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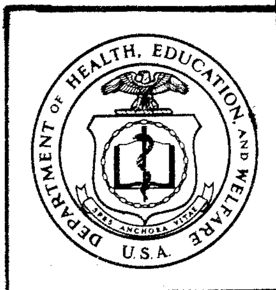
Justifications of Appropriation Estimates for Committee on Appropriations Fiscal year 1973

DEPARTMENT OF LABOR, AND HEALTH, EDUCATION, AND WELFARE, AND RELATED AGENCIES

VOLUME I

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health Through Health Services Delivery



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Appropriation Title	1973 Appropriation Estimate		Page
	Pos.	Amount	
Mental health..................	2,178	$612,170,000	1
Saint Elizabeths Hospital......	4,132	28,271,000	78
Health services planning and development..............	757	329,596,000	96
Health services delivery.......	7,678	745,657,000	184

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

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Appropriation Estimate

MENTAL HEALTH

For carrying out the Public Health Service Act with respect to mental health and, except as otherwise provided, the Community Mental Health Centers Act (42 U.S.C. 2681, et seq.), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91-616), and the Narcotic Addict Rehabilitation Act of 1966 (Public Law 89-793), [($612,201,000)] (80 Stat. 1438), *$612,170,000* of which [$75,000,000] *$141,491,000* shall remain available until June 30, [1973] *1974* for grants pursuant to parts A, C, and D of the Community Mental Health Centers Act.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Amounts Available for Obligation

	1972	1973
Appropriation......................	$612,201,000	$612,170,000
Real transfer to:		
"Operating expenses, Public Building, General Services Administration".	-4,000	---
Comparative transfer to:		
"Departmental management"..........	-115,000	---
"Saint Elizabeths Hospital"........	-1,600,000	---
Subtotal, budget authority...........	610,482,000	612,170,000
Receipts and reimbursements from:		
Non-Federal sources................	5,000	5,000
Other accounts.....................	155,000	155,000
Unobligated balance, start of year...	196,000	9,800,000
Unobligated balance lapsing..........	-223,000	---
Unobligated balance, end of year.....	-9,800,000	---
Total, obligations..........	600,815,000	622,130,000

Obligations by Activity

Page Ref.		1972 Estimate Pos.	1972 Estimate Amount	1973 Estimate Pos.	1973 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
	Research:						
20	Grants............	---	$97,400,000	---	$101,400,000	---	+$4,000,000
28	Direct operations..	1,170	41,699,000	1,184	43,268,000	+14	+1,569,000
	Manpower development:						
31	Training grants and fellowships...	---	120,050,000	---	105,050,000	---	-15,000,000
39	Direct operations..	135	7,741,000	135	7,779,000	---	+38,000
	State & Community programs:						
	Community mental health centers:						
42	Construction......	---	5,200,000	---	9,800,000	---	+4,600,000
43	Staffing..........	---	135,100,000	---	135,100,000	---	---
44	Narcotic addiction..	---	76,390,000	---	91,298,000	---	+14,908,000
	Alcoholism:						
48	Project Grants....	---	40,297,000	---	50,193,000	---	+9,896,000
51	Grants to states..	---	30,000,000	---	30,000,000	---	---
52	Mental health of children...........	---	10,000,000	---	10,000,000	---	---
53	Direct operations...	187	6,816,000	194	7,239,000	+7	+423,000
54	Rehabilitation of drug abusers.......	157	13,323,000	164	13,926,000	+7	+603,000
	Program support activities:						
56	Field activities...	152	3,739,000	152	4,015,000	---	+276,000
57	Scientific communication & public education.........	90	7,298,000	90	7,293,000	---	-5,000
59	Executive direction & management services..........	259	5,762,000	259	5,769,000	---	+7,000
	Total obligations....	2,150	600,815,000	2,178	622,130,000	+28	+21,315,000

Obligations by Object

	1972 Estimate	1973 Estimate	Increase or Decrease
Total number of permanent positions..................	2,150	2,178	+28
Full-time equivalent of all other positions.............	404	404	---
Average number of all employees....................	2,485	2,538	+53
Personnel compensation:			
Permanent positions.........	$31,006,000	$32,415,000	+$1,409,000
Positions other than permanent.................	1,973,000	1,973,000	---
Other personnel compensation....................	1,324,000	1,324,000	---
Total personnel compensation............	34,303,000	35,712,000	+1,409,000
Personnel benefits...........	3,045,000	3,201,000	+156,000
Travel and transportation of persons.....................	1,954,000	1,981,000	+27,000
Transportation of things......	255,000	255,000	---
Rent, communications and utilities..................	1,843,000	2,001,000	+158,000
Printing and reproduction.....	1,094,000	1,094,000	---
Other services...............	9,621,000	10,471,000	+850,000
Project contracts...........	31,436,000	31,436,000	---
Supplies and materials........	1,946,000	1,958,000	+12,000
Equipment....................	893,000	1,192,000	+299,000
Grants, subsidies and contributions...............	514,437,000	532,841,000	+18,404,000
Subtotal..................	600,827,000	622,142,000	+21,315,000
Quarters & subsistence charges	-12,000	-12,000	---
Total obligations by object....................	600,815,000	622,130,000	+21,315,000

Summary of Changes

1972 estimated obligations........................	$600,815,000
1973 estimated obligations........................	622,130,000
Net change........................	+21,315,000

	Base Pos.	Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Within-grade increases......	---	---	---	+850,000
2. Annualization of 1972 new positions.................	---	---	---	+1,021,000
3. Equipment replacements......	---	---	---	+283,000
4. Annualization of 1972 increase of benefits for commissioned officers......	---	---	---	+72,000
5. Increase in Federal Telecommunications service charges..................	---	---	---	+153,000
6. Holiday pay................	---	---	---	+6,000
7. Increased payments to other accounts:				
a. NIH Management Fund.....	---	---	---	+676,000
b. DHEW Working Capital Fund..................	---	---	---	+46,000
c. HSMHA Service and Supply Fund...........	---	---	---	+102,000
8. Payments to Bureau of Employees' Compensation....	---	---	---	+17,000
Total, increases.......	---	---	---	+3,226,000
B. Program:				
1. Direct operations:				
a. Child mental health.....	---	---	4	+40,000
b. Minority mental health..	---	---	5	+50,000
c. Crime and delinquency...	---	---	5	+50,000
d. Alcoholism.............	---	---	7	+70,000
e. Drug abuse.............	---	---	7	+70,000
f. Upward mobility program.	---	---	---	+147,000

	Base Pos.	Base Amount	Change from Base Pos.	Change from Base Amount
2. Grants:				
a. Research..............	---	$97,400,000	---	+4,000,000
b. Community mental health centers construction...	---	5,200,000	---	+4,600,000
c. Narcotic addiction community assistance...	---	76,390,000	---	+14,908,000
d. Alcoholism projects.....	---	40,297,000	---	+9,896,000
Total, program increases	---	---	+28	+33,831,000
Total, increases......	---	---	+28	+37,057,000
Decreases:				
A. Built-in:				
1. Two less days of pay........	---	---	---	-169,000
2. Annualization of 1972 employment reductions......	---	---	---	-573,000
Total built-in increases...........	---	---	---	-742,000
B. Program:				
1. Training grants............	---	120,050,000	---	-15,000,000
Total, decreases......	---	---	---	-15,742,000
Total, net change....................	---	---	+28	+21,315,000

Explanation of Changes

Increases:

A. Built-in:

1. Within-grade increases: An increase of $850,000 will provide coverage for escalations in the cost of personal services resulting from normal periodic within-grade advances, to the extent that they are not offset by savings resulting from employee turnover.

2. Annualization of FY 1972 New Positions: An increase of $1,021,000 will provide full year funding for 153 new positions established in 1972 to support the Institute's expanded narcotic addiction and alcoholism programs.

3. Equipment Replacements: Additional funding is required to cover the larger cost of research equipment items requiring replacement in 1973.

4. Annualization of FY 1972 Increase of Benefits for Commissioned Officers: An additional $72,000 will cover the full-year costs of continuation pay increases approved for Public Health Service officers in December of 1971.

5. Increase of Federal Telecommunications Service Charges: An increment of $153,000 is requested to cover increased costs of telephone services provided to the Institute.

6. Holiday Pay: Premium pay costs related to Inauguration Day, a legal holiday, are estimated at $6,000.

7. Increased Payments to Other Accounts: A total increase of $824,000 is requested to provide for central service costs provided to the Institute by the Department ($46,000), Health Services and Mental Health Administration ($102,000), and National Institutes of Health ($676,000).

8. Bureau of Employees' Compensation: Payments to the Bureau of Employees' Compensation will increase from $38,000 in 1972 to $55,000 in 1973.

B. Program:

1. Direct Operations: A total of $427,000 is requested for program increases in direct operations. Of this amount, $140,000 will provide first-year funding for 14 new positions in the research activity for programs in Child Mental Health (4), Minority Mental Health (5), and Crime and Delinquency (5). An additional 7 positions and $70,000 are requested to support the Institute's expanded alcoholism programs, and an equal number of positions and dollars is requested for support of narcotic addiction and drug abuse activities. An increase of $147,000 is requested to finance services provided to the Institute by HSMHA in connection with the Upward Mobility Program.

2. Grants:

a. Research: The increase of $4,000,000 is requested for expanded research efforts in drug abuse ($500,000), child mental health ($1,500,000), alcoholism ($500,000), minority mental health problems ($1,000,000), and crime and delinquency ($500,000).

b. Community Mental Health Centers Construction: Using funds carried over from 1972, obligations for construction of Community Mental Health Centers will increase by $4,600,000, to $9,800,000 in 1973. This will provide funds for

construction of approximately 24 new centers in 1973. No new appropriations are requested for centers construction in 1973.

c. Narcotic Addiction Community Assistance: An increase of $14,908,000 is requested for narcotic addiction and drug abuse community assistance projects. This will bring the 1973 funding level to a total of $91,298,000 for this budget activity. Priority will be given to funding programs serving metropolitan areas with a high incidence of drug addiction.

d. Alcoholism Project Grants: An increase of $9,896,000 is requested for alcoholism community assistance projects, bringing the total 1973 program level to $50,193,000. The increase will be used to support projects previously funded by the Office of Economic Opportunity.

Decreases:

A. Built-in:

1. Two Less Days of Pay: A decrease of $169,000 is included to reflect two less working days in FY 1973.

2. Annualization of FY 1972 Employment Reductions: A reduction of 52 filled positions in 1972, will result in annualized savings of $573,000 in 1973.

B. Program:

1. Training Grants: A total program decrease of $15,000,000 is proposed for mental health training programs in 1973, including $7,000,000 for the psychiatry residency program and $8,000,000 for other training programs.

Authorizing Legislation

Legislation	1973 Authorized	1973 Appropriation requested
Public Health Service Act, Section 301:		
Research grants........................	Indefinite	$101,400,000
Training grants........................	Indefinite	105,050,000
Direct operations......................	Indefinite	89,129,000
Community Mental Health Centers Act:		
Part A, Section 201--Construction of Community Mental Health Centers.........	$100,000,000	---
Part B, Section 224--Staffing of Community Mental Health Centers:		
Initial grants........................	60,000,000	9,131,000
Continuation grants...................	Indefinite	125,969,000
Parts C and D, Alcohol Abuse and Alcoholism, Narcotic Addiction, Drug Abuse, and Drug Dependence Prevention and Rehabiiitation:		
Section 247--Grants and contracts for the prevention and treatment of alcohol abuse and alcoholism..........	50,000,000	26,490,000
Section 253--Drug abuse education......	14,000,000	1,732,000
Section 256--Special projects for narcotic addicts and drug dependent persons............................	35,000,000	35,000,000
Section 261--Construction and staffing of alcoholism, narcotic addiction, and drug abuser rehabilitation facilities, training and evaluation, and direct grants for special projects:		
Initial grants.....................	80,000,000	24,616,000
Continuations......................	Indefinite	58,043,000
Part E, Section 264--Grants for consultation services:		
Initial grants.......................	5,000,000	100,000
Continuation grants..................	Indefinite	---
Part F, Section 271--Construction and staffing of child mental health treatment facilities:		
Initial grants.......................	30,000,000	1,515,000
Continuations........................	Indefinite	8,485,000
Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970:		
Title III, Part A, Section 301--Formula grants...............................	80,000,000	30,000,000

Authorizing Legislation for Grants

I. The following Sections of the Public Health Service Act authorize grants under the activities "Research" and "Manpower Development."

Sec. 301. The language of this Section will be found under the tab "Preamble Paragraph" in Volume II.

Section. 302. (a) In carrying out the purposes of Section 301 with respect to narcotics, the studies and investigations shall include the use and misuse of narcotic drugs, the quantities of crude opium, coca leaves, and their salts, derivatives, and preparations, together with reserves thereof, necessary to supply the normal and emergency medicinal and scientific requirements of the United States. The results of studies and investigations of the quantities of crude opium, coca leaves, or other narcotic drugs, together with such reserves thereof, as are necessary to supply the normal and emergency medicinal and scientific requirements of the United States, shall be reported not later than the 1st day of September each year to the Secretary of the Treasury, to be used at his discretion in determining the amounts of crude opium and coca leaves to be imported under the Narcotic Drugs Import and Export Act, as amended.

(b) The Surgeon General shall cooperate with States for the purpose of aiding them to solve their narcotic drug problems and shall give authorized representatives of the States the benefit of his experience in the care, treatment, and rehabilitation of narcotic addicts to the end that each State may be encouraged to provide adequate facilities and methods for the care and treatment of its narcotic addicts.

Sec. 303 (a) In carrying out the purposes of Section 301 with respect to mental health, the Surgeon General is authorized--

(1) to provide training and instruction and to establish and maintain traineeships, in accordance with the provisions of Section 433 (a);

(2) to make grants to State or local agencies, laboratories, and other public or nonprofit agencies and institutions, and to individuals for investigations, experiments, demonstrations, studies, and research projects with respect to the development of improved methods of diagnosing mental illness, and of care, treatment, and rehabilitation of the mentally ill, including grants to State agencies responsible for

administration of State institutions for care, or care and treatment, of mentally ill persons for developing and establishing improved methods of operation and administration of such institutions.

(b) Grants under paragraph (2) of subsection (a) may be made only upon recommendation of the National Advisory Mental Health Council. Such grants may be paid in advance or by way of reimbursement, as may be determined by the Surgeon General; and shall be made on such conditions as the Surgeon General finds necessary.

Sec. 507. Appropriations to the Public Health Service available for research, training, or demonstration project grants pursuant to this Act shall also be available on the same terms and conditions as applied to non-Federal institutions, for grants for the same purpose to hospitals of the Service, of the Veteran's Administration, or of the Bureau of Prisons of the Department of Justice, and the Saint Elizabeths Hospital.

II. Community Mental Health Centers Act

Part A--Construction of Community Mental Health Centers

Authorization of Appropriations

Sec. 201. There are authorized to be appropriated, for grants for construction of public and other nonprofit community mental health centers, $35,000,000 for the fiscal year ending June 30, 1965, $50,000,000 for the fiscal year ending June 30, 1966, $65,000,000 for the fiscal year ending June 30, 1967, $50,000,000 for the fiscal year ending June 30, 1968, $60,000,000 for the fiscal year ending June 30, 1969, $70,000,000 for the fiscal year ending June 30, 1970, $80,000,000 for the fiscal year ending June 30, 1971, $90,000,000 for the fiscal year ending June 30, 1972, and $100,000,000 for the fiscal year ending June 30, 1973.

Part B--Staffing of Community Mental Health Centers

Authorization of Appropriations

Sec. 224. There are hereby authorized to be appropriated $19,500,000 for the fiscal year ending June 30, 1966, $24,000,000 for the fiscal year ending June 30, 1967, $30,000,000 for the fiscal year ending June 30, 1968, $26,000,000 for the fiscal year ending June 30, 1969, $32,000,000 for the fiscal year ending June 30, 1970, $45,000,000 for the fiscal year ending June 30, 1971, $50,000,000 for the fiscal year ending June 30, 1972, and $60,000,000 for the fiscal year ending June 30, 1973, to enable the Secretary to make initial grants to community mental health centers under the provisions of this part. For the fiscal year ending June 30, 1967, and for each of the thirteen succeeding years, there are hereby authorized to be appropriated

such sums as may be necessary to make grants to such centers which have previously received a grant under this part and are eligible for such a grant for the year for which sums are being appropriated under this sentence.

Parts C and D--Alcohol Abuse and Alcoholism, Narcotic Addiction, Drug Abuse, and Drug Dependence Prevention and Rehabilitation

ALCOHOL ABUSE AND ALCOHOLISM

Authorization of Appropriations

Sec. 247. (d) To carry out the purposes of this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971, $40,000,000 for the fiscal year ending June 30, 1972, and $50,000,000 for the fiscal year ending June 30, 1973.

DRUG ABUSE EDUCATION

Authorization of Appropriations

Sec. 253. (d) To carry out the purposes of this section, there are authorized to be appropriated $3,000,000 for the fiscal year ending June 30, 1971, $12,000,000 for the fiscal year ending June 30, 1972, and $14,000,000 for the fiscal year ending June 30, 1973.

SPECIAL PROJECTS FOR NARCOTIC ADDICTS AND DRUG DEPENDENT PERSONS

Authorization of Appropriations

Sec. 256. (e) There are authorized to be appropriated to carry out this section not to exceed $20,000,000 for the fiscal year ending June 30, 1971, $30,000,000 for the fiscal year ending June 30, 1972, and $35,000,000 for the fiscal year ending June 30, 1973.

CONSTRUCTION AND STAFFING OF FACILITIES

Authorization of Appropriations

Sec. 261. (a) There are authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1970, $40,000,000 for the fiscal year ending June 30, 1971, $60,000,000 for the fiscal year ending June 30, 1972, and $80,000,000 for the fiscal year ending June 30, 1973, for project grants for construction and staffing of facilities for the prevention and treatment of alcoholism under Part C, or the prevention and treatment of narcotic addiction, drug abuse, and drug dependence, under Part D and for grants under Section 252 and Section 246. Sums so appropriated for any fiscal year shall remain available for obligation until the close of the next fiscal year.

(b) There are also authorized to be appropriated for the fiscal year ending June 30, 1971, and each of the next nine fiscal years such sums as may be necessary to continue to make grants for staffing with respect to any project under Part C or D for which a staffing grant was made from appropriations under subsection (a) of this section for any fiscal year ending before July 1, 1973.

Part E--Grant for Consultation Services

Authorization of Appropriations

Sec. 264. (c) For purposes of making initial grants under this section, there are authorized to be appropriated $5,000,000 for each of the fiscal years ending June 30, 1971, June 30, 1972, and June 30, 1973. There are also authorized to be appropriated for the fiscal year ending June 30, 1972, and for each of the next eight fiscal years such sums as may be necessary to continue to make grants under this section for projects which received initial grants under this section from appropriations authorized for any fiscal year ending before July 1, 1973.

Part F--Mental Health of Children

Authorization of Appropriations

Sec. 271. (d) (1) There are authorized to be appropriated $12,000,000 for the fiscal year ending June 30, 1971, $20,000,000 for the fiscal year ending June 30, 1972, and $30,000,000 for the fiscal year ending June 30, 1973, for grants under this part for construction and for initial grants under this part for compensation of professional and technical personnel, and for training and evaluation grants under section 272.

(2) There are also authorized to be appropriated for the fiscal year ending June 30, 1972, and each of the next eight fiscal years such sums as may be necessary to continue to make grants with respect to any project under this part for which an initial staffing grant was made from appropriations under paragraph (1) for any fiscal year ending before July 1, 1973.

III. The following sections of Public Law 91-616, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, establish within NIMH, the National Institute of Alcohol Abuse and Alcoholism and authorize the award of formula grants to the States. P.L. 91-616 also amends the Community Mental Health Centers Act to authorize grants and contracts for the prevention and treatment of alcohol abuse and alcoholism. The amendatory language is set forth below. The dollar authorization appears in the appropriate section of the Community Mental Health Centers Act (Section 247).

Title I - National Institute on Alcohol Abuse and Alcoholism

Establishment of the Institute

Sec. 101. (a) There is established in the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism (hereafter in this Act referred to as the "Institute") to administer the programs and authorities assigned to the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the "Secretary") by this Act and part C of the Community Mental Health Centers Act. The Secretary, acting through the Institute, shall, in carrying out the purposes of section 301 of the Public Health Service Act with respect to alcohol abuse and alcoholism, develop and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics.

(b) The Institute shall be under the direction of a Director who shall be appointed by the Secretary.

Title III - Federal Assistance for State and Local Programs

Part A - Formula Grants

Authorization of Appropriations

Sec. 301. There are authorized to be appropriated $40,000,000 for the fiscal year ending June 30, 1971, $60,000,000 for the fiscal year ending June 30, 1972, $80,000,000 for the fiscal year ending June 30, 1973, for grants to States to assist them in planning, establishing, maintaining, coordinating, and evaluating projects for the development of more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism. For purposes of this part, the term "State" includes the District of Columbia, the Virgin Islands, the Commonwealth of Puerto Rico, Guam, American Samoa, and the Trust Territory of the Pacific Islands, in addition to the fifty States.

Explanation of Transfers

	1972 Estimate	Purpose
Real Transfer to:		
"Operating expenses, Public Building, General Services Administration"	- $4,000	Rental of space, Seattle, Washington Regional Office.
Comparative Transfer to:		
"Departmental Management"	-115,000	For DHEW central service and support in the following areas: 1. Upward Mobility Program (1 position, $13,000) 2. Model Cities Program (2 positions , $30,000) 3. Executive Secretariat (1 position, $16,000) 4. Public Affairs (2 positions, $55,000) 5. Central personnel office improvement ($1,000)
"Saint Elizabeths Hospital"	-1,600,000	Transfer of resources which support clinically based training and research activities at the hospital. 1. Training (35 positions, $1,250,000) 2. Research (17 positions, $350,000).

Mental Health

Year	Budget estimate to Congress	House Allowance	Senate Allowance	Appropriation
1963	126,899,000	133,599,000	148,599,000	143,599,000
1964	190,096,000	177,288,000	190,096,000	183,288,000
1965	224,085,000	223,273,000	223,273,000	223,273,000
1966	278,669,000	278,669,000	283,169,000	283,169,000
1967	305,115,000	310,119,000	315,619,000	315,619,000
1968	346,909,000	296,909,000	346,909,000	346,909,000
1969	364,939,000	342,439,000	364,939,000	350,439,000
1970	357,904,000	360,302,000	385,000,000	360,302,000
1971	346,656,000	371,738,000	456,738,000	389,238,000
1972	499,451,000	581,201,000	658,201,000	612,201,000
1973	612,170,000			

General Statement

The basic mission of the National Institute of Mental Health is to develop knowledge, manpower, and services to prevent mental illness, to treat and rehabilitate the mentally ill, and to promote and sustain mental health.

Underlying the great diversity of studies and projects supported by the National Institute of Mental Health is a clear unity of purpose, which is to increase understanding of the forces within and around man which affect or dictate his emotional and mental health, and to apply this knowledge in effective treatment and prevention services.

A total approach to the problem of mental illness must also provide for focusing upon acute, critical problems. For this purpose, the Institute has established several centers which focus on specific high-priority areas such as alcoholism and drug abuse.

The organization of the Institute and the distribution of its resources, as reflected in this document, are intended to optimize support among research, training, and service activities.

Research is carried out by the Institute's intramural research program and is also supported by grants and contracts awarded to investigators in universities, hospitals, and other institutions. Training programs to develop skilled manpower in the mental health professions and allied fields are supported through training grants to institutions and through research fellowships. Financial and technical assistance to States and local communities aids the development of community mental health services.

1. Research

a. Grants: Included in this subactivity are the Institute's research grant and hospital improvement programs, each of which is described below:

RESEARCH GRANTS

	1972	1973	Increase or Decrease
Grants..................	$90,500,000	$94,500,000	+$4,000,000

To find better ways to treat, control, and prevent mental illness, many types of research are supported. Besides the clinical research to study this illness in patients, basic research is conducted to discover how genetic factors, the environment, and our social systems affect thought and behavior. In services development, research investigators test new methods and concepts in care and prevention of mental illness which have been suggested by the results of basic research.

Support is provided to individual investigators on a project basis for basic applied and clinical research, throughout the broad areas of mental illness as well as areas of special interest such as drug abuse, pshcho-pharmacology, alcoholism,child mental health, minority mental health, crime and delinquency, and services development research. Tables 1 and 2 show the distribution of research grant funds by type of grant and by program.

Table 1. Distribution of Research Grants

	1972		1973		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations...........	741	$49,851,000	655	$49,851,000	-86	---
Competing renewals......	153	9,943,000	174	11,927,000	+21	+$1,984,000
New Projects............	628	20,804,000	656	22,820,000	+28	+2,016,000
Supplementals...........	(78)	1,500,000	(-78)	1,500,000	--	---
Total..............	1,522	82,098,000	1,485	86,098,000	-37	+4,000,000

Table 2. Research Grants Program Distribution

	1972	1973	Increase or Decrease
Narcotic Addiction & Drug Abuse..........	$10,549,000	$11,049,000	+$500,000
Alcoholism..............................	7,543,000	8,043,000	+500,000
Crime and Delinquency...................	3,643,000	4,143,000	+500,000
Minority Studies........................	1,135,000	2,135,000	+1,000,000
Suicide Prevention......................	1,744,000	1,744,000	---
Early Child Care........................	2,000,000	2,000,000	---
Metropolitan Problems...................	2,183,000	2,183,000	---
Mental Health Services..................	7,589,000	9,089,000	+1,500,000
Psychopharmacology......................	10,110,000	10,110,000	---
Behavioral Sciences.....................	17,713,000	17,713,000	---
Applied Research........................	8,563,000	8,563,000	---
Epidemiology............................	1,120,000	1,120,000	---
Clinical Research.......................	8,206,000	8,206,000	---
	82,098,000	86,098,000	+4,000,000
Scientific Evaluation...................	375,000	375,000	---
General Research Support................	8,027,000	8,027,000	---
Total Regular Research..................	90,500,000	94,500,000	+4,000,000

Narcotic Addiction and Drug Abuse: The Institute requests an increase of $500,000 for research in narcotic addiction and drug abuse in 1973 to expand the intensified research program conducted in 1972. Among the areas of this broad and complex field requiring the development of new knowledge are: the mechanisms of drug action; the metabolism of abused drugs; the identification of drugs of abuse in body tissues and fluids; the development of narcotic substitutes and antagonists; the psychological and behavioral effects of drugs; and the genetic effects of abused drugs.

One objective of the research program is to investigate the biochemical basis of drug tolerance and physical dependence to gain an understanding of the processes that underlie drug addiction in man. For example, one investigator has found that protein synthesis in the brain is altered biphasically by narcotics. This effect is now being explored in the rat brain using several avenues of research: (1) measuring the change in the rate of protein synthesis after a single injection of morphine using the _in vivo_ amino acids into brain proteins; (2) by assaying tyrosine hydroxlase, an enzyme, in six areas of the rat brain after morphine treatment; and (3) by studying the binding of morphine to nucleic acids.

The cognitive effects of chronic marihuana and/or hallucinogenic drug usage on the intellectual and adaptive abilities of a young male undergraduate population are being studied on one campus, utilizing students who voluntarily report various levels of usage over a defined time period. Results of a variety of standardized tests will be compared with those made by students reporting no usage to determine if verbal intelligence, spatial orientation, concept formation and ability to abstract have been adversely affected.

In another study, an investigator is attempting to determine the effect of marihuana on the cell nucleus and its relationship to gene transcrytion, metabolism of chromosomal protein, and energy metabolism. This study utilizes the _in vivo_ study of rats injected with radioactively labeled marihuana constituents, which are then traced in the

Brain after various time intervals.

Important studies are being conducted to determine the potential of marihuana extract to produce damage to chromosomes in both human and animal systems following dosages of varying strength and over differing periods of time.

Research is also being conducted in the area of amphetamine abuse. For example, the effects of methamphetamine on the cerebrovascular system in Rhesus monkeys is being studied. This may be of particular importance in view of the number of clinical reports describing cerebrovascular changes in drug abusers who take amphetamines. Following intravenous dosage of varying periodicity, all animals will have arterial catheterization and arteriograms to determine the extent of changes in the arterial wall, arterial occlusions, and damaged arterioles. At the conclusion of test periods, or earlier if fatalities occur, the animals will be killed and both gross and microscopic histopathological examinations will be conducted to determine the form and extent of cerebrovascular damage.

One aspect of the work in progress on effective narcotic antagonists involves the development of a sustained release vehicle for their administration. To this end, several projects are being supported to dissolve or suspend narcotic antagonists in a variety of potential depots, including glycogen, cholesterol, polyvinyl alcohol and others. The investigators are also considering the possibility of administering the antagonists in tooth fillings or dental prosthetic devices.

The acceptability and the effectiveness of methadone as a treatment agent is being studied under a grant to a large metropolitan multimodality treatment facility. This study is examining (a) the client's initial concerns and feelings about methadone, (b) the impact of orientation on his attitudes, (c) the attitude of staff and patients undergoing other forms of treatment, and (d) the response of clients to the methadone maintenance program. Both behavioral and personality measures will be made, and follow-up data will be collected to show changes in functioning of clients in maintenance, abstinence, and other treatment programs.

In view of the increasing use of methadone and the dearth of information on the fate of methadone in the pregnant state, a project is being supported to determine the distribution and effects of methadone and its metabolites in pregnant rats and sheep, following acute and chronic administration of the drug, information about its nature, causes, treatment and prevention.

Alcoholism: Since alcoholism is the product of a complex and as yet unexplained interaction of biological, psychological and sociological factors, researchers in a number of different fields seek answers to a broad range of questions about the nature of alcoholism and its antecedents. Only as knowledge in the field grows will the capability develop to apply these research findings to treatment and prevention programs. The 1973 budget request provides an increase of $500,000 for alcoholism related research. The material below provides examples of existing activities that will continue to receive support and, where necessary, be expanded.

1. Clinical research: This area continues to be an important part of the grant program, and ongoing projects are concerned with the effects of alcohol on the stomach, and the identification of different patterns of alcoholism. Research has also been conducted on hemodialysis, the rapid removal of alcohol from the bloodstream. Although this process is not currently practical, it has been accomplished without serious complications. More study on a practical means of channelling alcohol from the bloodstream is planned for 1973.

2. Prevention and education: Studies concerning the youth and young adult are needed. In a large scale study of high school youths it was demonstrated that parental rejection, deprivation and impulsivity are factors which can predict problem drinking in youth. Research is being planned to categorize and evaluate the major characteristics and effectiveness of existing preventive programs to develop theory-based programs of public education. Although primary emphasis will be on observing the development of problem drinking, the investigators will also study drug use, delinquency, and antisocial behavior in school.

3. Behavioral and psychological studies: Two studies have been done in an attempt to differentiate between subtypes of alcoholic patients to optimally match specific treatment modalities to particular patients. One of these has identified "essential" and "reactive" types of alcoholic persons and the other has described four subtypes based on the relationship between social factors and drinking patterns. Studies such as these will provide information about the perceptual motivation of the alcoholic person, differences in personality characteristics of non-drinkers and drinkers, and other factors associated with the preference for alcohol.

4. Studies of alcohol and driving: The effect of alcohol on driving skills is another area requiring considerably more development. It is estimated that at least 50% of the 56,000 annual highway fatalities are alcohol-related. Experiments are being conducted to determine the effects of alcohol on attention in performing such tasks as driving a vehicle. These experiments suggest that attention is seriously impaired by relatively low doses of alcohol, in contrast to its effects on such functions as vision where relatively high doses are required to produce impairment. Under the effects of alcohol, subjects attempted to cope with the divided attention task by restricting their attention increasingly to one type of task. While the subjects maintained performance closer to normal on the preferred task, nearly all the performance impairment occurred on one of the two tasks. The subjects were generally unaware of any impairment in their own performance. Other aspects of the drinking-driving area in great need of research include the identification of population of of high risk drivers and the specification of its demographic characteristics in order to implement an effective program in driver education.

5. Evaluation of physiological effects: Grants which investigate the physiological effects of alcohol will continue to receive emphasis. Increasing the rate of metabolism of alcohol or preventing its absorption in the body may facilitate the care of acutely intoxicated persons by rapidly inducing sobriety or as a preventive measure against intoxication. Further research needs to be conducted to determine the validity of these findings and to explore in greater depth the similarities and differences between the addictive processes of alcohol and other substances.

Child Mental Health: Activities directed at improving the mental health of children carry the highest priority for NIMH. The foundation of the Institute's efforts in child mental health is research--an effort to understand both normal and abnormal behavior. The goals of the current program are to (1) develop and demonstrate new approaches to prevention of learning and behavioral disabilities in children through family-centered programs; (2) stimulate innovative approaches to the improvement of early child care services and education through existing community institutions, and (3) foster the development of a family and child advocacy system based on control by community organizations of parents rather than by professionals in order to improve and integrate family and child services.

The 1973 budget request includes an increase of $1,500,000 for Child Mental Health research programs. This increase will be used to stimulate research in the following six priority areas.

--- Coordination of children's services with allied delivery systems: these projects will be concerned with services extended by community mental health facilities as they relate to welfare, medical, educational, correctional, and rehabilitation programs for the handicapped.

--- Expansion and upgrading of preventive programs for children in community mental health centers contacts and other settings: research activities will include the development of models of children's services in centers and related facilities, with particular attention directed to consultation and education services among community agencies with parent groups.

--- Developing methods of reducing hospitalization of children and youth: projects will test innovative approaches to alternative care programs as well as to such direct intervention techniques as family crisis intervention.

--- Supporting models of mental health oriented day care, nursery, and kindergarten programs: special emphasis will be placed upon the role of mental health centers staff in providing technical assistance to partnership agencies providing programs for young children.

--- Development of adequate services for minority children: aspects to be stressed are helping parents and referral sources utilize the availability of services in manners that are acceptable to them, the design of services to meet special needs of minority children, and intervention in community conditions which militate against the mental well-being of minority children.

--- Developing special services for the adolescent who is likely to drop out of school or to resort to drugs: efforts will be made to develop subtle assistance that will not require labeling of the students to receive help--a factor that has been found to be a deterrent in referral of students for help.

Mental Health of Minority Groups: The Institute's Center for Minority Group Mental Health Programs focuses its attention on the special mental health problems of the almost 40 million minority group members in the United States. The general conditions of the life of many minorities are associated with high levels of schizophrenia, alcoholism, drug usage and other mental health problems and institutionalization in mental health facilities, though it is inaccurate to generalize for all minorities since there are inter-group and intra-group differences.

Research is supported to understand the causes, results, and mechanisms of prejudice and discrimination, and to evaluate methods of correcting the attitudes and conditions which place minorities in a disadvantaged position. This is done with minority groups themselves playing a major role in design, administration, and conduct of the research. The 1973 request includes $1,000,000 to expand research programs related to improving our understanding of the mental health problems of minority groups.

Areas of emphasis will include (1) continued study of causes and methods of combatting prejudice, discrimination, stereotypes and racism with emphasis on the aged and institutional change; (2) the relation of social class and minority mental health problems; (3) effective organization and delivery of mental health services for minorities; and (4) ways of building on the strengths of minority groups. The research program will also focus on the connection between residential segregation and assimilation; the factors that affect economic and occupational placement of minority group members as well as studies of minority group institutions and services such as churches and colleges.

Crime and Delinquency: The risk of becoming a victim of a serious crime has more than doubled since 1960. Five million serious crimes were reported during 1969, representing 12 percent increase over 1968. Between 1960 and

1969, arrests of juveniles for serious crimes increased 90 percent, while the number of persons in the 10-17 year age group increased only 27 percent. Work in this field is based on the premise that effective prevention, treatment, and control of social deviance will depend largely upon a sound knowledge base. Some projects currently receiving support include improving the capabilities of the public schools to deal effectively with emotional, interpersonal and academic problems presented by adolescent boys; and studies on the effect of the "social climate" of correctional institutions on inmate behavior and on the relationship between the personal experiences of institutional inmates and the organizational structure and function of the total institution.

In an effort to help determine and reduce the causes of crime and delinquency, the 1973 request provides an increase of $500,000 for the study of various forms of deviant and maladaptive behavior, including development of a sound understanding of its etiological factors; development of means and technology for prevention; and development of adequate methods of intervention.

Other Research Programs: In addition to the fields of investigation just summarized, the Institute plans to continue the following programs in 1973 at their current-year funding level.

--- Clinical research will emphasize studies leading to improved treatment methods, and the study of the complex of factors from which mental illness and emotional distress arise.

--- Behavioral sciences research will cover a variety of subjects, encompassing a range of biological and social sciences. Studies will be conducted into the processes whereby the personality, motives, emotional and intellectual characteristics of children are shaped by the family and social environment.

--- Psychopharmacology, one of the most successful of the Institute's research programs, will continue to support studies to assess the pharmacological properties of new compounds; to analyze the physiological and behavioral effects of drugs on animal and human subjects; and to evaluate the efficacy of new chemotherapeutic agents in the treatment of specific disorders such as schizophrenia, depression, drug abuse and alcoholism.

--- Applied research will continue to pursue one of its primary aims: the prompt and effective application and evaluation of research findings. The program also seeks to test pioneering approaches and new concepts, such as the use of a mobile unit to provide mental health services to children and their mothers in a deprived urban environment.

--- Studies of metropolitan problems deal with the mental disorders and emotional distress that are most prevalent in the inner cities and decaying fringes of our urban areas. The Institute will continue to support studies that attempt to delineate the causes, determine why some are stricken while others are unaffected, and improve existing measures for prevention and treatment.

2. Hospital Improvement Grants

	1972		1973		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations..........	44	$4,100,000	57	$5,400,000	+13	+$1,300,000
Competing renewals.....	17	1,500,000	8	701,000	-9	-799,000
New projects...........	15	1,300,000	9	799,000	-6	-501,000
Total.............	76	6,900,000	74	6,900,000	-2	---

The major emphasis of the Hospital Improvement Program is directed toward improving the treatment, care, and rehabilitation of the mentally ill in the 302 eligible state-supported mental hospitals throughout the Nation. The program specifically focuses on the use of latest techniques and knowledge in demonstrating improved services for patients. Programs are planned in response to the hospitals' highest priority needs, and directed to the long-range goal of improving patient care throughout the Institution.

In 1972 the Institute decentralized the administration of the Hospital Improvement Program to the Department of Health, Education, and Welfare Regional Offices. As a result of the close proximity of the Regional Offices to the State hospitals it is felt that they can be more responsive to the needs of the hospitals and can provide improved monitoring of those institutions which have received grants.

As part of the program, hospitals are encouraged to move toward the development of cooperative relationships with comprehensive community mental health programs and by the close of 1971, 162 State hospitals reported the start or growth of cooperative relationships with local groups and agencies. Within this number 134 are directly affiliated with community mental health centers and have demonstrated the crucial value of State hospitals as back-up or special resources to newly developing mental health centers. They have assisted in providing a range of services not available in mental health centers and provide component parts of center programs such as inpatient care, emergency care, aftercare, outpatient care, diagnostic services, rehabilitation, consultation and education. As a result of improved delivery of services achieved through a Hospital Improvement award, six state hospitals have received staffing support through the Community Mental Health Centers program. At the end of 1971 a total of 249 Hospital Improvement grants had been awarded to 179 of the 302 eligible State mental hospitals.

