have an impact on the decisionmaking process at an early stage. Agencies are encouraged to hold public meetings to permit the Department to receive information on the notice of intent or other proposed regulatory documents. Such hearings aid the Department in developing its position on the issues involved. For example, last July a useful hearing was held with about 150 members of the public on issues concerning the regulation of clinical laboratories.

BILATERAL HEALTH AGREEMENTS

Mr. CONTE. What bilateral health agreements were modified or expanded last year?

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ANSWER. During fiscal year 1976, there were no modifications or expanded commitments within the terms of our various existing bilateral agreements. During the transition quarter, however, the PHS did undertake responsibility for a new bilateral agreement with the Federal Republic of Germany. On September 22, 1976, the Assistant Secretary for Health, and the German Minister for Research and Technology signed an Agreement for Cooperation in Biomedical Research and Technology which reaffirmed the two Nations' commitment to cooperate in and coordinate selected research efforts. Although no specific research commitments were identified in the agreement, the two countries agreed that a greater effort might begin in the areas of cancer and heart disease. The Director of the National Institutes of Health is responsible for implementing the terms of this agreement and he and his staff have already begun substantive discussions with their counterparts in the Federal Republic of Germany.

MALPRACTICE INSURANCE

Mr. CONTE. It seems that the malpractice insurance problem is somewhat less in the news than it used to be. Is it still a problem? What is your office doing about it? Do you foresee a need for some sort of Federal coinsurance program in the malpractice area?

ANSWER. While not receiving the publicity it did 2 years ago, medical malpractice insurance is still a national problem. Aspects of the problem that cause the greatest concern to us are the inequities in the current system, the need to reduce malpractice by quality assurance and other programs, and the steadily increasing cost of insurance.

Our office is involved in a number of malpractice-related activities. These include: (1) Obtaining and analyzing individual malpractice claims—such information should be useful in efforts to reduce future injuries, (2) encouraging hospital injury reduction programs, (3) through a contract with the American Bar Association, studying tort law changes, (4) through another contract, studying State physician discipline activities, to help States in the reviewing of their licensing laws, (5) with medicare staff, developing self-insurance alternatives for hospitals, and (6) with others, planning to evaluate an innovative alternative approach, compensable event insurance, that could have a major impact on the problem.

We feel that Federal malpractice coinsurance, by itself, is not indicated at this time, because it will do little to address the problems of greatest concern listed above. However, because of the relationship of malpractice and quality of care, and because of the steadily increasing cost of malpractice insurance, we will continue to review various options for further Federal involvement.

PHYSICAL FITNESS AND SPORTS

Mr. CONTE. Why have you requested a slight decrease for the PCPFS?

ANSWER. A concerted effort is being made to reduce manpower requirements in the Public Health Service. Part of this effort has been an overall reduction in administrative positions throughout the Public Health Service. Thirty-five positions in the Office of the Assistant Secretary for Health and an additional 126 administrative positions from the six health agencies are being eliminated in 1977 and 1978. The office of physical fitness, like all other staff offices funded from this appropriation, took a proportionate share of the 35-position reduction and this resulted in the loss of 1 position. This cut in staff resulted in the fiscal year 1978 funding request being reduced by $10,000 from the 1977 level.

Mr. CONTE. Would you explain exactly how the national youth sports program works? Is that year-round or a program only in the summer months?

ANSWER. The national youth sports program (NYSP) makes available to many American youths important experiences which they are unable to secure through their own means. Excellent facilities are utilized to provide supervised sports training and competition on an unprecedented scale. Program participants acquire valuable skills and health knowledge, improve their physical fitness and are acquainted with career and educational opportunities. Principal partners in this effort are selected institutions of higher education, the National Collegiate Athletic Association (NCAA) and the Community Services Administration (CSA). Representatives of the President's Council on Physical Fitness and Sports serve as members of the program's advisory committee and have input into program design an devaluation of individual programs at local institutions. There are approximately 140 institutions participating in this worthwhile effort.

Each institution has the necessary facilities and is accessible to serve disadvantaged areas. At least 90 percent of the participants in each project shall meet criteria set forth in the Community Services Administration poverty guidelines. Add projects must include boys and girls, and eligible ages are 10 to 18.

Program content: (1) Activities including instructional swimming programs and instruction and competition in at least three specified sports; each program includes vigorous conditioning activities; (2) enrichment program includes drug abuse education; career opportunities and health education; (3) nutrition—a daily meal must be prvided for each enrollee.

Each enrollee must receive a medical examination prior to participating in sports activities and referral of health problems must be made to the youth's family and appropriate health agency. When a health problem is discovered, proper treatment must be provided.

Each staff shall have a nucleus of trained professions to be assisted by student athletes and others competent to supervise youth sport activities.

The National Collegiate Athletic Association (NCAA) is responsible for program direction and control, including institution selection and responsibility for program detail. The NCAA has been awarded a grant by the CSA and in turn awards subgrants to designated institutions whose budgets have been approved by the NYSP Advisory Committee.

The NYSP on a college campus must operate continuously for at least 5 weeks during the period between June 1 and September 3. Institutions must provide year-round activities for enrollees, with a minimum of 12 activity sessions and/or meetings during the period October 1976–May 1978. There must be at least one session during each month in this period.

Mr. CONTE. Your justification refers to special emphasis on fitness programs for the elderly through the President's Council. What do such programs entail?

ANSWER. The special emphasis on fitness programs for the elderly is provided by the PCPFS through expanding leadership, training workshops, and the development of instructional resource materials.

PRESIDENT'S COMMISSION ON OLYMPIC SPORTS

Mr. CONTE. Would you outline the recommendations of the President's Commission on Olympic Sports as they affect amateur sports in this country, and explain the role of the PCPFS in that reorganization.

ANSWER. The President's Commission on Olympic Sports recommendations are contained in a two-volume, 613-page report.

The PCOS recommended the creation of a private central sports organization (CSO) designed to achieve a unified national sports system, settle organizational disputes, guarantee athletes' rights to compete, and finance amateur sport more effectively. The CSO would be derived from the organizational structure of the United States Olympic Committee (USOC) but would be a much smaller and less cumbersome body.

The PCOS proposes that the PCPFS serve as the link between the executive branch of the Federal Government and the CSO. The report states:

". . . The President's Council on Physical Fitness and Sports (PCPFS) is the only ongoing Government agency solely concerned with physical fitness and sports. While not a grant-making agency, the Council provides valuable service to the physical fitness and sports community through promotion and cooperation with groups to structure programs benefiting sports and physical fitness.

"In order to insure that the best working relations are established between the executive branch of the Federal Government and the CSO, the commission recommends that a position be designated to serve as a liaison with the CSO at the highest level of government to advise the CSO on the availability of Federal funds for amateur sports. The Commission has taken note of the success of PCPFS in acting as a catalyst upon private business and education. While a new position could be created for the purpose of liaison with the CSO, the commission recommends that the Executive order governing the operations of the PCPFS be modified to expand PCPFS responsibility to include liaison with the CSO.