There are a number of noteworthy examples of progress in the Hospital Improvement program that illustrate its success in improving patient care. In one typical program, the project was designed to bring together approximately 72 back ward chronic schizophrenic patients into a single ward for resocialization and rehabilitation in preparation for community placement, gainful employment, and to provide them with opportunity to assume the major responsibility for their own conduct and activities. The protocol involved a five step operant conditioning program with each higher step representing an increase of income (the range of income was from $3 to $12 per week) and a commensurate degree of increased responsibility and privilege. In the final stages the patient was permitted to spend his own money and assume almost full responsibility for his activity and actions of others in the group. After a period of time patients were moved in small groups to a rented furnished home in the community under supervision of a community coordinator. During this period, appropriate job placements were made and the income used to help pay for rent, food and other items. About 165 patients have been discharged through this project with a return rate of only 10% as compared to 30% in most hospitals.

Another program was developed in response to the rapidly growing number of admissions in the 12 to 18 year old age group. During the first years of operation of this program admissions more than doubled. Educational

recreational and occupational programs were extensively used and individual attention and psychotherapy was provided. Of the 272 patients admitted to the program about 84% have been released. The average stay of patients in the program was reduced from 26 months to 13 months.

b. Direct Operations

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.........	1,170	$18,903,000	1,184	$19,169,000	+14	+$266,000
Other expenses........	---	22,796,000	---	24,099,000	---	+1,303,000
Total............	1,170	41,699,000	1,184	43,268,000	+14	+1,569,000

This activity supports 1) staff who are responsible for the planning, development and administration of the research grant and contract program; 2) funding for the intramural research program which is conducted in the Institute's own laboratories and clinics; 3) the Clinical Research Center at Lexington, Kentucky; and 4) a limited amount of research performed on a contract basis.

The Division of Extramural Research Programs plans and administers research programs in the areas of behavioral science, clinical research, applied research, psychopharmacology and epidemiologic studies. Included in this Division is the Center for Studies of Schizophrenia which serves as a coordinating unit to analyze current research to avoid unjustified duplication of effort and to stimulate promising new avenues of scientific investigation.

The Division of Special Mental Health Programs administers programs directed toward problems of special significance such as crime and delinquency, metropolitan problems, mental health of children and families, and minority group mental health problems. These highly responsive centers were established to coordinate and focus grant and contract funds on specific problem areas.

Intramural Research: The NIMH Intramural Research Program conducts basic and clinical research on the problems of mental illness and related pathologies. Strategically located on the campus of the National Institutes of Health where opportunities for fruitful exchange abound, its scientists pursue the new knowledge without which we cannot hope to alleviate the scourge of mental illness for millions of Americans or to reduce the enormous economic toll it exacts. These scientists are members of a research cadre whose excellence is esteemed throughout the scientific world, a fact evidenced by the honors which continue to be bestowed on them in this country and abroad.

Dr. Julius Axelrod, 1970 Nobel Prize winner, together with a team of collaborators, is currently engaged in a search for enzymes involved in biogenic amine biosynthesis and metabolism in the blood. The measurement of these enzymes makes it possible to determine the activity of the sympathetic nervous system in stress and in a number of diseases, (e.g., manic depression and familial dysautonomia) and after drug treatment. Other members of the research team are working on development of the adrenergic neurones in the fetal brain. Their findings have given considerable insight into the development of these important nerves as the brain grows to maturity. Still another team is engaged in clinical studies of drugs which are frequently abused, e.g., amphetamine and tetrahydrocannabinol (THC), the active ingredient in marihuana. They have found that although tetrahydrocannabinol is partly metabolized, a considerable residue is stored in the tissues and is released so slowly that it can be detected in the blood for several days after its administration. Chronic users of marihuana metabolize it more rapidly than controls who had never used the drug. Another aspect of the THC story concerns the role of an enzyme which induces metabolism of the drug in the lung but which is not present in the liver. Data from another Intramural study suggest that since marihuana is usually smoked, this lung enzyme may play a significant role in determining biochemical patterns of drug distribution in abusers of cannabinols.

A team of intramural scientists is now reporting their findings from data collected over the past several years on early family development. The sequence begins with the newly wedded couple, examines their adjustment to marriage, the birth of their first child, the newborn infant in the first few hours of life, mother-infant interaction, the same infant when he becomes 2 1/2 years old and attends nursery school, the pre-school period and later, the early school period. The findings clearly demonstrate relationships between newborn and later behavior, and between pre-school behavior and that of the school-age period. For example, vigorous and goal-oriented behavior (assertiveness) in the pre-school period has proved to be related to later verbal intelligence and use of imagination in the early school-age period, as well as to social ease, lack of fearfulness and more adequate coping with strange new situations. These findings are important for parents, educators and others concerned with fostering the development of learning capability in the young child.

Thirteen years of planning, designing and building became a reality this past year when the Institutes' Laboratory of Brain Evolution and Behavior was dedicated at the National Institutes of Health Animal Center in Poolesville, Maryland. The new facility will help Institute scientists conduct brain function and behavior studies on animals living in semi-natural habitats thus eliminating some of the obvious difficulties inherent in behavioral studies of animals confined in laboratory cages and living under largely artificial conditions.

In an engrossing study of overcrowding in caged mice, one scientist has witnessed what he terms "the dissolution of social organization", the end result of which is an incapacity on the part of the subjects to replace themselves through reproduction. Even when some of the mice were removed to less crowded quarters, their capacities for carrying out the complex behaviors (social relating, courtship, mating and motherhood) which are requisite for survival of the species, were impaired. Although these studies were conducted with mice, the findings may have application for other species, including man.

In other studies of the brain, investigators have shown that cerebral vessels are remarkably sensitive to oxygen and that concentrations no higher than those commonly used therapeutically for premature and newborn infants with cardiac or respiratory diseases cause as much as 35% reduction in blood flow in most parts of the brain. These findings suggest that oxygen inhalation therapy should be used cautiously during the peri-natal period lest it lead to retarded brain development and other deleterious effects in the nervous system.

Alcoholism: The Intramural research portion of the National Institute of Alcoholism and Alcohol Abuse, carried out in special research facilities at Saint Elizabeths Hospital in Washington, D. C., is particularly concerned with the nature of the addictive process in alcoholism. The research model that is used allows the investigators to study both the behavior and biochemistry of alcoholic individuals in all phases of experimentally-induced intoxication. An important reason for studies of the drinking pattern and behavior of chronic alcoholics is the need to examine the many untested assumptions about how and why an alcoholic drinks. These assumptions are based on retrospective reports of alcoholic individuals made during periods of sobriety and their validity may be affected both by deliberate and unintentional distortions or by the patient's inability to recall and adequately state his attitudes toward alcohol.

The program uses experimental animals to test hypothesis developed from intensive study of the alcoholic individual. For more than a decade, much effort has been expended to produce alcoholism in an animal in order to facilitate the study of the development sequence and the actions of possible neurochemical, neurophysiological and metabolic factors which are concomitants of alcohol addiction. Data obtained from analyzing the development of such addiction will ultimately help to clarify the biological mechanisms of alcohol addiction and suggest ways to stop or reverse the disease process.

The Narcotic Addiction Research Center, as the intramural research arm of the Division of Narcotic Addiction and Drug Abuse, carries out the continuing responsibility for producing laboratory and clinical data on the effects of drugs. This includes studies which assess the psychic dependence producing properties of new non-narcotic drugs prior to their entry into the commercial market, the continued research into new methodologies for improved research on drugs and diagnosis of drug usage, and pharmacological studies of drugs and their action on the nervous system. The center is the only facility which can be called upon to do human assessment of narcotic and non-narcotic drugs.

With positions and funds provided in the 1972 budget amendment the Addiction Research Center will expand its existing efforts to assess the dependence producing properties of narcotic analgesics to include studies of non-narcotic drugs to determine their abuse potential prior to their entry into the commercial market. Clinical pharmacological research on new non-narcotic drugs often reveals the presence of addictive properties which had not been discovered in animal testing. Moreover manipulation of dose range in clinical testing brings about variances in subjective reactions which are invaluable in understanding the nature and assessing the danger of drugs. This determination is necessary so that the Secretary can carry out his responsibilities under the Comprehensive Drug Abuse Prevention and Control Act of 1970 (P.L. 91-513), which requires that he make recommendations to the Attorney General on the control classification of a drug.

Efforts are continuing in order to develop, assess and validate methods for the determination of narcotics in the urine. One method which shows great promise as a practical means for the diagnosis of drug abuse uses thin layer chromatography applied to the urine. This detects the presence of certain drugs and differentiates them from one another.

Clinical Research Center: In recognition of its primary research orientation, funding for the Institute's Clinical Research Center at Lexington, Kentucky has been transferred to this activity from the "Rehabilitation of Drug Abusers" account. The Center will continue to provide services to addicts committed to the care of the Federal Government under the Narcotic Addict Rehabilitation Act of 1966, by the courts, from cities that do not have adequate facilities sustained either by local funds or with Federal grant or contract support. Research at the Lexington Clinical Research Center focuses on the followup of the discharged patient. Post hospital services are provided in collaboration with community agencies, and a controlled evaluation of these activities is being completed.

Directed Research: Included in this activity is $6,000,000 in 1973 for research contracts. Although a large majority of the drug abuse research is supported under grants to independent scientists, some promising fields of research are not represented by sufficient numbers of investigators to achieve an acceptable rate of progress through the normal grant procedure. These funds will be used to carry out extensive controlled clinical tests with presently available antagonists such as naloxone and cyclazocine; begin a research and development program to develop substitutes for opium derivatives; study the receptivity of prescribers to adopt non-opiate drugs in their medical practice; develop educational programs to assist physicians in making the switch to synthetics as soon as they become available; and to fill gaps in knowledge identified through surveys and assessment of progress during 1972. Funds are also included to continue the marihuana research contract study which is designed to determine the effects on humans of the prolonged use of marihuana.

A total of 14 new positions is requested under this activity in 1973. Four of these positions will provide additional staff support for programs related to the mental health of children. Five positions will be directed toward studies of minority group mental health problems, and the five remaining positions will support research in the field of crime and delinquency.

2. Manpower Development

a) Training grants and fellowships

	1972	1973	Increase or Decrease
Training grants and fellowships...............	$120,050,000	$105,050,000	-$15,000,000

An adequate supply of trained manpower is essential to sustain the Nation's efforts to increase mental health services, to obtain new knowledge through research, and to develop and improve methods of organizing and delivering mental health services.

Training Grants

Institute efforts related to the training of mental health manpower are supported through a variety of programs including:

(1) Professional Training: Grants are awarded to training centers and educational organizations for support of training programs in psychiatry, psychology, social work, and psychiatric nursing. This support covers teaching costs and enables institutions to offer financial assistance to students, including stipends, tuition, and dependency allowances.

(2) Experimental and Special Training Projects: Grants are made to eligible institutions and agencies for innovative, experimental training projects. These may include the development of training programs for new types of mental health personnel, programs for persons whose roles or functions may be related to mental health, or the development of new and experimental methods of training. Support is provided for teaching costs and for full-time training, for student support as well.

(3) Continuing Education in Mental Health: Grants are awarded to eligible institutions which develop strong continuing education divisions within professional schools and training centers for the mental health professions, make continuing education an integral component in implementing community and State mental health planning and programs, or provide for program development directed to the needs of a specific group of potential trainees, as opposed to offering isolated courses for whomever can be recruited. Programs are supported at both the professional and nonprofessional levels and are primarily for support of teaching costs only.

Although the NIMH supported programs have contributed to the growth in the supply of manpower providing mental health services to the public, the demand for such services has also grown at a rapid rate. The following table summarizes the unmet need for mental health personnel, by comparing budgeted positions in public mental health facilities (Manpower Demand) with filled positions (Manpower Supply):

Discipline	Manpower Demand	Manpower Supply	Unmet Needs
Psychiatry.................	20,612	18,588	2,024
Psychology.................	13,190	11,350	1,840
Psychiatric social work.....	21,153	18,133	3,020
Nonprofessionals...........	17,039	16,241	798
Total....................	71,994	64,312	7,682

Within this data, Community Mental Health Centers and State and county mental health hospitals show the greatest need for increased professional and nonprofessional workers to meet the increasing demand for services.

Tables 1 and 2 below show the distribution of training grant funds by type of grant and by functional program respectively. The narrative material following the tables describes the training grants structure on a programmatic basis.

Table 1. Distribution of Training Grants by Type of Grant

	1972		1973		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Noncompeting continuation......	1,670	$90,500,000	1,334	$73,000,000	-336	-$17,500,000
Competing continuations............	179	11,734,000	216	15,314,000	+37	+3,580,000
New Projects.......	155	8,080,000	134	7,000,000	-21	-1,080,000
Supplemental Awards	(27)	700,000	(27)	700,000	---	---
Scientific Evaluation............	16	336,000	16	336,000	---	---
Total..........	2,020	111,350,000	1,700	96,350,000	-320	-15,000,000

Table 2. Training Grants Program Distribution

	1972	1973	Increase or Decrease
Narcotic addiction and drug abuse...	$1,700,000	$1,700,000	---
Alcoholism.........................	4,013,000	4,013,000	---
Minority Training..................	1,300,000	1,300,000	---
Psychiatry.........................	32,433,000	20,473,000	-11,960,000
General Practitioner...............	5,533,000	5,533,000	---
Behavioral Sciences................	24,279,000	24,279,000	---
Psychiatric Nursing................	10,299,000	7,259,000	-3,040,000
Social Work........................	12,678,000	12,678,000	---
Experimental and Special...........	7,743,000	7,743,000	---
Continuing Education...............	4,264,000	4,264,000	---
Hospital Staff Development.........	3,800,000	3,800,000	---
Crime and Delinquency..............	2,204,000	2,204,000	---
Metropolitan Problems..............	374,000	374,000	---
Suicide Prevention.................	394,000	394,000	---
Scientific Evaluation..............	336,000	336,000	---
Total..........................	111,350,000	96,350,000	-15,000,000

<u>Narcotic Addiction and Drug Abuse</u>: The purpose of these programs is to assure an increased supply of trained professional and paraprofessional manpower to provide treatment and rehabilitation services and to obtain new knowledge through research. Some new awards planned in this area include grants providing students in health fields with training in the drug abuse area. A grant funded jointly with the National Institute on Alcohol Abuse and Alcoholism provides support to medical schools to develop courses of instructions on drug and alcohol abuse and a career teacher award intended to train medical school faculty members in the field of drug addiction.

<u>Alcoholism</u>: Currently the Institute is emphasizing the development of training programs which concentrate on the training of individuals who will work with alcoholic employees, drinking drivers, American Indians, public intoxicants and other identified target groups. In 1973 the Institute will continue these programs and support programs to provide manpower for after-treatment care of the alcoholic persons.

Finally, efforts will be intensified to develop a cadre of well trained individuals who can develop alcoholism training programs which will increase the number of persons receiving training and at the same time reduce the period of training, with no expense to the quality of the students graduated. Disciplines in which such efforts should be successful are sociology, psychiatry, social work, psychology, nursing, and rehabilitation counseling.

<u>Minority Training</u>: Support will focus on the development of techniques for the recruitment and training of minority students in graduate, post-graduate, and baccalaureate programs and in community college human services associate mental health worker programs. Additionally, the Institute will maintain and expand its interest in, and recruitment of minority members in teaching as a career. It will also foster training researchers, as well as programs designed to enable trained minority group members to enter Federal and private decision and policy-making positions in mental health and health related agencies. Further, there will be a concerted effort in training professionals to work in the area of psycho-somatic illness prevention, especially in those most prevalent among minority group members.

<u>Psychiatry Training Program</u>: Support is provided for the training of physicians and medical students in the broad concepts of mental health and in the delivery of mental health services. Every medical school and school of osteopathy and almost all accredited psychiatric training programs in the country receive support through one or more of the ten types of grants administered and funded under this program. Highest priority for support is given to applications in the areas of child mental health and minority mental health services, drug abuse prevention and treatment, and health manpower deficiencies.

Support provided by this program may be grouped into two different grant categories: Pre M.D. Psychiatry Training, and Graduate Psychiatry Training.

1. Pre M.D. Programs - Medical school training in psychiatry not only serves to increase the number of persons entering the mental health field, but also enhances the knowledge and skills of persons who may be involved, directly or indirectly with the care and treatment of mental health problems. These grants provide faculty support and student support in order to introduce the principles of psychiatry and mental health into the curriculum of the medical student early in his training. This program will be reduced by $4,960,000 in 1973. It is intended that financial assistance be funded in the future through the student assistance programs administered by other Federal agencies.

2. Graduate Psychiatry Training - Support is provided to medical schools, hospitals, and clinics for programs of residency training at the graduate level in psychiatry, including child psychiatry, and for training in special areas such as community psychiatry, student mental health, and others.

In community psychiatry training, interdisciplinary programs have been encouraged which involve jurists, attorneys, penologists, and other law enforcement officials, in addition to professionals and lay personnel involved in problems of drug abuse, suicide prevention and alcoholism.

The 1973 President's Budget contains a decrease of $7,000,000 for psychiatry residency training. Substituted for the present system will be an expanded institutional support grant program.

Behavioral Sciences Training Programs: Support of training in the behavioral sciences include grants to institutions for the training of psychologists, for the training of biological and social scientists for research in mental health, and for the training of mental health specialists in the biological or social sciences. In each instance, grants include funds for both institutional costs and for a limited number of stipends.

Psychiatric Nursing: This program produces the manpower for training additional graduate, undergraduate and non-professional nursing personnel to meet the increasing demands for psychiatric nurses in community mental health centers, hospitals and their service agencies, as well as in teaching roles. The graduate and undergraduate components of this program are discussed below.

1. Undergraduate training: This program provides an opportunity to strengthen the teaching of community mental health and behavioral sciences content throughout the curriculum in baccalaureate and associate degree nursing programs. In addition, it serves to increase the number of graduate nurses continuing their education in the mental health field and provides a sound basis for advanced training and specialization at the graduate level. This program will be reduced by $3,040,000 in 1973. It is intended that financial assistance be funded in the future through the student assistance programs administered by other Federal agencies.

2. Graduate training: This program produces the highly qualified manpower for training additional graduate, undergraduate and non-professional nursing personnel to meet the increasing demands for psychiatric nurses in community mental health centers, hospitals and their service agencies, as well as in teaching and consultation roles. All programs are heavily focused upon training for the delivery of community mental health services, with program content in the areas of community crisis and systems theory, community organization and planning with supervised field training. This training takes place in a variety of community agencies and institutions including mental health centers, in-patient services, out-patient clinics, schools, churches, courts, prisons, nursing homes and housing developments.

Social Work Training: Training support in the field of social work is designed to augment the supply of social workers trained in mental health and to improve the quality of social work training relevant to mental health. With these objectives, grants are made to graduate schools of social work and other training centers or institutions for support of graduate training programs in any area of social work relevant to mental health. These grants provide both institutional support and to a lesser degree, student support.

High priority in 1973 will be given to projects with the general objectives of improving and extending training capabilities to produce more manpower in community mental health, in minority group development, in innovative educational efforts and in child mental health.

Continuing Education Training: This program supports efforts to improve and increase the skills of mental health specialists so that they can keep abreast of the most recent advances in theory, practice and technology. In addition, the program assists training institutions by increasing their capacity to make established mental health personnel more effective and supports continuing education courses for general practitioners.

The continuing education training program will be used extensively during 1973 as part of a multi-faceted approach throughout the training programs to stimulate paraprofessional training activities. In addition to upgrading the skills of the existing cadre of mental health workers and to provide them more meaningful roles on a total health service team, continuing education will also focus on training professional mental health personnel in the effective use of mental health workers, and on a restructuring of roles and service functions to capitalize on the potential contributions of these workers. Emphasis in the training will be placed upon providing specific mental health skills in response to expressed needs of individuals and service agencies.

Hospital Staff Development: The Hospital Staff Development Program is designed to improve the quality of patient care in public mental health hospitals included in state systems of care through inservice training of staff personnel. It encourages hospitals to provide staff development programs at the subprofessional and professional levels through a variety of courses, such as orientation, refresher and continuation training, as well as through special courses for those who conduct the training.

The difficulties encountered in securing and retaining adequate mental health personnel in state mental hospitals has long been recognized. The Hospital Staff Development Program is directed toward alleviating these difficulties by providing a source of funds for some 300 eligible state-supported mental hospitals to initiate or expand new training programs. Of these eligible hospitals, 214 have received staff development grants providing training to an estimated 60,000 persons.

Crime and Delinquency: A major emphasis in this area is placed on the development of training models and programs for both professional and non-professional service personnel, and behavioral and social science researchers. In addition to the development of innovative training models for professional service manpower, the Institute is devoting more effort to the expansion of work opportunities in this field for various non-professionals--including ex-offenders--as probation officer case aides in the supervision of criminal offenders. Results of this program are quite promising and are expected to shed light on the future role of indigenous non-professionals in the community treatment of offenders.

Metropolitan Problems: Training is supported for professionals and non-professionals which will enable them to contribute substantially to metropolitan mental health problems. This training has been interdisciplinary, combining facets of urban planning, systems analysis, and social and behavioral sciences. An example of this approach is a training program sponsored jointly with the Bureau of Community and Environmental Management which will train students in the areas of community development and leadership in the solution of social and environmental problems.

Fellowships

The Research Fellowship Program: This program provides advanced research training relevant to mental health at three levels, (1) predoctoral, for graduate training toward the doctoral degree; (2) postdoctoral, for advanced training and; (3) special fellowships, usually for individuals in mid-career who have contributed effectively to behavioral research. The fellowship program provides basic scientific training as well as advanced and specialized training in a variety of mental health research areas. These include the psychiatric and psychological study of mental development and mental illness; the biological, psychosocial, and cultural correlates of behavior; and research in basic psychological processes.

Awards are made for research training in any area of behavioral science, clinical or non-clinical, in which the applicant's proposed program shows relevance to the understanding of normal or abnormal behavior. These include the general categories of biological and physiological correlates of behavior; psychiatric and psychological study of mental development and mental illness; psychosocial and cultural correlates of behavior, and basic psychological processes.

There is great benefit in improving the capacity of individual scientists to increase our knowledge of mental health and mental disease problems. Especially in newly emerging fields, such as community mental health, it is important for outstanding research-oriented behavioral scientists to have the brief period of training necessary to enable them to acquire such specialized knowledge. Other areas of special interest are those concerned with drug addiction, anti-social behavior, brain damage, alcoholism, child mental health, and problems of living in overcrowded or underprivileged communities.

Research Development Program: The Research Development Program is designed for the support of research, as well as research training, of mental health problems. Its function is to insure continuity of effort in research programs. There is a conspicuous deficiency of both scientific knowledge for mental health services, and non-Federal funds for the support of scientists in research positions in centers for the treatment of the mentally ill. More than half of the awards in the Research Development Program support scientists in psychiatric centers, mainly psychiatric departments in medical schools.

Programs of both basic and applied research on problems relevant to mental health and mental illness are supported, including research on personality and on human development in relation to mental health, studies of social factors in mental health, studies of physiological and biochemical substrates in relation to behavior, and investigations to clarify mental disorders and illness, with reference to etiology, diagnosis, treatment or prevention.

Research on Child Mental Health: Of the current awardees, about 35% are studying various aspects of problems related to the growth and development of infants and children. These investigators represent a variety of fields, such as psychiatry, animal behavior, neuropsychology, psychophysiology, medicine, biology, endocrinology, and social, experimental, and developmental psychology.

The following are examples of the many problem areas under study: the nature of the early infant-mother bond; the effects of early "tutoring" to counteract the effects of deprived environments; treatment methods for pre-delinquent children; carefully controlled drug studies with hyperactive children; factors contributing to the strengths of black children and families; and longitudinal studies of the effects of preventive interventions in the early school years.

Research on Minority Groups: About 15 awardees are working on problems directly related to minority and disadvantaged groups, while the research findings of many others can be considered to be of potential relevance (e.g., studies of learning, thought processes, language, memory and attention). Of more immediate import are the current studies of the development of racial attitudes and how they can be influenced; the approach of Puerto Rican children to new learning situations; the incidence and epidemiological trends for mental illness, suicide and alcoholism among Blacks, Indians, and other cultural groupings; and longitudinal studies of the school adjustment and mental health status of children in ghetto areas.

Research on Service-Delivery: A variety of investigations are relevant to the improvement of delivery of mental health services, ranging, in the medical area, from problems relating to the treatment of Parkinson's disease, depression, schizophrenia, hyperactive children and children with learning disorders, to attempts at understanding the emotional impact of kidney transplants.

The previous examples of Research Development Program awards in the areas of children, minority groups, and aspects of service-delivery represent but a small fraction of the diversity of the program in terms of disciplines represented, and the continuum of approaches from basic to clinical and applied research.

Research on Narcotic Addiction and Alcoholism: In the area of research on drugs and alcoholism, at least 25 awardees are investigating the mechanism of action of various hallucinogens and drugs, psychological reactions to the use of drugs or alcohol, as well as epidemiological data on incidence and social correlates of addictions.

As shown in the following tables, the request for 1973 reflects a program level identical to 1972.

Distribution of Fellowship Awards by type

	1972		1973		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Noncompeting continuations.............	399	$5,182,000	418	$5,428,000	+19	+246
Competing renewals.........	185	1,310,000	150	1,064,000	-35	-246
Supplemental awards........	89	208,000	89	208,000	---	---
New Projects..............	192	2,000,000	192	2,000,000	---	---
Total................	673	8,700,000	657	8,700,000	-16	---

Distribution of Fellowship Awards by Program

	1972		1973		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Predoctoral................	400	$2,624,000	370	$2,528,000	-30	-$96,000
Postdoctoral...............	58	480,000	75	624,000	+17	+144,000
Special....................	43	566,500	39	518,500	-4	-48,000
Research career............	18	534,500	16	472,500	-2	-62,000
Research scientist.........	62	1,645,000	70	1,857,000	+8	+212,000
Research scientist development.....................	92	2,850,000	87	2,700,000	-5	-150,000
Total................	673	8,700,000	657	8,700,000	-16	---

b. Direct Operations

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits...........	135	$3,004,000	135	$3,042,000	---	+$38,000
Other expenses..........	---	4,737,000	---	4,737,000	---	---
Total.............	135	7,741,000	135	7,779,000	---	+38,000

This activity supports Institute staff who are responsible for planning and administering the National Mental Health Manpower program, including mental health manpower studies and the training of paraprofessionals and includes funds for contract support of training centers.

The Division of Manpower and Training Programs administers most of the Institute's training grant and fellowship programs. A high priority is placed upon developing programs which emphasize community mental health concepts and practices; interdisciplinary awareness and coöperation; the care and treatment of children; the provision of services to minority communities, and the recruitment and effective utilization of minority group members into the mental health manpower pool; and the development and training of new types of mental health workers for responsible roles in the delivery of mental health services. In relation to research training, stress is given to programs that prepare biological, psychological and sociological scientists to undertake studies relevant to: (a) the understanding of mental illness and social problems and (b) the delivery of mental health services.

Staff of this Division also perform continuing analyses and evaluations of the Nation's mental health manpower requirements, periodic assessment of available and projected manpower resources, and appraisal of the contribution of NIMH-supported training programs toward meeting the Nation's needs. Among studies currently in process are a jointly funded NIH/NIMH survey of the sources of funding of graduate research training throughout the Nation, including an assessment of the consequences of possible changes in current patterns of funding; and a project to develop a design for evaluating training programs for new careerists in mental health roles. An additional study explores staffing patterns and training requirements of Community Mental Health Centers, and assesses the relationship of current NIMH programs of training support to the staffing needs of the Centers.

Included in the Division of Manpower and Training is the Mental Health Career Development Program, which is designed to supply the Public Health Service, including the National Institute of Mental Health, with professional personnel trained in mental health related disciplines. The training programs focus on the development of psychiatrists and mental health nurses who are planning on a Federal professional career. The persons currently being trained are working in a wide variety of health-related settings, including patient care facilities, mental health research units, demonstration projects and mental health administration.

Contract support will continue in 1973 for specialized training programs designed to improve the ability of physicians, mental health and educational professionals to identify, treat and counsel drug abusers. Three of the training institutes located in Oklahoma City, New Haven, and Hayward, California will continue to train a broad range of professional and paraprofessional personnel whose vocational activities relate to drug abuse. The fourth training institute established in 1972 will continue to be devoted exclusively to clinical training.

3. Support of State and Community Programs

a. Community Mental Health Centers Program:

The objective of the Community Mental Health Centers (CMHC) Program is to facilitate the organization and delivery of mental health services so that all Americans will have access to quality mental health care. Through this program, resources are utilized so that greater progress can be made in the treatment and prevention of mental illness. It is essential that the Nation continue its efforts in establishing a basic network of mental health services at the community level.

Through the grant mechanism, Federal monies are being expended to assist in the construction and staffing of community mental health centers. Each center must provide five basic treatment and prevention services to a specific catchment or service area to insure that the community will be the front line of defense against mental illness. To achieve this capability, each center must provide as a minimum inpatient care, outpatient care, 24-hour emergency service, partial hospitalization, and consultation and education. In addition to these five essential services, centers are encouraged to develop rehabilitation services, training activities, research and evaluation programs, and an administrative organization which will achieve the intent of the program.

A total of $478.9 million awarded since the CMHC program began in 1965 has assisted communities to develop 452 community mental health centers. When fully operational, these centers will serve geographic areas with an estimated 61 million people. Types of areas served by these centers differ markedly. They range from the poverty of Appalachia to the urban-suburban affluence of our major cities. Seventy-two of the centers serve catchment areas in cities with a population of 500,000 or more; 221 will serve smaller cities; 157 are located in small towns and communities and will serve large rural areas through use of outreach teams and satellite facilities where mental health services have not been available in the past. In its short history, the CMHC program has demonstrated one aspect of its effectiveness by providing mental health services to people who previously had no access to them.

As of June 30, 1971, 300 community mental health centers were operational. During the calendar year 1970, there were 399,000 individuals admitted to community mental health centers case load. Of the 452 funded centers, 168 have received construction grants, 103 have received staffing grants, and 181 have received both staffing and construction grants.

In a number of inner-city areas, community mental health centers demonstrate imaginative and innovative programming which involve a wide variety of professional and para-professional staff and volunteers. Inspired by the leadership developed in the community mental health center movement, many educational institutions have initiated formal educational programs for training new careers personnel.

Community mental health centers also provide an opportunity for demonstration and application of exciting new therapeutic concepts and techniques. These include the provision of crisis intervention, alternatives to 24-hour care, consultation to community care-takers and outreach to previously underserved groups. Among the alternatives to 24-hour inpatient care are daycare, which engages the patient in therapeutic activity during the day, and permits him to return to his family at night and on week-ends, and night care which assists those who are able to function in a job or at home but who require more intensive supervision than can be provided on an outpatient basis.

Beginning in 1969, the program increased its evaluation activities including a major effort to measure the effectiveness of the community mental health center model as a service delivery system and to monitor its impact on existing mental health programs.

(1) Construction of Community Mental Health Centers

	1972	1973	Increase or Decrease
Construction grants........	$5,200,000	$9,800,000	$+4,600,000
(Budget authority).........	(15,000,000)	---	(-15,000,000)

The purpose of this program is to improve the organization and allocation of mental health services and their effectiveness so that the highest possible quality of modern treatment and care will be available and accessible to all who need it. Grants are authorized for the construction of public and other nonprofit community mental health centers. Projects may consist of the construction of completely new facilities or the acquisition, remodeling, alteration or expansion of existing facilities. The center program may be based in one or more facilities in the community under central administration which assures continuity of patient care.

Community program objectives include the provision of those essential elements of service that make it possible for the resources to serve the community as a first line of defense against mental illness; the linking of service elements to assure continuity of care; the provision of services to the population of a specifically defined catchment area; the affiliation of treatment and service facilities into a network of comprehensive services; and the establishment and maintenance of preventive services.

The funds available in 1973 represent a carryover of unobligated funds from the 1972 appropriation. No new obligational authority is requested for this program since Community Mental Health Centers are eligible for Hill-Burton funds under the outpatient and rehabilitation categories funding through the Hill-Burton mechanism will ensure conformity with local facility needs.

(2) Staffing of Community Mental Health Centers.

	1972	1973	Increase or Decrease
Staffing grants..........	$135,100,000	$135,100,000	---

Staffing grants support a portion of the initial salary costs for professional and technical staff in community mental health centers. Federal participation in staffing costs enables the community to initiate new or improved services and makes them available while longer term sources of financial support are being developed. Under current legislation, higher funding rates are available for centers serving designated poverty areas.

Because of the emphasis on new services, Federal staffing grants have their greatest impact on creation of improved delivery systems for community mental health care. To meet the basic requirements, a center must provide at least the five essential services outlined in the introduction to this activity, and provide mental health care to those living in the catchment or service area. To do this, it is necessary in most cases for an applicant to obtain the cooperation and help of a number of organizations who then affiliate with the center. As of June 30, 1970, 80% of the centers had more than 2 affiliates. Centers created through the joint planning and development of a number of service providers and community leaders maximize the potential of community resources and provide a coordinated network of services to consumers. Federal funds thus serve as a stimulus in developing innovative programs and in obtaining local private and public funds as well as state support.

The Westside Community Mental Health Center in San Francisco, California, organized by four private General Hospitals and twelve other community agencies is an excellent example of cooperative planning. This group has designed a community mental health center for its catchment area which makes maximal use of existing services and which includes community representatives in its decision and policy making.

A number of centers - particularly those which serve metropolitan areas with unusual concentrations of special needs - have used a series of phased staffing grants to put together comprehensive community programs. Bernalillo County Mental Health Center, Albuquerque, New Mexico, has received five staffing grants and a construction grant. Nine services are presently provided by the center as well as a specialized children's program, a geriatric program and services for those with alcoholism and drug abuse problems. The CMHC program has made a great effort toward providing mental health care to the poor - those who most need treatment but are least able to provide it. As of June 30, 1971, 57.4% of the centers receiving staffing support were serving designated proverty areas.

Special emphasis in 1973 will be given to those applicants who have previously received a construction grant, and are ready to begin operation, as well as applications from centers serving poverty and minority areas. The request will provide continuation support for 479 staffing grants and the awarding of 22 new staffing grants. In addition, one percent of the amounts appropriated will be available for program evaluation activities.

b. Narcotic addiction

	1972 Estimate	1973 Estimate	Increase or Decrease
Obligations............	$76,390,000	$91,298,000	+$14,908
Budget authority........	76,298,000	91,298,000	+15,000

This activity supports the Institute's program to develop and conduct comprehensive health, education, training and planning programs for the prevention and treatment of drug abuse. The program was initially authorized on October 15, 1968 when the Congress enacted the Alcoholic and Narcotic Addict Amendments (PL 91-574) to the Community Mental Health Centers Act. Additional legislation was enacted during 1971 which revised existing authorizations and established some new programs.

It has been estimated that in 1970 as many as 250,000 Americans were heroin addicts, and that drug addiction and abuse in general had risen sharply over the previous year. The President demonstrated the importance he has placed on combatting narcotic addiction and drug abuse by submitting a budget amendment in 1972 of $67 million for the Institute's drug abuse programs with the intent of developing resources within the Federal Government to combat the problem which he has characterized a "National Emergency." Simultaneously, he established a Special Action Office for Drug Abuse Prevention to coordinate the efforts of the Federal Government in this area.

In 1971, $21,252,000 was obligated in the community assistance activity for drug abuse programs. This included a $6.5 million supplemental appropriation enacted to implement the provisions of the Comprehensive Drug Act (P.L. 91-513). At the close of 1971, there were 9,574 drug abuse patients receiving treatment and rehabilitation in 23 operational community based programs supported by the NIMH. This represents a threefold patient load increase over 1970. In terms of patients seen there were 13,228 new admissions to these operational programs.

The 1973 request for community assistance programs is $91,928,000, an increase of $14,908,000 over the 1972 level of support. This increase will allow the Institute to continue to develop and conduct comprehensive health, education, training, and planning programs for the prevention and treatment of narcotic addiction and drug abuse. The following table sets forth the 1972 and 1973 funding levels by program area.

All of the programs funded in this budget activity are authorized under Part D of the Community Mental Health Centers Act (CMHC), as amended. Funds are provided to assist communities in establishing programs to treat and control narcotic addiction and drug abuse through awards for planning and development of a broad range of treatment facilities, consultation services, training and education activities and evaluation projects. A description of each of the specific programs is provided in the material which follows.

Staffing Grants - These grants are authorized under Section 251 of the CMHC Act and provide for a portion of the initial salary costs for professional and technical personnel hired by the Center to provide treatment and rehabilitation services to an addict or drug abuser. Federal support for the program enables the community to initiate new and improved services and makes them available while longer term sources of financial support are being developed. Under current legislation, higher funding rates are available for Centers serving designated poverty areas.

The programs supported will provide a variety of treatment modalities including inpatient, outpatient, emergency, and partial hospitalization services. Methadone maintenance treatment and therapeutic communities can also be offered by these centers. In addition, centers provide extensive community education and consultation services and could conduct professional training, rehabilitation, and aftercare services.

By the close of 1972, 31 programs will have received staffing grant support, providing services to an estimated 26,600 addicts or drug abusers. Many of these programs will be incorporated in or have strong linkage to existing community mental health centers, thus providing additional professional and technical resources for the treatment and prevention program. The request for 1973 will provide continued support for the existing 31 programs and $2,100,000 in new funds for 2 additional programs.

Special Projects - These grants are authorized under Section 252 of the CMHC Act and provide for treatment and rehabilitation programs of narcotic addicts and other persons with drug abuse and drug dependence problems which have special significance because they demonstrate new or relatively effective or efficient methods of delivery of health services to the narcotic addict or drug abuser. These grants are awarded on a project basis and do not require any matching funds on the part of the grantee.

With the funds available in 1972, an estimated 47 projects will receive funding under this authority. When fully operational these programs will provide services to an estimated 33,100 addicts or drug abusers. The request for 1973 will provide continued support for these 47 programs and $6,581,000 in new funds for 15 new programs.

Service Grants - These grants are authorized under Section 256 of the CMHC Act and provide partial Federal support for programs of treatment and rehabilitation to narcotic addicts and drug abusers which include one or more of the following: (1) Detoxification services or (2) institutional services (including medical, psychological, educational, or counseling services) or (3) community based aftercare services. The criteria by which service grants are made are designed to provide priority to areas having higher percentages of the population who are narcotic addicts or drug dependent persons. Federal participation in funding service grants enables the community to initiate new and improved services and makes them available while longer term sources of financial support are being developed. The detoxification units that are supported under this program are designed to help addicts withdraw from drugs, principally heroin and barbiturates, and to prepare them for treatment by other means.

With the funds available in 1972, an estimated 81 projects will receive funding under this authority, including continuation support for 16 projects funded initially in 1971 and 65 new projects. The request for 1973 will provide continuation funding for these 81 projects and $6,367,000 for support of 16 new projects. The total request of $35,000,000 for this program represents the full amount authorized in the legislation.

Training Grants - These grants are also authorized under Sections 252 of the CMHC Act and provide for specialized training programs or materials for the prevention and treatment of narcotic addiction, drug abuse, and drug dependence or developing in-service training or short term or refresher courses with respect to the provision of such services. Some of the programs supported include training for persons in the "helping professions," who may come in contact with narcotic addicts or drug abusers; programs for new types of treatment, rehabilitation, and prevention

personnel; evaluation of teaching methods and development of new training methods; and training of health professionals in the field of narcotic addiction and drug abuse.

With the funds available in 1972, an estimated 45 projects will receive funding under this authority, including continuation support for 4 projects funded initially in prior fiscal years and $6,110,000 for 41 new projects. The request for 1973 will provide continuation funding for these 45 projects and $2,641,000 for support of 11 new projects.

Education Projects - These projects are authorized under Section 253 of the CMHC Act and provides for the awarding of grants and contracts on a project basis for the collection, preparation, and dissemination of educational materials dealing with the use and abuse of drugs and the prevention of drug abuse. These programs are directed at the general public, school-age children, and special high risk groups. In 1972, $1,604,000 was obligated for the support of approximately 20 education projects. The 1973 request will provide for the continued support of the program at approximately the same level.

Planning and Initiation - Section 261 of the CMHC Act authorizes projects for assessing local needs for treatment and rehabilitation programs. The $2,200,000 available for the program in 1972 and requested for 1973 will provide planning grants to states, metropolitan areas, cities and small towns to stimulate coordinated, adequately focused programs at the state and local levels.

Summary

As noted in the above material the Institute's community assistance program provides support for a variety of programs aimed at reducing the incidence of narcotic addiction and drug abuse. In 1973 priority will be given to the continued targeting of new service and special projects in areas with high incidence of drug addiction relative to treatment capability. Emphasis will also be placed on making available to the addict a choice of treatment modalities either through the establishment of multi-modality treatment facilities or the development of linkages among drug treatment facilities in a given area insuring referral among modalities.

Narcotic Addiction Community Assistance

(In Thousands)

	1972		1973		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Staffing:						
Continuations.......	29	$13,368,000	31	$15,145,000	+2	$+1,777,000
New.................	2	2,100,000	2	2,100,000	--	---
Total............	31	15,468,000	33	17,245,000	+2	+1,777,000
Special Projects:						
Continuations.......	--	---	47	18,559,000	+47	+18,559,000
New.................	47	19,536,000	15	6,581,000	-32	-12,955,000
Total............	47	19,536,000	62	25,140,000	+15	+5,604,000
Service Projects:						
Continuations.......	16	4,059,000	81	28,633,000	+65	+24,574,000
New.................	65	25,941,000	16	6,367,000	-49	-19,574,000
Total............	81	30,000,000	97	35,000,000	+16	+5,000,000
Training Projects:						
Continuations.......	4	604,000	45	6,359,000	+41	+5,755,000
New.................	41	6,110,000	11	2,641,000	-30	-3,469,000
Total............	45	6,714,000	56	9,000,000	+11	+2,286,000
Education Projects....	20	1,604,000	20	1,700,000	--	+96,000
I & D................	44	2,200,000	44	2,200,000	--	---
Evaluation...........	3	768,000	4	913,000	+1	+145,000
Consultation.........	1	100,000	1	100,000	--	---
Total...........	272	76,390,000	317	91,298,000	+45	+14,908,000

C. Alcoholism:

(1) Project Grants:

	1972	1973	Increase or Decrease
Obligations............	$40,297,000	$50,193,000	+$9,896,000
Budget authority.......	(40,193,000)	(50,193,000)	(+10,000,000)

Alcoholism or problem drinking today affects an estimated 9 million Americans and directly or indirectly affects some 36 million persons in the United States. Alcohol related problems are the cause of more than 85,000 deaths in the United States each year, including half of the more than 50,000 individuals killed annually in highway accidents. There are approximately 2 1/2 million arrests related to alcohol each year. Alcoholism shortens life expectancy 10-12 years and the total economic loss to the Nation from alcohol problems is an estimated $15 billion annually. To these statistics must be added immeasurable human costs and suffering - broken homes, deserted families, and psychological problems - resulting from alcohol abuse and alcoholism.

This activity supports the program efforts of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to develop and conduct comprehensive health, training and planning programs for the treatment of alcohol abuse. The program was initially authorized on October 15, 1968 when the Congress enacted the Alcoholic and Narcotic Addiction Amendments (PL 90-574) to the Community Mental Health Centers Act. Additional legislation was enacted in December 1970, which revised existing authorizations and established some new programs including grants to states allocated on a formula basis.

The goal of the alcohol community assistance program is to reduce the seriousness, prevalence and incidence of alcoholism and alcohol problems in the Nation. This is done through a variety of programs which are described in the material which follows. All these programs are authorized under Part C of the Community Mental Health Centers Act (CMHC), as amended. Funds are provided to assist communities in establishing programs to treat and control alcoholism through awards for planning and development of a broad range of treatment facilities, consultation services, training, and evaluation projects. A description of each of the specific programs is provided in the material which follows.

Staffing Grants: These grants are authorized under Section 242 of the CMHC Act and support a portion of the initial salary costs for professional and technical staff in facilities for the prevention and treatment of alcoholism. Federal participation in staffing costs enables the community to initiate new or improved services and makes them available while longer term sources of financial support are being developed. Under current legislation, higher Federal funding rates are available for centers serving designated poverty areas. All program funded under this activity must be community based and provide a comprehensive range of services, including emergency, inpatient, outpatient'intermediate care services and consultation and education. Identification and referral services should also be included as well as mechanism for ensuring continuity of care.

In 1972, a total of 68 staffing projects were funded and, when fully operational, will provide treatment to 109,000 alcoholic persons and alcoholic abusers. At the end of 1973, a total of 88 centers will be funded and will provide services to a total of 141,000 alcoholic persons. These programs represent a variety of approaches to treatment and care of alcoholics. One program, located in a medium size city, serves three catchment areas, and includes affiliation arrangements with one Community Mental Health Center and two hospitals in the area. Another, located in a rural area of a midwestern state, is an example of a largely non-medical approach to the treatment and care of alcoholics.

Special Projects: These grants are authorized under Section 246 of the CMHC Act and provide support for:
(1) Developing specialized training programs or materials relating to the provision of public health services for the prevention and treatment of alcoholism.
(2) Training personnel to operate, supervise and administer such services.
(3) Conducting surveys and field trials to evaluate the adequacy of the program for the prevention and treatment of alcoholism with the several states.
(4) Programs for treatment and rehabilitation which demonstrate new or relatively efficient methods of delivery of services to such alcoholics.

In his 1972 Health Message, the President increased the budget request by $7,000,000 for alcohol programs to support field trials and demonstrations to develop innovative ways to treat alcoholic persons. These projects are designed to find the best way to influence medical and other helping professionals to utilize the information available on alcoholism therapy, as well as to assess the most effective organization and delivery of care in community treatment and rehabilitation programs. The funds available in 1972 will support an estimated 29 projects and provide treatment services to approximately 17,000 alcoholics. The request for 1973 will support an additional 13 projects. These projects will provide services to an additional 7,800 alcoholic persons.

Grants and Contracts: These awards are authorized by Section 247 of the CMHC Act and may be used to: (1) conduct demonstrations, services and evaluation projects, (2) provide education and training, (3) provide programs and services in cooperation with schools, courts, penal institutions and other public agencies, and (4) provide counseling and education activities on an individual or community basis.

One of the major efforts conducted by the Institute is this provision of services to the American Indian population. Because of poverty, dislocation and failure of this population to be acclimated into the mainstream of American society, the Indians have developed many serious social problems, including alcoholism. To help meet these needs, the Institute provided $750,000 for educational programs and treatment and rehabilitation services according to guidelines established by the Indians themselves.

Another group of special concern is the chronic drunkenness offender. Although only about 5% of all alcoholic persons are the homeless and socially isolated individuals known as "skid row drunks", they account for 40% of all annual arrests for non-traffic offensers. The NIAAA is working with other agencies of the Federal Government to find more practical and effective alternatives for handling and rehabilitating these individuals. The Institute will also initiate a series of occupational alcoholism programs at the State and Community level as well as private industry. The funds available in 1972 will support approximately 70 projects and will provide treatment services to approximately 4,200 alcoholics. The request for 1973 includes a $10,000,000 increase for treatment projects previously supported by the Community Action Program of the OEO.

<u>Initiation and Development</u>: These grants are authorized under Section 224 of the CMHC Act and provide one year planning grants to local public or non-profit private agencies to plan and develop alcoholism services in a particular area. The purpose of these awards is to assess local needs, design alcoholism treatment programs and obtain local financial and professional assistance, and foster community involvement in developing local treatment services.

A summary of the alcoholism project grant program appears in the following table:

Distribution of Alcohol Project Grants

	Alcohol Community Assistance					
	1972 Estimate		1973 Estimate		Change	
	No.	Amount	No.	Amount	No.	Amount
Staffing:						
Continuations	32	$6,098,000	68	$15,510,000	+36	+$9,412,000
New	36	10,904,000	4	1,100,000	-32	-9,804,000
Subtotal	68	17,002,000	72	16,610,000	+4	-392,000
Special Projects:						
Continuations	1	150,000	29	5,410,000	+28	+5,260,000
New	28	5,773,000	3	581,000	-25	-5,192,000
Subtotal	29	5,923,000	32	5,991,000	+3	+68,000
Grants and Contracts:						
Continuations	--	---	70	14,490,000	+70	+14,490,000
New	70	15,970,000	259	12,000,000	+189	-3,970,000
Subtotal	70	15,970,000	329	26,490,000	+259	+10,520,000
Initiation & Development	20	1,000,000	12	600,000	-8	-400,000
Evaluation		402,000		502,000		+100,000
Total		40,297,000		50,193,000		+9,896,000

(2) Grants to States

	1972	1973	Increase or Decrease
Obligations/Budget authority........	$30,000,000	$30,000,000	---

Part A, Title III of the Comprehensive Alcohol Abuse and Alcoholism Act of 1970 (Public Law 91-616) authorizes formula grants to states for the planning, establishment, maintenance, coordination and evaluation of projects for the development of alcoholism prevention, treatment and rehabilitation programs. The $30,000,000 included in the President's budget request will be allotted to the States on the basis of their relative population, financial need and the need for more effective prevention, treatment and rehabilitation programs. The minimum allotment for each state is $200,000. At the request of any State, a portion of any allotment shall be available to pay for a portion of the administration of the state alcoholism program.

In addition the plans submitted by the states must set forth a survey of need for the prevention and treatment of alcohol abuse and alcoholism, including an assessment of the health facilities needed to provide services.

d. Child Mental Health Program

	1972	1973	Increase or Decrease
Child mental health (obligations/Budget Authority)......	$10,000,000	$10,000,000	---

Up to now the mental health of children, contrary to general belief, has been neglected. In 1968, approximately 437,000 children were seen in out-patient psychiatric clinics, 33,000 were patients in public and private mental hospitals, 26,000 were in residential treatment centers, and 52,000 were patients in community mental health centers. Almost ten percent of our young people will have had at least one psychiatric contact by the time they are 25. Statistics such as these, and the realization that adult mental illness often has its roots in childhood, has led the National Institute of Mental Health to designate child mental health as its number one priority.

In developing improved services for children, the extensive network of community mental health centers provide a base for local services. In 1972 funding for the Child Mental Health program authorized by Part F of the Community Mental Health Centers Act, was initiated to stimulate innovative approaches toward expanding the range of services for children. This is done by awarding staffing grants to applicants which are already a part of or affiliated with a community mental health center and who are establishing or expanding services directed primarily at children. These grants support a portion of the initial salary costs for professional and technical staff employed by the center. If there is no center serving the community, a grant may be awarded to a public or non-profit agency which can provide an adequate range of prevention and treatment services for all children within their area.

In 1972, priority for support will be given to programs which emphasize: (1) the prevention and early treatment of mental health problems in children with emphasis on consultation and education to improve and increase service to children in their normal life settings; (2) have impact on children early in life at the pre-school and elementary school levels and particularly on children who are likely to be at high risk later in life such as those from poverty-stricken areas; (3) aim for the total integration of children's services in the community, creating partnerships between mental health staff and others who work with children in setting such as the schools and day care centers to increase their expertise in the prevention, identification and management of mental health problems; (4) utilize existing resources to their maximum extent and combine resources and funding from a variety of health and human services sources to develop new services and expertise; (5) develop innovative uses of new types of personnel; and (6) show promise of transferability to other community settings.

The 1973 request will provide continued funding for 28 grants initially awarded in 1972, and 4 new awards.

Childrens Grants by Type of Grant

	1972		1973		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuations........	--	---	28	$8,485,000	+28	+$8,485,000
New Projects.........	28	$10,000,000	4	1,515,000	-24	-8,485,000
Total...........	28	10,000,000	32	10,000,000	+4	---

e. Direct operations

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensations & Other Benefits	187	$3,289,000	194	$3,695,000	+7	+$406,000
Other Expenses	---	3,527,000	---	3,544,000	--	+ 17,000
Total	187	6,816,000	194	7,239,000	+7	+ 423,000

The funds in this activity provide staff support for the Division of Mental Health Service Programs, and the National Institute on Alcohol Abuse and Alcoholism.

The Division of Mental Health Service Programs provides program planning at the National level for Parts A, B and F of the Community Mental Health Centers programs which are administered on a project basis in the HEW Regional Offices. The Division also operates the Mental Health Study Center located in Adelphi, Maryland which plans and administers a community laboratory for the development, innovation and evaluation of approved service delivery methods in a community context. In 1973, the primary areas of emphasis will be on the provision of services to young children, adolescents and the aged.

In May 1971, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was established within the National Institute of Mental Health, by Public Law 91-616. This legislation provided, for the first time, some of the resources necessary to build an innovative and outreaching alcoholism program for the nation.

The NIAAA has adopted two principal goals to guide its program development (1) to mobilize all existing treatment and rehabilitation resources at the Federal, State, and local levels to provide care for the alcoholic individual and (2) to develop and begin viable and comprehensive programs of prevention of alcohol abuse and alcoholism. The organization of the NIAAA includes four divisions, each representing a significant program emphasis in the Institute. These are the Division of Research, State and Community Assistance, Special Treatment and Rehabilitation programs, and Prevention.

To make maximum use of all available Federal resources, the NIAAA is also cooperating in various areas with other agencies such as, the Office of Economic Opportunity, the Department of Transportation and the Department of Labor. The NIAAA has been working with the Civil Service Commission to develop guidelines for the implementation of alcohol programs in all Federal agencies. The Institute has also been consulting actively with State and local governments and industry to help them develop alcoholism treatment programs for their employees.

There are 7 new positions requested for the Institute to administer the expanded alcohol programs and to meet the demands for consultation and technical assistance.

Rehabilitation of Drug Abusers

	1972		1973		Increase or or	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation & Benefits............	157	$3,227,000	164	$3,795,000	+7	+$568,000
Other Expenses..........	---	10,096,000	---	10,131,000	--	+ 35,000
Total.............	157	13,323,000	164	13,926,000	+7	+ 603,000

This activity provides support for the NIMH staff who administer the Institute's narcotic addiction and drug abuse program and funding for the treatment and rehabilitation of narcotic addicts under contract arrangements with community agencies. The staff operates within the Institute's Division of Narcotic Addiction and Drug Abuse.

The Division of Narcotic Addiction and Drug Abuse (1) plans and develops programs of research, training, community services, and public education for prevention and control of narcotic addiction and drug abuse; (2) conducts and supports research on the biological, environmental, and social causes of addiction and drug abuse; (3) supports the training of professional and paraprofessional personnel in drug abuse prevention and control; (4) supports the development of community facilities and services for addicts and other drug abusers; (5) collaborates with other Federal agencies, national, state, and local organizations, and voluntary groups to facilitate and extend programs for the prevention of drug abuse and for the care, treatment, and rehabilitation of addicts; (6) coordinates and stimulates statistical and biometric programs necessary for epidemiologic and longitudinal studies of drug addiction and abuse; (7) stimulates the communication of appropriate information and educational material through the development of conferences, committees, publications, and use of public media; (8) administers the Institute's program for rehabilitation of narcotic addicts authorized under the Narcotic Addict Rehabilitation Act through (a) operation of a Clinical Research Center (funded under "Research - Direct Operation"), and (b) contract support of patient care activities in the community.

The Narcotic Addict Rehabilitation Program, authorized by the Narcotic Addict Rehabilitation Act of 1966, provides an opportunity for individuals addicted to narcotic drugs to volunteer for civil commitment for treatment (Title III) and allows addicted individuals charged with violating certain Federal criminal laws to apply for civil commitment in lieu of prosecution (Title I). At the present time the program is utilizing the Clinical Research Center at Lexington, Kentucky, and under contract arrangements, local community agencies to provide the examination and evaluation and inpatient phases of the program. Following initial treatment at the Lexington Center or by a contract agency, the patient is conditionally released to his home community and provided with supervised treatment and rehabilitative services for up to an additional 36 months. Again these aftercare services are provided by local mental health, family service, vocational rehabilitation, and other agencies under contract with the National Institute of Mental Health. The community agency provides the patient supervision, treatment, and rehabilitation services which are tailored to his individual needs. The agency must also facilitate and coordinate the use of existing community services for continuing psychotherapy, education, vocational training, job placement, medical care, and welfare.

By the end of 1971 approximately 165 contracts were awarded to local agencies for the treatment of narcotic addicts committed to the care of the Surgeon General. These contracts provided a wide range of service in 153 cities

and 44 states. On June 30, 1971, there were 2,078 patients remaining in the program, which represents an increase of 420 over the previous year. Efforts during the year to redirect services from the Clinical Research Centers to local facilities in the addicts' home communities resulted in the extension of 42 aftercare contracts to provide examination and evaluation, and 19 contracts to provide inpatient treatment. During the year 629 examinations, representing twice the previous year, were conducted in 29 community agencies, and 106 patients, representing five times the previous year, received inpatient treatment in 9 community agencies.

In 1973, a major emphasis will be placed on reducing the level of direct patient care provided under the NARA Act commensurate with the development of community-based grant programs under State and local management. To initiate this plan, $2,131,000 has been redirected to the community assistance grant program for narcotic addiction treatment and rehabilitation programs.

In recognition of its primary research orientation, the Clinical Research Center at Lexington, Kentucky, formerly funded under this activity, appears in the budget under Research - Direct Operations activity. However, the Center will continue to provide services to addicts under the NARA program from cities that do not have adequate facilities sustained either by local funds, or with Federal grant or contract support.

Included in the 1973 request are 7 new positions to provide continued improvement of the administration of the Institute's drug abuse programs.

5. Program Support Activities

a. Field Activities

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation and Benefits...........	162	$3,181,000	162	$3,457,000	---	+$276,000
Other Expenses	---	558,000	---	558,000	---	---
Total..............	162	3,739,000	162	4,015,000	---	+ 276,000

This activity includes funds for NIMH staff located in the HEW Regional Offices to carry out programs of assistance to the states and serve as field units providing technical assistance on mental health programs to state and community institutions. The regional offices have responsibility for the administration, on a project basis, of the community mental health centers program, the Hospital Improvement Program, and the Hospital Staff Development Program.

Funds are also included in this activity for the Office of Program Coordination which is responsible for coordinating Institute activities with other DHEW components, Federal agencies, international groups, and with regional, state and local mental health agencies and citizen groups. It also acts as liaison between the Institute's regional organization and other Institute program areas.

b. Scientific communication and public education

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation and Benefits	80	$1,485,000	80	$1,480,000	--	-$5,000
Other Expenses	--	5,813,000	--	5,813,000	--	---
Total	80	7,298,000	80	7,293,000	--	- 5,000

This activity supports the Office of Communications which operates the National Clearinghouse for Mental Health Information (NCMHI) in conjunction with its scientific communications program, and in collaboration with respective program areas of the Institute is responsible for the Institute's public information activities, as well as the National Clearinghouse for Drug Abuse Information.

The NCMHI is the Institute's resource for collecting, analyzing and disseminating scientific and technical information. It has basically three functions: first, it provides scientific information both upon individual request and in the form of recurring and single issue publications; second, it provides scientific analyses and compilations which present an overview and synthesis of current research activities; and third, it attempts to develop new solutions to scientific information problems and devises improvements in its storage and retrieval system.

The National Clearinghouse for Drug Abuse Information (NCDAI) provides the public with a central office within the Federal Government to contact for information and assistance concerning this critical social problem. The NCDAI collects and disseminates materials and data taken not only from Federal programs, but from appropriate private, state, and local community projects. The Clearinghouse will continue to improve and expand its computerized information system. The drug abuse information resources and materials file, which contains abstracts and descriptions of drug abuse literature and audiovisual materials, will be evaluated and improved to provide better and more information. The file on drug abuse programs, which includes information on treatment, education, information, and law enforcement programs across the country, will be made current and kept up to date.

In addition to filling individual requests for information, the Clearinghouse will produce a number of publications derived from its data base, including an annotated bibliography, directories of voluntary action and religious programs, a guide to speakers bureaus, a listing of treatment and rehabilitation resources, topical bibliographies, and a current awareness system.

The pilot operation of 8 to 10 cooperating state and regional information centers will initiate the decentralized information network of the NCDAI. At the direction of the Special Action Office on Drug Abuse Prevention, the Clearinghouse will develop national statistical and descriptive information to make up a National Inventory of Drug Abuse Programs. The Inventory will make it possible to store and retrieve information about all the known drug abuse programs in the United States, supported by statistical information and tabulations.

Drug abuse public information activities will include production of printed and other materials directed at four points of emphasis in the mass media campaign against drug abuse being conducted by the Federal agencies in cooperation with the Advertising Council: warnings to traveling Americans against violating foreign drug laws; added activities relating to the national observance of Drug

Abuse Prevention Week; a separate minority-oriented drug abuse campaign, and alternatives to drug abuse.

Increased public information activities concerning the first two categories will utilize primarily the print and electronic mass media -- posters, pamphlets, and radio/television exposure. For example, to meet President Nixon's mandate for a Drug Abuse Prevention Week, the Institute produced a broad range of materials for distribution to local and national press, radio, and TV outlets.

A key to preventing alcohol abuse and alcoholism lies in the broadscale education of the public on the dangers of alcohol use and abuse. The Institute's education and prevention program has several objectives: (1) to develop public recognition of alcoholism as an illness for which the afflicted individual needs help, and can be helped; (2) to encourage the health system to accept alcoholism as a medical-social-behavioral problem and to treat the alcoholic person with the same attention and consideration as any other patient; (3) to develop public awareness of the properties of alcohol, its effects on the body and behavior, and its potential for harm; and (4) to produce a new national environment concerning the use and misuse of alcoholic beverages in the United States to bring about an eventual reduction in the rate of drunkenness, problem drinking, and alcoholism.

The NIMH information and education programs in this health area begun in 1971 and expanded in 1972, will be continued at approximately the same level in 1973. The first year of the information/education program, devoted in large part to "tooling up" for a long-range effort, and to building a foundation of awareness of the nature and scope of alcohol-related problems in the U.S., included such activities as a public service advertising program, surveys of existing printed materials and films on alcohol and alcoholism, development of general and scientific publications, and production of a brief film for junior high and high school use. Based on findings in surveys, further publication and film presentations, the Institute has prepared a nationwide advertising campaign to build a foundation of awareness of the nature and scope of alcohol-related problems in the Nation. Additional and intensified efforts, including a major effort in curriculum development and teacher training, will be needed to reach young people, and to encourage and assist community groups, churches, industries, schools, and other groups in initiating local information and education activities. One of the major mechanisms for implementing these programs is the new National Clearinghouse on Alcohol Information, established in 1972.

c. Executive direction and management services

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation & Other Benefits	259	$4,302,000	259	$4,162,000	---	-$140,000
Other Expenses	---	1,460,000	---	1,607,000	---	+ 147,000
Total	259	5,762,000	259	5,769,000	---	+ 7,000

The funds in this activity support Institute staff in the Immediate Office of the Director, the Offices of Program Planning and Evaluation, and Administrative Management.

The Immediate Office of the Director provides for the overall planning, direction and administration of the Institute's programs. The Office of Administrative Management is responsible for centralized services in financial management, management and administrative services. It has broad responsibility for the design, issuance, and implementation of administrative operating procedures for the conduct of Institute operations.

The Office of Program Planning and Evaluation is responsible for the stimulation, development, and coordination of the Institute's planning, program analysis, data collection analysis, and evaluation activities. Of highest priority is the development of the Institute evaluation program which is directed at evaluating the responsiveness of community mental health services to the needs of the community and the individual, the effectiveness of the Institute's training programs, and the impact of NIMH supported research on the treatment and prevention of mental illness. The approach is not only to evaluate the input of individual programs, but also to assess interrelationships among them. Examples of new studies planned for FY 1973 include: (1) evaluation of the new careers training program; (2) evaluation of the impact of increased Federal matching rates for community mental health centers serving designated poverty areas; and (3) analysis and evaluation of NIMH research, training, and services activities related to the aged for purposes of determining future program direction.

The other priority activity of this office is the coordination of overall mental health strategy, developed for the period 1973 through 1977. This comprehensive planning approach involves the development of a strategy integrating future financing of mental health programs, delivery system development, manpower development, and research priorities.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: Research-(a) Grants (Public Health Service Act, Sections 301, 302, 303).

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$97,400,000	Indefinite	---	$101,400,000

Purpose: Sections 301, 302, and 303 of the Public Health Service Act authorizes a grant-supported program of research, experimentation, and demonstration relating to the causes, diagnosis, treatment, and prevention of mental diseases. Two major grant programs are included in this subactivity. First, the regular research grants program provides support on a project basis for behavioral, clinical, psychopharmacology and applied research as well as clinical research centers and areas of special interest such as alcoholism, drug abuse, violence, early child care, minority studies and services development research. Secondly, the hospital improvement program provides grants to state mental hospitals for projects which provide immediate improvement in the care, treatment, and rehabilitation of patients.

Explanation: The grants go to investigators affiliated with hospitals, academic and research institutions, and other nonprofit organizations in the United States. Under very special circumstances, grants may be awarded to foreign institutions for research in areas of top priority. The grants may provide support for large-scale, broad-based research, usually on a long-term basis. Such research, usually interdisciplinary, consists of several projects with a common focus or target. Small grants limited to a maximum of $6,000 including indirect costs, may be awarded for a period of 1 year for pilot studies or for exploration of an unusual research opportunity.

Accomplishments: In Fiscal Year 1972, a total of 1,522 regular research grants, 200 small grants and 76 hospital improvement grants were supported with special emphasis given to research into the causes and prevention of alcoholism, narcotic addiction and drug abuse. In addition, the Institute undertook a reprogramming of the research grant funds to establish a minority studies research program and to provide resources for an expanded services development research program.

Objectives: The increase provided in 1973 will allow expanded support of the high priority research programs in drug abuse, alcoholism, child mental health, minority mental health, and crime and delinquency will receive new emphasis.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: Research-(b) Direct Operations (Public Health Service Act, Sections 301, 302, and 303).

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
1,170	$41,639,000	Indefinite	1,184	$43,208,000

Purpose: This activity supports (1) intramural laboratory and clinical research in the behavioral and biological sciences, and (2) the planning, development and administration of most of the Institute's grant and contract research programs.

Explanation: This is a program of direct research support for NIMH staff in the Institute's own laboratories and clinics. Funds are also provided for research activities supported on a contract basis and for support of the Clinical Research Center at Lexington, Kentucky.

Accomplishments: It has now been clearly demonstrated in animals that certain chemicals which occur naturally in the brain play a crucial role in its function and that certain drugs influence their activity. This work with its promising implications for future treatment of mental disorders, particularly schizophrenia and depression, earned a Nobel Prize for a pharmacologist working for the NIMH Intramural research program. Basic research continues to discover physiological and neurological phenomena which lead to the production of new drugs which biochemically reduce or remove behavioral defects.

The addiction research center expanded its existing efforts to assess the dependence producing properties of narcotic analgesics to include non-narcotic drugs. The Institute also began a contract research program on drug abuse to investigate promising fields of research which at present are not represented by sufficient numbers of investigators to achieve an acceptable rate of progress through the normal grant procedure.

Objectives: The Institute plans to continue research on psychiatric disorders as well as on the basic biological and psychosocial processes which determine normal and abnormal behavior. The additional positions requested will provide much needed staff support for the child mental health, crime and delinquency and minority group mental health programs.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: Manpower Development - (a) Training Grants and Fellowships (Public Health Service Act, Section 301 and 303).

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
___	$120,050,000	Indefinite	---	$105,050,000

Purpose: Sections 301 and 303 of the Public Health Service Act authorize training grants and fellowships to meet the mental health needs of the nation. Grants are made to institutions for training in psychiatry, behavioral sciences, psychiatric nursing, and social work, and other mental health disciplines. Experimental and special programs and continuing education in the mental health field are supported, as well as special training in such areas as alcoholism, drug abuse, suicide prevention, and minority studies. Fellowships are made on the basis of excellence to individuals involved in mental health research.

Explanation: Grants are awarded to training centers and organizations for professional training in mental health to enable them to offer financial assistance to students and for partial support of teaching costs. Funds to support continuing education programs are awarded to public or private non-profit institutions, professional organizations, or State or community agencies. Grants are also made to eligible institutions and agencies for innovative, experimental training projects. Research Fellowships are awarded to qualified persons in mental health and related disciplines for research training.

Accomplishments: Within the funds available for new grants in 1972 the Institute gave priority consideration to training programs which stressed: (1) training professional and paraprofessional personnel in the area of child mental health; (2) developing models and training programs for crime and delinquency; (3) training of individuals who work with alcoholics and drinking drivers; (4) training for professionals and non-professionals directly involved in the treatment and rehabilitation of drug addicts and drug abusers; and (5) the recruitment and training of minority group mental health personnel.

Objectives: In 1973, continued emphasis will be given to initiating training programs in the areas of child mental health, crime and delinquency, alcoholism and narcotic addiction treatment and rehabilitation, and minority group mental health. The psychiatric residency program is being reduced by $7,000,000. An expanded institutional support grant program will be substituted. Undergraduate programs have been reduced by $8,000,000. It is intended that financial assistance be funded in the future through the student assistance programs administered by other Federal agencies.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: Manpower Development-(b) Direct Operations (Public Health Service Act, Section 301 and 303).

1972 Available		1973 Authorization	1973 Budget Estimate	
Pos.	Amount		Pos.	Amount
135	$7,741,000	Indefinite	135	$7,779,000

Purpose: Analytic studies of manpower are undertaken in this activity with emphasis given to the full range of manpower requirements in the field of mental health including the disciplines of psychiatry, behavioral sciences, psychiatric nursing, and social work. Also, a direct training program is supported for mental health professionals who are interested in a wide variety of career possibilities in the Public Health Service.

Explanation: The funds requested support the salary and related costs for employees who administer most of the Institute's grant and contract training programs.

Accomplishments: Resources were directed toward the coordination of grants and contract support functions to plan and administer the National Mental Health Manpower Program, collection and evaluation of data on mental health manpower, and conducting the intramural training program of the Institute. Support was also given to direct training programs for mental health professionals and sub-professionals who are presently or potentially engaged in the treatment and rehabilitation of narcotic addicts and drug abusers.

Objectives: In addition to continuing programs begun in 1972, emphasis will be continued on programs emphasizing community mental health concepts and practices, the care and treatment of children, and the provision of service to the minority community.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: State and Community Programs: (a) Community Mental Health Centers (1) Construction (Community Mental Health Centers Act, Section 201, as amended).

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$15,000,000	$100,000,000	---	---
---	(5,200,000)	(Obligations)	---	($9,800,000)

Purpose: For grants for construction of public and other non-profit community mental health centers. Construction grants assist communities in establishing appropriate facilities for the delivery of comprehensive community mental health services by supplementing state, local, and private financial resources.

Explanation: Funds appropriated for this program are allocated to the States on a formula basis taking into account such factors as population and per capita income. Grants are awarded on a matching basis with the percent of Federal support varying depending on whether or not the catchment area served has been designated by the Secretary as a "poverty area."

Accomplishments: It is expected that 24 new centers will be established with the $5.2 million available for obligation in 1972. This will bring the total number of centers receiving construction support to 385.

Objectives: The $9.8 million available for obligation in 1973 will provide support for approximately 24 additional centers. No new budget authority is requested for FY 1973. Community Mental Health Centers can be funded under the Hill-Burton program.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: State and Community Programs: (a) Community Mental Health Centers (2) Staffing (Community Mental Health Centers Act, Section 224, as amended).

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	44,200,000 new	60,000,000 new		9,131 new
---	90,900,000 continuations	--- continuations		125,969 continuations

Purpose: For grants to assist in the establishment and operation of community mental health centers in areas designated by State Mental Health Authorities as "Catchment Areas" (geographical areas containing between 75,000 and 200,000 people among whom there is to be a coordinated, comprehensive system for providing mental health care). Grants are awarded on a project basis to eligible centers for partial support of staffing costs of professional and technical personnel.

Explanation: This assistance enables the community to initiate new or improved mental health services and make them available while longer term sources of financial support are being developed. Grants are awarded on a matching basis with the percent of Federal support varying, depending on whether the catchment area served has been designated by the Secretary as a "poverty" area.

Accomplishments: An estimated 119 new awards will be made in 1972, raising the number of funded centers to 529. Of these, 389 will be operational by the end of the year. Primary emphasis in awarding new grants was given to applications approved but unfunded from prior fiscal years. High priority was also given to applicants for initial staffing support from centers which had received prior construction awards.

Objectives: The request for 1973 will provide continuation support of the 529 centers funded through 1972 and support 22 new awards. This will raise the number of funded centers to 562, of which 422 will be operational by the close of FY 1973.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: State and Community Programs: (b) Narcotic Addiction (Community Mental Health Centers Act, as amended: Sections 261 and 256)

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$76,390,000	$134,000,000	---	$91,298,000

Authorization includes the following section of the Community Mental Health Center Act:

Section	Description	Authorization
253:	Drug abuse education..............	$14,000,000 A/
256:	Special projects..................	35,000,000 A/
261:	Construction, staffing, training, evaluation, special projects.....	80,000,000 B/ C/
264:	Consultation services.............	5,000,000 B/ D/

A/ Includes continuation costs.
B/ Excludes continuation costs, which are authorized as "sums necessary."
C/ Authorization is shared with alcoholism.
D/ Authorization is shared with alcoholism and Centers staffing.

Purpose: This activity supports Institute efforts to develop and conduct comprehensive health, education, training and planning programs for the prevention and treatment of drug abuse.

Explanation: This activity provides funding for all the programs authorized under Part D of the Community Mental Health Centers Act, including:

Staffing grants which provide for a portion of the salary costs of professional and technical personnel to staff comprehensive community centers for the treatment of narcotic addiction and drug abuse.

Special Projects finance treatment and rehabilitation programs which demonstrate new or relatively effective or efficient methods of delivery of health services.

Service grants provide partial Federal support for programs of treatment and rehabilitation which include detoxification services, institutional services, or community based aftercare services.

Training grants support specialized training programs or materials for the prevention and treatment of narcotic addiction and drug abuse.

Education projects provide for the collection, preparation, and dissemination of educational materials dealing with the use and abuse of drugs and the prevention of drug abuse.

Planning and Initiation Grants are awarded to plan or develop narcotic addiction and drug abuse treatment services in a particular area.

Accomplishments: In the area of narcotic addiction and drug abuse, funds have been allocated in the following areas in 1972:

1. Treatment Programs: Funds were used for a broad variety of narcotic addiction and drug abuse treatment services to meet the general and particular needs of the communities across the Nation. Emphasis in this fiscal year was on targeting funds so as to extend the opportunities for treatment and rehabilitation to those drug abusers and narcotic addicts who have a strong motivation for recovery, but for whom community services were not available. By the close of 1972 approximately 162 treatment programs will be supported which, when fully operational, will provide treatment services to 33,600 individuals.

2. Training: Funds were utilized for specialized training programs for prevention and treatment of narcotic addicts and drug abusers. These programs train physicians, social workers, psychologists, other professionals, and subprofessionals to cope with expanded narcotic addiction and drug abuse prevention, treatment and rehabilitation programs throughout the Nation. In 1972, an estimated 45 training projects will be supported under this program.

3. Planning: Funds will be provided for planning grants to states, metropolitan areas, cities and small towns to stimulate coordinated, adequately focused programs at the state and local levels. An estimated 44 grants will be supported in 1972.

Objectives: Efforts in this area will continue to be directed towards developing treatment and rehabilitation services at the community level. A major portion of the increased funds will be used to support the continued development of comprehensive treatment centers.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: State and Community Programs: (c) Alcoholism Projects and Grants to States (Community Mental Health Centers Act, as amended, Section 261 and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970 - PL 91-616).

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$70,173,000	$215,000,000	---	$80,193,000

Authorization includes the following:

Community Mental Health Centers Act

Section	Description	Authorization
247	Prevention and treatment...........	$50,000,000 A/
261	Construction, staffing, training and evaluation, special projects..	80,000,000 C/
264	Consultation services.............	5,000,000 B/ C/ D/

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970

Section	Description	Authorization
301	Formula grants.....................	$80,000,000

A/ Includes continuation costs.
B/ Excludes continuation costs which are authorized as "sums necessary."
C/ Authorization shared with narcotic addiction.
D/ Authorization shared with narcotic addiction and centers staffing.

Purpose: Communities are assisted in establishing "centers" to help prevent and control alcoholism through awards for the support of construction and/or staffing of facilities, development of new services in poverty areas, and special projects. Public Law 91-616 authorizes formula grants to states for the planning, establishment, maintenance, coordination and evaluation of projects for the development of alcoholism prevention, treatment and rehabilitation programs.

Explanation: The project grant program included in this activity is authorized under Part C of the CMHC Act, as amended. These programs include:

Staffing grants which support a portion of the initial salary costs for professional and technical staff to enable communities to initiate facilities for the prevention and treatment of alcoholism while longer term sources of financial support are being developed.

Special projects provide support for training programs or materials for the prevention and treatment of alcoholism and treatment and rehabilitation programs which demonstrate new or relatively effective or efficient methods of delivery of health services.

Grants and contracts for the prevention and treatment of alcohol abuse and alcoholism. Includes support for demonstration, service, education and training programs in cooperation with schools, courts, penal institutions and other community-based public agencies.

Planning and Initiation grants are awarded to plan or develop alcoholism treatment and prevention services in a particular area.

Accomplishments: In 1972, an estimated 75 staffing projects were funded which, when fully operational, will provide services to 109,000 individuals. In addition the Institute funded a series of projects to provide treatment services for the Indian population as well as a number of special projects to develop innovative ways to deliver services to alcoholics.

Objectives 1973: The 1973 request will provide continued support of the treatment and rehabilitation programs established in 1972. A major portion of the increase in 1973 will provide continued support for alcoholism projects transferred from OEO. Funds provided for the formula grant program will permit the states to plan, establish and maintain projects for the development of alcoholism prevention, treatment and rehabilitation programs. These funds will be allotted to states on the basis of relative population and financial need.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: State and Community Programs: (d) Mental Health of Children (Community Mental Health Centers Act, Part F).

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$10,000,000	$35,000,000 (new)	---	$1,515,000
---	---	Indefinite (continuation)	---	8,485,000

Purpose: This activity supports grants which will improve the quality and quantity of services to children through staffing and training grants.

Explanation: Funds will provide staffing support to existing community mental health centers for establishment or expansion of mental health services to children.