"In order to insure that Federal efforts satisfy priorities established by the CSO, the commission recommends that a sub-Cabinet level committee by established by Executive order to coordinate Federal response. As the sub-Cabinet level committee will, of necessity, meet on an infrequent basis, the Commission further recommends that FCPFS be established as the staff and coordinating arm

of the sub-Cabinet level committee. 'While the PCPFS budget will undoubtedly require some slight increase to enable the organization to serve as liaison with the CSO and as staff arm to the sub-Cabinet level Committee on Amateur Athletics, the Commission believes that the increased funding requirement will be minimal. Further, PCPFS is in an ideal position to serve as Federal liaison (1) from the standpoint of existing expertise, (2) due to its stature both within the Federal Government and as viewed by private corporations and amateur athletic organizations and (3) by virtue of the organization's proven ability to act as a catalyst."

MEDICAL PRACTICE DEMONSTRATION PROJECT

Mr. CONTE. What is the medical practice information demonstration project and when will it be completed?

ANSWER. Health care practitioners depend uopn certain scientific information as the working basis for nearly all that they do. However, they face three major problems in relation to such knowledge: (1) most medical science information produced today is of little use to the needs of practitioners, (2) much of that which might be of use may be invalid or unsupportable scientifically, and (3) most of that which is both relevant and valid is likely to be inaccessible. Consequently, there exists an urgent need for a feasible and practical program to cope with this problem regarding medical practice information.

It is the purpose of this project to demonstrate available procedures for meeting the above need. Three goals will be achieved in this effort:

A conceptual outline of that information most urgently needed by health care practitioners will be finalized and illustrated for three health problems;

Practical procedures for validating such information will be formalized and demonstrated;

The information, including its validation, will be documented and archived in a manner making it readily accessible and understood by practitioners, educators, or researchers who might benefit by this knowledge.

During the 15-month contract period, a progress report and a final report will be produced describing the work accomplished, evaluating the results, and offering policy options as well as immediate applicational recommendations regarding the medical practice information program thus demonstrated.

PSRO PROGRAM

Mr. CONTE. At this point, how do you assess the results of the PSRO program? Is it proving to be worthwhile? Do you have any estimates of the amount of savings which have been made through the PSRO program?

ANSWER. A comprehensive evalution of the PSRO program has not yet been completed. A PSRO evaluation plan has been undertaken and preliminary information is anticipated this summer.

Initial information, indicates an impact on hospital utilization and length of stay. For example, an ORS/SSA study on the Sacramento CHAP program revealed a decreasing day utilization rate for medicare beneficiaries. Distribution of lengths of stay shifted toward shorter stays. The preadmission review component at Sacramento had a delayed effect manifested in the second year of review program activities.

Several other PROSs, including South Carolina, Multnaomah (Oregon), and Delmarvia (Maryland), have provided self-assessment data that indicates impact in the areas of length of stay and hospital admission.

RETIREMENT PAY AND MEDICAL BENEFITS

Mr. CONTE. This is essentially an uncontrollable account, isn't it? Don't we in some sense have to appropriate the full amount?

ANSWER. That is correct, this is an uncontrollable account which requires full funding. Payments made from this appropriation are required by law as set forth in 10 USC chapter 12 for retirement pay, 10 USC chapter 73 for survivors, and 10 USC chapter 55 for dependents medical care.

Mr. CONTE. What was the relationship between the amount requested for retirement pay and medical benefits in 1976 and the amount which was actually needed? What can be done to improve the estimations?

ANSWER. In the fiscal year 1976 budget, we requested $45,013,000 for retirement pay and medical benefits for commissioned officers. Actual obligations for 1976 amounted to $44,990,000, which was 99.95 percent of the original estimate. With only a .05 percent difference between the estimate and the actual obligations. We feel that our projections are very good.

EXCESS CURRENCY PROGRAM

Mr. CONTE. Why are you requesting a $6 million decrease from the 1977 operating level for scientific activities overseas? What will this reduced level of funding mean in terms of the activities in which you will be able to engage? What won't you be able to do that you did last year?

ANSWER. The overriding reason for the reduction is because there will be fewer excess currency countries. Poland, where we have had a large program for several years, was removed from the excess currency list on December 31, 1976. Tunisia will be removed from the excess currency list on September 30, 1977. Additionally, we expect our program to level off in Egypt.

Because the principal reason for the reduction is that there will be fewer excess currency countries, the reduced program level will have no impact on the remaining activities in which we expect to be engaged.

We won't be able to obligate funds for projects in Poland and Tunisia. As already indicated, this is because the Treasury Department has already removed Poland from the excess currency list and will be doing the same with Tunisia on September 30.

Mr. CONTE. How much will you be carrying over in unobligated balances this year?

ANSWER. We do not now anticipate carrying any unobligated balance into 1978. It is possible, however, that some projects will not be ready for funding by the end of the fiscal year and that there would then be some carryover.

Mr. CONTE. Your jurisdiction indicates that this program operates in India. How large is the Indian program? What has it accomplished?

ANSWER. At the present time, there are 21 active projects in India representing a total obligated cost of $7.4 million equivalent in India rupees.

The most successful projects in India have taken advantage of unusual research opportunities there, such as the presence of a natural resource, the high incidence of a particular disease and the like. An example of such a project is one where native plants are being collected and identified in an effort to develop therapeutic agents against cancer. Over 1,900 plant extracts have been sent to our National Cancer Institute. Several of the plants found to be active against animal tumors have been or are being studied for the isolation and identification of fractions yielding active agents. Many compounds have been isolated and some will be moved into pharmacology and clinical trial as justified by testing results. In a second project, being conducted by the Tata Memorial Hospital in Bombay, plants indigenous to the Bombay area have been collected and crude extracts have been made and tested for efficacy against a defined type of leukemia. Five crude extracts have shown efficacy against this type of leukemia. Of these five extracts, two have also demonstrated efficacy against another type of leukemia which is the principal tumor utilized in the National Cancer Institute's testing program.

These are only two examples of the projects in India which relate directly to U.S. domestic programs and which have promise for benefiting the people of the United States.

EXCESS FOREIGN CURRENCY PROJECTS

Mr. CONTE. Would you provide some additional examples of projects funded under this program?

ANSWER. Additional examples of projects funded under the Scientific Activities Overseas program are:

Tunisia.—Although only 15 projects have been financed in Tunisia since the beginning of the Program the work there has been unusually productive. A study of inflammatory breast cancer which was established to characterize the "pousee evolutive" (PEV) form of breast cancer, is uncovering genetic and pathologic clues which may assist oncologists throughout the world in identifying the cause of breast cancer and limiting its impact. PEV, a particularly agressive form of breast cancer, affects 55 percent of Tunisian women compared to 18 percent reported in France and 5 percent in the United States.

Poland.—Poland is the site of several important biomedical studies. One is a study of the "Regulation of Life Cycle in Bacteria." The basis of this study is that for any cell, animal or bacterial, to maintain a constant complement of genetic information it must be equipped with mechanisms to control cell division and the synthesis of its genetic material, DNA. When conditions are unfavorable for growth, no DNA is made and cell division does not take place. In this project, the researchers are approaching the problems of the control of DNA synthesis and cell division by genetic means. They have succeeded in isolating a number of mutants of the bacterium, salmonella typhimurium, which are defective in these processes when the cells are incubated at 105 degrees F but which behave normally and therefore grow when incubated at 91 degrees F. Apparently, several different genes are involved in the process and the Polish scientists are currently attempting further analyses of the mutant types. The importance of this work stems from the fact that the control of DNA replication and cell division lies at the very heart of the problem of uncontrollable cell division-cancer.

India.—A project at the University of Rajasthan has resulted in the successful synthesis and standardization of compounds of interest in psychopharmacological studies. In order to design more effective psychotropic agents, it is important to understand fully the mode of action of drugs in widespread use today. Essential to this understanding is a knowledge of their metabolites, whose identification is dependent upon the availability of appropriate reference standards. This project is currently providing us with reference compounds which will be used for further research on psychoactive drugs of schizophrenia.

Yugoslavia.—A study of the "Effects of Hormones on Metabolism of Adipose Tissue" is demonstrating, along with other research, the dynamic nature of fat tissue as an active participant in the energy economy of the body in various physiological states. We now know that the old concept of fat tissue as a passive "bank" of available energy is no longer valid. Another Yugoslav project is studying "Brain survival in anoxia and hypothermia." The information being provided is important to us because of the widespread use of hypothermia in experimental physiology as well as in medicine and surgery. This project is one of several important neurobiological studies financed under this program in Yugoslavia which are providing valuable information about brain and central nervous system functions.

Egypt.—A long standing Egyptian-based study of tick sand tickborne diseases in Africa, Asia, and Europe has been quite successful. Several new viruses have been isolated, and the integration of natural history and laboratory investigations has made possible a fuller understanding of the biological factors of tick vectorship. An extensive collection of specimens and books assembled in the course of the research has been transferred to the Rocky Mountain Laboratory of the National Institute of Allergy and Infectious Diseases.

RELATIONSHIP OF EXCESS CURRENCY PROGRAM AND AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. CONTE. What is the relationship between your overseas program and the health programs run by the Agency for International Development?

ANSWER. We cooperate with AID and complement their activities when it is possible to do so in those excess currency countries where both PHS and AID have program activities. For the "Scientific activities overseas" appropriation, these countries are Egypt, Pakistan, and Tunisia. An example of such cooperation with AID is on a study of zinc nutrition in Tunisia sponsored by the Food and Dug Administration. This study has been conducted in conjunction with the AID-supported national nutrition survey. In Egypt, AID is a member of the United States-Egypt Medical Cooperation Working Group, with the U.S. Assistant Secretary for Health cochairs with the Egyptian Minister of Health. AID representatives are involved in the identification of projects which may ultimately be financed by PHS and vice versa.

Additionally, the entire Public Health Service cooperates with AID through provision of experts to assist with its overseas health activities. In short, we work with AID in a variety of ways on a broad spectrum of overseas activities.

JUSTIFICATION OF THE BUDGET ESTIMATES

Appropriation Estimate

SALARIES AND EXPENSES

For expenses necessary for the Office of the Assistant Secretary for Health, [$22,316,000] *$23,178,000*.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Amounts Available for Obligation 1/

	1977	1978
Appropriation	$22,316,000	$23,178,000
Comparative transfer from:		
"Health Services" Transfer of administrative support for Health Maintenance Organizations Qualifications and Compliance functions	811,000	---
"Health Resources" Transfer of administrative support for health planning for Public Health Services	50,000	---
Total obligations	23,177,000	23,178,000

1/ Excludes amounts for reimbursable activities carried out by this account as follows: 1977, $751,000; 1978, $370,000.

Summary of Changes

1977 Estimated obligations	$23,177,000
1978 Estimated obligations	23,178,000
Net change	+1,000

	1977 Base Pos.	1977 Base Amount	Change from base Pos.	Change from base Amount
Increases:				
Built-in:				
1. Within grade increases	---	---	---	+$262,000
2. FTS and telephone rate increase	---	158,000	---	+2,000
3. Standard Level User Charge	---	1,534,000	---	+146,000
4. PHS Service and Supply Fund costs	---	2,638,000	---	+99,000
5. Working Capital Fund costs	---	281,000	---	+15,000
6. PHS Federal Employee Health Unit costs	---	26,000	---	+3,000
7. Department of Labor Bureau of Employee Compensation costs	---	1,000	---	+1,000
Subtotal increases				+528,000
Decreases:				
1. One less day of pay				-64,000
2. Annualized saving due to a reduction of 35 positions in fiscal year 1977				-463,000
Subtotal decreases				-527,000
Total, net change				+1,000

Obligations by Activity

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Regional Management..	147	$5,711,000	147	$5,625,000	---	-$86,000
Standard Level User Charge.....	---	(462,000)	---	(508,000)	---	(+46,000)
Program Direction and Support Services...	400	14,338,000	400	14,502,000	---	+164,000
Standard Level User Charge.....	---	(1,072,000)	---	(1,172,000)	---	(+100,000)
Health Care Assurance	60	2,328,000	60	2,261,000	---	-67,000
President's Council on Physical Fitness and Sports.....	11	800,000	11	790,000	---	-10,000
Total obligations..	618	23,177,000	618	23,178,000	---	+1,000

Obligations by Object

	1977 Appropriation	1978 Estimate	Increase or Decrease
Total number of permanent positions	618	618	---
Full-time equivalent of all other positions	65	65	---
Average number of all employees	699	683	-16
Personnel compensation:			
Permanent positions	$14 752,000	$14,504,000	-248,000
Positions other than permanent	1,032,000	1,032,000	---
Other personnel compensation	215,000	215,000	---
Subtotal, personnel compensation	15,999,000	15,751,000	-248,000
Personnel benefits	1,765,000	1,748,000	-17,000
Travel and transportation of persons	973,000	973,000	---
Transportation of things	45,000	45,000	---
Rent, communications, and utilities	2,230,000	2,378,000	+148,000
Printing and reproduction	210,000	210,000	---
Other services	1,673,000	1,791,000	+118,000
Supplies and materials	175,000	175,000	---
Equipment	107,000	107,000	---
Total obligations by object	23,177,000	23,178,000	+1,000

Significant Items in House and Senate
Appropriations Committee Reports

Items	Action taken or to be taken
1977 House Report	
Assistant Secretary for Health	
1. The Committee directed that report be prepared not only on NIH's dissemination activities but also on the dissemination activities of the other health agencies (page 24).	1. In carrying out this directive the Office of the Assistant Secretary for Health is currently compiling a report on the dissemination activities of the health agencies. Upon completion of this effort, a report will be submitted to the Committee.
2. Committee directed that any increase in delegated authority to regional directors be reported (page 57).	2. No additional authority was delegated to regional directors during fiscal year 1977 or contemplated for fiscal year 1978.
1977 Senate Report	
1. The Committee directed that the Assistant Secretary for Health review each agency's travel expenditures and determine travel priorities (page 26).	1. The Public Health Service agencies have developed FY 1977 travel plans to restrict travel to a minimum level. These travel plans are being monitored quarterly with an explanation of any significant differences if obligations exceed plans. An explanation of the steps which will be taken to make a corresponding reduction in obligations during the remaining months is required.