Accomplishments: This program received its initial funding in FY 1972 and provides partial support of professional and technical staff in community mental health centers providing initial or expanded mental health services to children. The funds were used to stimulate innovative approaches toward expanding the range of services for children with an emphasis on prevention and early treatment. A total of 28 new awards were made in 1972.

Objectives: In 1973 the Institute will continue to utilize existing resources for staffing grants to initiate or expand children's services in community mental health centers. It is anticipated that the funds requested will provide continuation support for the 28 grants initially awarded in 1972 and provide support for 4 new awards.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: Rehabilitation of Drug Abusers (Public Health Service Act, as amended: Narcotic Addict Rehabilitation Act).

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
157	$13,323,000	Indefinite	164	$13,926,000

Purpose: This activity supports the administration of the Narcotic Addict Rehabilitation Program, authorized by the Narcotic Addict Rehabilitation Act of 1966, which provides for the rehabilitation of narcotic addicts through contract arrangements with community agencies and in the Clinical Research Center located at Lexington, Kentucky. Under this program individuals addicted to narcotic drugs may volunteer for civil commitment for treatment (Title III), or those addicted individuals charged with violating certain Federal criminal laws may apply for civil commitment in lieu of prosecution (Title I). The staff supported under this activity also administer the marihuana research contract program and the community narcotic addiction treatment and rehabilitation grant program, both of which are funded under a different activity.

Explanation: This program provides (1) contract funds for the community "aftercare" of addicts upon their release from inpatient treatment at the Clinical Research Center and (2) salary and related support for the staff who administer the Institute's over-all drug abuse program.

Accomplishments: The development and administration of the civil commitment program has continued to be a major activity in response to increasing numbers of commitments by the U. S. Courts. In 1972 the Institute transferred the Fort Worth Center to the Bureau of Prisons, Department of Justice, who will operate it as a medium security general medical facility for narcotic addicts. The services which had been provided at Ft. Worth are now provided by local health agencies in the addicts community under contracts with NIMH.

Objectives: In 1973 the community assistance program is being expanded to provide community based treatment to addicts formerly treated under the aftercare contract program. This action will reduce the Federal Government's involvement in direct care programs and is in keeping with our goal of supporting the development of State and local capabilities to deal with narcotic addiction and drug abuse.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Mental Health

Program Purpose and Accomplishments

Activity: Program Support Activities (Public Health Service Act, as amended).

1972 Available		1973	1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
501	$16,699,000	Indefinite	501	$16,977,000

Purpose: There are three Institute programs included under the Program Support Activity. These are: (1) Field Activities - which provide central office coordination of regional programs and maintain Institute relationships with other Federal agencies and State and community organizations. (2) Scientific Communication and Public Education Activity-which supports the National Clearinghouse for Mental Health Information, a public education program on the dangers of drug abuse and alcoholism and the National Clearinghouse for Drug Abuse Information. (3) Executive Direction and Program Management Services--which supports the program planning and evaluation, biometric and legislative services, and administrative management of the Institute.

Explanation: The funds requested support salary and related costs of employees who work in the activities described above.

Accomplishments: The Institute's drug abuse information and education program has been expanded with development of the National Clearinghouse for Drug Abuse Information to full operational status. An alcoholism public information program was expanded in 1972 to include an information and education campaign in the public media, including television and radio spot announcements, newspaper and magazine advertisements, posters and other materials. Also, the National Clearinghouse for Alcohol Information was established to provide support for programs of education, prevention, treatment, rehabilitation, research and training in the areas of alcohol abuse and alcoholism.

Objectives: As a result of increases in the size and number of decentralized programs, the Institute will increase coordination and collaboration between headquarters and regional offices. Collaboration with other Federal and state agencies and citizens groups will be increased.

The Information programs of the Institute will continue its efforts to disseminate information on mental health as well as its public information programs to educate the public on the dangers of drug abuse and alcoholism.

Allocation of Funds for Construction Grants of Community Mental Health Centers

	1971 Actual	1972 Allocations	1973 Allocations
Alabama	617,582	291,445	---
Alaska	89,040	100,000	---
Arizona	---	125,829	---
Arkansas	195,984	163,258	---
California	1,846,971	1,222,364	---
Colorado	105,816	151,104	---
Connecticut	424,655	179,172	---
Delaware	---	100,000	---
District of Columbia	100,000	100,000	---
Florida	535,021	480,427	---
Georgia	728,123	340,564	---
Hawaii	255,742	100,000	---
Idaho	124,286	100,000	---
Illinois	1,349,474	675,977	---
Indiana	---	352,254	---
Iowa	383,725	196,013	---
Kansas	322,488	152,031	---
Kentucky	542,608	254,479	---
Louisiana	608,795	288,161	---
Maine	217,933	100,000	---
Maryland	483,890	248,865	---
Massachusetts	690,826	355,061	---
Michigan	295,500	567,915	---
Minnesota	510,518	258,226	---
Mississippi	470,160	206,300	---
Missouri	652,870	322,783	---
Montana	175,343	100,000	---
Nebraska	335,523	101,508	---
Nevada	75,320	100,000	---
New Hampshire	100,365	100,000	---
New Jersey	1,141,141	432,711	---
New Mexico	68,520	100,000	---
New York	1,024,251	1,068,452	---
North Carolina	842,016	392,012	---
North Dakota	88,500	100,000	---
Ohio	1,430,990	699,835	---
Oklahoma	392,420	191,803	---
Oregon	---	142,684	---
Pennsylvania	1,598,712	789,652	---
Rhode Island	54,867	100,000	---

	1971 Actual	1972 Allocations	1973 Allocations
South Carolina................	472,334	211,914	---
South Dakota..................	---	100,000	---
Tennessee.....................	184,608	311,555	---
Texas.........................	1,751,086	806,493	---
Utah..........................	161,544	100,000	---
Vermont.......................	100,000	100,000	---
Virginia......................	717,744	329,800	---
Washington....................	106,568	219,394	---
West Virginia.................	314,971	141,281	---
Wisconsin.....................	86,087	305,001	---
Wyoming.......................	98,405	100,000	---
Guam..........................	---	7,480	---
Puerto Rico...................	548,446	249,342	---
Virgin Islands................	---	5,150	---
American Samoa................	---	2,344	---
Trust Territories.............	---	9,361	---
Total.....................	23,421,768	14,850,000	-0-

Allocation of Funds for Alcohol Formula Grants

	1971 Actual	1972 Allocations	1973 Allocations
Alabama	---	589,488	589,488
Alaska	---	200,000	200,000
Arizona	---	254,507	254,507
Arkansas	---	330,212	330,212
California	---	2,472,403	2,472,403
Colorado	---	305,630	305,630
Connecticut	---	362,402	362,402
Delaware	---	200,000	200,000
District of Columbia	---	200,000	200,000
Florida	---	971,731	971,731
Georgia	---	688,838	688,838
Hawaii	---	200,000	200,000
Idaho	---	200,000	200,000
Illinois	---	1,367,259	1,367,259
Indiana	---	712,484	712,484
Iowa	---	396,464	396,464
Kansas	---	307,503	307,503
Kentucky	---	514,720	514,720
Louisiana	---	582,846	582,846
Maine	---	200,000	200,000
Maryland	---	503,365	503,365
Massachusetts	---	718,161	718,161
Michigan	---	1,148,688	1,148,688
Minnesota	---	522,299	522,299
Mississippi	---	417,271	417,271
Missouri	---	652,873	652,873
Montana	---	200,000	200,000
Nebraska	---	205,314	205,314
Nevada	---	200,000	200,000
New Hampshire	---	200,000	200,000
New Jersey	---	875,219	875,219
New Mexico	---	200,000	200,000
New York	---	2,161,096	2,161,096
North Carolina	---	792,901	792,901
North Dakota	---	200,000	200,000
Ohio	---	1,415,515	1,415,515
Oklahoma	---	387,949	387,949
Oregon	---	288,598	288,598
Pennsylvania	---	1,597,184	1,597,184
Rhode Island	---	200,000	200,000

	1971 Actual	1972 Allocations	1973 Allocations
South Carolina..................	---	428,626	428,626
South Dakota....................	---	200,000	200,000
Tennessee.......................	---	630,165	630,165
Texas...........................	---	1,631,247	1,631,247
Utah............................	---	200,000	200,000
Vermont.........................	---	200,000	200,000
Virginia........................	---	667,066	667,066
Washington......................	---	443,755	443,755
West Virginia...................	---	285,760	285,760
Wisconsin.......................	---	616,909	616,909
Wyoming.........................	---	200,000	200,000
Guam............................	---	15,130	15,130
Puerto Rico.....................	---	504,331	504,331
Virgin Islands..................	---	10,418	10,418
American Samoa..................	---	4,740	4,740
Trust Territory.................	---	18,933	18,933
Total......................	-0-	30,000,000	30,000,000

New Positions Requested
Fiscal Year 1973

	Grade	Number	Annual Salary
Research			
Psychologist........................	GS-15	1	$24,251
Anthropologist......................	GS-14	1	20,815
Child Psychologist..................	GS-14	1	20,815
Sociologist.........................	GS-14	2	41,630
Psychologist........................	GS-14	1	20,815
Anthropologist......................	GS-13	1	17,761
Economist...........................	GS-13	1	17,761
Political Scientist.................	GS-13	1	17,761
Ecologist...........................	GS-12	1	15,040
Public Health Analyst...............	GS-11	1	12,615
Public Health Analyst...............	GS- 9	1	10,470
Secretary...........................	GS- 5	2	13,876
		14	233,610
State and Community Programs			
Public Health Advisor...............	GS-14	2	41,630
Public Health Advisor...............	GS-13	2	35,522
Public Health Advisor...............	GS-12	1	15,040
Secretary...........................	GS- 5	2	13,876
		7	106,068
Rehabilitation of Drug Abusers			
Public Health Advisor...............	GS-13	1	17,761
Public Health Advisor...............	GS-12	1	15,040
Program Analyst.....................	GS- 9	1	10,470
Secretary...........................	GS- 6	1	7,727
Clerk-typist........................	GS- 5	1	6,938
Clerk-typist........................	GS- 4	2	12,404
		7	70,340
Total new positions, all activities		28	410,018

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SAINT ELIZABETHS HOSPITAL

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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, [$23,144,000] *$28,271,000* 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 [$49,709,000] *$55,860,000* (Department of Health, Education, and Welfare Appropriation Act, 1972).

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SAINT ELIZABETHS HOSPITAL

Amounts Available for Obligation

	1972	1973
Appropriation	$24,936,000	$28,271,000
Comparative transfer to:		
"Departmental Management"	-13,000	---
Comparative transfer from:		
"Mental Health"	1,600,000	---
Subtotal, budget authority	26,523,000	28,271,000
Receipts and Reimbursements from:		
Federal funds	721,000	807,000
Trust funds	300,000	300,000
Non-Federal sources	23,826,000	26,482,000
Total obligations	51,370,000	55,860,000

Obligations by Activity

Page Ref.		1972 Estimate		1973 Estimate		Increase or Decrease	
		Pos.	Amount	Pos.	Amount	Pos.	Amount
86	Clinical & Community Services: Total obligations	4,132	$51,370,000	4,132	$55,860,000	---	+$4,490,000

Obligations by Object

	1972 Estimate	1973 Estimate	Increase or Decrease
Total number of permanent positions	4,132	4,132	---
Full-time equivalent of all other positions	195	220	+25
Average number of all employees	4,016	4,204	+188
Personnel compensation:			
Permanent positions	$36,451,000	$38,921,000	+$2,470,000
Positions other than permanent	1,388,000	1,657,000	+269,000
Other personnel compensation .	2,277,000	2,395,000	+118,000
Special personal service payments	41,000	41,000	---
Total personnel compensation	40,157,000	43,014,000	+2,857,000
Personnel benefits	3,472,000	3,709,000	+237,000
Travel and transportation of persons	151,000	165,000	+14,000
Transportation of things	107,000	107,000	---
Rent, communications and utilities	658,000	734,000	+76,000
Printing and reproduction	35,000	35,000	---
Other services	1,195,000	1,899,000	+704,000
Supplies and materials	4,751,000	5,114,000	+363,000
Equipment	764,000	937,000	+173,000
Lands and structures	110,000	176,000	+66,000
Insurance claims and indemnities	2,000	2,000	---
Subtotal	51,402,000	55,892,000	+4,490,000
Deduct charges for quarters ..	-32,000	-32,000	---
Total obligations by object ..	51,370,000	55,860,000	+4,490,000

Summary of Changes

1972 estimated obligations	$51,370,000
1973 estimated obligations	55,860,000
Net change	+4,490,000

	Base Pos.	Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Annualization of employment and related support to effect unitization	---	---	---	1,804,000
2. Average salary and wage grade adjustments plus additional holiday	---	---	---	1,236,000
3. Other (including FTC, DHEW Working Capital Fund)	---	---	---	400,000
B. Program:				
1. Equipment replacements	---	874,000	---	239,000
2. Restoration of Interns and Residents staffing	---	---	---	280,000
3. Scheduled support for Upward Mobility Program	---	---	---	523,000
4. Scheduled support for WOW Program	---	---	---	107,000
Total, increases	---	---	---	4,589,000
Decreases:				
A. Built-in:				
1. One less day of pay	---	---	---	-99,000
Total, net change	---	---	---	4,490,000

Explanation of Changes

Increases:

A. Built-in:

1. Full year funding of 300 additional positions (291 man years) authorized in 1972 for necessary programmatic changes including the initial implementation of the unit system of organization which has been widely adopted by other progressive, psychiatric hospitals. Funds are also needed to make necessary alterations to patient care facilities and to support required community related activities required for unitization and other service improvements.

2. Increases in the pay costs for within grade increases, quarters allowances for PHS officers, wage grade reclassifications and adjustments, and holiday pay for the Presidential Inauguration.

3. Additional funds are required for increased telephone costs, working capital fund assessments, increased electricity for air conditioning and supplies for patients.

B. Program:

1. Additional funds to cover the larger cost of equipment items requiring replacement in 1973.

2. Restoration of funding support for Intern and Resident positions to be transferred at the beginning of 1973 to NIMH's Division of Manpower and Training. These participants in the Hospital's clinical training program provide a valuable source of recruitment for scarce-category medical officers and other related professional staff.

3. Full year costs with increased enrollment in the Upward Mobility College, which was established for the purpose of providing educational opportunities and career development to primarily disadvantaged minority employees. Requested funds will also support required Hospital participation in other Upward Mobility Program efforts.

4. Funds to cover 10 additional trainees and increased costs for 26 trainees completing program requirements under the Washington Opportunity for Women program, a social service for sub-professional indigenous workers.

Decreases:

A. Built-in:

1. One less day of pay below 1972 base.

Explanation of Transfers

	1972 Estimate	Purpose
Comparative transfer to:		
Departmental Management	-$13,000	Central services provided to Saint Elizabeths Hospital for administration of Upward Mobility Program.
Comparative transfer from:		
Mental Health	1,600,000	Transfer would align fiscal responsibility with organizational changes resulting from the disestablishment of National Center for Mental Health Services, Training and Research. As a result of these changes, research and training programs integrally related to clinical operation of Hospital were transferred to Saint Elizabeths.

SAINT ELIZABETHS HOSPITAL

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1963	$5,974,000	$6,332,000	$6,332,000	$6,332,000
1964	10,178,000	7,816,000	7,816,000	7,852,000
1965	9,429,000	9,216,000	9,216,000	9,620,000
1966	10,084,000	10,217,000	10,217,000	10,290,000
1967	9,073,000	9,906,000	9,906,000	10,171,000
1968	9,044,000	9,028,000	9,028,000	10,749,000
1969	11,077,000	11,077,000	11,077,000	13,380,000
1970	10,405,000	10,405,000	10,405,000	16,883,000
1971	14,823,000	14,823,000	14,823,000	23,796,000
1972	23,144,000	23,144,000	23,144,000	24,936,000 1/
1973	28,271,000			

1/ Difference between estimated appropriation and House and Senate allowances is due to changes in estimated patient load.

Justification

SAINT ELIZABETHS HOSPITAL

	1972 Estimate		1973 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	4,132	$43,629,000	4,132	$46,723,000	--	+$3,094,000
Other Expenses	--	7,773,000	--	9,169,000	--	+1,396,000
Deduct charges for quarters	--	-32,000	--	-32,000	--	--
Total	4,132	$51,370,000	4,132	$55,860,000	--	+$4,490,000

General Statement

This appropriation supports the operation of the Saint Elizabeths Hospital - Division of Clinical and Community Services. Saint Elizabeths provides treatment and rehabilitation for approximately 3,300 inpatients and 2,650 outpatients and operates a community mental health center which serves District of Columbia residents in the southeast quadrant of the city, south of the Anacostia River, commonly referred to in this context as "Area D". The 1973 budget request of $55,860,000 includes $1,600,000 to support Saint Elizabeths' clinical research and training programs which, in previous years, were budgeted under the "Mental Health" Appropriation.

Saint Elizabeths Hospital - Division of Clinical and Community Services

The Hospital provides treatment, care, and rehabilitation services for a variety of patient categories including District of Columbia residents, persons charged with or convicted of crimes in the United States or District of Columbia courts, U.S. Nationals who become mentally ill while abroad, residents of the Virgin Islands and U.S. Soldiers' Home, and other categories of Federal beneficiaries. Facilities of the Division include a forensic psychiatry and security unit for the examination, treatment and rehabilitation of patients referred by the courts under various types of criminal proceedings, and a comprehensive community mental health center.

The Hospital conducts a clinical research program for the purpose of obtaining a better understanding of the causes of mental disorders, and the factors bearing upon their development, treatment and possible

prevention. Saint Elizabeths also provides multidisciplinary clinical training for professional and ancillary personnel engaged in or interested in mental health activities. It also provides administrative and logistical support to NIMH activities located at the Hospital.

Major Accomplishments

Since its organizational placement within NIMH, the Hospital has given its highest priority of effort to the reduction of its inpatient resident population. This has been accomplished by careful screening of the patient population to ascertain sound alternatives to hospitalization. Patients no longer in need of hospital psychiatric care and who are not dangerous to themselves or others are being returned to normal community living. Since this intensive program has been in operation, the inpatient population has been reduced by almost 2,000. This accomplishment has materially assisted with upgrading of patient care by elimination of much of the dehumanizing aspects of residing in obsolete and substandard Hospital areas. Success in reducing the necessity for inpatient hospitalization is evidenced by the average daily outpatient load increasing by approximately 500 to an average of 2,650 in 1972, primarily due to the Community Mental Health Center. Over 10,000 patients were treated at Saint Elizabeths last year, with admissions rising from 3,650 in 1970 to 4,012 in 1971.

In its continuing effort to provide better services to its patients, the Hospital made the following programmatic improvements:

(a) Unitization. With the additional staffing authorized in 1972, the Hospital began the initial implementation of unitization of services to patients. Actions were taken to begin reorganizing 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. Selected patient services were reorganized internally into units and teams, and some organizational components within the Hospital are being consolidated to reflect proper alignment with the health area served. Decentralization was initiated in medical service functions such as nursing, psychology and social service with related personnel now being directly assigned to clinical directors.

(b) Special Programs. The narcotic addiction program, a drug-free therapeutic community known as Last Renaissance, was expanded to serve approximately thirty patients. There have been 105 admissions into this program in nineteen months, with a current waiting list of seventeen addicts. Sixteen patients have graduated, with seven graduates now employed in drug rehabilitation centers throughout the country. The program also provides a variety of consultative and educational services to neighborhood drug programs, schools and medical societies. A mental health program for the deaf was established, including inpat-

ient, outpatient, partial hospitalization and full emergency services. This pioneering effort integrates services, training, research and combined communication methods to provide comprehensive mental health services to deaf people. It also provides consultation, education and rehabilitative services, and serves as a resource in training and research. There is an average of 47 patients receiving treatment under this program, of whom an average of 24 are outpatients. A special alcohol program was also established for women.

(c) Services to Children. Another ward, with a capacity of 30 patients, was opened to serve a selected group of children.

(d) Medical and Surgical Support. Intensive care units are being developed to strengthen these services which are seriously overburdened.

(e) New Admission Service. A new admission service for nonresident and no-fixed-address patients of all ages was established in the Geriatrics Division. This is in keeping with the modern practice of admitting patients to age-integrated wards.

(f) Forensic services. This program, under which the number of cases to determine competency to stand trial has rapidly increased, was reorganized to separate pretrial from treatment patients, and maximum security from minimum security patients.

(g) In-service training. The Hospital reassessed its in-service training and staff development efforts in order to increase staff productivity. The Upward Mobility College, which currently has 150 students, was established in collaboration with Federal City College for the purpose of providing educational opportunities and career development to primarily disadvantaged minority employees. A collaborative effort was also undertaken with Washington Opportunities for Women for training indigenous social work aides.

Patient Profile

Continued efforts to improve treatment, especially for new patients, and to speed the return of patients to the community have sustained the sharp reduction in the average length of hospitalization experienced in recent years. The median time spent on the Hospital rolls by patients who were discharged during 1971 was slightly more than three months, in contrast to a comparable stay period of nearly eleven months only six years ago. The median time since admission for those patients on the end of year rolls has dropped during the last six years from nearly 9.5 years to 5.3 years at the end of 1971. A concentrated effort has also been made to place patients in the community after hospitalization is no longer necessary.

The unprecedented reduction in the resident patient census during recent years reflects the accelerated return to the community of those

patients who could most readily make the transition back to the community environment. The residual patients having an outplacement potential include those presenting medically related (not psychiatric) problems and those whose long period of institutionalization make such action more difficult. The lack of suitable, alternative living arrangements and adequate financial support for the indigent patient will also have an inhibiting influence on further outplacements. Because efforts must now be directed toward the movement of the more chronic patients, of whom fifty-eight percent are over 54 years of age, it is anticipated that the markedly slower outplacement rate currently being experienced will continue and result in an average daily load of 3,150 during 1973.

Area D Community Mental Health Center

A major step in the conversion of Saint Elizabeths Hospital into a modern community-based mental health facility was the establishment of the Area D Community Mental Health Center (CMHC) in 1969. The CMHC serves approximately 175,000 residents of that southeast portion of the District of Columbia designated as Area D, and which has the massive social problems associated with urban localities. The Center offers all the elements of a model community center including continuity of care, a complete range of children's services, consultation activities and community involvement. Specialized programs are offered in alcoholism, drug addiction, and suicidology, including the clinical and community media for a psychiatric residency program. In addition, five satellites have been developed in Area D to service immediate neighborhoods. Through close involvement with the residents of the community, mental illness can be detected earlier, thus reducing the probability of inpatient hospitalization. The policy has also been established to treat the patient in his community environment until such time that the degree of illness passes the threshold whereby inpatient hospitalization becomes essential. The Area D CMHC now has on its rolls an average of 1,400 patients, of which 1,160 are outpatients. From its inception, 5,267 patients have been admitted for treatment in the Center.

Community Relations

Saint Elizabeths continues to expand its participation in community activities, such as the vocational rehabilitation program which is operated jointly with the D.C. Department of Vocational Rehabilitation. During the past year, the Hospital accepted 600 referrals with 191 patients being successfully rehabilitated (i.e. the patients were working and no longer needed the group's services). The District also cooperates with the Hospital in the operation of a transitional workshop for patients.

The Hospital also supplies the clinical base for the provision of accredited course work for students from local schools and universities in the fields of medicine, social work, psychology, hospital administrat-

ion, vocational rehabilitation, chaplaincy and nursing. Saint Elizabeths also provides formal orientation in mental health concepts to such community groups as police officers, probation officers, Secret Service and FBI agents, and the clergy. In addition, the Hospital has oriented over 25,000 college and high school student visitors to its operations during the past eight years.

Members of the professional staff, both officially and individually, provide consultative and educational services on request to D.C. community agencies and personnel. The Hospital also cooperates with local mental health associations in finding jobs for former patients.

Patient Population

The average daily outpatient load will increase to approximately 2,650 in 1972, and to 2,750 in 1973, primarily due to the operation of the Area D Community Mental Health Center, and will offset the gradual decrease in the average daily inpatient load. Consequently, the average daily load for all patients is expected to remain relatively stable, going from 5,950 in 1972 to 5,900 in 1973. With a planned average daily inpatient load of 3,300 in 1972, it is estimated that an average of 3,150 will be experienced in 1973. The number of patients treated will approximate the 1971 level of 10,100. Since the Hospital's growing outpatient population is requiring the diversion of increasing amounts of scarce time for services to outpatients, the total number of patients is considered in determining staffing levels. Based on the projected level of employment and the average daily load of all patients, the staffing ratio would be sixty-eight employees per one-hundred patients in 1973.

Clinical Research and Training

The 1973 request includes $1,600,000 to support clinical research and training programs which, in previous years, were budgeted under the "Mental Health" Appropriation. This change in funding is proposed for the purpose of aligning fiscal responsibility with the organizational changes effected in May, 1971, wherein the National Center for Mental Health Services, Training, and Research was disestablished. In the deactivation of the National Center, those research and training programs which were integrally related to the clinical operation of the Hospital were transferred to Saint Elizabeths.

The goal of the Hospital's research activities, which are intimately linked with related programs of clinical care and training, is to better understand the causes of mental disorders and the factors bearing upon their development, treatment, and prevention. Research studies in 1973 will be conducted primarily in the areas of operant behavior, criminal behavior, clinical psychology and psychiatric sociology. The principal objective of the training program is to increase the number and improve the skills of persons serving medical, nursing

and allied medical and mental health disciplines concerned with the treatment and rehabilitation of the mentally ill. In 1973, the Hospital will provide: training to 120 medical students; graduate and postgraduate programs in mental health such as those for internships and psychiatric residency training; training for mental health professionals, counselors and technicians; and special workshops for Community Mental Health and other community groups. The training program serves as a valuable source of recruitment for scarce-category medical officers and other related professional staff.

Unitization

During 1973 the highest priority of the Hospital will be to proceed towards the full implementation of the unitization of services to patients. Unitization is considered the most essential step in the conversion of Saint Elizabeths Hospital into a modern community-oriented facility.

Under the planned Unitization of the Hospital, the clinical services will be decentralized into smaller treatment units within which a basic unit team will provide patient-centered treatment and continuity care to an individual patient. Each unit will provide comprehensive care and treatment services to all patients within its catchment area including diagnosis, inpatient treatment, rehabilitation, evaulation, outpatient and outplacement services. Training will be provided to aid many employees whose work activity will be shifting from primarily a custodial orientation to that of a community-oriented active treatment effort.

The Unit system will stimulate extensive interchangeability and jointness of fuctions among staff members in a constructive team approach. This should produce better staff and patient morale and will improve communication between staff, the patient, the patient's family, and the community. The morale of the ward staff should also improve because, after becoming more therapeutically oriented, their feeling of contribution to the effectiveness of the total program should be enhanced. More community involvement can be expected with the added participation by the staff in consultation activities with local health, welfare and other institutions.

The Hospital will also continue to make such needed improvements in medical and surgical support services, services to geriatric patients, forensic services and improved services to children. Continuing efforts will be made to reduce the necessity for inpatient hospitalization, and to speed the return of patients to normal community life.

The requested increase of $4,490,000 includes $1,804,000 to cover additional costs to continue with the implementation of the unit system of services to patients, including full year costs of additional employment authorized during 1972. An additional $1,776,000 is required to cover built-in salary and wage adjustments, increased operational

support costs such as Working Capital Fund assessments, plus necessary equipment replacements. Full year cost with increased enrollment in the Upward Mobility College, together with scheduled support for the Washington Opportunities for Women Program, will require an additional $630,000. The remaining amount of $280,000 is requested for the restoration of Intern and Resident trainee positions.

Reimbursement Detail

	1972 Estimate	1973 Estimate	Increase or Decrease
Reimbursements for services performed (patient care):			
Veterans Administration	$15,000	$17,100	+$2,100
U.S. Soldiers Home	90,200	85,900	-4,300
Public Health Service (Indians)	30,100	34,300	+4,200
U.S. Nationals	450,200	515,300	+65,100
U.S. Prisoners	135,500	154,400	+18,900
Soc. Sec. (Medicare payments)	300,000	300,000	---
Subtotal	1,021,000	1,107,000	+86,000
Payment received from Non-Federal sources:			
Patient care:			
District of Columbia	23,667,000	26,372,000	+2,705,000
Cafeteria sales	82,000	68,000	-14,000
Sale of scrap	3,000	2,000	-1,000
Washington Opportunity for Women	74,000	40,000	-34,000
Subtotal	23,826,000	26,482,000	+2,656,000
Total reimbursements	24,847,000	27,589,000	+2,742,000

Per diem rate:	1972	1973	Change
District of Columbia	$22.84	$26.38	+$3.54
Other	41.09	47.10	+6.01

Statement of Average Daily Patient Population

	1971 Actual	1972 Estimate	1973 Estimate
Reimbursable			
Public Health Service (Indians)	2	2	2
D.C. (Residents)	2,376	2,173	2,078
D.C. (Vol. and Non-Protesting).	361	366	370
D.C. (Prisoners)	303	290	285
D.C. (Jury Trial)	41	38	37
U.S. Soldiers Home	6	6	5
Veterans Administration	2	1	1
U.S. Nationals	32	30	30
U.S. Prisoners	10	9	9
Reimbursable Totals	3,133	2,915	2,817
Nonreimbursable			
Military	92	85	70
D.C. Non-residents	205	190	165
Public Health Service	6	5	5
Virgin Islands	85	80	72
Miscellaneous	26	25	21
Nonreimbursable Totals ..	414	385	333
Total In Hospital Patients	3,547	3,300	3,150

SAINT ELIZABETHS HOSPITAL
Clinical and Community Services
Program Purpose and Accomplishments

Activity: Clinical and Community Services

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
4,132	$26,523,000	Indefinite	4,132	$28,271,000

Purpose: Saint Elizabeths Hospital provides treatment, care, and rehabilitation services for approximately 3,300 inpatients and 2,650 outpatients. 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. Prior to 1973, the clinical research and training programs were funded from the Mental Health appropriation.

Accomplishments in 1972: The Hospital began the initial implementation of unitization of services to patients, with initial actions being taken to reorganize the Hospital into a number of semi-autonomous patient services. Medical and Surgical intensive care units are being set up. Special programs in narcotic addiction, alcohol and services to children were expanded. Over 10,000 patients were treated and, due to the emphasis placed on the early return of patients to productive community life, the average daily patient load was reduced by 247. The Upward Mobility College, with 150 students, was established to provide career development opportunities to primarily disadvantaged minority employees.

Objectives for 1973: To continue further implementation of the unit plan, including closer working relations with community agencies, active treatment with early return to the community and effective follow-up, and provision of treatment efforts to avert the need for inpatient care. To be able to offer comprehensive care and treatment services within a catchment area, including the acute and chronic patients, the non-psychiatric special care patients, and special groups such as children, drug abusers, alcoholics and geriatric patients. Other needed improvements are the strengthening of medical and surgical support services, improved services to geriatric patients, strengthening of forensic services and improved services to children. It is hoped that the unitization of patient services will enable the Hospital to further reduce the inpatient population.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health Services Planning and Development

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health Services Planning and Development

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Appropriation Estimate

HEALTH SERVICES PLANNING AND DEVELOPMENT

To carry out titles VI and IX, sections 314(a) through 314(c), and except as otherwise provided, sections 301, 304, 311, 402(g), 403(a)(1), and 433(a) of the Public Health Service Act; $329,596,000, of which $85,000,000 shall be available until June 30, 1975 for grants pursuant to section 601 of the Public Health Service Act for the construction or modernization of medical facilities, and $2,500,000 shall remain available without fiscal year limitation for payment of interest on guaranteed loans as authorized by section 626 of the Act.[1]

[HEALTH SERVICES RESEARCH AND DEVELOPMENT] [2]

[To carry out, except as otherwise provided, sections 301 and 304 of the Public Health Service Act, with respect to health services research and development, $62,070,000.]

[REGIONAL MEDICAL PROGRAMS] [2]

[To carry out title IX, sections 402(g), 403(a)(1), 433(a), and, to the extent not otherwise provided, 301 and 311 of the Public Health Service Act, $102,771,000.]

[MEDICAL FACILITIES CONSTRUCTION] [2]

[To carry out title VI of the Public Health Service Act, and, except as otherwise provided, section 304 of the Act for administrative and technical services under parts B and C of the Developmental Disabilities Services and Facilities Construction Act (42 U.S.C. 2661-2677), the District of Columbia Medical Facilities Construction Act of 1968 (Public Law 90-457), and the Community Mental Health Centers Act (42 U.S.C. 2681-2687), $306,704,000; of which $197,200,000 shall be available until June 30, 1974

for grants pursuant to section 601 of the Public Health Service Act for the construction or modernization of medical facilities, of which $41,400,000 shall be available only for grants for the construction of public of other nonprofit hospitals and public health centers; $8,300,000 for grants and $6,700,000 for loans shall remain available until expended for hospital experimentation projects pursuant to section 304 and section 643A of the Public Health Service Act; $50,300,000 shall be for deposit in the fund established under section 626, and shall be available without fiscal year limitation for the purposes of that section of the Act of which $30,000,000 shall be available for direct loans pursuant to section 627 of the Act; $24,052,000 shall be for grants and $16,575,000 shall be for loans for nonprofit private facilities pursuant to the District of Columbia Medical Facilities Construction Act of 1968 (Public Law 90-457); *Provided*, That there are authorized to be deposited in the fund established under section 626(a)(1) of the Act amounts received by the Secretary and derived by him from his operations under part B of title VI of the Act which shall be available for the purposes of section 626(a)(1): *Provided further*, That sums received by the Secretary from the sale of loans made pursuant to section 627 of the Act shall be available to him for the purposes of that section.]

[For an additional amount for "Medical facilities construction", $1,500,000, to remain available until expended: *Provided*, That these funds shall be available only for loans for nonprofit private facilities pursuant to the District of Columbia Medical Facilities Construction Act of 1968 (Public Law 90-457): *Provided further*, That the funds appropriated to carry out that Act in the Departments of Labor, and Health, Education, and Welfare, and Related Agencies Appropriation Act, 1972 (Public Law 92-80) shall remain available until expended.]

Appropriation Estimate

MEDICAL FACILITIES GUARANTEE AND LOAN FUND

There are hereby authorized to be deposited in the "Medical facilities guarantee and loan fund" amounts received by the Secretary from operations under part B of title VI of the Public Health Service Act and such amounts shall be available to the Secretary without fiscal year limitation for carrying out his functions under section 626 (a) (1) of the Act: Provided, That sums received from the sale of loans made pursuant to section 627 of the Act shall be available to carry out the purposes of that section. [1]

Explanation of Language Changes

HEALTH SERVICES PLANNING AND DEVELOPMENT

1. A new account is proposed as a result of the consolidation of three HSMHA appropriations, "Health Services Research and Development", "Regional Medical Programs", and "Medical Facilities Construction". This consolidation creates a new appropriation which not only reflects a functional grouping of the accounts, but also provides for better administration by making the appropriation structure consistent with the current HSMHA organization structure.

2. Language formerly used for the three consolidated accounts is deleted.

MEDICAL FACILITIES GUARANTEE AND LOAN FUND

1. The proposed language provides authorization for the Secretary to use monies received from the sale of direct Hill-Burton loans to make additional loans.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health Services Planning and Development

Amounts Available for Obligation

	1972	1973
Appropriation....................	$473,045,000	$329,596,000
Real transfers to:		
"Operating expenses," Public Buildings Service, GSA........	-3,000	---
"Medical facilities guarantee and loan fund"...............	-30,000,000	---
Real transfer from:		
"Nursing home improvement".......	1,000,000	---
Comparative transfers to:		
"Departmental management"........	-27,000	---
"Preventive health services".....	-2,189,000	---
"Office of the Administrator.....	-55,000	---
Comparative transfers from:		
"Health services delivery".......	25,935,000	---
"Office of the Administrator"....	27,000	---
Subtotal, budget authority.........	467,733,000	329,596,000
Unobligated balance, start of year.	44,500,000	---
Unobligated balance, lapsing.......	-109,000	---
Total, obligations........	512,124,000	329,596,000

Obligations by Activity[1/]

Page Ref.		1972 Estimate Pos.	1972 Estimate Amount	1973 Estimate Pos.	1973 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
122	Health services research and development:						
123	(a) Grants and contracts...	---	$56,118,000	---	$58,018,000	---	+$1,900,000
135	(b) Direct operations..	218	5,898,000	230	6,325,000	+12	+427,000
	Subtotal...	218	62,016,000	230	64,343,000	+12	+2,327,000
136	Comprehensive health planning:						
136	(a) Planning grants......	---	25,000,000	---	39,800,000	---	+14,800,000
140	(b) Direct operations	24	935,000	49	1,833,000	+25	+898,000
	Subtotal...	24	25,935,000	49	41,633,000	+25	+15,698,000
141	Regional medical programs:						
142	(a) Grants and contracts...	---	139,300,000	---	125,100,000	---	-14,200,000
147	(b) Direct operations..	169	4,602,000	194	5,051,000	+25	+449,000
	Subtotal...	169	143,902,000	194	130,151,000	+25	-13,751,000
148	Medical facilities construction:						
149	(a) Construction grants......	---	197,200,000	---	85,000,000	---	-112,200,000
149	(b) Interest subsidies...	---	20,300,000	---	2,500,000	---	-17,800,000
149	(c) District of Columbia medical facilities..	---	42,127,000	---	---	---	-42,127,000
150	(d) Hospital experimentation project.....	---	15,000,000	---	---	---	-15,000,000
150	(e) Direct operations	135	3,058,000	135	3,259,000	---	+201,000
	Subtotal...	135	277,685,000	135	90,759,000	---	-186,926,000
151	Program direction and management services........	149	2,586,000	149	2,710,000	---	+124,000
	Total obligations.	695	512,124,000	757	329,596,000	+62	-182,528,000

1/ Amounts included for Medical facilities construction activity are budget authority.

Obligations by Object[1/]

	1972 Estimate	1973 Estimate	Increase or Decrease
Total number of permanent positions..................	695	757	+62
Full-time equivalent of all other positions...........	90	96	+6
Average number of all employees..................	710	797	+58
Personnel compensation:			
Permanent positions........	$10,045,000	$10,915,000	+$870,000
Positions other than permanent................	654,000	728,000	+74,000
Other personnel compensation..................	72,000	72,000	---
Subtotal, personnel compensation........	10,771,000	11,715,000	+944,000
Personnel benefits..........	1,069,000	1,209,000	+140,000
Travel and transportation of persons..................	1,126,000	1,271,000	+145,000
Transportation of things.....	99,000	114,000	+15,000
Rent, communications and utilities..................	688,000	810,000	+122,000
Printing and reproduction....	293,000	333,000	+40,000
Other services..............	2,544,000	2,961,000	+417,000
Project contracts..........	27,888,000	28,133,000	+245,000
Supplies and materials.......	127,000	145,000	+18,000
Equipment..................	130,000	143,000	+13,000
Investments and loans........	24,775,000	---	-24,775,000
Grants, subsidies and contributions.............	442,614,000	282,762,000	-159,852,000
Total obligations by object	512,124,000	329,596,000	-182,528,000

1/ Amounts included for Medical facilities construction activity are budget authority.