Significant Items in House and Senate
Appropriations Committee Reports

	Action taken or to be taken
1977 Senate Report - cont'd	
2. Committee directed that a report on implementation of the nutrition research and education programs be submitted no later than 9 months following enactment of the bill (page 28).	2. In carrying out this directive, this office is collecting information from the health agencies, NIH, CDC, and HSA, which received additional funds for nutrition research and education programs. The data being collected describes the research projects that are being supported and how they relate to other ongoing nutrition activities. A progress report on this initiative will be provided to the Committee by June 30, 1977.

Assistant Secretary for Health

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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	22,416,000	22,216,000	22,316,000
1978.....	23,178,000			

Assistant Secretary for Health

	1977 Appropriation		1978 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Activities						
1. Regional Management..	147	$5,711,000	147	$5,625,000	---	-$86,000
2. Program Direction and Support Services...	400	14,338,000	400	14,502,000	---	+164,000
3. Health Care Assurance	60	2,328,000	60	2,261,000	---	-67,000
4. President's Council on Physical Fitness and Sports.....	11	800,000	11	790,000	---	-10,000
Total.....	618	23,177,000	618	23,178,000	---	+1,000

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 coordination of the overall National efforts to assure the quality of health care standards, and resources necessary for 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 direction of the Public Health Service agencies. The Assistant Secretary for Health 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.

As a result of recent legislation and new regulations, the Office of the Assistant Secretary for Health has been given additional functions and responsibilities. The National Consumer Health Information and Health Promotion Act of 1976 (P.L. 94-317) requires the establishment of an Office of Health Information and Health Promotion in the Office of the Assistant Secretary for Health. Recent amendments to the Health Maintenance Organization Amendments of 1976

(P.L. 94-460) require that the HMO Qualification and Compliance function also be conducted in this office. Further, the implementation of the new regulation pertaining to Maximum Allowable Costs for drugs requires the coordination of the activities of PHS, SSA, and SRS in connection with limiting the cost of drugs paid through Medicare, Medicaid, and other federally supported health care programs.

During 1977, the Office of the Assistant Secretary for Health eliminated 35 budgeted positions and by so doing was able to absorb the October 1976 pay raise for general schedule and commissioned officer personnel.

Regional Management

1977 Appropriation		1978 Estimate		Increase or Decrease	
Pos.	Amount	Pos.	Amount	Pos.	Amount
147	$5,711,000	147	$5,625,000	---	-$86,000

The staff supported by this activity is located in the ten PHS regional offices and the headquarters staff of 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 acts as an advisor to the Assistant Secretary for Health on matters pertaining to 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 6,400 grants totaling $1.6 billion being awarded and administered in the regional offices.

In 1977, the Regional Management staff continued to provide the overall management capabilities necessary for administration of health programs in the ten regional offices. There was a concerted effort directed toward a 100 percent validation of regional Manpower Management Programs (MMP). The MMP data was used in special budget and management analyses involving allocation and use of staff. In addition, increased effort was expended on the regional evaluation system to implement improvements, including establishment of more explicit guidance from headquarters agencies to the regions on relating evaluation to long-range plans in national program development, and monitoring results of studies supported in prior years with a view toward linking those results with ongoing management and planning decisions.

In 1978, the regional offices will implement cost containment and quality control aspects of grant and contract programs, including application of the Health Services Funding Regulations on a cross-cutting basis for all service delivery programs and institution of medical care quality assessment procedures.

In order to absorb the October 1976 pay raise in fiscal year 1977, 13 positions have been eliminated. This reduction will be continued in fiscal year 1978.

A total of $5,625,000 is required to carry out the 1978 objectives. The net decrease of $86,000, from the 1977 operating level of $5,711,000, represents $86,000 for mandatory costs and a reduction of 13 positions and $172,000 as follows:

1. Within grade increases	+$54,000
2. Payments to the HEW Working Capital Fund	+2,000
3. Standard Level User Charges	+46,000
4. Less one day of pay	-16,000
5. Annualized savings due to a reduction of 13 positions in fiscal year 1977	-172,000
Total net change	-86,000

Program Direction and Support Services

1977 Appropriation		1978 Estimate		Increase or Decrease	
Pos.	Amount	Pos.	Amount	Pos.	Amount
400	$14,338,000	400	$14,502,000	---	+$164,000

This activity provides staff support for the Assistant Secretary for Health for guidance, leadership, and direction to the Public Health Service agencies on all health and health-related activities, including research and development; education and training, organization, financing and delivery of health care services; provision of preventive health services; and protection to the public from unsafe foods, drugs, and medical devices.

This activity includes staff and related costs for the Immediate Office of the Assistant Secretary for Health, and the Offices of Health Legislation, Program Implementation, International Health, Administrative Management, Policy Development and Planning, Child Health, Health Information and Health Promotion, Public Affairs, and Equal Employment Opportunity.

During 1977, there was increased activity related to Administration and Congressional legislative priorities, including preparations dealing with the expiration of 14 health authorities, as well as Medicare and Medicaid amendments, and Nationwide Health Financing bills. Fiscal year 1978 legislative workload requirements will be determined by priorities set by the Administration and the 95th Congress.

The program implementation function has begun a program intended to make PHS regulations more responsive and understandable to the public. Progress will continue in 1978 and focus on development of mechanisms to further encourage public participation in our regulations development process.

During 1977, bilateral health agreements were modified and in some cases expanded. In collaboration with the Agency for International Development, analytic studies on the interrelation between health and economic development were completed in three countries. In 1978, evaluation of bilateral programs will be directed towards identifying those which provide substantial benefit to the United States. Continuing analysis of activities of the World Health Organization and other international bodies will ensure that United States input to those organizations has maximum impact.

In the area of administrative management, progress was made in establishment of a manpower management program for all agencies and staff offices as well as the prototype of a manpower reports system that will enable managers to compare cost elements across organizational components. During 1978, we shall begin implementation of the manpower reports system and conduct a comprehensive review of regional office organizational structure and functional alignments. To contain the level of Federal expenditures,

we will expand our efforts to improve grantees' overall efficiency by emphasizing improved business management performance on the part of grant recipients. A key element in this program will be the dissemination of specific and uniform financial and administrative guidelines in a handbook format to grantees.

The Forward Plan through 1982 was prepared which coordinated health strategies and gave direction to policy development, research, evaluation and legislative and statistical plans. Other accomplishments include providing staff support to the Health Insurance Benefits Advisory Council in its review of methodologies for improving health services delivery under Medicare and Medicaid, directing and coordinating PHS efforts in developing a policy position for credentialing health manpower, providing staff support to the Department's medical malpractice effort and directing the development of a Department-wide Health Statistics Plan. These functions will continue in 1978 to aid in major policy development and planning.

Within this activity is included coordination of agency programs directed towards strengthening and expanding delivery of health care to children and mothers. Also included is the focal point for a major PHS effort in the area of health information and health promotion. In both areas of activity emphasis will be placed in 1978 on increased coordination and collaboration with other Federal agencies.

In order to absorb the October 1976 pay raise in fiscal year 1977, 15 positions have been eliminated. The reduction will be continued in fiscal year 1978.

In summary, a total of $14,502,000 is required for the continuation of this activity. The net increase of $164,000 over the 1977 operating level of $14,338,000 represents mandatory costs of $363,000 and a reduction of 15 positions and $199,000 as follows:

1.	Within grade increases.....	+$187,000
2.	Standard Level User Charges.....	+100,000
3.	Payments to PHS Service and Supply Fund	+99,000
4.	Payments to HEW Working Capital Fund.	+13,000
5.	FTS and telephone rate increases....	+2,000
6.	Payments to Bureau of Employee Compensation Fund, Department of Labor.....	+1,000
7.	Payments to PHS Federal Employee Health program.....	+3,000
8.	Less one day of pay.....	-42,000
9.	Annualized saving due to a reduction of 15 positions in fiscal year 1977	-199,000
	Total net change.....	+164,000

Health Care Assurance

1977 Appropriation		1978 Estimate		Increase or Decrease	
Pos.	Amount	Pos.	Amount	Pos.	Amount
60	$2,328,000	60	$2,261,000	---	-$67,000

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.

This activity includes staff and related costs for the Offices of Quality Standards, Long Term Care, and Population Affairs.

As a part of its quality assurance activities, the Office of Quality Standards continued to coordinate development of Professional Standards Review Organizations program policy, and provided technical assistance for implementation of program evaluation. Completion of the Medical Practice Information Project demonstrated a technique for categorizing, documenting, and determining validity and reliability of information concerning specific health programs. Other accomplishments included completion of hospital utilization review regulations for the Medicaid programs, continued management and development of policies for the Maximum Allowable Cost for drugs program, and preparation of new regulations for the recently passed Health Maintenance Organizations (HMO) amendments (P.L. 94-460). Of the 47 applications for HMO qualification received, 45 were qualified and are under continuing regulation.

In 1978, the Office of Quality Standards will continue to coordinate and develop with the Social Security Administration and Social and Rehabilitation Service all Department policies relating to quality assurance and standards of health care. Emphasis will be placed on developing and streamlining procedures pertaining to Maximum Allowable Cost determinations and approximately 33 additional HMO's will be qualified and under continuing regulation, totaling 80 by the end of the fiscal year.

In 1977, the Office of Long Term Care continued to coordinate Phase II of the Long Term Care Improvement Campaign which was expanded to a total of 288 facilities, an increase of 100 from the initial estimate. The major objective of the Phase II study was to introduce on a nationwide voluntary basis a consolidated Patient Appraisal and Care Evaluation System designed to measure outcomes of approximately 5,760 patients in facilities participating in Federal programs.

In 1978, Phase II of the Long Term Care Improvement Campaign will be expanded to assess the Medicare and Medicaid reimbursement mechanism with a view toward developing reimbursement procedures with incentives linked to patient care performance. In addition to the Phase II activity, the office will seek greater recognition and utilization of out-of-institutional services.

The Office of Population Affairs provides staff assistance to the Secretary, the Assistant Secretary for Health, and program direction to the Bureau of Community Health Services and the Center for Population Research. In 1977, this office participated in the review and evaluation of proposed grants and contracts for the population research and family planning services. Over 4 million women received services from organized programs mainly supported by Federal, State and local government funding.

In FY 1978, the Office of Population Affairs will continue efforts to increase sources of revenue for family planning services other than project grants along with continued efforts to integrate family planning services programs into the general health care system. Efforts will also be continued to extend population education activities.

In order to absorb the October 1976 pay raise in fiscal year 1977, 6 positions have been eliminated. This reduction will be continued in fiscal year 1978.

A total of $2,261,000, a decrease of $67,000 from the 1977 operating level, is requested to carry out the 1978 objectives. This net decrease of $67,000 consists of $12,000 in mandatory costs and a reduction of 6 positions and $79,000 as follows:

1. Within grade increases	+$17,000
2. Less one day of pay	-5,000
3. Annualized savings due to a reduction of 6 positions in fiscal year 1977	-79,000
Total net change	-67,000

President's Council on Physical Fitness and Sports

1977 Appropriation		1978 Estimate		Increase or Decrease	
Pos.	Amount	Pos.	Amount	Pos.	Amount
11	$800,000	11	$790,000	---	-$10,000

This activity supports staff and related costs for the National Physical Fitness and Sports Program; provides technical services and advice for physical fitness and participatory sports programs; operates incentive programs for youth, adults, teachers, and schools; conducts continuing public education and information campaigns; sponsors training sessions for physicians, physical educators, and other fitness professionals; promotes private support for physical fitness and sports programs; and cooperates with appropriate professional associations, and with Federal, State, and local agencies, in the development and supervision of programs.

During 1977, more than 16 million boys and girls participated in the Presidential Physical Fitness Award program, and 1.2 million adults took part in the Presidential Sports Award program. Nearly 1,200 schools in the 50 States and the District of Columbia took part in a competition that resulted in the selection of "State Champion" schools in each of the 51 jurisdictions. The Council designated 153 schools as demonstration centers; staged regional clinics attended by 5,000 fitness professionals; presented leadership training sessions for 1,600 persons who work with the elderly; organized 300 of the Nation's largest private employers for the exchange of fitness program ideas and information; and helped supervise and evaluate the National Youth Sports program operating on 127 college campuses. The 1972 National Adult Fitness Survey was updated by incorporating fitness questions in the annual National Health Survey.

In 1978, the Council will continue its programs with special emphasis placed on training leaders for fitness programs for the elderly and development of employee fitness programs and facilities in the private sector. A concerted effort will be made to persuade municipal recreation agencies to enlarge their role in providing opportunities for participation in fitness and sports activities. The Council will assume new responsibilities by serving as liaison between amateur sport associations and the Federal Government in the reorganization of amateur sports recommended by the President's Commission on Olympic Sports, and it will coordinate the activities of other Federal agencies in this process.

In order to absorb the October 1976 pay raise in fiscal year 1977, one position has been eliminated. This reduction will be continued in fiscal year 1978.

A total of $790,000 is required to carry out the 1978 objectives. The net decrease of $10,000, from the 1977 operating level of $800,000 represents $3,000 for mandatory costs and a reduction of 1 position and $13,000 as follows:

1. Within grade increases.....	+$4,000
2. Less one day of pay.....	-1,000
3. Annualized savings due to a reduction of 1 position in fiscal year 1977.	-13,000
Total net change.....	-10,000

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: Regional Management

1977			1978 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
147	$5,711,000	Indefinite	147	$5,625,000

Purpose: This activity supports the immediate offices of the Regional Health Administrators and a headquarters staff advisory on regional matters 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 managerial, advisory, and administrative support in the implementation of decentralized health programs funded by appropriations from four of the six health agencies.

Accomplishments in 1977: In 1977, the main impetus focused on the linking of long-range plans emanating from evaluation studies to program objectives. In addition, a 100 percent validation of regional Manpower Management activities was conducted so that the regional offices will be in a position to more effectively carry out their responsibilities as an operational component of PHS.