Summary of Changes 1/

1972 estimated obligations................................ $512,124,000

1973 estimated obligations................................ 329,596,000

Net change................................ -182,528,000

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. Annualization of positions new in 1972..............	---	---	---	+330,000
2. Within grade and longevity increases................	---	---	---	+325,000
3. Annualization of uniformed services pay increase (PL 92-129)..............	---	---	---	+19,000
4. Increases for DHEW Working Capital Fund, HSMHA Service and Supply Fund, and FTS charges..................	---	---	---	+168,000
5. Increase in continuation costs for area-wide planning grants..............	---	---	---	+2,900,000
B. Program:				
1. Health services research and development:				
a. Grants and contracts....	---	56,118,000	---	+1,900,000
b. Direct operations.......	218	5,898,000	+12	+251,000
2. Comprehensive health planning:				
a. Formula grants to States for health planning...	---	7,675,000	---	+2,325,000
b. Project grants for area-wide planning.........	---	13,200,000	---	+9,000,000
c. Project grants for training, studies, and demonstrations.............	---	4,125,000	---	+575,000
d. Direct operations.......	24	935,000	+25	+890,000
3. Regional medical programs:				
a. Emergency medical services...............	---	---	+25	+350,000
4. Program direction and management services.......	149	2,658,000	---	+68,000
Total, increases........			+62	+19,101,000

1/ Amounts included for Medical facilities construction activity are budget authority.

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Decreases:				
A. Built-in:				
1. Two less days of pay	---	---	---	-$74,000
2. Decrease resulting from employment cut-back during 1972	---	---	---	-204,000
3. Non-recurring equipment and change of station costs	---	---	---	-24,000
B. Program:				
1. Regional medical programs:				
a. ~~Grants and contracts~~	---	139,300,000	---	-14,200,000
2. Medical facilities construction:				
a. Construction grants	---	197,200,000	---	-112,200,000
b. D.C. medical facilities construction	---	42,127,000	---	-42,127,000
c. Hospital experimentation project	---	15,000,000	---	-15,000,000
d. Interest subsidies of guaranteed loans	---	20,300,000	---	-17,800,000
Total, decreases			---	-201,629,000
Total, net change			+62	-182,528,000

Explanation of Changes

Increases:

A. Built-in:

An increase of $3,742,000 is for mandatory items. Of this $330,000 is for full-year costs of positions new in 1972, $325,000 is for net additional costs of within grade and longevity increases, $168,000 is for DHEW Working Capital Fund, HSMHA Service and Supply Fund, and FTS charges, and $2,900,000 is for an increase in continuation costs for area-wide planning grants.

B. Program:

Grants and contracts--The increase of $1,900,000 will support an expanded R&D effort in the development of a cooperative Federal-State-local health services data system. This system is the tool by which the Federal Government can measure progress in reaching its health goals.

Direct operations--An increase of 12 positions and $251,000 is requested in 1973. The increased program effort in the development of health services data systems requires personnel with capability to develop health status surveys, monitor data systems for ambulatory care, and to collect and analyze the national data resulting from this program.

Explanation of Changes--continued

Formula grants to States for comprehensive health planning--The increase of $2,325,000 would allow State agencies to increase professional staffs by 25% and in addition provide for an increase in special studies and consultation to support effective planning at the areawide level; a crucial undertaking in FY 1973 due to the substantial increase in the number of new areawide agencies.

Project grants for areawide comprehensive health planning--The increase of $9,000,000 includes $5,100,000 to establish approximately 100 new areawide agencies and 20 new State assisted local councils and $3,900,000 to increase the average Federal share to avoid financial dependence upon organizations whose activities must be reviewed and commented upon by 314(b) agencies.

Project grants for training, studies and demonstrations--An increase of $575,000 is requested for 1973. This amount would enable the graduate programs to increase the level of technical assistance to be provided to the operating agencies and would be directed in part to further emphasis on the development of planning for innovative systems for the delivery of health care.

Direct operations--An increase of 25 positions and $890,000 is requested for 1973. Twenty (20) of the additional positions and equivalent funds will be placed in the Regional Offices to enable the staff to be more responsive to both the State and Areawide agencies in providing technical assistance and consultation.

Emergency medical services--25 positions and $350,000 are included for the new Emergency Medical Services Program. These resources will be used to provide planning and evaluation, professional and technical assistance, standard setting, project review, project grants and contracts management and data system development.

Program direction and management services--Includes $68,000 to support the Upward Mobility Program.

Decreases:

A. Built-in:

The decrease of $74,000 represents non-recurring salary costs resulting from a reduction of two days of pay in 1973.

The decrease of $204,000 results from position reductions in line with the Administration's economic policy.

The decrease of $24,000 is due to non-recurring equipment items and change-of-station costs associated with positions new in 1972.

B. Program:

Regional medical program grants and contracts--The decrease of $14,200,000 in 1973 reflects adjustments for two non-recurring items in 1972 of $21,000,000 and an increase of $7,000,000 for a new program of grants and contracts for emergency medical services. These funds will be used to support 5 projects in addition to the 5 funded in 1972.

Explanation of Changes--continued

Medical facilities construction:

Construction grants--A decrease of $112,200,000 in construction and modernization of hospitals and long-term care facilities is a result of the continued redirection of Hill-Burton activities from a grant program to a program of loan guarantees with interest subsidies for inpatient health facilities. Ambulatory care facilities do not have the same revenue producing potential as do general and long-term hospital beds and therefore the capital costs of construction for these facilities will continue to be supported through Federal grants.

District of Columbia medical facilities--A decrease of $42,127,000 occurs in the construction or modernization of medical facilities in the District of Columbia because the full amount authorized by the Statute has been appropriated. The statute expires on June 30, 1972.

Hospital experimentation projects--A decrease of $15,000,000 occurs in the construction of hospital experimentation projects because appropriated funds are sufficient for currently authorized projects.

Interest subsidies--A decrease of $17,800,000 is due to the availability of $20,300,000 brought forward from prior appropriations.

Significant Items in House and Senate Appropriations Committee Reports

Item	Action taken or to be taken
1972 House Report	
Research and demonstration grants	
Committee directed that the Pediatric Pulmonary Program be continued in 1972 at not less than the 1971 level. (page 16 of the report).	Eight Pediatric Pulmonary projects were funded at a $1,000,000 level in 1971. It is anticipated that the 1972 and 1973 levels will be approximately the same.
1972 Senate Report	
Research and demonstration grants	
1. Committee expressed keen interest in a long-range plan to develop interrelated kidney programs aimed at providing therapy for the 8,000 to 10,000 Americans who fell victim to kidney disease annually. (page 25 of the report).	1. Recent studies have begun to develop long-range plans for combating end-stage kidney disease. There will be much greater emphasis on placing each project in the context of both regional and national needs. In keeping with expanded plans, funds invested in these activities will increase from $4,800,000 in 1971 to an estimated $8,500,000 in 1972.
2. Committee directed that a portion of RMP increases be used to prove out HMO programs. (page 25 of the report).	2. Up to $16,200,000 will be used to fund the planning and development of HMO's in 1972.
3. Committee concurred with the House and further directed that all pediatric pulmonary projects ongoing in 1971 were to be funded in 1972. (page 26 of the report).	3. All projects ongoing in 1971 which have been included in their applications by the RMP's affected have been approved for 1972. At the same time, final funding decisions have been left to the individual regions within their own systems of priorities.

Significant Items in House and Senate
Appropriations Committee Reports - (Cont'd)

Item	Action taken or to be taken
1972 Senate Report (Cont'd)	
4. Committee directed HSMHA and the National Advisory Council to address themselves to questions surrounding the flexibility and individuality allowed RMP's which could impair their effectiveness. (page 25 of the report).	4. Over the past year specific criteria and policy have been developed and issued to the RMP's. There has been a marked increase in efforts of staff to meet with Regional Advisory Groups. In January, 1972, a National Coordinators Conference was held. It brought together all coordinators, RAG members from every region and Council members to discuss with staff issues, policy, etc.
5. Committee directed that increased funds be targeted to a review of the availability of and access to special surgical teams in open-heart and coronary artery surgery, especially in the District of Columbia. (page 25 of the report).	5. A new survey of cardiovascular surgery facilities in the District of Columbia is currently in progress under the auspices of the Metropolitan Washington RMP. A report will be available before 6/30/72. In addition, Regional Medical Programs Service, in order to carry out Sec. 907 of the Public Health Service Act, contracted with the Joint Commission on Accreditation of Hospitals to develop the Secretary's Lists. One of the criteria which will be used in identifying eligible institutions for those lists will be their participation in a regional plan for the optimal development and utilization of specialized facilities and services.
1972 Conference Report	
Research and demonstration grants	
Committee agreed that no existing regional medical program is to receive a lesser amount in FY 1972 than it received in 1971. (page 6 of the report).	All RMP's will, where consistent with National Advisory Council approved funding levels, be funded at or above the FY 1971 level.

Authorizing Legislation

Legislation	1973 Authorization	1973 Appropriation requested
Public Health Service Act		
Section 301	Indefinite	$22,726,000
Section 304	$94,000,000	41,617,000

Public Health Service Act

Research, Research Training, and Fellowships

Section 301 of the Act provides legislative authority for the award of grants for research, research training, and fellowships.

Research and Demonstrations Relating to Health Facilities and Services

Section 304. (a) (1) The Secretary is authorized--

(A) to make grants to States, political subdivisions, universities, hospitals, and other public or nonprofit private agencies, institutions, or organizations for projects for the conduct of research, experiments, or demonstrations (and related training), and

(B) to make contracts with public or private agencies, institutions, or organizations for the conduct of research, experiments, or demonstrations (and related training),

relating to the development, utilization, quality, organization, and financing of services, facilities and resources of hospitals, facilities for long-term care, or other medical facilities (including, for purposes of this section, facilities for the mentally retarded, as defined in the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963), agencies, institutions, or organizations or to development of new methods or improvement of existing methods of organization, delivery, or financing of health services, including among others --

(iv) projects for research, experiments, and demonstrations dealing with the effective combination or coordination of public, private, or combined public-private methods or systems for the delivery of health services at regional, State, or local levels.

"(c) (1) There are authorized to be appropriated for payment of grants or under contracts under subsection (a), and for purposes of carrying out the provisions of subsection (b), $71,000,000 for the fiscal year ending June 30, 1971 (of which not less than $2,000,000 shall be available only for purposes of carrying out the provisions of subsection (b)), $82,000,000 for the fiscal year ending June 30, 1972, and $94,000,000 for the fiscal year ending June 30, 1973.

"(2) In addition to the funds authorized to be appropriated under paragraph (1) to carry out the provisions of subsection (b) there are hereby authorized to be appropriated to carry out such provisions for each fiscal year such sums as may be necessary."

Authorizing Legislation

Legislation	1973 Authorized	1973 Appropriation requested
Public Health Service Act		
Section 314(a)--Grants to States for Comprehensive State Health Planning	$20,000,000	$10,000,000
Section 314(b)--Project Grants for Areawide Health Planning	40,000,000	25,100,000
Section 314(c)--Project Grants for Training, Studies, and Demonstrations	12,000,000	4,700,000

PUBLIC HEALTH SERVICE

Title III--General Powers and Duties of Public Health Service

Part B - Federal-State Cooperation

"Grants to States for Comprehensive State Health Planning

"Sec. 314. (a) (1) AUTHORIZATION.--In order to assist the States in comprehensive and continuing planning for their current and future health needs, the Secretary is authorized during the period beginning July 1, 1966, and ending June 30, 1973, to make grants to States which have submitted, and had approved by the Secretary, State plans for comprehensive State health planning. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $2,500,000 for the fiscal year ending June 30, 1967, $7,000,000 for the fiscal year ending June 30, 1968, $10,000,000 for the fiscal year ending June 30, 1969, $15,000,000 for the fiscal year ending June 30, 1970, $15,000,000 for the fiscal year ending June 30, 1971, $17,000,000 for the fiscal year ending June 30, 1972, and $20,000,000 for the fiscal year ending June 30, 1973.

"Project Grants for Areawide Health Planning

"(b) (1) (A) The Secretary is authorized, during the period beginning July 1, 1966, and ending June 30, 1973, to make, with the approval of the State agency administering or supervising the administration of the State plan approved under subsection (a), project grants to any other public or nonprofit private agency or organization (but with appropriate representation of the interests of local Government where the recipient of the grant is not a local Government or combination thereof or an agency of such Government or combination) to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services and including the provision of such services through home health care; except that in the case of project grants made in any State prior to July 1, 1968, approval of such State agency shall be required only if such State has such a State plan in effect at the time of such grants. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1967, $7,500,000 for the fiscal year ending June 30, 1968, $10,000,000 for the fiscal year ending June 30, 1969, $15,000,000 for the fiscal year ending June 30, 1970, $20,000,000 for the fiscal year ending June 30, 1971, $30,000,000 for the fiscal year ending June 30, 1972, and $40,000,000 for the fiscal year ending June 30, 1973.

"Project Grants for Training, Studies, and Demonstrations

"(c) The Secretary is also authorized, during the period beginning July 1, 1966, and ending June 30, 1973, to make grants to any public or nonprofit private agency, institution, or other organization to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the Nation. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $1,500,000 for the fiscal year ending June 30, 1967, $2,500,000 for the fiscal year ending June 30, 1968, $5,000,000 for the fiscal year ending June 30, 1969, $7,500,000 for the fiscal year ending June 30, 1970, $8,000,000 for the fiscal year ending June 30, 1971, $10,000,000 for the fiscal year ending June 30, 1972, and $12,000,000 for the fiscal year ending June 30, 1973."

Authorizing Legislation

Legislation	1973 Authorized	1973 Appropriation requested
Public Health Service Act:		
Section 601 -- Construction grants........	$417,500,000	$85,000,000
Section 626(a)(1) Interest subsidies......	Indefinite	2,500,000

PUBLIC HEALTH SERVICE ACT

Title VI--Assistance for Construction and Modernization of Hospitals and Other Medical Facilities

Part A--Grants for Construction and Modernization of Hospitals and Other Medical Facilities

Appropriation

"Sec. 601, In order to assist the States in carrying out the purpose of section 600, there are authorized to be appropriated--

"(a) for the fiscal year ending June 30, 1965, and each of the next eight fiscal years--

"(1) $85,000,000 for grants for the construction of public or other nonprofit facilities for long-term care;

"(2) $70,000,000 for grants for the construction of public or other nonprofit diagnostic or treatment centers;

"(3) $15,000,000 for grants for the construction of public or other nonprofit rehabilitation facilities;

"(b) for grants for the construction of public or other nonprofit hospitals and public health centers and for grants for modernization of such facilities and the facilities referred to in paragraph (a), $150,000,000 for the fiscal year ending June 30, 1965, $160,000,000 for the fiscal year ending June 30, 1966, $170,000,000 for the fiscal year ending June 30, 1967, $180,000,000 each for the next two fiscal years, $195,000,000 for the fiscal year ending June 30, 1970, $147,500,000 for the fiscal year ending June 30, 1971, $152,500,000 for the fiscal year ending June 30, 1972, and $157,500,000 for the fiscal year ending June 30, 1973.

"(c) for grants for modernization of the facilities referred to in paragraphs (a) and (b), $65,000,000 for the fiscal year ending June 30, 1971, $80,000,000 for the fiscal year ending June 30, 1972, and $90,000,000 for the fiscal year ending June 30, 1973.

Title VI--Assistance for Construction and
Modernization of Hospitals and
Other Health Facilities

Part B--Loan Guarantees and Loans
for Modernization and Construction
of Hospitals and Other Medical Facilities

Appropriation

"Sec. 626. (a)(1) There is hereby established in the Treasury a loan guarantee and loan fund (Hereinafter in this section referred to as the 'fund') which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriations Acts, (i) to enable him to discharge his responsibilities under guarantees issued by him under this part, (ii) for payment of interest on the loans to nonprofit agencies which are guaranteed, (iii) for direct loans to public agencies which are sold and guaranteed, (iv) for payment of interest with respect to such loans, and (v) for repurchase by him of direct loans to public agencies which have been sold and guaranteed. There are authorized to be appropriated to the fund from time to time such amounts as may be necessary to provide capital required for the fund. To the extent authorized from time to time in appropriations Acts, there shall be deposited in the fund amounts received by the Secretary as interest payments or repayments of prinicpal on loans and any other moneys, property, or assets derived by him from his operations under this part, including any moneys derived from the sale of assets.

RMP

Authorizing Legislation

Legislation	1973 Authorized	1973 Appropriation requested
Public Health Service Act		
Title IX -- Education, Research, Training, and Demonstrations in the Fields of Heart Disease, Cancer, Stroke, Kidney Disease, and other Related Diseases.....	$250,000,000	$120,800,000

PUBLIC HEALTH SERVICE ACT

The Public Health Service Act, Title IX, Education, Research, Training and Demonstrations in the Fields of Heart Disease, Cancer, Stroke, Kidney Disease, and other Related Diseases.

"Sec. 900. The purposes of this title are--

"(a) through grants and contracts, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education), for medical data exchange, and for demonstrations of patient care in the fields of heart disease, cancer, stroke, and kidney disease, and other related diseases;

"(b) to afford to the medical profession and the medical institutions of the Nation through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the prevention, diagnosis, and treatment and rehabilitation of persons suffering from these diseases;

"(c) to promote and foster regional linkages among health care institutions and providers so as to strengthen and improve primary care and the relationship between specialized and primary care; and

"(d) by these means, to improve generally the quality and enhance the capacity of the health manpower and facilities available to the Nation and to improve health services for persons residing in areas with limited health services, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies."

Sec. 901(a) There are authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1966, $90,000,000 for the fiscal year ending June 30, 1967, $200,000,000 for the fiscal year ending June 30, 1968, $65,000,000 for the fiscal year ending June 30, 1969, $120,000,000 for the next fiscal year, $125,000,000 for the fiscal year ending June 30, 1971, $150,000,000 for the fiscal year ending June 30, 1972, and $250,000,000 for the fiscal year ending June 30, 1973, for grants to assist public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private institutions and agencies in planning, in conducting feasibility studies, and in operating pilot projects for the establishment of regional medical programs of

research, training and demonstration activities for carrying out the purposes of this title and for contracts to carry out the purposes of this title. Of the sums appropriated under this section for the fiscal year ending June 30, 1971, not more than $15,000,000 shall be available for activities in the field of kidney disease. Of the sums appropriated under this section for any fiscal year ending after June 30, 1970, not more than $5,000,000 may be made available in any such fiscal year for grants for new construction. For any fiscal year ending after June 30, 1969, such portions of the appropriations pursuant to this section as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the program authorized by this title."

"MULTIPROGRAM SERVICES

"Sec. 910. (a)To facilitate interregional cooperation, and develop improved national capability for delivery of health services, the Secretary is authorized to utilize funds appropriated under this title to make grants to public or non-profit private agencies or institutions or combinations thereof and to contract for--

"(1) programs, services, and activities of substantial use to two or more regional medical programs;

"(2) development, trial, or demonstration of methods for control of heart disease, cancer, stroke, kidney disease, or other related diseases;

"(3) the collection and study of epidemiologic data related to any of the diseases referred to in paragraph (2);

"(4) development of training specifically related to the prevention, diagnosis, or treatment of any of the diseases referred to in paragraph (2), or to the rehabilitation of persons suffering from any of such diseases; and for continuing programs of such training where shortage of trained personnel would otherwise limit application of knowledge and skills important to the control of any of such diseases; and

"(5) the conduct of cooperative clinical field trials.

"(b) The Secretary is authorized to assist in meeting the costs of special projects for improving or developing new means for the delivery of health services concerned with the diseases with which this title is concerned.

"(c) The Secretary is authorized to support research, studies, investigations, training, and demonstrations designed to maximize the utilization of manpower in the delivery of health services."

Explanation of Transfers

	1972 Estimate	Purpose
Real transfers to:		
Operating expenses Public Building Service, GSA.......	-$3,000	Transfer to GSA for rental of space.
Medical facilities guarantee and loan fund.........	-30,000,000	To establish the "Medical facilities guarantee and loan fund" to provide funds for direct loans to public agencies for the construction of health care facilities.
Real transfer from:		
Nursing home improvement.....	1,000,000	Transfer to the research and development elements of the nursing home improvement program (National Center for Health Services Research and Development). Funds for a Department-wide nursing home initiative were appropriated in the Supplemental Appropriations Act, 1972. Subsequently, the entire appropriation was transferred to the appropriate agencies for implementation.
Comparative transfers to:		
Departmental Management.....	-27,000	Transfer to support the departmental public affairs activities.
Preventive health services..	-2,189,000	Transfer of National Clearing house for Smoking and Health.
Office of the Administrator.	-55,000	Transfer of 3 positions to the Office of Financial Management to establish a loan accounting section.
Comparative transfers from:		
Health Services Delivery....	25,935,000	Transfer of planning grants and related direct operations due to reorganization of HSMHA.
Office of the Administrator.	27,000	Transfer of Deputy and staff due to reorganization of HSMHA.

Health Services Planning and Development

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1963	$176,220,000	$188,672,000	$226,220,000	$226,220,000
1964	184,589,000	182,981,000	233,281,000	231,287,000
1965	247,057,000	44,407,000	267,057,000	266,907,000
1966	328,304,000	259,089,000 1/	328,304,000	328,304,000
1967	358,568,000	358,529,000	358,529,000	358,529,000
1968	372,671,000	347,671,000	357,671,000	342,171,000
1969	327,290,000	273,368,000 1/	388,489,000	335,275,000
1970	319,548,000	327,748,000	351,748,000	351,748,000
1971	266,029,000	358,229,000	400,430,000	393,717,000
1972	249,653,000	437,480,000	542,480,000	498,980,000
1973	329,596,000			

1/ The Regional Medical Programs activity was not considered by the House.

Justification

Health Services Planning and Development

	1972 estimate		1973 estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.	695	$11,840,000	757	$12,924,000	+62	+$1,084,000
Other expenses......	---	500,284,000	---	316,672,000	---	-183,612,000
Total..........	695	512,124,000	757	329,596,000	+62	-182,582,000

General Statement

This budget proposes a consolidated appropriation, Health Services Planning and Development, for HSMHA's health services planning and development programs which were supported previously by four separate appropriations: Health services research and development, Comprehensive health planning and services, Regional medical programs, and Medical facilities construction.

The proposed appropriation is consistent with the recent internal reorganization of the Health Services and Mental Health Administration. It reflects a functional grouping of the health services planning and development programs and as such provides for improved coordination and administration of these activities.

Research and Development

The National Center for Health Services Research and Development will continue major studies designed to improve the way in which health care is delivered in this country. Special emphasis will be placed on cost, distribution and quality of health care. The budget includes $64,343,000, an increase of $2,327,000 over 1972. The increase will support the continued development of a cooperative Federal-State-local health statistics system. This project is designed to produce the most comprehensive data base yet developed for assessing the Nation's health.

Comprehensive Health Planning

For Comprehensive health planning, $41,633,000 is requested. The increase of $15,698,000 over the 1972 appropriation would permit the funding of 100 new areawide health planning agencies and 20 new State assisted councils in rural areas for a total of 272 and 28 respectively. This increase is a further significant step towards the development of a comprehensive, Nationwide health planning system.

Regional Medical Programs

The 1973 estimate for the Regional medical programs includes $130,191,000 a net decrease of $13,751,000 below the 1972 obligations (but an increase of $30,681,000 in actual appropriations), consisting of increases of $7,449,000 offset by decreases totalling $21,200,000 for non-recurring construction and

transfer of planning projects for the health maintenance organization effort to that activity. The additional funds, together with the substantial increase in 1972, will provide for a special initiative in emergency medical services and will strengthen the 56 RMP's and will permit new and increased efforts associated with (1) manpower development and utilization programs, such as Area Health Education Centers, (2) emergency medical service and rural health care systems aimed at improving the accessibility, efficiency, and quality of health care for all Americans, (3) a systematic approach to the treatment of end-stage kidney disease patients through the sharing of facilities, manpower and other resources, (4) the development, demonstration and application of the latest advances in biomedical and management technology as they relate to the delivery of health care.

Medical Facilities Construction

The 1973 estimate for Medical facilities construction reflects a balanced program of loans, guaranteed loans and grants. Over $600,000,000 in loans will be made or guaranteed in 1973, adding over 12,000 new or modernized hospital beds to the health care system. In addition to the loan program, $85,000,000 in grants is included for construction of outpatient and rehabilitation facilities, $2,500,000 for interest subsidies and $486,000 for direct operations.

Health Services Research and Development

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits...........	218	$3,675,000	230	$3,968,000	+12	+$293,000
Other expenses..........	--	58,341,000	--	60,375,000	--	+2,034,000
Total.............	218	62,016,000	230	64,343,000	+12	+2,327,000

Introduction

The primary national health goal is the provision of the highest level of health attainable for the entire population of this country. In keeping with this goal, special attention must be directed to the persisting inability of the health care system to meet the demand for high quality health services, the continuing disproportionate rise in medical care costs and the unequal distribution and utilization of health services. As the health services delivery arm of HEW, the Health Service and Mental Health Administration has concentrated most of its R&D effort in the National Center for Health Services Research and Development. The National Center stimulates, supports and manages research, research and development, demonstration, and related training activities which will lead to increased efficiency and effectiveness in the organization, delivery and financing of health services in the United States.

The National Center's role, working with both the public and private health sectors, is to develop and test innovations to determine their effectiveness, acceptability, and applicability on a large scale. The collective impact of the R&D program should be increased efficiency in the public and private delivery of health services and increased effectiveness of publicly funded service programs in meeting national health goals and in responding to the public's needs.

Priority has been given to innovations which appear to offer the greatest potential for improving access, moderating cost increases and assuring quality. These include:

1. new types of health manpower, especially development and evaluation of physician-extenders like physicians' assistants, including MEDEX and their civilian counterparts, pediatric and family nurse practitioners, and mid-level dental workers;

2. evaluating the effectiveness of various HMO models and monitoring their fiscal impact;

3. cost containment in health care institutions through all-inclusive rate reimbursement and common claims forms, mergers and shared services;

4. methods for objectively assessing health care needs and adequacy of manpower, facilities and services for communities and states;

5. experimental medical care review organizations to provide operating prototypes for Professional Standards Review Organizations;

6. cost-effective health care technology;

7. Experimental Health Services Delivery Systems to optimize the use of Federal, State and private dollars in bringing comprehensive health care for the total population of communities or entire states.

Health Services Research and Development

(a) Grants and Contracts	1972 Estimate		1973 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses............	--	$56,118,000	--	$58,018,000	--	+$1,900,000
Subactivities:						
Research and development grants and contracts............	--	51,118,000	--	53,018,000	--	+1,900,000
Research and development training.........	--	5,000,000	--	5,000,000	--	---
Total.............	--	56,118,000	--	58,018,000	--	+1,900,000

(1) Research and Development Grants and Contracts:

	1972 Estimate		1973 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Research, Development and Demonstration Grants:						
Non-competing continuations.	90	$18,559,000	103	$22,045,000	+13	+$3,486,000
New and renewal grants......	40	9,291,000	33	7,705,000	-7	-1,586,000
Supplementals...............	(15)	200,000	(15)	200,000	--	---
Subtotal..............	130	28,050,000	136	29,950,000	+6	+1,900,000
Contracts:						
Continuations..............	61	16,150,000	61	16,150,000	--	---
New contracts..............	38	6,918,000	38	6,918,000	--	---
Subtotal..............	99	23,068,000	99	23,068,000	--	---
Total......................	229	51,118,000	235	53,018,000	+6	+1,900,000

Distribution by Program

	1972 Estimate	1973 Estimate	Increase or Decrease
Research and Development:			
Health services manpower............	$5,000,000	$5,000,000	---
Health maintenance organizations - evaluation.........	2,000,000	2,000,000	---
Health care institutions, costs, and financing.....................	9,518,000	9,518,000	---
Federal-State-local health services data system..............	1,600,000	3,500,000	+$1,900,000
Performance accounting..............	11,000,000	11,000,000	---
Health care technology..............	7,000,000	7,000,000	---
Health care systems.................	15,000,000	15,000,000	---
Total.......................	51,118,000	53,018,000	+1,900,000

Building on previous health services research, the National Center has established a research and development program directed to creating, introducing, testing and evaluating the essential components of comprehensive community health care delivery systems that will increase the supply, improve the distribution, and moderate the cost of health services.

The problems and approaches of the R&D program are developed through consultation with private and public health care providers, both institutional and individual, third-party payers, consumers, and university-based specialists and researchers in health care organization, delivery or financing. The Center also maintains working liaison with other programs of HSMHA, DHEW, and other federal agencies concerned with health services. By these means, program areas, major projects, and other principal aspects of the program are defined, focused, and kept under continuous critical review and appraisal.

The National Center's strategy for carrying out its R&D program consists of the development of prototype community health services systems. The systems approach calls for identification and examination of the inter-related components which constitute community health care and modification of these components in order to maximize their individual and joint contributions. The major components which have been identified for special attention are new types of health manpower; evaluation of health care financing mechanisms; cost containment through innovative institutional arrangements and insuring quality of care; the development of a cooperative Federal-State-local health statistics system; cost effective technology; and community health services R&D.

In addition, in 1973 the Center will begin to develop its second generation R&D programs. Building upon its current R&D program and the commitment of HSMHA to integrate its service and development programs, this will lead to the HSMHA R&D strategy for systematically introducing at State and regional levels the tested organizational, manpower and technological innovations that predictably will bring about constructive reform in health services delivery. This national implementation strategy will provide the mechanisms needed to assure the attainment of the intended purposes of financial entitlement legislation.

Data from the various studies will be combined in designs for R&D projects, which will put into effect and test the new planning and development methods. It is expected that several alternative patterns of planning and development will be offered for evaluation to States, regions, and localities. Both the planning studies and the implementation studies will emphasize the development of cost/effective preventive health services through the creation of HMOs and similar health services organizations. Planning and implementation studies will be carried out with involvement of CHP and RMP agencies and personnel, and the Regional Offices. The National Center will design and guide studies and provide technical assistance and financial support for key R&D projects.

To support the R&D effort, the National Center is requesting a budget of $53,018,000 for grants and contracts in 1973, an increase of $1,900,000 over the 1972 level. The increase will support the continued development of the cooperative Federal-State-local health statistics system. Specifically, the following high priority R&D programs will be supported in 1973.

I. Health Services Manpower

It is estimated that some 200 physician's assistant programs of the widest possible range of types may now be in existence or in some stage of development. The proliferation of many different and uncoordinated programs may cause great confusion and be disruptive to the attempts to use these new types of health manpower effectively.

Moreover, few of the current physician's assistant programs address themselves to anything but the numerical shortage of physicians. It is not clear that physician's assistants, who must function under the supervision of

licensed practitioners, will be able to relieve the shortage. This cannot occur if requirements for supervision cause them to distribute themselves in accordance with the existing pattern of physician distribution, which reflects over-concentration in certain medical specialties and in affluent population centers.

In addition, the kind of training now being given to physician's assistants tends to assume that established patterns of medical practice and organization will remain unchanged. Little attention is given to coming technological developments and new forms of health care organization, which will undoubtedly have a pronounced influence on the duties to be performed and the skills required by the physician's assistant. A climate of acceptance of the physician's assistant unquestionably now exists. But answers to these basic questions must be found before we can move effectively to develop the potential which the physician's assistant appears to offer.

Several projects currently supported by the National Center are developing and evaluating physician-extender manpower which can be used in normal practice settings, group practice clinics or remote health care centers linked to medical supervision by radio, television, or special telephonic connections. These demonstrations are being evaluated by use of procedure which will permit direct comparisons of results. The Uniform National Evaluation Protocol includes the effects of introducing physician's assistants in various sized medical practices on the costs and quality of care, patient and physician satisfaction, delegation of tasks, and relationships with other health professionals. Recruitment, selection and curriculum are also being studied.

This evaluation is now under way with six MEDEX projects as well as with the Center-sponsored demonstrations of the family nurse practitioner, school nurse practitioner, the pediatric nurse practitioner, the nurse midwife, and the dental auxiliary. Data is being gathered in 25 states from 200 cooperating medical practices which range in size from solo-general practices to large-scale urban group clinics. Ways in which physicians productivity is being increased is being documented: Preliminary findings, based on a random sample of 3,000 cases from 20 solo family practices show a potential savings of approximately 20% of physician time through assignment of patients in certain diagnostic categories to primary contact with only the nurse.

In 1973, demonstrations and uniform evaluation of mid-level medical workers will be extended to a total of 35 states. Comparable data will be available in sufficient quantity to permit assessment of the cost effectiveness of mid-level workers. By the end of 1973, the licensure and credentialing issues will be sufficiently analyzed to suggest guidelines for national policy, which will supplement and expand those transmitted to the Congress by the Secretary in June 1971. (Report on Licensure and Related Health Personnel Credentialing)

In 1973, R&D emphasis will shift to problems of multiple alternative staffing patterns in regionalized delivery programs and in group practices, including HMOs.

An estimated $5,000,000 will be used to support manpower studies in 1973.

II. Health Maintenance Organizations - Evaluation

The National Center is supporting a variety of projects related to research, development and evaluation of Health Maintenance Organizations (HMOs). HMOs will be studied with respect to such factors as enrolled population, benefit structures, utilization patterns, monitoring of services, costs and quality of care and financing mechanisms. A provisional HMO data monitoring plan is being developed in 1972 and will be ready for installation and evaluation in 1973.

The uniform national evaluation protocol under development can be used by Federal and private agencies to evaluate the benefits of the HMO form of health services delivery. The protocol will bring together in one technique the several different types of measurements needed to assess the net effects of HMOs, such as the breadth and continuity of services delivered to people, the quality of the services, the resources required by the HMO, and the costs to individuals and families and to supporting public and private programs. This will make possible a comparison of HMO costs and efficiency with other forms of medical practice organization.

In 1973 an estimated $2,000,000 will be used to support the evaluation of Health Maintenance Organizations.

III. Health Care Institutions, Costs and Financing

A. Costs and Financing

The cost of medical care continues to increase at a fast pace; by the end of fiscal 1971 the bill for the Nation's health care had risen to $75.0 billion, 7.4 percent of the Gross National Product. On the average, each man, woman and child in the United States was paying $358.00 annually for medical care, an increase of $31.00 per person over the previous year alone. As a result, consumers have difficulty purchasing comprehensive health care coverage, or even worse, they are completely denied medical care because of its costs. It is obvious that costs must be effectively controlled if significant progress is to be made in the improvement of the delivery of health services to the population.

An ongoing study of Title XIX in the State of California is comparing the quality, use and costs of care among six different forms of physician organization. The use and costs patterns differ depending upon the degree of physician responsibility actually exerted in maintaining surveillance over the appropriateness and quality of care.

The provision and utilization of medical services often requires substantial costs to patients which are not reflected in dollar expenditures, e.g. waiting times, travel times and costs, and time and effort involved in patient participation. These costs are likely to increase in the event of a substantial increase in insurance coverage, resulting in little net change in access to many population groups. Research and development is being undertaken in these non-monetary costs including the magnitude of such costs, their effect on patient behavior, and possibilities for reducing the level of these costs.

The National Center is supporting a major study of the efficiency of alternative organizational forms for the delivery of ambulatory care, including prepayment plans, fee-for-service group practices, and traditional solo practice. The study focuses on economic aspects and implications of medical organizations, use of non-physician personnel in new ambulatory care systems, and problems in the definition of price and productivity indices for such systems. It is expected that preliminary data will be available in the summer of 1972. These analyses will serve as a basis for fundamental decisions affecting government support of various modes of practice, including the

development and implementation of HMOs.

B. Institutions

The costs of hospital care continue to rise more rapidly than the costs of any other component of the health care industry and twice as fast as the overall cost of living. The National Center is deeply involved in research and development directed to cost containment projects which are intended to produce nationally applicable results. It is the nationwide installation of the new procedures that will moderate cost increases, improve interinstitutional relationships and reduce unnecessary hospitalization. The R&D projects encompass hospitals and other care institutions.

Simplifying administrative procedures in hospitals has great potential for reducing costs of health care. Two approaches to simplification, each of which is being evaluated on a national basis, are:

1. Implementation of an all-inclusive rate charging and reimbursement procedure in hospitals. Instead of charging for each specific item, hospitals will establish average costs in typical patient categories and then bill each carrier or agency or patient the appropriate standard daily rate.

2. Establishment of a nationally accepted uniform hospital discharge abstract and common insurance claim data. This project, currently being tested in five communities, will facilitate analysis of hospital costs in relation to the number and types of patients served and to the size and type of hospital. This will for the first time permit nationwide comparisons of hospitalization experience by length of stay, diagnosis, medical procedures, age, sex, size of hospital, and other variables. In time, it will provide useful data for determining community needs for additional hospital beds and for other types of services, such as nursing home beds and outpatient facilities.

Previous studies of both approaches to cost moderation, indicated potential savings of hundreds of millions of dollars annually if the procedures were adopted by all hospitals and accepted by third-party payers.

Savings can also be realized by reducing management overhead, better utilization of skilled manpower in short supply, avoiding the duplication of facilities, equipment, or services through shared services among similar or diverse types of facilities; mergers of facilities into one common corporate identity; agreements among different types of facilities to insure appropriate placement of patients relative to their needs; and formal relationships between ambulatory care facilities and hospitals.

1. A major national study of hospital mergers and shared services is being made by the Health Services Research Center jointly sponsored by the American Hospital Association and Northwestern University. The Center is supporting an evaluation of the integrated health care facilities established by the Samaritan Health Service, Phoenix, Arizona. Special attention is given to the efficiencies resulting from common management of groups of hospitals and sharing of medical services such as obstetrics, pediatrics, radiation therapy and the like. Economies resulting from centralized purchasing, laundry, food services, computer services, billing, laboratory testing and maintenance are being demonstrated. The potential impact on quality of care resulting from sharing of clinical services will also be evaluated. In addition, insights gained in the Samaritan study have been incorporated in two publications dealing with hospital mergers and shared services which have been made available to the hospital community on a national basis.

Although studies of the different forms of arrangements have been completed or are in progress, available reports do not permit a precise estimate on a national scale of the magnitude of potential cost reduction. The evidence is clear, however, that cost savings will be achieved.

The results of these analyses will be published in the form of R&D guidelines for communities, systems or institutions who wish to test these methods of implementing interinstitutional arrangements.

In 1973, an estimated $9,518,000 will be used to support studies in the area of health care institutions, costs and financing.

IV. Federal-State-Local Health Statistics System

Rational decision making for any substantial investment requires reliable baseline and trend data. This is particularly true of the health care system, which has been undergoing tremendous expansion in recent years without attendant refinement of its data-gathering and handling mechanisms. In an era when the health care system has investments from all sectors, and, particularly, when there appears to be great merit and emphasis upon decentralization of as much decision making as possible, a cooperative Federal-State-local health data system is imperative.

Lead responsibility within the Health Services and Mental Health Administration for the research and development phase of the program is located in the National Center for Health Services Research and Development. This project is being developed jointly with the National Center for Health Statistics which has responsibility for the implementation of the system.

Consistent with current national priorities, the cooperative system gives priority attention to data needed for the planning, operation, management, and evaluation of health services delivery. If individual access to health services is to be improved, while maintaining quality and containing costs, the health care system cannot continue to operate without adequate knowledge of its effects upon the health of the population. The Cooperative Federal-State-Local Health Services Data System must serve to coordinate data-collection activities at various levels, from individual patient care to local, State, and national decision making. Emphasis, therefore, is placed on developing an intimate working relationship between the data system, health services delivery systems, and local, State, and Federal governments.

The system will be developed through the use of standard definitions, standard measurements for quality of performance, and standard procedures for the collection, processing, and analysis of health data. The system should provide data which will accurately and adequately reflect (1) the physical and mental health of the people, (2) the use of ambulatory, hospital, and long-term care services, including preventive, diagnostic, curative and rehabilitative services, (3) the cost of these services, (4) the available health resources--facilities, manpower, and services, (5) the character and quality of the environment as it relates to health, (6) the basic demographic characteristics of the population, including patterns of family growth, births, deaths, etc., and (7) the knowledge, practices, and attitudes toward health and health care.

In 1973, an estimated $3,500,000 will be used to support the R&D phase of this cooperative project, an increase of $1,900,000 over the 1972 level.

V. Performance Accounting

A. Quality Assurance and Review

The National Center, working in cooperation with the Regional Medical Program, has supported basic research and development on the quality of medical care and on improving methods of measuring and monitoring quality. In 1971, the National Center began support of experimental medical care review organizations (EMCROs) by eight State and county medical societies to review the quality of health services delivered by all providers in specified geographic areas. In 1972, these experimental organizations are being extended to 10-12 sites. The purpose of the EMCRO is to develop and test alternative methods for conducting objective peer review of the content, appropriateness and quality of medical care. Those which prove successful will be prototypes for implementation of Professional Standards Review Organizations legislation. Review mechanisms will encompass office and hospital care, nursing home drug use, drug utilization review, criteria for admission to hospitals and long-term care facilities.

Health professions other than medicine are to participate and establish review mechanisms. The public is to be appropriately represented in the review process at a suitable level. The elimination of medical care and procedures which are unnecessary, without compromising quality of care is a necessary objective in the effort to contain costs. The quality assurance program seeks to achieve this effect while also impacting on the delivery of care to insure an acceptable level of quality.

In 1973, the Center will expand research and development in two parts of the future quality assurance system which have as yet received little attention. These are measures of outcome of medical care, and methods for developing and installing in office practice and hospitals the patterns of medical practice which reasonably assure high quality outcomes. The results of the basic research previously supported and of these new studies will provide the methods for quality assurance in HMOs, as well as in all other forms of provider organizations.

B. Health Services Data System

Developmental projects have been initiated and will continue in selected communities with the goal of establishing continuing and flexible systems for making available and using health services data in the planning, operation and evaluation of health services delivery programs.

In the short-run, these efforts will be focused on providing information for evaluating Experimental Health Services Delivery Systems and Health Maintenance Organizations. Data collection activities within the experimental community systems and the HMOs occur concurrently with the planning and development of these new organizations and will relate specifically to their activities. Comparison and evaluation of the various data efforts produced during the development of these activities will be carried out with a view to determining the most useful and least costly means of gathering and evaluating health care data.

Initial attention is being given to developing a community profile from census and other data. The first components of the data system are the household survey, hospital discharge abstract data and methods for obtaining information on cash flow. At a later time, attention will be given to designing an encounter form for ambulatory care data and for methods of collecting data for quality assessment. The basic data elements will include descriptive information such as demographic information, community surveys and data on manpower and facilities; ambulatory care data; hospital discharge data; quality assessment data; and financial data. The hospital discharge abstracts and ambulatory care surveys, together with other utilization data, are being developed for further implementation and evaluation within the context of the Federal-State-local health services data system, which is being jointly developed with the National Center for Health Statistics.

These prototype health services data systems are being developed and evaluated in four locations. Two, Rhode Island and Colorado are statewide; two others are local efforts at Livingston and San Joaquin in California. Timetables for component development, implementation, evaluation and modification have been established at all four locations and the expectation is that health services data systems, including survey, ambulatory, funds flow and uniform hospital discharge components will be in operation by May 1973. Techniques for demographic analysis of existing census data will be available by December 1972.

A similar data collection effort will be undertaken in order to monitor and evaluate the performance of Health Maintenance Organizations. Standardized data systems will be installed in experimental HMOs and HMO-like installations. These will be more formal management information systems, for internal management and control within the HMO as well as providing for effective and objective review by outside authorities. The data collected will provide for the continuous monitoring and periodic evaluation of performance within individual HMOs and for comparison between HMOs.

C. Nursing Home Improvements

In 1972 the DHEW received a supplemental appropriation to implement the President's request that new initiatives be taken to improve the general conditions of the Nation's nursing homes and extended care facilities. The National Center received $900,000 to support a new R&D effort with respect to nursing home standards and quality.

The R&D approach will: (1) improve the techniques of quality performance assessment of nursing homes to enable inspectors to detect deficits in patient care and environmental hazards; (2) introduce new types of mid-level manpower such as nurse clinicians and physician extender personnel to augment the physician's care and provide medical management supervision; and (3) design a data system that would provide a systematic inter-agency data/report sharing and implementation plan. The latter would achieve a uniform minimum core data set compatible with data used by other agencies.

In 1973, an estimated $11,000,000 will be used to support studies relating to quality assurance and review, EMCROs, data systems development, and other evaluation activities.

IV. Health Care Technology

The projects undertaken by the National Center's Technology Division are directed to the issues of cost-containment, efficiency and productivity in the delivery of health services. These projects employ state of the art computer techniques to: Automate certain service functions; process data to improve the clinical management of patients; and provide management information to improve the operation of health care facilities.

Health care technology research and development is directed to four areas:

1. Medical information technology includes work in hospital information systems and medical signal processing. The current strategy is to support two approaches to the development of hospital information systems. One capitalizes on the sizeable public and private monies already invested in achieving a workable total hospital information system (HIS). This evaluation assesses the impact of HIS on manpower requirements, level of skills, length of stay, quality of care, cash flow, inventory and fiscal controls. The second is based on time shared computers which make feasible a shared, modular hospital information system. This approach supports a group of cooperating hospitals to implement modules of the system and share cost based on computer time utilization. Both of these approaches are currently undergoing the test of demonstration and

objective evaluation in operational settings.

The hospital information system at the Massachusetts General Hospital utilizes in a modular fashion small computers and the MUMPS language (a high-level language interpreter). Several examples of economies achieved with individual modules are available. For example, the Census and Bed Control Module at Framingham Union Hospital in Massachusetts, requiring daily physician updating of estimated length of stay, resulted in a 14% increase in bed utilization for the 150 medical/surgical beds of this 288 bed hospital. With daily charges at $75 per day, this module thus resulted in an increased cash flow of $1,500 per day, which calculated on a yearly basis, produced $500,000 of income to offset fixed operating costs. Other modules, such as radiology and pharmacy, may achieve cost savings through rationalizing information flow within these departments and thus facilitate optimal resource allocation.

2. Automated health maintenance systems R&D include projects in laboratory automation and screening and disease detection and screening. Two projects are currently being supported which successfully demonstrate the use of computers in improving the operation of the clinical laboratory. The new activity planned in this area is to explore the feasibility of extending automation techniques into the microbiological laboratory. Developmental work on mass screening devices will continue for white cell differential counts, sputum cytology and ECG analysis. These are clinically important, high volume activities that are labor intensive. Automation of these tests would result in significant cost reduction and conservation of skilled manpower.

Private enterprise has moved in to further development and expansion of many of the Technology Division's projects. For example, the automated ECG program developed by the Division is the focus of an ECG Data Pool supported by more than one hundred members, largely from the private sector. The studies show that a 75% savings in physician manpower may be achieved by using a computer assisted ECG analysis program. On a national scale, this would free an estimated 1,300 cardiologists for direct patient care. Equally important, this system improves patient care by providing rapid access to a correct ECG interpretation in medically underserved areas. This project has progressed to the point where it is providing a valuable service to a community of hospitals within the city and the outlying regions surrounding Denver. This activity which was initially funded for three years as a demonstration will be completely self supporting in 1973.

3. Technology for Logistics and Data Systems. Data System activities are directed toward the design and development of computer systems for handling medical transactions and claims data. One such contract is a pilot study for the On-Line Medicaid Claims Processing for the entire State of Alabama.

In the area of medical logistics, the delivery of health services to remote areas has been identified as a problem of significant scope in which existing technology offers possible solutions. One such possible solution is the use of picture-phones and closed circuit television to extend medical support to health services personnel and facilities operating in remote or isolated locations. An activity to explore these possibilities has been initiated.

4. Ambulatory Services. Priority is given to increasing productivity and efficiency of the physician in the individual office, group practice, or clinic settings, where in fact the majority of health care in this country is delivered. Significant gains in ambulatory care management can be made through automating medical record systems, medical history acquisition, and providing physician consultative support. Major projects in these categories will be subjected to a nationally-based assessment in order to concentrate R&D on those approaches which promise the best pay-offs in savings of physician time and increasing productivity.

The automated history is considered the most probable cost-effective vehicle for bringing the time-shared computer terminal into the physician's office. This versatile communication device will permit such innovations in the office as computer aided diagnosis; drug interaction warnings; educational materials and treatment plans; special instructions in diets; patient scheduling to hospitals, clinics, and laboratories; communication with hospital information systems that will allow entering of preadmit data, review of patient charts, and entering of medical orders; and record, billing, and accounting functions.

In 1973, an estimated $7,000,000 will be used to support health care technology research and development.

VII. Health Care Systems

The National Center for Health Services Research and Development supports the implementation of model health care delivery community systems which stress preventive measures, ambulatory care, improved financing methods, and improved use of manpower and technology.

A. Experimental Health Service Delivery Systems. The "health care delivery system" in the United States consists of practitioners, administrators, financers, consumers, and private and public agencies at all levels and frequently having overlapping jurisdictions. It is often impossible for a community to allocate resources for maximum community benefit because conflicting or competing programs may provide multiple sponsorship for some services or beneficiary groups, while other desirable services and needy beneficiaries are not covered by any program.

In response to this situation, the Health Services and Mental Health Administration, through the National Center for Health Services Research and Development, is supporting the creation of experimental health services delivery systems for entire communities. In 1971, the Center served as lead agency for the cooperative initiation of Experimental Health Services Delivery Systems (EHSDS), in 12 urban and rural communities across the United States, including the States of Vermont and Arkansas. Up to eight new EHSDS will be started in 1972.

These are voluntarily established projects covering entire communities or states whose purposes are to:

1. Establish a voluntary management capability reflecting a balance of control between the providers, third-party payors, political elements, and the public.
2. Assure access to the system by all inhabitants of the area.
3. Assure the quality of care in the component organizations.
4. Evaluate performance of the system in terms of community needs.
5. Combine public and private funds to increase access, moderate cost increase, and insure adequate quality of care.

The NCHSRD is evaluating the EHSDS program and assisting EHSDS communities in developing a uniform health services data system. Innovations,

developed through research and development elsewhere, will be installed and tested in EHSDS. Examples are new manpower types, financing arrangements, quality assurance techniques, and cooperative arrangements among health care facilities.

The EHSDS program reflects, at the national level, a common effort by all HSMHA programs. It includes the development of joint funding of these large-scale projects to improve community health care delivery. The EHSDS program also involves coordination with other HEW agencies and with other Federal departments.

At the community level, the EHSDS projects first establish and then determine whether a management structure can improve performance of the health services delivery system in improving access to care for the entire community at reasonable cost and of assured quality. Major consideration is given to redirecting private and public (Federal, regional, State and local) sources of funds more efficiently, and to integrating community services.

The R&D will be supported for a limited period only. More efficient use of existing dollar flow will enable each system to support the necessary staff and special activities. The service money flowing through the community includes medicare, medicaid or private insurance as well as HEW funds.

B. Community health services research and development. Community health services R&D projects are carefully selected laboratories within which the separate manpower, institutional, financing and other R&D programs of the National Center are given final test of effectiveness. Each such laboratory analyzes the health care requirements of the population in relation to existing resources. On the basis of this, R&D is conducted in installing new kinds of manpower, financing, ambulatory care services, interinstitutional agreements and the like. Their effect will be evaluated in terms of increased access to, and utilization of, health services, costs, and patient and provider satisfaction.

One of the first prototypes to emerge under this strategy is Rhode Island Health Services Research, Inc., a non-profit corporation which includes in its membership the major health provider, payer, and organizations in the State. The development of this health services corporation is the first step in the creation of a statewide comprehensive health services system which will incorporate results of the Center-supported research and development.

The Corporation is presently considering revised programs of ambulatory care in the community, establishing a health services information system, and experimenting with hospital reimbursement mechanisms in which all hospitals will participate. Each of these changes, if instituted, will be scientifically evaluated. Several other innovations are under discussion. The corporation has completed an analysis of its needs and is now studying its health services resources. The survey of health care needs will be refined and reapplied periodically.

In 1973, an estimated $15,000,000 will be spent on 1) the development of experimental health services delivery systems; and 2) community health service research and development.

In summary, the National Center is requesting $53,018,000 for support of its research and development activities in 1973, an increase of $1,900,000 over the 1972 level. The additional $1,900,000 is requested to support the continued development of a cooperative Federal-State-local health services data system.

(2) Research and Development Training

	1972 Estimate		1973 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Training grants:						
Non-competing continuations..............	43	$3,771,000	43	$3,771,000	--	---
New and renewal grants..	1	67,000	1	67,000	--	---
Supplementals...........	(8)	150,000	(8)	150,000	--	---
Subtotal...........	44	3,988,000	44	3,988,000	--	---
Fellowships:						
Non-competing continuations..............	62	574,500	62	574,500	--	---
New grants..............	5	71,500	5	71,500	--	---
Supplemental............	(8)	30,000	(8)	30,000	--	---
Subtotal...........	67	676,000	67	676,000	--	---
Contracts:						
Continuations...........	2	166,000	2	166,000	--	---
New contracts...........	2	170,000	2	170,000	--	---
Subtotal...........	4	336,000	4	336,000	--	---
Total......................	115	5,000,000	115	5,000,000	--	---

As the development of new systems for the organization, delivery and financing of personal health services evolves, the focus of training activities within the National Center is shifting in anticipation of the research and management capabilities which will be required.

In 1972-1973, a major emphasis of the training program will be the development of training in health services management and evaluation. Implementation of the innovations in health services delivery systems resulting from the Center's R&D program will require training of new types of managers and administrators. These new types, including physicians, hospital administrators and others from non-health backgrounds, must be prepared to plan, implement, operate and evaluate evolving systems. Experience in health services R&D is essential in training programs geared to produce these skills.

This training, while it may be conducted in an academic setting, will not be entirely degree-oriented. It will emphasize the development of quantitative, analytical skills for existing health services administrators to provide increased managerial and executive capabilities. It is not intended solely to develop independent health services research personnel, but will focus on mid-career experience designed to produce improved capacity for planning, more rational allocation of scarce resources, and knowledge of processes for systematic, objective evaluation of the impact of innovation on the health care delivery system.

The 1973 level of $5,000,000 will support 48 awards to institutional programs and 67 individual fellowships. This is the same level as in 1972.

Health Services Research and Development

(b) Direct Operations	1972 Pos.	1972 Amount	1973 Pos.	1973 Amount	Increase or Decrease Pos.	Increase or Decrease Amount
Personnel compensation and benefits..............	218	$3,675,000	230	$3,968,000	+12	+$293,000
Other expenses..............	--	2,223,000	--	2,357,000	--	+134,000
Total.................	218	5,898,000	230	6,325,000	+12	+427,000

The National Center for Health Services Research and Development is responsible for the appraisal and evaluation of the effectiveness of health services operations and for developing a research and development program that is geared to improving health care nationally.

The staff of the National Center devoted major effort to designing and directing the strategic program of research and development. The staff obtains high-level evaluation of all proposals, closely monitors contracts, reviews results, informs the professional community of significant progress and identifies the next steps in research and development. Considerable time and effort is devoted to close collaboration with the investigators, providers, payors and major national organizations.

The staff of the Center is organized into three major programs:

1. Special Projects R&D, addressing highest priority problems through short-term research and development.

2. Social and Economic Analysis with programs in the social sciences, economics, epidemiology, and legal medicine; addressing fundamental long-term issues in health care.

3. Health Care Technology which encourages applications of advanced instrumentation and automation to improving the delivery of health services.

The National Center is requesting a program increase of 12 positions and $251,000 in 1973. The increase is essential for the National Center to further develop the managerial and technical capability to carry out its large-scale R&D efforts. The increased program effort in the development of community-wide health services data systems requires additional personnel with statistical and computer capability to develop health status surveys, to monitor data systems for ambulatory care, and to collect and analyze the national data resulting from this program.

The additional increase of $256,000 provides for built-in changes, which is partially offset by a decrease of $80,000 due to non-recurring program costs.

Comprehensive Health Planning

	1972 estimate		1973 estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits............	24	$546,000	49	$872,000	+25	+$326,000
Other expenses............	--	25,389,000	--	40,761,000	--	+15,372,000
Total.............	24	25,935,000	49	41,633,000	+25	+15,698,000

Planning Grants

	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits............	--	38,000	--	38,000	--	--
Other expenses............	--	24,962,000	--	39,762,000	--	+14,800,000
Total.............	--	25,000,000	--	39,800,000	--	+14,800,000

Subactivities:

	1972 estimate	1973 estimate	Increase or Decrease
(a) Formula grants to States for comprehensive health planning..	7,675,000	10,000,000	+2,325,000
(b) Project grants for areawide comprehensive health planning.......	13,200,000	25,100,000	+11,900,000
(c) Project grants for training, studies and demonstrations........	4,125,000	4,700,000	+575,000
Total...........	25,000,000	39,800,000	+14,800,000

(a) Formula Grants for State Comprehensive Health Planning Agencies

The Partnership for Health Program introduced the concept of comprehensive health planning as a mechanism through which the planning activities of health and related elements can be linked together within the States. Formula grant funds are awarded to the 50 States, District of Columbia, and 5 Territories based on population and per capita income. The funds support up to 75% of the costs associated with conducting State comprehensive health planning.

The 1970 amendments to Title III of the Public Health Service Act contained in P.L. 91-515 have led to expansion of State advisory councils to include representatives of the Veterans Administration facilities and Regional Medical Programs operating in the State. State agencies have continued to be involved in planning, priority setting, and special studies that in many cases have led to recommendations to improve provisions of health services. For example, two State agencies recently accomplished studies that led to recommendations for expanded and improved services to crippled children. Both of these recommendations led to legislation expanding and improving these services. Other State agencies have recommended environmental programs such as solid waste disposal, emergency medical care programs, certificate of need programs to assure effective review of proposed health facilities, and a variety of other programs. Many have been implemented.

States will be continuing to place emphasis upon the setting of priorities for health within their jurisdictions and making recommendations for the implementation of these priorities within the State.

Comprehensive Health Planning is a continuous process which requires not only the participation of both providers and consumers, but also is equally dependent upon close cooperation of State and local planning bodies. Thus, in 1973, many State agencies will become increasingly involved in coordinating the efforts of areawide health planning agencies within their jurisdiction and working with them toward a joint accomplishment of mutual objectives.

The continuing close ties of the State comprehensive health planning programs to the State political, economic and social systems will, in 1973, facilitate the adoption by the States of recommended planning priorities and recommended alternatives for the solution of their problems. More and more of the States will be drawing together the categorical programs in health for the purpose of attacking health problems through joint efforts. As they accumulate more knowledge and experience, States will be in a better position to modify or realign health resources in order to more effectively combat problems. State comprehensive health planning organizations will review and comment on a wider range and variety of health projects.

The increase of $2,325,000 will allow State agencies to increase professional staffs by 25%, from just over 300 persons to over 400. In addition, there will be an increase in consultation and special studies to support effective planning. These increases will enable agencies to increase not only their manpower but also their breadth and scope of skills. A primary emphasis will be for State agencies to become substantially more involved in assisting the development of new areawide planning agencies.

(b) Project Grants for Areawide Comprehensive Health Planning

It is essential to the health planning process that every area identify its health needs, inventory resources, establish priorities and goals, and recommend courses of action. To assist public or nonprofit private agencies in this vital effort, project grants will be awarded in 1973 which will comprise about 60% of the total amount spent for the purpose. The remaining funds will be obtained from a broad range of community or local sources. The Federal share may reach as high as 75% if the area has been designated as a poverty area.

During 1970 and 1971, the number of areawide agencies increased from 93 to 158 agencies. The number of these agencies which have finished organizing and have launched active planning programs has increased to 110 and is expected to reach 125 by the end of 1972.

Recommendations from areawide health planning agencies have had important consequences. For example:

Hospital mergers have been effected with more efficient services at lower cost resulting, unnecessary facility construction has been avoided, modernized facilities have been developed, neighborhood health centers have been introduced into communities, immunization and screening programs have been started, lead poisoning prevention programs have been designed, ambulance and other emergency care programs have been operationalized, city water and sewage systems have been improved, and a vast array of other services have been improved.

As these examples suggest, comprehensive health planning agencies work across the whole range of health concerns with attention paid to personal health, mental health and environmental health, as well as health facilities. Emphasis is placed on the cost, availability, and accessibility of health care. While each agency defines its own agenda in relation to the needs of its own communities, there are

commonalities. For example, more than half of the operational areawide agencies were active in drug abuse and alchoholism in 1972, and similar percentages would be true of other health problems of current concern.

In 1973 there will be increased emphasis on review and comment of proposed health programs and facilities. Such review and comment is now required by law for Hill-Burton, RMP, and 314(e). In addition, there are administrative requirements for review and comment by 314(b) agencies on local applications under 314(d) and migrant health applications, and various States have laws requiring additional review and comment, certification of need, or even approval of some applications by the areawide comprehensive health planning agencies.

The increase of $11,900,000 will provide $2,900,000 for continuation costs of the 172 agencies expected to be receiving grants by the end of 1972. Of the balance, $5,100,000 is included to establish approximately 100 new areawide agencies and 20 new State assisted local councils. In addition $3,900,000 is included to increase the average Federal share to avoid financial dependence upon organizations whose activities must be reviewed and commented upon by 314(b) agencies.

The following table reflects the actual/estimated number of 314(b) agencies:

AREAWIDE COMPREHENSIVE HEALTH PLANNING
UNDER SECTION 314(b)

	1969	1970	1971	1972	1973
1. Number of Areawide Planning Agencies	93	127	158	172	272
(a) Planning	7	36	90	127	158
(b) Organizational	86	91	68	45	114
2. Number of State Assisted Local Councils	--	--	--	8	28
% of Population covered by Areawide Agencies	Not Available	55	65	67	80+

(c) Project Grants for Training, Studies and Demonstrations for Comprehensive Health Planning

Effective health planning is dependent on skilled health planners - a resource in short supply. To help remedy this situation, about 400 graduate students were trained in the principles, concepts, and techniques of comprehensive health planning through grants to 22 graduate institutions. Further, about 400 local elected officials, health professionals, administrators, planners, consultants and policy level personnel were trained through ten continuing education programs aimed at "upgrading" individuals already involved or connected with health planning in 1972.

The improved ability of consumers to participate in comprehensive health planning is extremely important to its success and to foster that objective about 1,500 consumers were trained in thirteen consumer education programs during 1972.

The 1973 request will continue support of the graduate programs with about 240 expected to graduate with advanced degrees in the spring of 1973. It will also

support about ten continuing education programs which will reach about 600 individuals already involved or connected with health planning. Consumer education programs will be continued and will reach approximately 1,750 people.

The success of State and areawide planning will depend to a large extent upon the availability of personnel skilled in health planning and on constructive consumer participation in health planning.

The increase of $575,000 for project grants for training, studies and demonstrations will enable the university programs to provide an increased level of technical assistance to the planning agencies. It will also allow greater emphasis on the development of health planning methodology.

Direct Operations

	1972 estimate		1973 estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits............	24	$508,000	49	$834,000	+25	+$326,000
Other expenses............	--	427,000	--	999,000	--	+572,000
Total.............	24	$935,000	49	$1,833,000	+25	+$898,000

The efforts of Federal, State, and local governments and the private sector to improve significantly the health status of the individual have fallen below expectations, in part due to the lack of a planning process which links health needs to health resources at the various levels of community health organization. This lack results in an inability to identify such organizational problems as gaps in health coverage, deficiencies in financing, and rational alternative arrangements for patient care as opposed to our presently fragmented health system and subsystem. The development of comprehensive health planning agencies at the State and areawide levels provides a focus where planning and analysis can be undertaken and those interested, both as providers and consumers of health services, can participate in reaching mutually satisfactory decisions. Through the operation of this planning process, more systematic attention can be given to problems, community health goals, relationships, the development of alternative solutions, and evaluation. One possible outcome will be a more integrated use of Federal, State and local resources to improve the health of the people.

The Comprehensive Health Planning Program develops national policies and criteria for use by the Regional Offices and provides guidance and technical assistance to 56 State and territorial Comprehensive Health Planning Agencies as well as the 172 areawide agencies expected to be in operation by the end of 1972. Section 314(a) formula grants are supporting 56 State and Territorial Comprehensive Health Planning agencies. In 1973, Section 314(b) project grants will support 272 areawide comprehensive health planning agencies, 100 of which will be new with about 28 special grants made to States to help provide planning assistance to sparsely populated areas. In addition, the Program develops and provides assistance to projects, supported under Section 314(c), which train participants in the comprehensive health planning process.

Program emphasis in 1973 is on the provision of developmental assistance to aid the large number of new 314(b) agencies to achieve successful operations, and to meet the increasing demand from both 314(a) and 314(b) agencies for Federal help and guidance.

1973 Increases

A net increase of $898,000 is requested for these activities. It includes 25 positions and $495,000 to increase staff capability to respond to State and areawide agencies' requests for technical assistance and consultation. In addition, $395,000 is included for project contracts aimed at determining various patterns of effective on-going comprehensive health planning and making information about them available to all 314(a) and 314(b) agencies. The total also includes $10,000 for built-in items, partially offset by a decrease of $2,000 for two less days of pay.

RMP

Regional Medical Programs

	1972 Estimate		1973 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	169	$3,157,000	194	$3,523,000	+25	+ 366,000
Other expenses........	--	140,745,000	--	126,628,000	--	-14,117,000
Total............	169	143,902,000	194	130,151,000	+25	-13,751,000

Introduction

The Regional Medical Programs Service provides a major mechanism and supports activities required to enhance the capacity of the health care system to furnish services of satisfactory quality to all Americans.

Regional Medical Programs Service: (1) supports grants and contracts which on a regional basis bring together in a common effort the local medical centers, hospitals, and other health care facilities, health care providers and other resources to systematically identify health problems, commitments, and undertake the solutions; (2) furnishes professional and technical assistance and advice to the Regional Medical Programs, States, local communities and other relevant health agencies; (3) conducts programs through voluntary commitment of regional resources to bring about an increased, effective use of medical knowledge, make more efficient use of physical and human medical care resources and help remove barriers which impede entry of patients into the health care system, maintaining major focus on those diseases which are the greatest causes of morbidity, disability, and death in the United States and (4) facilitates and provides professional guidance at the regional level to other governmental and private efforts aimed at improving the organization and delivery of health care.

Regional Medical Programs:

	1972 Estimate	1973 Estimate	Increase or Decrease
(a) Grants & Contracts..	$139,300,000	$125,100,000	-$14,200,000

The Administration's proposed national health strategy is as follows:

1. There must be assurance of equal access to our health care system.

2. Supply and demand for health and medical services must be brought into balance.

3. A purposeful organization of our efforts to improve efficiency must be implemented: first, by emphasizing preventative services and health maintenance on a prospective and systematic basis; second, by maintaining a reasonable and understood relationship between expenditure and care rendered. Cost consciousness and economy need to be introduced by direct incentives.

4. Finally we must build upon our present strengths in the Nation's pluralistic health enterprise.

It is specifically these goals that Regional Medical Programs have been organized and geared to accomplish. Regional Medical Programs have been organized as functional consortiums of health care providers, each with special and specific resources which can be made responsive to health needs. They are also structures deliberately designed to take into account local resources, patterns of practice and referrals, and needs. As such they have been important forces for bringing about institutional reform through changes in the provision of personal health service and care.

This merger of providers has already produced systematic approaches to the major diseases of the heart as well as cancer, stroke and kidney disease. Several regions have accomplished the pooling of training resources to more effectively meet the manpower needs of each region. In some areas, health maintenance projects are being supported in a variety of ways.

For example, a prepaid health care insurance program for the residents of Milwaukee's inner city has been developed with the assistance of the Wisconsin Regional Medical Program. The Cream City Community Health Center has been established by nine physicians who organized into a group practice to provide medical services for the health center clientele. Technical and financial assistance were provided by the Wisconsin Regional Medical Program for early planning of the Center. Grants funds were obtained from the Office of Economic Opportunity, with Wisconsin Regional Medical Program assistance, to help support the first year of operation. The Center is working with Medicaid, Blue Cross-Blue Shield and the Milwaukee County Medical Society to develop a completely self-supporting experimental health maintenance organization.

During 1971 and 1972 the affiliated health providers with the aid of the Regional Medical Program mechanism, have promoted and demonstrated at the local levels, new techniques and innovative delivery patterns that lead to improved accessibility, efficiency and effectiveness of health care. For instance, five community hospitals on the north shore of Massachusetts have begun home care programs through the efforts of the Tri-State Regional Medical Program and the Massachusetts Hospital Association. Such programs will provide continuity of care for hospitalized patients after discharge, as well as reduce the length of stay in the hospital. To date, one hospital has achieved a fully coordinated

home care program with excellent multi-disciplinary input. Three hospitals are planning to hire full-time nurse coordinators and have opened a much improved information interchange with the local Visiting Nurse Association. One hospital moved the Visiting Nurse Association right into the hospital building and also appointed a full-time qualified nurse as coordinator.

In the rural and inner city areas and in concert with related Federal, local State, regional officials and programs, specific efforts have been directed to encourage the providers of health care to make care available and accessible to those areas where there is a distinct scarcity of resources. As an example, in the State of Washington, because of a physician manpower shortage, the isolated community of South Bend and surrounding areas were about to lose their hospital until the Washington/Alaska Regional Medical Program stepped in to organize community, State, and Federal interest and resources to save it. Not only are new physicians locating in South Bend but additional services beyond those formerly offered are now available.

In 1972 a grant has been made for a regional cancer center in Seattle, Washington.

Health Maintenance Organizations - Assuming that authorizing legislation has been approved, there are likely to be about 350 Health Maintenance Organizations in either planning or operational stages by June 30, 1974. Nearly every Regional Medical Program already has been involved in the development of professional activities at the local level. Because of their provider linkages, Regional Medical Programs, act as catalytic agents to bring together the various elements of the health care system, provide an environment conducive to planning, and give staff support and professional guidance, when necessary. In this way, Regional Medical Programs support professional organizations which have the potential for becoming Health Maintenance Organizations. In addition, subsequent to the establishment of Health Maintenance Organizations, Regional Medical Programs have actively engaged in the professional aspects of planning for manpower programs, mechanisms for monitoring the quality of care, ambulatory and emergency medical care services, centralization of laboratory facilities, data systems, etc.

Regional Medical Programs is, within present legislative authority, also providing funding through grants and contracts to support the planning and development of Health Maintenance Organizations in 1972.

Experimental Health Service Delivery Systems - Regional Medical Programs are playing the same catalytic role with respect to Experimental Health Service Delivery Systems. Some are providing staff support even after an Experimental Health Service Delivery System contract has been signed. For instance, the interim director of the project in Boise, Idaho also is an area coordinator for the Mountain States Regional Medical Program.

Program for 1972-73

Although Regional Medical Programs have been moving away from the narrow categorical disease approach and the emphasis on continuing education projects, the substantial increase in funds in 1972 has provided the impetus to substantially speed up that redirection.

Goals

1. Manpower Development and Utilization - Programs aimed at enabling existing health manpower to provide more and better care and training and more effective utilization of new kinds of health manpower. New funds will be used to plan and develop Area Health Education Centers. These programs which focus on improved patient care services, depend on affiliations of hospitals and other treatment

facilities, nursing homes, junior colleges, etc., usually linked with a university health science center, to improve manpower distribution and to provide the missing link between manpower education and patterns of delivery. Area Health Education Centers will be a source of manpower for Health Maintenance Organizations, Experimental Health Service Delivery Systems and other comprehensive health care systems.

Area Health Education Centers and other Regional Medical Program funded projects will emphasize improved utilization of new kinds of health manpower, particularly physician extenders, who can take over many of the traditional functions of the physician enabling him to see more patients while, at the same time, lowering the cost of care.

Another important aspect of Regional Medical Program efforts will be to encourage the expansion of existing family practice programs and the establishment of new ones. One important specific contribution will be to assist in identifying intern and residency training sites (e.g., preceptorships, group practices) and setting up such graduate training programs at the community level. In addition, Regional Medical Programs will seek to favorably influence the distribution of family practitioners -- that is, to get them to locate in areas of greater need -- by strengthening the professional linkages between family and speciality practice, between small community hospitals and larger hospitals and medical centers. They will attempt to minimize or remove the sense of isolation and enhance the professional growth of these individuals through such efforts as the partial support of circuit-riding Directors of Medical Education serving several small hospitals and the outreach programs of medical centers providing speciality consultation to family practitioners.

2. New Techniques and Innovative Delivery Patterns - Activities aimed at improving the accessibility, efficiency, and quality of health care. They provide opportunities to increase the rate of implementation of systems innovations, new technologies including automation, and changes in delivery patterns, particularly those developed through the efforts of the National Center for Health Services Research and Development.

Rural Health Care Systems

New techniques and innovative delivery patterns have allowed Regional Medical Programs to improve access to quality health care and provide emergency services to Americans in urban and suburban areas. Thus far, however, no one has found a way to adapt the same techniques and patterns of care to rural areas. Geography has been the stumbling block. For example, a rural area of South Georgia and Northern Florida which has a staggering number of serious auto accidents has round-the-clock emergency service for the first time under a Georgia Regional Medical Program Project.

In a typical year, December 1, 1968 to December 31, 1969, there were 1,618 motor vehicle accidents on the section of Highway I-75 which passes through this Florida resort area. At that time, all hospitals in the area were relying on practicing physicians to be called on a rotating basis for emergencies. Virtually the only ambulances available were those from local funeral homes, which, in most cases, did not meet medical standards. The population of 200,000 in land area of 3,800 square miles is served by 96 physicians (the national average is 141 physicians per 100,000 population) and ten hospitals with a capacity of 838 beds.

The project staffs and equips round-the-clock emergency rooms in two of the larger hospitals and provides emergency ambulances with intensive care capabilities. In addition, Moody Air Force Base has agreed to provide helicopter ambulance service in dire emergencies.

Although projects like this are worthy, they are not comprehensive nor do they begin either to provide adequate emergency services or to touch the majority of the residents of rural and remote areas. For the first time, rural health care systems will be developed which will have as their long-range goals:

a. The same quality of care enjoyed by those Americans fortunate enough to reside in areas where favorable distributions of health care resources exist.

b. Primary and emergency care within a reasonable travel time even under the poorest of weather conditions.

c. Care that is not only available and accessible but also care which is provided in such a way as not to encroach on the dignity of the consumer.

Comprehensive rural health care systems will include (1) health education for the consumer, (2) primary/preventive care, (3) emergency care, (4) secondary/tertiary care, (5) rehabilitation services, (6) extended care, and (7) home care.

Emergency Health Services Systems

Today more Americans require hospitalization for accidents than for any other diseases except cancer and heart disease. In the last decade the mortality rate for males has been rising with increasing changes in younger age groups primarily due to external causes including accidental death. Yet we spend less than 1% of the amount spent on cancer or heart disease in alleviating this problem. It is not surprising, then, that adequate emergency care systems are sadly lacking.

What is needed are systems which bring together better transportation services, communication which would tie hospitals, transportation facilities and other emergency organizations into rapid response systems, and emergency medical centers with specially trained doctors and nurses. This will require a very carefully designed plan of coordination which includes firemen, police, highway safety officials, mayors, governors, as well as those who must provide the professional and technical services. There is also an urgent need for effective public education.

Emergency Medical Systems at a cost of $8,000,000 will be funded in 1972. An additional $7,000,000 is requested to allow the funding of additional projects totaling $15,000,000 in 1973. These will be implemented in major cities, medium size cities, combinations of cities and adjacent areas, rural areas, and entire States. In all cases they will be linked to adjacent systems and will address the larger question of ambulatory services for those who do not require emergency care.

Demonstration projects should clearly show the improvement in health which can be obtained by such systems. An improvement of only 10 percent in emergency care would save 15,000 lives and more than 3,000,000 hospitalizations and would return $3 billion to the economy.

3. Regionalization Activities - Provider-initiated activities leading to greater sharing of health facilities, manpower, and other resources. End stage kidney disease is one area in which the development of integrated regional systems could prevent the duplication which has characterized certain other specialized resources. These regional systems provide the opportunity to show how scarce resources can be linked together efficiently.

4. Development and Implementation of Quality of Care Guidelines and Performance Review Mechanisms - Such guidelines and mechanisms are necessary to the development of the new and more effective comprehensive systems of health services such as Health Maintenance Organizations, rural health delivery systems, and emergency health systems. The development of these guidelines and mechanisms is carried out in conjunction with the efforts of the National Center for Health Services Research and Development.

5. Development, Demonstration, and Application of Biomedical and Management Techniques - Activities aimed at increasing productivity of providers and extending specialized services to areas not currently covered.

6. Strengthening Regional Medical Programs - Thus far, this discussion has emphasized the direction of resources toward meeting new national objectives. One must not lose sight, however, of the overriding purpose for Regional Medical Program organizations which purpose is to bring together local resources in such a fashion as to create efficient and effective solutions to local health problems. While the new initiatives will contribute significantly to those solutions, they do not constitute a panacea.

It is equally true that some Regional Medical Programs have not well served that overriding purpose. Accordingly, the selective funding policy has sought to reward the effective regions and to provide a sufficient base from which new initiatives could be launched.

At the same time, concerted efforts are being made to improve the ability of the lesser Regional Medical Programs to attack the problems in their regions. Some have already made good progress. At some stage in their improvement, new funds must and will be made available to these Regional Medical Programs for new project activity.

In exercising the current authority to use funds for the purpose of program planning and evaluation, in addition to exercising this authority through grants and contracts, these funds will also be used to finance consultative and other services required to prepare, monitor, and review various forms of evaluation. Such consultative services would be performed under contract or through the use of part-time or intermittent consultants.

Regional Medical Programs:

(b) Direct operations	1972 Estimate		1973 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	169	3,157,000	194	3,523,000	+25	+$366,000
Other expenses........	--	1,445,000	--	1,528,000	--	+83,000
Total.............	169	4,602,000	194	5,051,000	+25	+449,000

This activity supports staff for reviewing, processing, awarding and administration of grants; provides health data required by the 56 local Regional Medical Programs in the implementation of their activities; develops and maintains appropriate relationships with government and private agencies concerned with improving the organization and delivery of health services.

This activity also provides technical assistance to the regions in the planning, development and implementation of their programs. Three of the many areas of assistance have been (1) development of professional concensus on regional programming for long-term control of hypertension, (2) development of regional information services to promulgate each region's experiences to the other regions, and (3) a study of the cooperation in trials and observation of experimental services such as "Physician Assistant" programs.

The rapid expansion of Regional Medical Program activity and the movement into new areas of emphasis carry with them additional requirements for development of policy guidance and criteria for project development. More finished products relating to specific professional issues of critical importance will be needed. They will range from technical problems to health delivery methods. The most outstanding example of this is the new emergency health services program. The 1973 increase includes 25 positions and $350,000 to develop and carry out this important health initiative. It also includes a $99,000 net increase partially offset by both program and mandatory decreases.