Objective in 1978: In 1978, the regional offices will implement cost containment and quality control aspects of grant and contract programs, including applications of the Health Services Funding Regulations on a cross-cutting basis for all service delivery programs and institution of medical care quality assessment procedures.

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: Program Direction and Support Services

1977		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
400	$14,338,000	Indefinite	400	$14,502,000

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 activites, 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 1977: In 1977, the Forward Plan for Health was prepared coordinating health strategies and giving direction to policy development, research, evaluation, legislative and statistical plans. In the area of Administrative Management, progress was made in the establishment of a manpower management program for all elements of PHS. Other accomplishments included coordination of agency programs directed towards strengthening and expanding delivery of health care to children and mothers and direction of development of a Department-wide Health Statistics Plan.

Objectives for 1978: The manpower reports system will be implemented along with conducting a comprehensive review of regional office organizational structure and functional alignments. Coordination and collaboration with other Federal agencies in the area of health information and health promotion will be expanded.

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: Health Care Assurance

1977		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
60	$2,328,000	Indefinite	60	$2,261,000

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, Long Term Care, and Population Affairs.

Accomplishments in 1977: The hospital utilization review regulations for the Medicare and Medicaid programs were completed. Initiation of a pre-test Patient Appraisal and Care Evaluation instrument to assess its potential for use in reimbursement of nursing home service costs was begun. In addition, a major study, the Medical Practice Information Project demonstrating technique for categorizing, documenting, and determining the validity and reliability of available information was begun.

Objectives in 1978: This activity will continue to administer all policies relating to quality assurance and standards of health care. In addition, emphasis will be placed on recognition and utilization of institutional services, and the integration of family planning services programs into the mainstream of the general health care system.

ASSISTANT SECRETARY FOR HEALTH

Salaries and Expenses

Program Purpose and Accomplishments

Activity: President's Council on Physical Fitness and Sports

1977		1978		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
11	$800,000	Indefinite	11	$790,000

Purpose: The staff supported by this activity provides technical services and advice for the National program of physical fitness and participating sports.

Explanation: To provide funding for the President's Council on Physical Fitness and Sports.

Accomplishments in 1977: During 1977, participation in the Presidential Physical Fitness Award program and the Presidential Sports Award program increased. The Council staged regional clinics, presented leadership training sessions, organized private employers for the exchange of fitness program ideas and information, and helped supervise and evaluate the National Youth Sports Programs.

Objectives for 1978: Special emphasis will be placed on training leaders for fitness programs for the elderly and the development of employee fitness programs and facilities in the private sector. Efforts will be continued to enlarge opportunities for participation in fitness and sports activities in municipal recreation agencies. The Council will serve as liaison between amateur sports and the Federal Government in the reorganization of amateur sports recommended by the President's Commission on Olympic Sports.

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 amounts 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

	1977	1978
Appropriation (indefinite).....	$52,352,000	$56,948,000

Summary of Changes

1977 Estimated Obligations	$52,352,000
1978 Estimated Obligations	56,948,000
Net change	+ 4,596,000

	1977 Base Amount	Change from Base Amount
Increases:		
A. Built-in:		
1. Annualization of retirements during 1977 and 104 additional retirements during 1978	$26,848,000	+$2,890,000
2. Net increase of 26 survivors receiving benefits	717,000	+ 84,000
3. Cost of increased inpatient and outpatient care for retirees and dependents	23,130,000	+ 1,910,000
Total increases		+ 4,884,000
Decreases:		
A. Built-in:		
1. Decrease for ancillary services (drugs, handicapped care, contractors' fees, etc.) due to reduced estimate based on current spending patterns	1,657,000	- 288,000
Total decreases		- 288,000
Net change		+ 4,596,000

Obligations by Activity

	1977 Estimate Amount	1978 Estimate Amount	Increase or Decrease Amount
Retirement payments.....	$26,848,000	$29,738,000	+$2,890,000
Survivors' benefits.....	717,000	801,000	+ 84,000
Dependents' medical care.....	24,787,000	26,409,000	+ 1,622,000
Total obligations.....	52,352,000	56,948,000	+ 4,596,000

Obligations by Object

	1977 Estimate Amount	1978 Estimate Amount	Increase or Decrease Amount
Benefits for former personnel.....	$27,565,000	$30,539,000	+$2,974,000
Other services.....	24,787,000	26,409,000	+ 1,622,000
Total obligation by object.....	52,352,000	56,948,000	+ 4,596,000

Retirement Pay and Medical Benefits
for Commissioned Officers

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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	44,990,000
1977	52,352,000	52,352,000	52,352,000	52,352,000
1978	56,948,000			

1978 Congressional Justification

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

	1977 Estimate Amount	1978 Estimate Amount	Increase or Decrease Amount
Retirement payments.....	$26,848,000	$29,738,000	$2,890,000
Survivors' benefits.....	717,000	801,000	84,000
Dependents' medical care.....	24,787,000	26,409,000	1,622,000
Total obligations.....	$52,352,000	$56,948,000	$4,596,000

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

	1977 Estimate Amount	1978 Estimate Amount	Increase or Decrease Amount
Retirement Payments.....	$26,848,000	$29,738,000	$2,890,000

This estimate provides for mandatory payments for officers retired for age, length of service, or disability.

Impact of the 1978 Budget:

- The estimate is based on payments to the following number of retirees:

Period Ending	Total
June 30, 1976	1,470
Sept. 30, 1977 (est.)	1,568
Sept. 30, 1978 (est.)	1,672

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

Survivors' Benefits

	1977 Estimate Amount	1978 Estimate Amount	Increase or Decrease Amount
Survivors' Benefits.....	$717,000	$801,000	$84,000

This activity provides for the payment of annuities to survivors of retired officers who had elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan.

Impact of the 1978 Budget:

- The estimate is based on payments to the following numbers of annuitants.

Period Ending	Total
June 30, 1976	122
Sept. 30, 1977 (est.)	139
Sept. 30, 1978 (est.)	165

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

Dependents' Medical Care

	1977 Estimate Amount	1978 Estimate Amount	Increase or Decrease Amount
Dependents' Medical Care...	$24,787,000	$26,409,000	$1,622,000

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 the 1978 Budget:

- The estimate is based upon the following workloads:

Period	Average Daily Patient Load	Outpatient Claims	Handicapped Care Recipients
1976	271	44,800	60
1977 (est.)	273	54,000	66
1978 (est.)	279	65,000	66

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

Program Purpose and Accomplishments

Activity: Retirement Payments (Public Health Service Act as amended, Sec. 211; 10 U.S.C., 1201)

1977 Estimate Amount	1978 Authorization	1978 Budget Estimate Amount
$26,848,000	Indefinite	$29,738,000

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 98 retirees in 1977 will be added to the retirement roll, resulting in a total of 1,568 as of September 30, 1977.

Objectives for 1978: A net increase of 104 officers will result in an estimated total of 1,672 retired officers at the end of fiscal year 1978.