Medical Facilities Construction

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	135	$2,223,000	135	$2,300,000	---	$77,000
Other expenses........	---	275,462,000	---	88,459,000	---	-187,003,000
Budget Authority						
Total...........	135	277,685,000	135	90,759,000	---	-186,926,000
Obligations						
	135	134,091,000	135	201,280,000	---	+67,189,000

Introduction

A request for $90,759,000 is submitted for 1973. This amount provides $85,000,000 for construction grants, $2,500,000 for interest subsidies on guaranteed loans and direct loans for construction and modernization of hospitals and other health care facilities, and $3,259,000 for direct operations.

The 1973 budget for medical facilities construction reflects a shift in the Federal role in financing hospital construction from a purely grant basis to a balanced program of direct loans, guaranteed loans and grants. With the recognition of depreciation as an integral part of hospital costs by Medicare, Medicaid and private insurance carriers, financing of hospital construction can be put on the same basis as other capital investment. In effect, the purchaser of the medical service bears the cost of the capital investment. With this change in concept, medical facilities are now able to compete in the mortgage market and do not have to rely upon grants and contributions for capital investment. The 1973 budget reflects this shift in emphasis away from outright grants as a financing mechanism to direct Federal loans and guarantees with interest subsidies on loans made by the private money market.

Maximum flexibility in the use of construction support funds will be further encouraged by applying them to projects which will serve other HSMHA and Department programs. Hill-Burton grants will be used to construct community mental health centers, for facilities to house health maintenance organizations and for comprehensive health care centers which include programs in maternal and child health, family planning, drug abuse prevention and care, and alcoholic rehabilitation. The administrative barriers between these several programs and the definition of those areas in planning and structural requirements which might require waivers of policy or regulations is already being explored at the staff level between a number of HSMHA programs.

Construction under Title VI, the Public Health Service Act (Hill-Burton)

	1972 Estimate	1973 Estimate	Increase or Decrease
Other expenses (B.A.)....	$217,500,000	$87,500,000	-$130,000,000
Other expenses (Oblig.).	92,192,000	198,021,000	+ 105,829,000

The $87,500,000 requested for 1973 under Title VI of the Public Health Service Act will provide $70,000,000 for grants for outpatient facilities, $15,000,000 for grants for rehabilitation facilities, and $2,500,000 for interest subsidies on guaranteed loans to private nonprofit organizations and direct loans to public agencies for construction and modernization of hospitals and other health care facilities.

1. Construction grants---The construction of health care facilities for ambulatory patients would be supported with the $85,000,000 requested for construction grants. The $70,000,000 requested for Outpatient Facilities would assist in the construction of an estimated 194 projects. The $15,000,000 requested for Rehabilitation Facilities would assist in the construction of an estimated 49 projects.

2. Direct loans---Construction of health care facilities owned by public agencies (States, cities, counties, hospital districts, etc.), which are precluded by local laws from borrowing mortgage funds from commercial lenders, is supported by a program of direct loans. Loans would be made by HEW and the resulting debt obligation sold to the Federal National Mortgage Association and other investors. Proceeds from these sales would be used to provide capital for additional direct loans.

3. Interest subsidies---Under the redirected Hill-Burton program, Federal support for construction of inpatient health facilities such as hospitals and long-term care centers would be available through guaranteed loans with interest subsidies for private, nonprofit hospitals and direct loans for facilities owned by public agencies. These types of facilities generate the income from fees for services and third-party payments necessary for repayment of mortgage loans. The $2,500,000 requested for 1973 would, when added to $20,300,000 carried forward form previous appropriations, subsidize over $600,000,000 worth of guaranteed and direct loans.

District of Columbia medical facilities

	1972 Estimate	1973 Estimate	Increase or Decrease
Other expenses (B.A.)......	$42,127,000	----	-$42,127,000
Other expenses (Oblig.)....	38,967,000	----	- 38,967,000

$40,052,000 has been appropriated for grants and $40,575,000 for loans to assist in meeting the cost of projects in the District of Columbia for the modernization of public or nonprofit hospitals and in meeting the cost of projects for the construction or modernization of public health centers, long-term care facilities, including extended care facilities, outpatient facilities, rehabilitation facilities, facilities for the mentally retarded, and community mental health centers. Legislation for this program expires on June 30,1972.

Hospital experimentation projects

	1972 Estimate	1973 Estimate	Increase or Decrease
Other expenses (B.A.).........	$15,000,000	----	-$15,000,000
Other expenses (Oblig.).......	----	----	----

Grants and loans are authorized to provide for construction of medical facilities which involve experimental designs or methods of construction to serve as demonstrations relating to delivery of health services. No funds are being requested for this activity in 1973.

Direct operations

	1972 Estimate		1973 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits................	135	$2,223,000	135	$2,300,000	---	$+77,000
Other expenses............	---	835,000	---	959,000	---	+124,000
Total..(B.A.).......	135	3,058,000	135	3,259,000	---	+201,000
(Oblig.).....	---	2,932,000	---	3,259,000	---	+327,000

The estimate of $3,259,000 and 135 positions requested for 1973 are necessary to continue the Federal Governments' role of providing national leadership in the planning, programming, design and functioning of all types of medical facilities.

The funds requested will support the staff necessary to provide technical assistance and consultation to project sponsors and State agencies regarding all aspects of program administration; to develop and revise guidelines for the design, construction, and equipping of health care facilities; to develop regulations, procedures, and policies for operation of the program; to review and approve basic documents, such as State plans and project applications: to compile and analyze data pertinent to health care facilities: and to assist health facility construction programs with the above activities.

The operation of this program requires a variety of specialized and highly technical skills relating to the planning, design, equipping, functional layout and construction of all types of health care facilities as well as the prerequisite talent necessary for administration of a significant Federal program of national scope. The professional staff includes deciplines such as medicine, nursing, hospital administration, architecture, engineering and public administration.

Program direction and management services

	1972 estimate		1973 estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	149	$2,239,000	149	$2,261,000	---	+$22,000
Other expenses........	---	347,000	---	449,000	---	+102,000
Total...........	149	2,586,000	149	2,710,000	---	+124,000

This activity includes program leadership and direction and staff services including administrative management, program planning and evaluation.

The immediate office of the Director is responsible for planning, directing, coordinating, and administering the Health services planning and development programs.

Administrative management is responsible for the development, coordination, direction, and assessment of management activities. It directs such services as financial, personnel, and contract management.

Planning activities focus on annual work plans, the longer-range goal-oriented planning system and encompasses efforts in program analysis and evaluation, as well.

The increase of $124,000 includes a program increase of $68,000 for the Upward Mobility program and a net increase of $56,000 for built-in items.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health Services Planning and Development

Program Purpose and Accomplishments

Activity: Health services research and development - Grants and contracts. (PHS Act: Sec. 301 and 304)

1972			1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$56,118,000	Sec. 301 - indefinite Sec. 304 $94,000,000	--	$58,018,000

Purpose: The National Center focuses on national priority problems in health services such as rising costs of medical care, unequal distribution and utilization of health services, inadequate methods for health services planning and decision-making at local and national levels and shortages of professional health personnel.

Explanation: The scientific programs of the National Center are carried out through research, development, demonstrations and related training. Research grants are awarded to organizations and individuals to perform studies and to conduct and evaluate demonstrations. Contracts are used to support research and development projects. Under the training program, grants are awarded on a competitive basis to institutions and to qualified scholars for research and managerial training programs in the health services field.

Accomplishments in 1972: In 1972 the National Center made progress in primary components essential to involving and increasing comprehensive and effective health services for total communities. Major projects involved new types of manpower, ambulatory care, automation of hospital services, methods for assessing and maintaining quality of care, methods for limiting hospital costs, and the launching of community-wide health services systems. For example:

1. To pave the way for using much larger numbers of physician's assistants and nurse practitioners in physician-extender roles, the Center designed a method for determining how and where these new types of manpower should be used. This method will provide data for future national health manpower policy and is being applied at first to the evaluation of the Medex type of physician's assistants and now to nurses such as pediatric nurse practitioners, nurse midwives, and family nurse practitioners.

2. The Center is supporting the first automated hospital patient care management system in the United States. This computer-based system controls the admission of patients, the scheduling of medical, nursing, and auxiliary services according to highly sophisticated patient care plans; reports and records services actually performed; measures patient changes in response to services, and feedback data essential to update the system as a whole. Other projects played major roles in creation of automated clinical hospital laboratories capable of producing the thousands of quality-controlled tests required daily in the operation of all large hospitals.

3. The 1972 budget is supporting research, development and evaluation of HMOs which were funded by HSMHA in 1971 and are now in the planning and organizational phase of development. The HMOs will be studied with respect to such factors as enrolled populations, benefit structures, utilization patterns, monitoring of services, and legal and market factors.

4. R&D is being carried out, in close cooperation with the National Center for Health Statistics, on the Cooperative Federal-State-local Health Statistics System. This work will begin in 4-6 communities, States and regions. The cooperative system will provide information about the health of the nation, its health resources, and the utilization of these resources. It will furnish the data needed to make rational decisions at all levels about health care delivery problems and ways of meeting these problems.

5. In 1971, the Center initiated and supported the development of Experimental Medical Care Review Organizations (EMCROS) by 8 States and county medical societies. In 1972, these experimental review organizations which are intended to be prototype Professional Standard Review Organizations (PSROs) will be extended to 10 to 12 sites.

Objectives for 1973: In 1973 the National Center will continue and expand its priority R&D in new types of manpower, HMOs, health care institutions, cost effective technology, experimental medical care review organizations, and health service delivery systems. The 1973 budget includes an increase of $1,900,000 for the continued development of the cooperative Federal-State-local health statistics system. Out of this project will come the most comprehensive data base yet developed for assessing the Nation's health.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health Services Planning and Development

Program Purpose and Accomplishments

Activity: Health services research and development - Direct operations. (PHS Act, Sec. 301 and 304)

1972			1973 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
218	$5,898,000	Indefinite	230	$6,325,000

Purpose and Explanation: The National Center for Health Services Research and Development is responsible for the appraisal and evaluation of the effectiveness of health services operations and for developing a research and development program that is geared to improving health care nationally.

Accomplishments in 1972: The staff of the National Center devotes major effort to designing and directing the strategic program of research and development. The staff obtains high-level evaluation of all proposals, closely monitors contracts, reviews results, informs the professional community of significant progress and identifies the next steps in research and development. Considerable time and effort is devoted to close collaboration with the investigators, providers, payors and major national organizations.

The 1972 budget provides additional specialized staff which are essential for the National Center to further develop its capability for mounting large-scale R&D projects. The increased program effort in the development of cooperative Federal-State-local statistics systems requires personnel with statistical and computer capability to develop health status surveys, to monitor data systems for ambulatory care, and to collect and analyze the national data resulting from this program.

Objectives, 1973: An increase of $251,000 and 12 positions is necessary to support the expanded R&D strategy. Nine of the positions would be used to support the continued development of the cooperative Federal-State-local health statistics system.

Parallel to the R&D studies and projects, a number of internal studies by staff would move ahead. These studies would identify political, legal, and organizational barriers to large-scale adoption of new policies, and program formats suggested by the R&D.

An additional increase of $176,000 will provide for mandatory increases.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Comprehensive health planning - Project grants for training, studies, and demonstrations for comprehensive health planning (PHS Act, Section 314(c))

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$4,125,000	$12,000,000	--	$4,700,000

Purpose: To train people in health planning skills. To improve the art and skills of comprehensive health planning.

Explanation: Grants are awarded to public and nonprofit private agencies, institutions, or organizations to support graduate education, continuing education, and training of consumers to participate in comprehensive health planning.

Accomplishments in 1972: In 22 graduate programs, over 400 students were trained in the principles, concepts, and techniques used by State and areawide comprehensive health planning agencies, preparing them to practice effectively in this field. Ten continuing education programs aimed at upgrading individuals already involved or connected with health planning reached approximately 400 local elected officials, health professionals, administrators, planners, consultants and policy level personnel. Consumer education programs reached approximately 1,500 persons.

Objectives for 1973: To increase the level of technical assistance provided by university programs to the planning agencies. To increase emphasis on the development of health planning methodology. To support short-term training for about 1,750 health professionals and consumers and long-term training for over 400 graduate students.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Comprehensive health planning - Project grants for areawide comprehensive health planning (PHS Act, Section 314(b))

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$13,200,000	$40,000,000	--	$25,100,000

Purpose: To provide a mechanism for the development and coordination of a strengthened planning capacity for solving the health needs of our citizens at the community level.

Explanation: It is essential to the health planning process that every area identify its health needs, inventory resources, establish priorities and goals, and recommend courses of action. To assist public or nonprofit private agencies in this vital areawide comprehensive health planning, project grants are awarded according to a matching fund formula. Federal funds will average 60% of the project with the additional remaining funds coming from a broad range of community groups and local governmental funds. The Federal share may reach as high as 75% if the area is all or partially designated as one of poverty by the Department of Commerce or if the Agency supports projects for poverty areas.

Accomplishments in 1972: The number of agencies which have finished organizing and have launched active planning programs is expected to reach 125 (of 172 total agencies) by the end of 1972. Agencies in the planning phase help set priorities for their communities and establish a framework of comprehensive health planning. Against that framework, they review and comment, as required by law and policy, upon a variety of proposals for health services and facilities. A broad range of health problems are addressed in these efforts; in 1971 and 72, for example, a majority of all agencies in the planning phase were involved in drug and alcohol abuse issues. Building cooperative relationships with other federal health programs is an essential element in 314(b) work. For instance, assistance may be provided in the development of health maintenance organizations, OEO Health Centers and Experimental Health Delivery Systems.

Objectives for 1973: Improve the effectiveness of the 172 agencies and 8 State assisted local councils expected to be in operation at that time. Increase Federal share of individual agency budgets to avoid financial dependence upon organizations whose activities must be reviewed and commented upon by 314(b) agencies. Establish approximately 100 new agencies and 20 new State assisted comprehensive health planning councils in rural areas. Agencies will be located in areas in which approximately 80% of the population reside.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Comprehensive health planning - Formula grants to states (PHS Act, Section 314(a))

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$7,675,000	$20,000,000	--	$10,000,000

Purpose: To assist the States in comprehensive and continuing planning for their current and future health needs.

Explanation: Formula grants are awarded to States, the District of Columbia, and five Territories, according to a formula based on population and per capita income. Federal financial participation cannot exceed 75% of the costs.

Accomplishments in 1972: Formula grants were awarded to the States, the District of Columbia, and five Territories and supported up to 75% of the costs of their programs. New Federal legislation led to expansion of State advisory councils to include representatives of the Veterans Administration facilities and Regional Medical Programs operating in the State. State agencies were involved in planning, priority setting, and special studies that in many cases led to recommendations to improve provision of health services. For example, two State agencies accomplished studies that led to recommendations for expanded and improved services to crippled children. Both of these recommendations led to legislation expanding and improving these services.

Objectives for 1973: To increase professional staffs of State agencies by 25%, from just over 300 persons to over 400. To upgrade capability of State agencies through increased consultation and special studies.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Comprehensive health planning - Direct operations

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
24	$935,000	Indefinite	49	$1,833,000

Purpose: This activity supports the comprehensive health planning staff that provides national leadership in the development and operation of programs to provide grants to States and local agencies for the conduct and improvement of comprehensive State and areawide health planning. In addition, the program develops and provides assistance to projects which train participants in the comprehensive health planning process.

Explanation: This activity provides consultation and technical assistance to States, communities, providers of health services, medical and health services, medical and health organizations and other Federal units. Also, develops national policies and criteria for use by the regional offices and provides leadership in the health planning field.

Accomplishments in 1972: Guidance and technical assistance were given to State planning agencies in each of the 50 States, the District of Columbia and 5 Territories, 172 areawide health planning agencies, and training institutions for health planning.

Objectives for 1973: To improve staff capability to respond to State and areawide agencies' needs for technical assistance and consultation. To devise ways to help State and areawide agencies to learn from each other's successes.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Regional medical programs - Grants and contracts
(PHS Act, Title IX, Secs. 301, 311, 402(g), 403(a)(1), 433(a))

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
--	$94,800,000	$250,000,000	--	$125,100,000
Obligations				
--	$139,300,000		--	$125,100,000

Purpose: Funds are used for grants and contracts which on a regional basis encourage common efforts of health providers at all levels to systematically identify health problems, and develop programs which provide solutions to these problems.

Explanation: Applications for grants are submitted by each regional medical program. Applications are received in Review Committee and by Council for approval of funding. Contracts are reviewed by a Contracts Committee and approved by the Director. The final contract is negotiated, in accordance with prescribed regulations, by Health Services and Mental Health Administration contract officers.

Accomplishments in 1972: Regional Medical Programs have been organized as functional consortiums of health care providers, each with special and specific resources which can be made responsive to health needs. The merger of providers has produced systematic approaches to the major diseases of the heart as well as cancer and kidney disease.

In 1972, the affiliated health providers with the aid of the Regional Medical Program mechanism, are promoting and demonstrating at the local levels, new techniques and innovative delivery patterns that lead to improved accessibility, efficiency and effectiveness of health care.

Efforts at both regional and national levels are being directed to encourage providers of health care to make care available and accessible to areas where there is a distinct scarcity of resources, particularly in the rural and inner city areas.

In 1972, a construction grant has been made for a regional cancer center in Seattle, Washington.

Objectives for 1973: Funds will be provided for programs to enable existing health manpower to provide more and better care and training and more effective utilization of new kinds of health manpower. New funds will be used to plan and develop Area Health Education Centers, which will be major sources of manpower for Health Maintenance Organizations, Experimental Health Service Delivery Systems and other comprehensive health care systems.

Activities aimed at improving the accessibility, efficiency, and quality of health care will provide opportunities to increase the rate of implementation of systems, innovations and new technology. Rural health care systems will be developed that are compatable with needs of rural areas; development of emergency health care systems and development of integrated regional systems which will prevent duplications of specialized resources. The provider-initiated activities leading to a greater sharing of health facilities, manpower, and other resources will provide the opportunity to show how scarce resources can be linked together efficiently.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Regional medical programs - Direct operations (PHS Act, Sec. 301)

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
169	$4,602,000	---	194	$5,051,000

Purpose: Evaluates, processes and awards grants; provides the principal point of contact between the service and the individual Regions for assisting in the development and implementation of cooperative program arrangements. Develops and maintains appropriate relationships with government and private agencies concerned with improving the organization and delivery of health services.

Explanation: Applications from Regional Medical Programs are reviewed by special consultants, other Federal agencies and Service staff and are then analyzed and integrated for presentation to Review Committee. A written Summary of Committee review is provided for presentation to the Council. Technical assistance is provided in the development and coordination of programs aimed at improving the availability and quality of health care.

Accomplishments in 1972: The Anniversary Review process has been refined and the review and award process is being accomplished through a triennial review by the National Advisory Council. Additionally, this activity continues to provide Health Services data to the 56 Regional Medical Programs as required for their planning and operational programs.

This activity provides technical assistance to the regions. In 1972 the primary emphasis will be on local health requirements and needs. Some major studies associated with the coordination and execution of continuing education are those associated with the coordination and training programs such as: (1) development of professional consensus on regional programming for long-term control of hypertension; (2) development of regional operational information services to promulgate each regions experiences to the other regions and (3) a study of the cooperation in trials and observation of experimental services such as "Physician Assistant" plans.

Each of these programs and studies are designed to develop criteria for evaluation and to assist in the development of effective regional systems of health.

Objectives for 1973: To provide the strong leadership to the Regional Medical Programs, particularly the weaker ones, required by the expansion and redirection of Regional Medical Program activities.

The rapid expansion of Regional Medical Program activity and the movement into new areas of emphasis will require additional development of policy guidance and criteria for project development.

Increased technical assistance will be needed for new projects in areas involving new techniques and innovative delivery patterns, more effective use of new kinds of health manpower, and the quality of care guidelines.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Medical facilities construction--Construction grants,(Public Health Service Act,Sec.601)

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
---	$197,200,000	$417,500,000	---	$85,000,000
Obligations				
---	87,192,00		---	175,221,000

Purpose: Formula grants, matched by local funds, are used for construction of new buildings, for expansion or remodeling of existing buildings, for modernization of obsolete facilities, for replacement of obsolete equipment, and for the purchase of initial equipment for new, expanded or modernized facilities.

Explanation: Applications for grants are submitted by public bodies or private nonprofit organizations to the designated state agency and selected for funding based on points established in the State plan. Applications are reviewed and approved by the DHEW Regional Offices.

Accomplishments in 1972: In 1972, the $197,200,000 appropriated for construction grants will assist in the construction of an estimated 445 health facility projects. Of those, 232 will be outpatient facility projects, 47 will be rehabilitation facility projects, 42 will be long-term care facility projects, 57 will be hospital projects and 67 will be modernization projects.

Objectives for 1973: The Health Care Facilities Service will encourage maximum flexibility in the use of construction support funds by applying them to projects which will serve other HSMHA and Department programs. Hill-Burton grants will be used to construct community mental health centers, for facilities to house health maintenence organizations and for comprehensive health care centers which include programs in maternal and child health, family planning, drug abuse prevention and care, and alcoholic rehabilitation. Of the $85,000,000 requested for construction grants in 1973, $70,000,000 will be invested in 194 outpatient facility projects and $15,000,000 will be used to support 49 rehabilitation facility projects.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Medical facilities construction--Direct loans, (Public Health Service Act, Sec. 626)

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$30,000,000	-------------	---	------

Purpose: Construction of health facilities owned by public agencies (states, cities, counties, hospital districts, etc.), which are precluded by local laws from borrowing mortgage funds from commercial lenders, is supported by a program of direct loans.

Explanation: This mechanism of assistance enables public agencies to participate in the loan guarantee and interest subsidy program. Loans would be made from a revolving fund capitalized with a $30,000,000 appropriation in 1972. The debt obligations, usually in the form of bonds, received for the loans would be sold by HEW to the Federal National Mortgage Association and other investors. Proceeds from these sales by HEW would be used to provide capital for additional direct loans.

Accomplishments in 1972: Program regulations have been published and agreements with the Federal National Mortgage Association and private bond investment concerns regarding procedures for committing and transferring bond obligations are being negotiated. Approximately $30,000,000 in direct loans will be committed in 1972.

Objectives for 1973: Additional experience and streamlining of procedures will permit extensive utilization of the program in 1973. Depending on the volume of loan applications, it is anticipated that committments to use revolving fund capital several times will be made.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Medical facilities construction--Interest subsidies (Sec. 626 (a) (1) of the Public Health Service Act)

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
---	$20,300,000	Such amounts as necessary	---	$2,500,000
Obligations				
---	5,000,000		---	22,000,000

Purpose: Loan guarantees with interest subsidies provide another form of Federal assistance to private nonprofit and public agencies for hospital construction. Federal participation in debt service costs is authorized to reduce the rate of interest paid on approved projects by 3 percent.

Explanation: Interest subsidies are paid on guaranteed loans made to private nonprofit and publicly-owned hospitals. The subsidy serves to reduce the rate of interest paid by the borrowing institution by three percent. In the case of private non-profit hospitals, subsidies are paid only on loans guaranteed by Hill-Burton. Hospitals owned by public agencies are eligible for direct Hill-Burton loans paid out of a revolving fund. The fund is replenished by selling the obligations received for the loans to the Federal National Mortgage Association and other investors at a higher, taxable interest rate. Interest subsidy appropriations are used to supplement the higher interest rate.

Accomplishments in 1972: Approximately $170 million worth of loans will be guaranteed or directly made in 1972, requiring $5,000,000 in interest subsidies. Twenty-three projects, building or modernizing facilities for 3,300 inpatient beds, will be supported.

Objectives for 1973: $605,000,000 worth of loans will be guaranteed in 1973 resulting in 83 projects adding or modernizing over 12,000 beds. The program will require $17,900,000 to subsidize current loan guarantees and $4,900,000 to subsidize prior loan guarantees for a total of $22,800,000. Of this amount $2,500,000 is requested in 1973 with the remainder carried forward from previous appropriations.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Medical facilities construction--District of Columbia medical facilities (Sections 2 and 3 of the District of Columbia Medical Facilities Construction Act of 1968)

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
---	$42,127,000	Expired	---	-----
Obligations				
---	38,967,000		---	-----

Purpose: Funds for grants or loans are for the construction and modernization of hospitals and other medical facilities in the District of Columbia.

Explanation: Grants and loans are awarded on a project basis. Federal payment made under this Act for the construction of long-term care facilities, including extended care facilities, outpatient facilities, or rehabilitation facilities, may not exceed 66-2/3% of cost of such project. In the case of any other project (including a modernization project), the Federal payment may not exceed 50% of the cost of such project. Loans shall bear interest at the rate of 2-1/2% per annum and shall be repaid over a period not to exceed 50 years.

Accomplishments in 1972: In 1972, 5 loans totaling $16,575,000 and 4 grants totaling $22,167,000 will be awarded to the following hospitals:

Loans

Rogers Memorial Hospital
Childrens Hospital
George Washington University Hospital
Georgetown University Hospital
Washington Hospital Center

Grants

Georgetown University Hospital
Washington Hospital Center
Childrens Hospital
Rogers Memorial Hospital

Legislation for this program expires on June 30,1972

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Medical facilities construction--Hospital expermentation projects (Public Health Service Act, section 304 and 643A)

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$15,000,000		---	------

Purpose: Funds for grants or loans are for the construction of hospitals or other medical facilities which demonstrate experimental hospital design.

Explanation: Grants and loans are awarded on a project basis. Grants are awarded to provide construction of hospitals, facilities for long-tern care, or other medical facilities which involve experimental designs or methods of construction to serve as demonstrations relating to delivery of health services. Loans are awarded to provide up to 66 2/3% of the increased cost of projects for the construction of demonstration of experimental hospitals. Loans shall bear interest at the rate of 2 1/2% per annum and shall be repaid over a period not to exceed 50 years.

Accomplishments in 1972: The $15,000,000 appropriated in 1972 will be placed in reserve in order to reduce Federal outlays.

Objectives for 1973: No funds are being requested for 1973.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Medical facilities construction--Direct operations

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
135	$3,058,000	-----------	135	$3,259,000
Obligations				
135	2,932,000		135	3,259,000

Purpose: To provide national leadership in the planning, programming, design and functioning of all types of medical facilities, and to provide State agencies with technical assistance in determining additional facilities required and developing programs to meet the indicated needs.

Explanation: State plans are reviewed for conformance with planning criteria and guidelines. Assistance is provided to the States and communities in the planning, programming, designing and functioning of hospitals and other health facilities, and proposed projects are reviewed to determine eligibility and compliance with the law and regulations.

Accomplishments in 1972: Technical assistance and consultation to project sponsors and State agencies regarding all aspects of program administration were provided; guidelines, regulations, procedures and policies were developed and revised; basic documents, such as State plans, project applications and design drawings were reviewed and approved: surveillance over bid awards and construction of facilities was maintained; statistical data regarding health facility planning was compiled and analyzed; and several other facility construction programs were assisted with the above activities. In addition, implementation in 1972 of the loan guarantee and direct loan program was undertaken.

Objectives for 1973: The staff will update and revise regulations and guidelines as changes occur in the planning, design, equipping, functional layout and construction of all types of health facilities and will continue to provide national leadership in all aspects of health facility construction. Considerable emphasis will be placed on completing implementation of the loan guarantee and direct loan program begun in 1972.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services planning and development

Program Purpose and Accomplishments

Activity: Program direction and management services

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
149	$2,586,000	Indefinite	149	$2,710,000

Purpose: This activity provides for the overall planning, direction and administration of the broad scope of programs of the Health services planning and development appropriation.

Explanation: It includes program planning and evaluation activities which focus on program, operational, and legislative planning. Administrative management is responsible for the development, coordination, direction, and assessment of management activities. It directs such services as financial, personnel, and contract management.

Health Services Planning and Development

Allocations of Grants to States for Comprehensive State Health Planning [1/]

	1971 Actual	1972 Allocation	1973 Estimate
Alabama	$151,600	$143,500	$180,000
Alaska	76,800	76,800	100,000
Arizona	76,800	76,800	100,000
Arkansas	86,200	83,200	102,800
California	491,500	500,500	674,500
Colorado	76,800	76,800	100,000
Connecticut	76,800	76,800	100,000
Delaware	76,800	76,800	100,000
District of Columbia	76,800	76,800	100,000
Florida	199,700	207,300	285,400
Georgia	167,400	160,800	206,600
Hawaii	76,800	76,800	100,000
Idaho	76,800	76,800	100,000
Illinois	278,400	279,000	367,100
Indiana	150,500	151,600	205,900
Iowa	85,400	85,700	114,200
Kansas	76,800	76,800	100,000
Kentucky	122,600	121,700	157,600
Louisiana	142,600	141,000	178,200
Maine	76,800	76,800	100,000
Maryland	100,900	103,600	138,800
Massachusetts	143,000	147,300	194,900
Michigan	239,300	239,100	327,200
Minnesota	111,100	112,600	149,800
Mississippi	113,800	107,500	127,600
Missouri	143,300	145,500	189,300
Montana	76,800	76,800	100,000
Nebraska	76,800	76,800	100,000
Nevada	76,800	76,800	100,000
New Hampshire	76,800	76,800	100,000
New Jersey	181,300	181,900	234,400
New Mexico	76,800	76,800	100,000
New York	442,800	440,700	569,200
North Carolina	196,000	189,300	236,900
North Dakota	76,800	76,800	100,000

Health Services Planning and Development

Allocations of Grants to States for Comprehensive State Health Planning (cont'd)

	1971 Actual	1972 Allocation	1973 Estimate
Ohio	$307,000	$306,600	$400,600
Oklahoma	89,400	90,400	116,300
Oregon	76,800	76,800	100,000
Pennsylvania	346,300	346,800	446,500
Rhode Island	76,800	76,800	100,000
South Carolina	113,500	106,900	132,100
South Dakota	76,800	76,800	100,000
Tennessee	155,000	150,400	190,900
Texas	370,500	369,700	479,100
Utah	76,800	76,800	100,000
Vermont	76,800	76,800	100,000
Virginia	152,700	151,200	192,900
Washington	92,500	95,300	127,500
West Virginia	76,800	76,800	100,000
Wisconsin	126,300	130,900	178,900
Wyoming	76,800	76,800	100,000
Guam	76,800	76,800	100,000
Puerto Rico	224,000	234,600	294,800
Virgin Islands	76,800	76,800	100,000
American Samoa	76,800	76,800	100,000
Trust Territory of the Pacific Islands	76,800	76,800	100,000
TOTAL	7,598,200	7,598,200	9,900,000
Evaluation Amount 2/	76,800	76,800	100,000
Grand Total	7,675,000	7,675,000	10,000,000

1/ Allocations are awarded to States based on population weighted by per capita income, and a requirement that each State receive a minimum of one percent of the amount available for allotment.

2/ Authorized by P.L. 91-296

Health Services Planning and Development

ALLOCATIONS TO STATES

For Construction and Modernization of Hospitals and Related Health Facilities

	Fiscal Year		
	1971	1972	1973
Totals	$171,720,000	$194,900,000	$85,000,000
Alabama	3,583,851	4,188,571	2,280,880
Alaska	1,200,000	1,200,000	300,000
Arizona	1,750,396	1,819,715	869,221
Arkansas	2,310,311	2,521,617	1,305,875
California	8,715,388	10,969,161	5,381,676
Colorado	1,966,225	2,149,437	927,368
Connecticut	1,967,408	1,967,424	650,977
Delaware	1,200,000	1,200,000	300,000
District of Columbia	1,200,000	1,200,000	300,000
Florida	5,042,959	6,013,391	3,062,420
Georgia	4,124,611	4,723,773	2,485,192
Hawaii	1,233,723	1,227,026	329,177
Idaho	1,317,315	1,334,854	438,668
Illinois	6,005,622	7,226,850	2,965,145
Indiana	3,906,922	4,639,957	2,024,093
Iowa	2,608,846	2,927,735	1,170,640
Kansas	2,345,838	2,463,324	947,392
Kentucky	3,201,234	3,669,239	1,910,800
Louisiana	3,857,231	4,400,140	2,143,059
Maine	1,454,903	1,475,010	541,781
Maryland	2,295,896	2,573,699	1,246,392
Massachusetts	4,351,125	4,794,952	1,667,528
Michigan	5,248,395	6,367,206	2,922,847
Minnesota	3,153,688	3,580,635	1,548,980
Mississippi	2,785,582	3,078,736	1,667,695
Missouri	3,940,580	4,536,710	2,013,164
Montana	1,278,915	1,294,566	396,023
Nebraska	1,492,746	1,523,755	626,199
Nevada	1,200,000	1,200,000	300,000
New Hampshire	1,254,586	1,262,946	367,454
New Jersey	4,527,306	5,150,828	1,986,719
New Mexico	1,466,199	1,489,209	588,587
New York	10,344,755	11,642,494	4,435,453
North Carolina	5,128,165	5,907,674	2,950,461
North Dakota	1,281,757	1,288,394	387,355
Ohio	6,538,653	8,067,855	4,010,144
Oklahoma	2,567,115	2,870,251	1,370,029
Oregon	1,838,826	1,967,281	872,141
Pennsylvania	9,538,650	11,341,528	4,599,219
Rhode Island	1,273,925	1,276,467	375,220

ALLOCATIONS TO STATES - Continued

For Construction and Modernization of Hospitals
and Related Health Facilities

	Fiscal Year		
	1971	1972	1973
South Carolina	2,996,889	3,342,108	1,703,903
South Dakota	1,298,046	1,299,489	396,855
Tennessee	4,233,766	4,886,243	2,370,731
Texas	9,504,132	11,333,449	5,512,489
Utah	1,454,762	1,478,323	589,072
Vermont	1,200,000	1,200,000	300,000
Virginia	4,125,804	4,702,248	2,210,385
Washington	2,461,557	2,747,025	1,156,791
West Virginia	2,450,982	2,627,584	1,108,238
Wisconsin	3,265,948	3,879,886	1,765,555
Wyoming	1,200,000	1,200,000	300,000
American Samoa	750,000	750,000	150,000
Guam	750,000	750,000	150,000
Puerto Rico	4,028,467	4,671,235	2,320,007
Trust Territory	750,000	750,000	150,000
Virgin Islands	750,000	750,000	150,000

ALLOCATIONS TO STATES FOR CONSTRUCTION AND MODERNIZATION OF HOSPITAL AND HEALTH RELATED FACILITIES FOR FISCAL YEAR 1971 AS OF JULY 1, 1971

State	Total	Moderni-zation	Hospitals and Public Health Centers	Long-Term Care Facilities	Outpatient Facilities	Rehabili-tation Facilities
Total	$171,720,000	$57,609,575	$19,252,623	$18,583,846	$62,179,897	$14,094,059
Alabama	3,583,851	1,286,706	600,000	581,445	818,645	297,055
Alaska	1,200,000	1,000,000	-	-	100,000	100,000
Arizona	1,750,396	300,000	300,000	300,000	707,061	143,335
Arkansas	2,310,311	498,327	790,000	110,000	780,816	131,168
California	8,715,388	2,325,744	300,000	867,725	4,341,761	880,158
Colorado	1,966,225	526,417	300,000	300,000	698,258	141,550
Connecticut	1,967,408	874,739	83,000	-	900,000	109,669
Delaware	1,200,000	300,000	300,000	300,000	200,000	100,000
Dist. of Col.	1,200,000	300,000	300,000	300,000	200,000	100,000
Florida	5,042,959	1,210,984	300,000	503,278	2,518,208	510,489
Georgia	4,124,611	1,020,000	326,492	434,998	1,976,564	366,557
Hawaii	1,233,723	220,325	379,675	300,000	233,723	100,000
Idaho	1,317,315	300,000	300,000	300,000	317,315	100,000
Illinois	6,005,622	2,431,271	300,000	466,568	2,334,529	473,254
Indiana	3,906,922	1,392,815	300,000	315,492	1,578,602	320,013
Iowa	2,608,846	920,196	313,921	300,000	905,157	169,572
Kansas	2,345,838	150,096	1,148,333	738,200	209,400	99,809
Kentucky	3,201,234	630,159	300,000	323,609	1,619,219	328,247
Louisiana	3,857,231	1,012,706	216,960	410,000	1,843,793	373,772
Maine	1,454,903	300,000	300,000	328,282	426,621	100,000
Maryland	2,295,896	477,365	300,000	300,000	1,013,147	205,384
Massachusetts	4,351,125	2,075,926	300,000	300,000	1,392,843	282,356
Michigan	5,248,395	1,676,086	300,000	466,277	2,333,073	472,959
Minnesota	3,153,688	925,870	1,653,914	-	320,451	253,453
Mississippi	2,785,582	364,414	900,000	2,249	1,312,339	206,580

Missouri	3,940,580	1,319,049	300,000	330,799	1,655,193	335,539
Montana	1,278,915	378,477	194,091	300,000	278,915	127,432
Nebraska	1,492,746	300,000	307,018	300,000	492,746	92,982
Nevada	1,200,000	1,184,265	-	-	-	15,735
New Hampshire	1,254,586	300,000	300,000	300,000	254,586	100,000
New Jersey	4,527,306	1,980,923	300,000	320,091	1,601,614	324,678
New Mexico	1,466,199	771,764	155,000	36,800	404,500	98,135
New York	10,344,755	4,563,297	300,000	781,063	3,908,140	792,255
North Carolina	5,128,165	3,500,781	300,000	516,811	386,356	424,217
North Dakota	1,281,757	300,000	300,000	300,000	281,757	100,000
Ohio	6,538,653	1,638,075	300,000	655,545	3,280,095	664,938
Oklahoma	2,567,115	1,029,364	175,000	-	1,133,058	229,693
Oregon	1,838,826	423,943	300,000	300,000	677,534	137,349
Pennsylvania	9,538,650	3,929,849	300,000	756,461	3,785,040	767,300
Rhode Island	1,273,925	300,000	300,000	300,000	273,925	100,000
South Carolina	2,996,889	594,310	300,000	300,000	1,498,753	303,826
South Dakota	1,298,046	300,000	300,000	300,000	298,046	100,000
Tennessee	4,233,766	2,327,741	977,277	241,016	380,012	307,720
Texas	9,504,132	2,656,156	300,000	1,418,733	4,277,059	852,184
Utah	1,454,762	900,000	-	200,000	254,762	100,000
Vermont	1,200,000	300,000	600,000	-	200,000	100,000
Virginia	4,125,804	1,174,806	300,000	377,746	1,890,094	383,158
Washington	2,461,557	766,321	300,000	300,000	910,633	184,603
West Virginia	2,450,982	717,316	300,000	300,000	942,586	191,080
Wisconsin	3,265,948	1,010,923	300,000	300,000	1,376,069	278,956
Wyoming	1,200,000	705,397	31,942	200,000	252,161	10,500
American Samoa	750,000	200,000	200,000	200,000	100,000	50,000
Guam	750,000	200,000	200,000	200,000	100,000	50,000
Puerto Rico	4,028,467	916,672	300,000	400,658	2,004,738	406,399
Trust Territory	750,000	200,000	200,000	200,000	100,000	50,000
Virgin Islands	750,000	200,000	200,000	200,000	100,000	50,000