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)

1977 Estimate Amount	1978 Authorization	1978 Budget Estimate Amount
$717,000	Indefinite	$801,000

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 139 annuitants as of September 30, 1977.

Objectives for 1978: It is estimated that there will be a total of 165 annuitants on the rolls at the end of fiscal year 1978.

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)

1977 Estimate Amount	1978 Authorization	1978 Budget Estimate Amount
$24,787,000	Indefinite	$26,409,000

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 obligataions 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 1977, a daily average of 273 persons will be hospitalized, 54,000 total outpatient claims will be processed, and 66 beneficiaries will receive care under the handicapped care provision of the Dependents' Medical Care Act.

Objectives in 1978: The estimated number of eligible beneficiaries in 1978 will be 2.2% greater than that of 1977. The level of funding requested will allow delivery of health care to this larger beneficiary population. Currently, we are anticipating in non-Public Health Service facilities, an average daily inpatient load of 279, total outpatient claims of 65,000 and 66 handicapped care cases.

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] *$11,387,000* to remain avilable 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

	1977 Estimate	1978 Estimate
Appropriation.....	$1,500,000	$11,387,000
Unobligated balance, start of period..	15,920,000	---
Unobligated balance, end of period....	---	---
Total, obligations.....	17,420,000	11,387,000

Summary of Changes

1977 Estimated Obligations	$17,420,000
1978 Estimated Obligations	11,387,000
Net Change	-6,033,000

	1977 Base	Change from Base
Program Decreases		
1. Disease Prevention Research - This decrease is attributed to the end of the excess designation for Poland and a reduction in new studies in Egypt, India, and Pakistan	$5,567,000	-$1,867,000
2. Health Services Research - This decrease is due to reduced need for financing new studies aimed at improving delivery of rural health services in Egypt and India	1,052,000	-303,000
3. Food and Drug Research - This decrease of $468,000 reflects the termination of the excess foreign currency designation for Poland and a reduction in drug and radiological health research in India and Egypt	1,227,000	-468,000
4. Biomedical Research and Health Science Communication - This reduction is attributed to the end of the excess designation in Poland and Tunisia	4,173,000	-1,747,000
5. Alcohol, Drug Abuse, and Mental Health - This decrease represents the termination of the excess foreign currency designation in Poland	878,000	-198,000
6. Health Resources Research - This decrease results from the termi-		

	1977 Base	Change from Base
nation of the excess foreign currency designation in Poland and Tunisia and the paring down of programs in Egypt and India.....	4,523,000	-1,450,000
Total, net change.....		-6,033,000

Obligations by Activity

	1977 Estimate	1978 Estimate	Increase or Decrease
Foreign health research	$17,420,000	$11,387,000	-$6,033,000

Obligations by Object

	1977 Estimate	1978 Estimate	Increase or Decrease
Travel and transportation of persons	$210,000	$500,000	+$290,000
Other services:			
Project contracts	17,210,000	10,887,000	-6,323,000
Total obligations	17,420,000	11,387,000	-6,033,000

Authorizing Legislation

Legislation	Amount Authorized	1978 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	$11,387,000

Scientific Activities Overseas (Special Foreign Currency Program)

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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	1,500,000	1,500,000	1,500,000
1978	11,387,000			

*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)

	1977 Base	1978 Estimate	Increase or Decrease
Foreign Health Research	$17,420,000	$11,387,000	-$6,033,000

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. Activities under the Program are supported entirely with U.S.-owned excess foreign currencies which were generated principally through the sale of surplus U.S. agricultural commodities to other countries and repayment of Mutual Security Loans. For Fiscal Year 1978, it is anticipated that funds will be available for use in the Arab Republic of Egypt, Burma, Guinea, India and Pakistan.

This Appropriation is under the general administration of the Office of International Health, a staff office to the Assistant Secretary for Health. The money is used by the six health agencies -- 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 -- to fund health research, training, symposia and conferences, translations, and related activities in the participating foreign countries. These activities are integrated into the domestic programs of the agencies and contribute to the achievement of the overall goals of the Public Health Service.

All research projects are collaborative in nature and are designed to benefit both the United States and the host country. The work is 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 an American university, hospital, or other institution. In many cases, the U.S. Project Officer is carrying out similar research in his own laboratory or program.

Since the Program's inception in 1962, nearly 450 projects have been funded in eleven countries. During Fiscal Year 1976, 45 projects at a total cost of $10,512,000 were funded. In Fiscal Year 1977 an estimated $17,420,000 will be obligated for approximately 75 new and continuing projects; and, in Fiscal Year 1978, an estimated $11,387,000 will be obligated for 55 new and continuing projects.

Cooperation between the United States and the Arab Republic of Egypt on health-related matters is continuing under the aegis of the U.S.-Egypt Joint Working Group on Medical Cooperation for which DHEW has lead responsibility. Priority areas for collaboration have been identified and the health agencies are developing new proposals in such priority areas as emergency medical services, cancer, and maternal and child health. Similarly, within the framework of the U.S.-India Joint Cooperation Commission established in 1974, priority areas have been identified and several new collaborative projects, including studies of stroke and in the field of nutrition, are being developed. As a result of vigorous efforts over the past few years, a productive cooperative health program with the Arab Republic of Egypt and India has emerged.

Although the excess currency designation for Poland terminated on December 31, 1976, the tradition of excellent cooperation between the United States and Poland will continue under the U.S.-Polish Joint Fund. Due to the proposed termination of the excess designation of Tunisia at the end of FY 1977, no new projects will be funded in that country. In 1978 a concerted effort is being made, however, to add momentum to the current health cooperation with Pakistan. The overall goals and objectives of the Program in 1978 are as follows:

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, the determination of the causes, treatment, prevention and control of mental and emotional illnesses and a great number of related public health problems, such as drug abuse and alcoholism.

The abuse of drugs is producing increasing social and public health problems in the United States. The widespread use of marijuana and other mind-altering drugs has resulted in the need for diversified research to assess the health consequences of their use. Because dependence on opiates is one of the prominent and most serious kinds of addiction in the Arab Republic of Egypt, an excellent project is being developed there which will compare and evaluate various treatment

modalities as well as a combination of them. Collaborative drug abuse projects in both India and Pakistan also have unusual potential since cannibis abuse has become a rapidly increasing problem among middle and upper class students in those countries as it has in the United States.

India offers the opportunity to carry out a unique and potentially valuable program of biofeedback research investigating the relationship between Yogic techniques and neurological and higher nervous functions. In Egypt, a project is planned that will investigate the etiology and epidemiology of mental illness in relation to cultural factors. Such research would contribute greatly to an understanding of the dynamics of an emerging industrial society.

Disease Prevention Research

Research in this category is directed toward prevention or control of communicable and vector-borne diseases, improvement of clinical laboratories, nutrition, and assuring safe and healthy working conditions, all of which are objectives of the Center for Disease Control.

Included in plans for 1978 are epidemiological studies and surveillance of diseases such as schistosomiasis, hepatitis, streptococcal infections, and tuberculosis; laboratory investigations in such areas as food microbiology; and, continuation of the collection and analysis of data related to a host of preventable diseases.

In the Arab Republic of Egypt, ongoing studies on schistosomiasis and streptococcal diseases will be continued. Also in Egypt, a study of the ecological aspects of epizootic lymphangitis, a disease about which little is known, will be initiated. Although this contagious fungal disease is not now prevalent in the United States, it is important for us to have knowledge of how to deal with it. The Special Foreign Currency Program will provide this opportunity. Similarly, the Program will provide the opportunity to initiate new studies in Pakistan of the role of arborviruses in human diseases.

In the field of occupational health, emphasis in 1978 will be on studies of occupationally-linked respiratory problems, their causes, prevention, and treatment; occupational noise; and, combined physical and chemical stresses in the work environment. In Egypt, occupational hazards in agricultural industry, such as flax and cotton production and the effects on workers of agricultural chemicals, will continue to be studied. In India, A project to study the mechanism of entry into the body by some pollutants, specifically skin versus inhalation, while working under hot industrial conditions is under development. The findings of these and other studies will be useful to the National Institute for Occupational Safety and Health for the development of criteria for occupational safety and health standards.

Food and Drug Research

Research projects under this activity fall into four broad areas: radiological health, drug research, medical devices, food research and nutrition.

Projects conducted and proposed under the Special Foreign Currency Program augment the Food and Drug Administration's domestic radiological health program through study and evaluation of microwaves and ultrasound. Proposed studies during 1978 will extend these collaborative investigations into the field of light radiation exposure. Two studies of the effects of light on cancer induction are under consideration for development.

There is a continuing need to do comparative studies of the safety and efficacy of the contraceptive agents, pills, foams, diaphrams, condoms and intrauterine devices. Studies are being planned with the Arab Republic of Egypt to obtain scientific and medical data for use in advising consumers and the medical community.

The excess currency countries are a valuable laboratory for studies of foods and nutrition. During 1978, emphasis will be on problems involving hazards and safety aspects of nitrosamines; natural plant toxins; mycotoxins; pathogenic bacterial and protozoa contaminants of foods; pesticide residues and toxic elements, such as cadmium, mercury, zinc, arsenic, fluoride, and celenium. Studies of unconventional proteins as food ingredients 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. Another project will focus efforts on development and testing of blood bank laboratory reagents and comparisons of red cell antigen and antibody patterns in U.S. and Egyptian populations.

The Food and Drug Administration is also proposing development of projects with India to establish baseline data on cardiovascular risk factors in adult-onset diabetics, along with assessment of different anti-diabetic therapies on cardiovascular morbidity and mortality. In Egypt, FDA is proposing to collaborate in long-term studies of the effects of anti-epileptic drugs.

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 with emphasis on problems such as barriers to obtaining service and maternal and child health, including nutrition and family planning.

The activities proposed for 1978 relate to these program areas and include projects in India and Egypt aimed at improving the delivery of health services in remote and medically underserved areas and in other areas where facilities are underutilized. Both India and Egypt are excellent laboratories for such studies with their extensive rural and urban poor populations. Experience will be gained which should be useful in dealing with service delivery problems in this country. Additionally, an emergency medical services project is under development in Egypt.

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 its renal disease program. A family planning project to test new approaches to the delivery of family planning services as well as to examine methodologies for motivating contraceptive users is under consideration also. It is anticipated that one or two projects will be developed, also in Egypt, dealing with nutritional problems of adolescent mothers and their offspring. In India a project relating to malnutritional eye disease is under discussion.

Health Resources Research

The health resources research supported under this appropriation is designed to strengthen domestic research goals and objectives such as the more efficient development and utilization of all types 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 inefficiencies in the distribution, supply, utilization and cost of health services. Areas now being studied under this activity include new approaches to training and the proper utilization of special categories of professional and allied health manpower and cost reduction related to hospitization. In 1978, special emphasis will be placed on the development of projects dealing with approaches to training for primary care services. For example, a new approach to primary care services using village workers and school teachers is under development in India. Several health manpower projects are currently under development in Egypt, including a feasibility study of new methods to evaluate technical and professional health training and a faculty exchange program between the United States and Egypt. Additionally, new and more efficient guidelines for the proper utilization of all types of learning resources will be developed through projects in both India and Egypt.

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

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.

Biomedical Research and Health Science Communications

The Special Foreign Currency Program is an integral and significant part of the NIH international and domestic effort to advance biomedical science knowledge. This program enables both the NIH intramural and extramural research programs to establish and maintain communication channels and working relationships for the purpose of bringing the resources of the international biomedical research community to bear upon problems of mutual interest and importance to the United States. These resources and this Program provide in some cases needed augmentation of parallel research efforts of the United States and in other cases research opportunities not available in the United States. Projects and their principal investigators are critically selected for their potential for furthering the understanding of fundamental biological, chemical and physical mechanisms of normal life processes and disease states of man.

The biomedical research efforts encompass investigations of reproductive physiology, cardiovascular disease, nutritional and metabolic mechanisms, cancer, and communicable and parasitic diseases. Since parasitic infections are a health problem throughout the world and drug treatment is decreasingly effective, the immunology of these infections offers a productive 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 is being assessed.

Other biomedical problems are posed by tuberculosis, both abroad and in the United States, and leprosy, which is prevalent in India and Egypt. Leprosy, which is caused by a bacterium related to the one causing tuberculosis, has been resistant to efforts to reveal the mechanism of its disease process. Research financed through this Program will advance the studies of these diseases.

The widespread occurrence of bladder cancer in the Arab Republic of Egypt, associated with infection by the schistosoma, a blood fluke, will be the basis for an extensive collaborative investigation. Other forms of cancer will be studied and a cancer chemotherapy program will be set up.

Emphasis under the health science communication activity continues to be the preparation and publication of critical reviews and the translation, documentation, and dissemination of information in the biomedical and health sciences.

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 Research Atct of 1960, Section 3,) as amended

1977			1978	
				Budget Estimate
Pos.	Amount	Authorization	Pos.	Amount
---	$1,500,000	Indefinite	---	$11,387,000

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 1977:

During 1977 an estimated $17,420,000 in foreign currencies will be obligated for new and continuations of ongoing activities in six countries. Plans include $4,173,000 for the programs of biomedical research and health science communication, $878,000 for mental health, including drug abuse and alcoholism; $5,567,000 for prevention and control of communicable diseases and occupational health; $1,227,000 for studies focused on food and drug safety, radiological health and medical product safey; $5,575,000 for studies aimed at improving the organization and delivery of health services, health statistics, medical education and other manpower development.

Objectives for 1978 :

The 1978 request of $11,387,000 in new obligational authority is required to meet expected program requirements in Egypt, Pakistan, and India. Obligations during 1978 are expected to include: $680,000 for mental health, alcoholism, and drug abuse; $3,700,000 for disease prevention and control, including occupational safety and health;

$759,000 for studies related to food protection, radiological health, medical devices and exchange of information in these areas; $3,822,000 for studies related to the organization and delivery of health services, including health manpower and maternal and child health, and $2,426,000 for biomedical research and the health science communications program of the National Library of Medicine.

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