FISCAL YEAR 1972 GRANT ALLOCATIONS TO STATES
FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER HEALTH FACILITIES

States	Total	Modernization	Hospitals and Public Health Centers	Long-Term Care Facilities	Outpatient Facilities	Rehabilitation Facilities
Total	$194,900,000	$50,000,000	$40,250,000	$19,650,000	$70,000,000	$15,000,000
Alabama	4,188,571	526,566	1,014,369	355,837	1,904,969	386,830
Alaska	1,200,000	300,000	300,000	300,000	200,000	100,000
Arizona	1,819,715	300,000	374,222	300,000	702,783	142,710
Arkansas	2,521,617	330,126	580,330	300,000	1,089,852	221,309
California	10,969,161	2,357,609	2,385,384	836,785	4,479,716	909,667
Colorado	2,149,437	536,814	402,727	300,000	756,316	153,580
Connecticut	1,967,424	717,225	300,000	300,000	540,453	109,746
Delaware	1,200,000	300,000	300,000	300,000	200,000	100,000
Dist. of Columbia	1,200,000	300,000	300,000	300,000	200,000	100,000
Florida	6,013,391	1,224,471	1,326,522	465,340	2,491,189	505,869
Georgia	4,723,773	757,180	1,098,739	385,434	2,063,416	419,004
Hawaii	1,227,026	300,000	300,000	300,000	227,026	100,000
Idaho	1,334,854	300,000	300,000	300,000	334,854	100,000
Illinois	7,226,850	2,453,126	1,322,313	463,863	2,483,284	504,264
Indiana	4,639,957	1,407,044	895,511	314,142	1,681,757	341,503
Iowa	2,927,735	929,882	520,920	300,000	978,280	198,653
Kansas	2,463,324	781,623	423,921	300,000	796,118	161,662
Kentucky	3,669,239	625,092	841,934	300,000	1,581,141	321,072
Louisiana	4,400,140	960,342	952,820	334,245	1,789,376	363,357
Maine	1,475,010	330,596	300,000	300,000	444,414	100,000
Maryland	2,573,699	484,261	549,019	300,000	1,031,050	209,369
Massachusetts	4,794,952	2,082,480	740,173	300,000	1,390,034	282,265
Michigan	6,367,206	1,691,057	1,295,285	454,382	2,432,525	493,957
Minnesota	3,580,635	1,056,987	682,240	300,000	1,281,236	260,172
Mississippi	3,078,736	346,767	746,155	300,000	1,401,268	284,546

Missouri	4,536,710	1,321,257	890,675	312,446	1,672,673	339,659
Montana	1,294,566	300,000	300,000	300,000	294,566	100,000
Nebraska	1,523,755	300,000	300,000	300,000	518,472	105,283
Nevada	1,200,000	300,000	300,000	300,000	200,000	100,000
New Hampshire	1,262,946	300,000	300,000	300,000	262,946	100,000
New Jersey	5,150,828	1,986,963	876,385	307,433	1,645,838	334,209
New Mexico	1,489,209	300,000	300,000	300,000	489,209	100,000
New York	11,642,494	4,527,098	1,970,952	691,403	3,701,418	751,623
North Carolina	5,907,674	1,182,071	1,308,984	459,187	2,458,251	499,181
North Dakota	1,288,394	300,000	300,000	300,000	288,394	100,000
Ohio	8,067,855	1,640,149	1,780,463	624,581	3,343,682	678,980
Oklahoma	2,870,251	603,422	603,445	300,000	1,133,260	230,124
Oregon	1,967,281	429,874	379,650	300,000	712,977	144,780
Pennsylvania	11,341,528	3,935,804	2,051,372	719,615	3,852,446	782,291
Rhode Island	1,276,467	300,000	300,000	300,000	276,467	100,000
South Carolina	3,342,108	581,376	754,980	300,000	1,417,840	287,912
South Dakota	1,299,489	300,000	300,000	300,000	299,489	100,000
Tennessee	4,886,243	1,104,934	1,047,416	367,430	1,967,031	399,432
Texas	11,333,449	2,598,329	2,419,612	848,793	4,543,996	922,719
Utah	1,478,323	300,000	300,000	300,000	478,323	100,000
Vermont	1,200,000	300,000	300,000	300,000	200,000	100,000
Virginia	4,702,248	1,167,546	979,105	343,467	1,838,748	373,382
Washington	2,747,025	772,880	513,646	300,000	964,620	195,879
West Virginia	2,627,584	712,289	495,591	300,000	930,711	188,993
Wisconisn	3,879,886	1,028,172	782,894	300,000	1,470,263	298,557
Wyoming	1,200,000	300,000	300,000	300,000	200,000	100,000
American Samoa	750,000	200,000	200,000	200,000	100,000	50,000
Guam	750,000	200,000	200,000	200,000	100,000	50,000
Puerto Rico	4,671,235	908,588	1,042,246	365,617	1,957,323	397,461
Trust Territory	750,000	200,000	200,000	200,000	100,000	50,000
Virgin Islands	750,000	200,000	200,000	200,000	100,000	50,000

TENTATIVE ALLOCATIONS TO STATES
FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER HEALTH FACILITIES
For Fiscal Year 1973

State	Total	Outpatient Facilities	Rehabilitation Facilities
Total	$85,000,000	$70,000,000	$15,000,000
Alabama	2,280,880	1,895,822	385,058
Alaska	300,000	200,000	100,000
Arizona	869,221	722,479	146,742
Arkansas	1,305,875	1,085,417	220,458
California	5,381,676	4,473,142	908,534
Colorado	927,368	770,810	156,558
Connecticut	650,977	541,079	109,898
Delaware	300,000	200,000	100,000
Dist. of Col.	300,000	200,000	100,000
Florida	3,062,420	2,545,422	516,998
Georgia	2,485,192	2,065,642	419,550
Hawaii	329,177	229,177	100,000
Idaho	438,668	338,668	100,000
Illinois	2,965,145	2,464,569	500,576
Indiana	2,024,093	1,682,386	341,707
Iowa	1,170,640	973,013	197,627
Kansas	947,392	787,453	159,939
Kentucky	1,910,800	1,588,219	322,581
Louisiana	2,143,059	1,781,268	361,791
Maine	541,781	441,781	100,000
Maryland	1,246,392	1,035,976	210,416
Massachusetts	1,667,528	1,386,016	281,512
Michigan	2,922,847	2,429,412	493,435
Minnesota	1,548,980	1,287,481	261,499
Mississippi	1,667,695	1,386,155	281,540
Missouri	2,013,164	1,673,302	339,862
Montana	396,023	296,023	100,000
Nebraska	626,199	520,484	105,715
Nevada	300,000	200,000	100,000
New Hampshire	367,454	267,454	100,000
New Jersey	1,986,719	1,651,321	335,398
New Mexico	588,587	488,587	100,000
New York	4,435,453	3,686,660	748,793
North Carolina	2,950,461	2,452,364	498,097
North Dakota	387,355	287,355	100,000
Ohio	4,010,144	3,333,152	676,992
Oklahoma	1,370,029	1,138,741	231,288
Oregon	872,141	724,906	147,235
Pennsylvania	4,599,219	3,822,779	776,440
Rhode Island	375,220	275,220	100,000
South Carolina	1,703,903	1,416,250	287,653
South Dakota	396,855	296,855	100,000
Tennessee	2,370,731	1,970,504	400,227
Texas	5,512,489	4,581,871	930,618
Utah	589,072	489,072	100,000

TENTATIVE ALLOCATIONS TO STATES
FOR CONSTRUCTION AND MODERNIZATION OF HOSPITALS AND OTHER HEALTH FACILITIES
(Continued)

State	Total	Outpatient Facilities	Rehabilitation Facilities
Vermont	300,000	200,000	100,000
Virginia	2,210,385	1,837,228	373,157
Washington	1,156,791	961,502	195,289
West Virginia	1,108,238	921,145	187,093
Wisconsin	1,765,555	1,467,494	298,061
Wyoming	300,000	200,000	100,000
American Samoa	150,000	100,000	50,000
Guam	150,000	100,000	50,000
Puerto Rico	2,320,007	1,928,344	391,663
Trust Territory	150,000	100,000	50,000
Virgin Islands	150,000	100,000	50,000

FY 1971 Loan and Loan Guarantee Allocations to States for Modernization and Construction of Hospitals and other Health Facilities

State	Amount	State	Amount
TOTAL	$500,000,000		
Alabama	8,236,500	New Jersey	18,222,500
Alaska	456,500	New Mexico	2,151,000
Arizona	3,247,500	New York	42,450,500
Arkansas	4,992,000	North Carolina	14,544,000
California	26,721,000	North Dakota	1,919,500
Colorado	5,432,500	Ohio	19,301,000
Connecticut	6,509,500	Oklahoma	6,954,000
Delaware	1,659,500	Oregon	4,624,500
Dist. of Columbia	1,355,000	Pennsylvania	37,465,500
Florida	14,470,500	Rhode Island	1,613,500
Georgia	10,460,000	South Carolina	7,670,500
Hawaii	1,323,000	South Dakota	2,496,500
Idaho	1,888,500	Tennessee	12,642,500
Illinois	23,163,000	Texas	29,653,500
Indiana	13,792,000	Utah	2,509,000
Iowa	8,813,500	Vermont	1,098,500
Kansas	7,577,000	Virginia	12,842,000
Kentucky	8,198,000	Washington	7,679,000
Louisiana	11,224,500	West Virginia	7,383,500
Maine	3,369,000	Wisconsin	10,508,500
		Wyoming	759,500
Maryland	5,748,500	American Samoa	79,500
Massachusetts	18,478,000	Guam	435,500
Michigan	17,534,500	Puerto Rico	11,167,000
Minnesota	10,527,000	Trust Territories	235,500
Mississippi	5,987,500	Virgin Islands	309,000
Missouri	13,408,000		
Montana	2,703,000		
Nebraska	3,202,500		
Nevada	912,000		
New Hampshire	1,894,500		

FY 1972 Loan and Loan Guarantee Allocations to States for Modernization and Construction of Hospitals and other Health Facilities

State	Allocation
TOTAL	$500,000,000
Alabama	8,041,500
Alaska	460,000
Arizona	3,255,000
Arkansas	4,815,500
California	27,244,500
Colorado	5,633,000
Connecticut	6,509,500
Delaware	1,720,000
Dist. of Columbia	1,353,500
Florida	14,506,000
Georgia	10,101,500
Hawaii	1,294,000
Idaho	1,936,000
Illinois	23,637,500
Indiana	14,114,500
Iowa	9,039,500
Kansas	7,542,000
Kentucky	8,075,000
Louisiana	11,021,000
Maine	3,423,000
Maryland	5,836,000
Massachusetts	18,512,500
Michigan	17,853,000
Minnesota	10,641,500
Mississippi	5,613,000
Missouri	13,456,500
Montana	2,746,500
Nebraska	3,286,000
Nevada	937,000
New Hampshire	1,924,000
New Jersey	18,354,500
New Mexico	2,221,500
New York	41,715,000
North Carolina	14,119,000
North Dakota	1,938,500
Ohio	19,445,000
Oklahoma	6,944,500
Oregon	4,743,000
Pennsylvania	37,638,500
Rhode Island	1,629,500
South Carolina	7,396,000
South Dakota	2,501,500
Tennessee	12,482,000
Texas	29,176,000
Utah	2,579,000
Vermont	1,102,500
Virginia	12,671,000
Washington	7,841,000
West Virginia	7,317,000
Wisconsin	10,836,000
Wyoming	794,500
American Samoa	68,000
Guam	389,000
Puerto Rico	10,999,000
Trust Territory	244,500
Virgin Islands	325,500

Tentative

FY 1973 Loan and Loan Guarantee Allocations to States for Modernization and Construction of Hospitals and other Health Facilities

State	Allocation
TOTAL	$500,000,000
Alabama	8,009,500
Alaska	466,000
Arizona	3,329,000
Arkansas	4,800,000
California	27,216,500
Colorado	5,689,000
Connecticut	6,512,000
Delaware	1,722,000
Dist. Of Columbia	1,333,000
Florida	14,711,500
Georgia	10,109,500
Hawaii	1,303,000
Idaho	1,949,500
Illinois	23,557,500
Indiana	14,117,000
Iowa	9,020,000
Kansas	7,509,000
Kentucky	8,100,000
Louisiana	10,992,500
Maine	3,413,000
Maryland	5,856,500
Massachusetts	18,496,000
Michigan	17,840,500
Minnesota	10,665,500
Mississippi	5,561,500
Missouri	13,458,500
Montana	2,752,500
Nebraska	3,294,000
Nevada	947,000
New Hampshire	1,941,000
New Jersey	18,377,500
New Mexico	2,219,500
New York	41,650,500
North Carolina	14,098,000
North Dakota	1,934,000
Ohio	19,403,500
Oklahoma	6,964,500
Oregon	4,789,000
Pennsylvania	37,523,500
Rhode Island	1,624,500
South Carolina	7,390,000
South Dakota	2,491,000
Tennessee	12,494,500
Texas	29,317,000
Utah	2,618,500
Vermont	1,112,000
Virginia	12,665,000
Washington	7,829,000
West Virginia	7,283,000
Wisconsin	10,825,000
Wyoming	798,500
American Samoa	67,500
Guam	385,000
Puerto Rico	10,903,000
Trust Territory	240,500
Virgin Islands	323,500

New Positions Requested
Fiscal Year 1973

	Grade	Number	Annual Salary
Health services research and development			
Direct operations			
Public Health Analyst..................	GS-14	1	$20,815
Health Science Administrator...........	GS-14	1	20,815
Social Science Analyst.................	GS-12	1	15,040
Public Health Analyst..................	GS-12	1	15,040
Program Analyst........................	GS-11	1	12,615
Health Statistician....................	GS-11	1	12,615
Statistician...........................	GS-9	1	10,470
Staff Assistant........................	GS-7	1	8,582
Secretary..............................	GS-6	2	15,454
Clerical Assistant.....................	GS-5	2	13,876
		12	145,322
Comprehensive health planning			
Direct operations			
Public Health Advisor..................	GS-15	1	25,583
Health Planner.........................	GS-14	1	21,960
Public Health Program Specialist...........................	GS-14	2	43,920
Health Planner.........................	GS-13	1	18,737
Public Health Program Specialist...........................	GS-13	3	56,211
Public Health Advisor..................	GS-12	2	31,732
Public Health Program Specialist...........................	GS-12	1	15,866
Program Management Officer.............................	GS-12	1	15,866
Administrative Assistant...............	GS-11	1	13,309
Clerical Assistant.....................	GS-6	3	24,459
Clerical Assistant.....................	GS-5	3	21,957
Clerical Assistant.....................	GS-4	2	13,088
Commissioned Officers:			
Director Grade.......................		2	46,048
Full Grade...........................		2	26,964
		25	375,700
Regional medical programs			
Direct operations			
Supervisory Public Health Analyst......	GS-15	1	24,251
Supervisory Systems Analyst............	GS-14	1	20,815
Public Health Analysts.................	GS-13	3	53,283
Systems Analyst........................	GS-13	1	17,761
Public Health Advisors.................	GS-12	7	105,280
Systems Analyst........................	GS-12	1	15,040
Administrative Assistant...............	GS-9	1	10,470
Secretary..............................	GS-6	1	7,727

Secretary/Clerk-Typist..............	GS-5	4	27,752
Clerk-Typist.......................	GS-4	5	31,010
		25	313,389
Total, new positions, all activities		62	834,411

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health Services Delivery

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health Services Delivery

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Appropriation Estimate

HEALTH SERVICES DELIVERY[1]

For carrying out, except as otherwise provided, sections 301, 310, 311, 314(d), 314(e), 321, 322, 324, 326, 328, 329, 331, 332, 502, 504, title X of the Public Health Service Act, the Act of August 8, 1946 (5 U.S.C. 7901), section 1010 of the Act of July 1, 1944 (33 U.S.C. 763c) section 1 of the Act of July 19, 1963 (42 U.S.C. 253a), and title V of the Social Security Act, $745,657,000, of which $1,200,000 shall be available only for payments to the State of Hawaii for care and treatment of persons afflicted with leprosy: Provided, That any allotment to a State pursuant to section 503(2) or 504(2) of the Social Security Act shall not be included in computing for the purposes of subsections (a) and (b) of section 506 of such Act an amount expended or estimated to be expended by the State: Provided further, That when the Health Services and Mental Health 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, $4,719,000 may be transferred to this appropriation as authorized by section 201(g)(1) of the Social Security Act, from any one or all the trust funds referred to therein:[2]*Provided further, That amounts received for services rendered under section 329 of such Act shall be credited to this appropriation.*

[COMPREHENSIVE HEALTH PLANNING AND SERVICES][3]

[To carry out sections 310, 314(a) through 314(e), 317, and 329 of the Public Health Service Act, and except as otherwise provided, sections 301 and 311 of the Act, $320,703,000: *Provided*, That $4,519,000 may be transferred to this appropriation, as authorized by section 201(g)(1) of the Social Security Act, as amended, from

any one or all of the trust funds referred to therein, and may be expended for functions delegated to the Administrator of the Health Services and Mental Health Administration under title XVIII of the Social Security Act.]

[MATERNAL AND CHILD HEALTH][3]

[For carrying out, except as otherwise provided, sections 301, 311, and title X of the Public Health Service Act and title V of the Social Security Act, $330,151,000: *Provided,* That any allotment to a State pursuant to section 503(2) or 504(2) of such Act shall not be included in computing for the purposes of subsections (a) and (b) of section 506 of such Act an amount expended or estimated to be expended by the State.]

[Grants made during the current fiscal year for any project under section 508, 509, or 510 of the Social Security Act may be for periods ending prior to July 1, 1973.]

[PATIENT CARE AND SPECIAL HEALTH SERVICES][3]

[For carrying out, except as otherwise provided, the Act of August 8, 1946 (5 U.S.C. 7901), and under sections 301, 311, 321, 322, 324, 326, 328, 331, 332, 502, and 504 of the Public Health Service Act, section 1010 of the Act of July 1, 1944 (33 U.S.C 763c) and section 1 of the Act of July 19, 1963 (42 U.S.C. 253a), $85,700,000, 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 when the Health Services and Mental Health Administration establishes or operates a health service program for

any department or agency, payment for the estimated cost shall be made by way of reimbursement or in advance for deposit to the credit of this appropriation.]

Explanation of Language Changes

1. New language is proposed as a result of the consolidation of three appropriations, "Comprehensive Health Planning and Services", "Maternal and Child Health", and "Patient Care and Special Health Service". This consolidation not only reflects a functional grouping of the accounts, but also provides for better administration of the programs by making the appropriation structure consistent with the current organization of HSMHA.

2. Language has been added for the National Health Service Corps which would allow funds collected for services to be returned to this appropriation. Under existing authority, any amounts received for services would be deposited in miscellaneous receipts of the Treasury.

This proviso is requested in order that fees from third-party payers and individuals who are able to pay may be collected and "re-used" by the program. Also crediting reimbursements to this appropriation would reduce the amount of direct appropriations required.

3. Language formerly used for the three consolidated accounts is deleted.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health Services Delivery

Amounts Available for Obligation

	1972	1973
Appropriation....................	$736,554,000	$745,657,000
Proposed supplemental............	5,610,000	---
Subtotal, appropriations..........	742,164,000	---
Real transfers to:		
"Operating expenses, Public Buildings Service," General Services Administration......	-31,000	---
"Salaries and expenses," Economic Stabilization Activities.....	-1,300,000	---
Real transfer from:		
"Nursing home improvement"......	4,300,000	---
Comparative transfers to:		
"Departmental management,"......	-125,000	---
"Health services planning and development"................	-25,935,000	---
"Preventive health services"....	-54,300,000	---
"Office of the Administrator"...	-20,000	---
Comparative transfer from:		
"Office of the Administrator"...	136,000	---
Subtotal, budget authority........	664,889,000	745,657,000
Receipts and reimbursements from:		
"Federal funds"................	16,665,000	16,559,000
"Trust funds"..................	4,719,000	4,719,000
"Non-Federal sources"...........	558,000	6,940,000
Unobligated balance, start of year	9,000,000	---
Unobligated balance, lapsing......	-459,000	---
Total, obligations..........	695,372,000	773,875,000

Obligations by Activity

Page Ref.		1972 Estimate Pos.	1972 Estimate Amount	1973 Estimate Pos.	1973 Estimate Amount	Increase or Decrease Pos.	Increase or Decrease Amount
211	Comprehensive Health services:						
212	(a) Grants to States.......	---	$90,000,000	---	$90,000,000	---	---
214	(b) Health services grants.......	---	103,913,000	---	116,200,000	---	+$12,287,000
215	(c) Migrant health grants.......	---	17,950,000	---	23,750,000	---	+5,800,000
217	(d) Direct operations...	445	17,981,000	445	18,862,000	---	+881,000
	Subtotal....	445	229,844,000	445	248,812,000	---	+18,968,000
223	Maternal and child health:						
224	(a) Grants to States.......	---	121,522,000	---	125,678,000	---	+4,156,000
227	(b) Project grants.	---	92,008,000	---	101,330,000	---	+9,322,000
231	(c) Research and training.....	---	21,106,000	---	21,392,000	---	+286,000
233	(d) Direct operations...	133	4,078,000	133	4,148,000	---	+70,000
	Subtotal....	133	238,714,000	133	252,548,000	---	+13,834,000
234	Family planning:						
235	(a) Project grants and contracts	---	94,815,000	---	137,024,000	---	+42,209,000
242	(b) Direct operations...	70	1,438,000	87	1,987,000	+17	+549,000
	Subtotal....	70	96,253,000	87	139,011,000	+17	+42,758,000
244	National health service corps......	637	14,117,000	637	14,803,000	---	+686,000
246	Patient care and special health services:						
248	(a) Inpatient and outpatient care.........	5,479	95,237,000	5,479	96,303,000	---	+1,066,000
249	(b) Coast Guard medical services.....	151	4,802,000	151	5,105,000	---	+303,000
250	(c) Federal employees....	260	4,487,000	260	4,498,000	---	+11,000
251	(d) Payment to Hawaii.......	---	1,200,000	---	1,200,000	---	---
	Subtotal....	5,890	105,726,000	5,890	107,106,000	---	+1,380,000
252	Regional office central staff......	250	5,287,000	250	5,281,000	---	-6,000

253	Program direction and management services..........	233	5,431,000	236	6,314,000	+3	+883,000
	Total obligations..	7,658	695,372,000	7,678	773,875,000	+20	+78,503,000

Obligations by Object

	1972 Estimate	1973 Estimate	Increase or Decrease
Total number of permanent positions	7,658	7,678	+20
Full-time equivalent of all other positions	401	422	+21
Average number of all employees	7,387	7,886	+499

	1972 Estimate	1973 Estimate	Increase or Decrease
Personnel compensation:			
Permanent positions.......	$80,918,000	$84,029,000	+$3,111,000
Positions other than permanent	3,956,000	3,918,000	-38,000
Special personal services	375,000	375,000	---
Other personnel compensation	4,529,000	4,527,000	-2,000
Subtotal, personnel compensation.......	89,778,000	92,849,000	+3,071,000
Personnel benefits	12,338,000	13,951,000	+1,613,000
Travel and transportation of persons	4,785,000	4,627,000	-158,000
Transportation of things ...	2,716,000	2,169,000	-547,000
Rent, communications and utilities	3,117,000	3,333,000	+216,000
Printing and reproduction	537,000	489,000	-48,000
Other services	15,109,000	15,782,000	+673,000
Project contracts	15,383,000	15,048,000	-335,000
Supplies and materials....	11,694,000	12,074,000	+380,000
Equipment	4,143,000	3,930,000	-213,000
Grants, subsidies and contributions	536,071,000	609,922,000	+73,851,000
Subtotal	695,671,000	774,174,000	+78,503,000

Obligation by Object

	1972 Estimate	1973 Estimate	Increase or Decrease
Deduct quarters and subsistence(-)	-299,000	-299,000	---
Total obligations by object...............	695,372,000	773,875,000	+78,503,000

Summary of Changes

1972 estimated obligations..	$695,372,000
1973 estimated obligations..	773,875,000
Net change..	+78,503,000

	Base Pos.	Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. Annualization of positions new in 1972..............	---	---	---	755,000
2. Within grade and longevity increases................	---	---	---	2,511,000
3. Continuation pay costs for commissioned officers (medical)................	---	---	---	547,000
4. Annualization of uniformed services pay increase (PL 92-129)..............	---	---	---	664,000
5. Increases for DHEW Working Capital Fund, HSMHA Service and Supply Fund, and FTS charges..........	---	---	---	249,000
6. Increase in continuation costs for migrant health projects................	---	---	---	2,800,000
7. Social Security contributions	---	---	---	36,000
8. Contract medical care and supply price increases ...	-- ---	---	---	358,000
B. Program:				
1. Comprehensive health services:				
a. Health service grants:				
(1) Comprehensive health centers...	---	88,618,000	---	9,287,000
(2) Family health centers..........	---	13,000,000	---	3,000,000
b. Migrant health grants...	---	17,950,000	---	3,000,000
c. Direct operations.......	445	18,811,000	---	120,000
2. Maternal and child health				
a. Grants to States for:				
(1) Maternal and child health services..	---	59,250,000	---	1,528,000
(2) Crippled children's services.........	---	62,272,000	---	2,628,000
b. Project grants for:				
(1) Maternity and infant care.............	---	43,428,000	---	3,804,000
(2) Comprehensive health care for children and youth........	---	47,400,000	---	5,442,000

	Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Program (continued)				
(3) Dental health of children........	---	1,180,000	---	76,000
c. Training..............	---	15,071,000	---	286,000
d. Direct operations......	133	4,078,000	---	46,000
3. Family planning:				
a. Project grants and contracts:				
(1) Service projects..	---	88,500,000	---	42,000,000
(2) Education and information.....	---	700,000	---	209,000
b. Direct operations......	70	1,438,000	17	233,000
4. Program direction and management services.........	83	2,133,000	3	694,000
Total, increases.......				80,273,000
Decreases:				
A. Built-in:				
1. Two less days of pay..................	---	---	---	-233,000
2. Decrease resulting from employment cut-back during 1972.............	---	---	---	-1,514,000
B. Program:				
1. Decrease in reimbursable programs................	---	---	---	-23,000
Total, decreases.......				-1,770,000
Total, net change				+78,503,000

Explanation of Changes

Increases:

A. Built-in:

An increase of $7,920,000 is for mandatory items. Of this $755,000 is for full-year costs of positions new in 1972, $2,511,000 is for net additional costs of within grade and longevity increases, $547,000 continuation pay costs for medical officers, $664,000 for annualization of uniformed services pay increases, $249,000 DHEW Working Capital Fund, HSMHA Service and Supply Fund, and FTS charges, $2,800,000 increase in continuation costs for migrant health projects, $36,000 increase in Social Security contributions, $358,000 contract medical care and supply price increases.

B. Program:

Health service grants--An increase of $12,287,000 is requested for this activity. These increases would provide support for additional neighborhood health centers previously funded by the Office of Economic Opportunity and the conversion of several Family Health Centers from planning to operational status.

Migrant health grants--The requested increase of $3,000,000 would be used for upgrading existing projects strategically located along the migrant streams to maximize their quality and utilization.

Direct operations--An increase of $120,000 is requested for project contracts to initiate a reporting system to collect information on the extent of health services obtained by migrants and seasonal farmworkers and their families.

Maternal and child health services--The $1,528,000 increase will help States maintain the current level of medical care services and partially offset the rising costs of medical care.

Crippled children's services--The increase of $2,628,000 will help States in meeting the increased costs of providing the more effective but technically more complex treatment of handicapped children.

Maternity and infant care--The increase of $3,804,000 will support expansion of the 56 existing maternity and infant care projects and extend services to an additional 12,000 mothers and infants, for a total of 205,000, in 1973. It will also assure continuation of intensive care to infants in ongoing projects and new projects becoming operational in 1972.

Children and youth--The increase of $5,422,000 will assure comprehensive health services to an estimated 547,000 children. This compares with a total of 504,000 expected to be served in 1972.

Dental health of children--The increase of $76,000 will support continuation of an estimated 17 dental projects planned to be in operation in 1972. It is expected that these projects will provide comprehensive dental health care to an estimated 22,000 children in 1973.

Explanation of changes (continued)

Training--The increase of $286,000 will provide the continued support of 19 university-affiliated mental retardation centers and for training personnel in health care and related services for mothers and children.

Direct operations--The increase of $46,000 provides for added costs of central services.

Family planning services-- The increase of $42,000,000 in obligations for family planning project grants includes $10,000,000 to fund established family planning projects presently funded by the Office of Economic Opportunity. The remaining $32,000,000 will support new or expanded family planning projects with State and local health departments, hospitals, universities, and other public and/or nonprofit organizations. Priority will be given to funding projects serving rural areas, migrants, Appalachia, Spanish-speaking Americans and other hard-to-reach areas and groups. The increase will extend services to approximately 700,000 additional women by the time the funds are totally expended. The total program level for 1973 will provide services to approximately 2,200,000 women when the projects are fully operational.

Education--The increase of $209,000 will be used to develop improved educational materials and promote the use of educational methods which have proven their usefulness.

Direct operations--The increase of $233,000 will support 17 new positions in the regions and central office to administer the expanded grants and contracts program.

Program direction and management services--The increase of $694,000 includes $649,000 to expand the upward mobility program and $45,000 for added costs of central services to administer an expanded family planning grants and contracts program.

Decreases:

A. Built-in:

The decrease of $233,000 represents non-recurring salary costs resulting from a reduction of two days of pay in 1973.

The decrease of $1,514,000 results from position reductions in line with the Administration's economic policy.

B. Program:

Inpatient and outpatient care--The decrease of $23,000 represents a decline in reimbursable program.

Authorizing Legislation

Legislation	1973 Authorized	1973 Appropriation requested
Public Health Service Act		
Section 310--Grants for Health Services for Domestic Agricultural Migrants	$30,000,000	$23,750,000
Section 314(d)--Grants for Comprehensive Public Health Services	165,000,000	90,000,000
Section 314(e)--Project Grants for Health Services Development	157,000,000	116,200,000
Section 329--Assignment of Medical and Other Health Personnel to Critical Need Areas	30,000,000	8,418,000

PUBLIC HEALTH SERVICE

"Health Services for Domestic Agricultural Migrants

"Section 310. There are hereby authorized to be appropriated not to exceed $7,000,000 for the fiscal year ending June 30, 1966, $8,000,000 for the fiscal year ending June 30, 1967, $9,000,000 each for the fiscal year ending June 30, 1968, and the next fiscal year, $15,000,000 for the fiscal year ending June 30, 1970, $20,000,000 for the fiscal year ending June 30, 1971, $25,000,000 for the fiscal year ending June 30, 1972, and $30,000,000 for the fiscal year ending June 30, 1973, to enable the Secretary (1) to make grants to public and other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons (including allied health professions personnel) to provide services in the establishing and operating of such clinics, and (ii) special projects to improve and provide a continuity in health services for and to improve the health conditions of domestic agricultural migratory workers and their families, including necessary hospital care, and including training persons (including allied health professions personnel) to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families. The Secretary may also use funds appropriated under this section to provide health services to persons (and their families) who perform seasonal agricultural services similar to the services performed by domestic agricultural migratory workers if the Secretary finds that the provision of health services under this sentence will contribute to the improvement of the health conditions of such migratory workers and their families. For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs.

"Grants for Comprehensive Public Health Services

"Section 314. (d) (1) AUTHORIZATION OF APPROPRIATIONS.--There are authorized to be appropriated $70,000,000 for the fiscal year ending June 30, 1968, $90,000,000 for the fiscal year ending June 30, 1969, $100,000,000 for the fiscal year ending June 30, 1970, $130,000,000 for the fiscal year ending June 30, 1971, $145,000,000 for the fiscal year ending June 30, 1972, and $165,000,000 for the fiscal year ending June 30, 1973, to enable the Secretary to make grants to State health or mental health authorities to assist the States in establishing and maintaining adequate public health services, including the training of personnel for State and local health work. The sums so appropriated shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for provision of public health services.

"Project Grants for Health Services Development

"(e) There are authorized to be appropriated $90,000,000 for the fiscal year ending June 30, 1968, $95,000,000 for the fiscal year ending June 30, 1969, $80,000,000 for the fiscal year ending June 30, 1970, $109,500,000 for the fiscal year ending June 30, 1971, $135,000,000 for the fiscal year ending June 30, 1972, and $157,000,000 for the fiscal year ending June 30, 1973, for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost (including equity requirements and amortization of loans on facilities acquired from the Office of Economic Opportunity or construction in connection with any program or project transferred from the Office of Economic Opportunity) of (1) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services (including related training). Any grant made under this subsection may be made only if the application for such grant has been referred for review and comment to the appropriate areawide health planning agency or agencies (or, if there is no such agency in the area, then to such other public or nonprofit private agency or organization (if any) which performs similar functions) and only if the services assisted under such grant will be provided in accordance with such plans as have been developed pursuant to subsection (a).

"Assignment of Medical and Other Health Personnel to Critical Need Areas

"Section 329. (a) It shall be the function of an identifiable administrative unit within the Service to improve the delivery of health services to persons living in communities and areas of the United States where health personnel and services are inadequate to meet the health needs of the residents of such communities and areas.

****

"(g) To carry out the purposes of this section, there are authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1971; $20,000,000 for the fiscal year ending June 30, 1972; and $30,000,000 for the fiscal year ending June 30, 1973."

Authorizing Legislation

Legislation	1973 Authorized	1973 Appropriation requested
Public Health Service Act Section 331--Lepers.................	Indefinite	$1,200,000

PUBLIC HEALTH SERVICE ACT

Title III--General Powers and Duties of
Public Health Service

Part D--Lepers

Appropriation

Section 331. "xxx when so provided in appropriations available for any fiscal year for the maintenance of hospitals of the Service, the Surgeon General is authorized and directed to make payments to the Board of Health of Hawaii for the care and treatment in its facilities of persons afflicted with leprosy at a per diem rate, determined from time to time by the Surgeon General, which shall, subject to the availability of appropriations, be approximately equal to the per diem operating cost per patient of such facilities, except that such per diem rate shall not be greater than the comparable per diem operating cost per patient at the National Leprosarium, Carville, Louisiana."

Authorizing Legislation

Legislation	1973 Authorized	1973 Appropriation Requested
Public Health Service Act:		
Section 1001 - Grants and contracts for family planning services . .	$90,000,000	$111,500,000[1/]
Section 1003 - Training grants and contracts	4,000,000	3,000,000
Section 1004 - Research grants and contracts	65,000,000	2,615,000
Section 1005 - Informational and educational materials	1,250,000	909,000

Project Grants and Contracts for Family Planning Services

Sec. 1001. (a) The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects.

(b) In making grants and contracts under this section the Secretary shall take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance.

(c) For the purpose of making grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $60,000,000 for the fiscal year ending June 30, 1972; and $90,000,000 for the fiscal year ending June 30, 1973.

Training Grants and Contracts

Sec. 1003. (a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to provide the training for personnel to carry out family planning service programs described in section 1001 or 1002.

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $2,000,000 for the fiscal year ending June 30, 1971; $3,000,000 for the fiscal year ending June 30, 1972; and $4,000,000 for the fiscal year ending June 30, 1973.

Research Grants and Contracts

Sec. 1004. (a) In order to promote research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population, the Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals for projects for research and research training in such fields.

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $30,000,000 for the fiscal year ending June 30, 1971; $50,000,000 for the fiscal year ending June 30,

1972; and $65,000,000 for the fiscal year ending June 30, 1973.

Informational and Educational Materials

Sec. 1005. (a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to assist in developing and making available family planning and population growth information (including educational materials) to all persons desiring such information (or materials).

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated $750,000 for the fiscal year ending June 30, 1971; $1,000,000 for the fiscal year ending June 30, 1972; and $1,250,000 for the fiscal year ending June 30, 1973.

1/ Additional authorizing legislation to be submitted

Authorizing Legislation

Legislation	1973 Authorized	1973 Appropriation requested
Social Security Act Section 501--Maternal and Child Health and Crippled Children's Services..........	$350,000,000	$267,400,000 1/

SOCIAL SECURITY ACT

Title V--Maternal and Child Health and Crippled Children's Services

Authorization of Appropriations

Section 501. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State,

(1) services for reducing infant mortality and otherwise promoting the health of mothers and children; and

(2) services for locating, and for medical, surgical, corrective, and other services and care for and facilities for diagnosis, hospitalization, and aftercare for, children who are crippled or who are suffering from conditions leading to crippling,

there are authorized to be appropriated $250,000,000 for the fiscal year ending June 30, 1969, $275,000,000 for the fiscal year ending June 30, 1970, $300,000,000 for the fiscal year ending June 30, 1971, $325,000,000 for the fiscal year ending June 30, 1972, and $350,000,000 for the fiscal year ending June 30, 1973, and each fiscal year thereafter.

Purposes for which Funds are Available

Section 502. Appropriations pursuant to section 501 shall be available for the following purposes in the following proportions:

(1) In the case of the fiscal year ending June 30, 1969, and each of the next 3 fiscal years, (A) 50 percent of the appropriation for such year shall be for allotments pursuant to sections 503 and 504; (B) 40 percent thereof shall be for grants pursuant to sections 508, 509, and 510; and (C) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511 and 512.

(2) In the case of the fiscal year ending June 30, 1973, and each fiscal year thereafter, (A) 90 percent of the appropriation for such years shall be for allotments pursuant to sections 503 and 504, and (B) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511 and 512.

Not to exceed 5 percent of the appropriation for any fiscal year under this section shall be transferred, at the request of the Secretary, from one of the purposes specified in paragraph (1) or (2) to another purpose or purposes so specified. For each fiscal year, the Secretary shall determine the portion of the appropriation, within the percentage determined above to be available for

1/ Includes $19,000,000 for family planning projects.

sections 503 and 504, which shall be available for allotment pursuant to section 503 and the portion thereof which shall be available for allotment pursuant to section 504. Notwithstanding the preceding provisions of this section, of the amount appropriated for any fiscal year pursuant to section 501, not less than 6 percent of the amount appropriated shall be available for family planning services from allotments under section 503 and for family planning services under projects under sections 508 and 512.

Administration

Section 513. (b) Such portion of the appropriations for grants under section 501 as the Secretary may determine, but not exceeding one-half of 1 percent thereof, shall be available for evaluation by the Secretary (directly or by grants or contracts) of the programs for which such appropriations are made and, in the case of allotments from any such appropriation, the amount available for allotments shall be reduced accordingly.

Explanation of Transfers

	1972 Estimate	
Real transfers to:		
Operating expenses, Public Buildings Service, GSA.......	-$31,000	Transfer to the General Services Administration for rental of space.
Salaries and expenses, Economic Stabilization Act...	-1,300,000	Reflects a transfer of funds to the Executive Office of the President, as authorized by the Economic Stabilization Act. Funds would be used for administrative expenses associated with carrying out provisions of the act.
Real transfer from:		
Nursing home improvement.....	4,300,000	Transfer to the research and development elements of nursing home improvement program from the Office of the National Center for Health Services Research and Development.
Comparative transfers to:		
Preventive health services...	-54,300,000	Transfer of project grants resulting from the reorganization of HSMHA.
Health planning and development..................	-25,935,000	Transfer of planning grants and related direct operations due to the reorganization of HSMHA.
Departmental management......	-125,000	Reflects transfers to support the departmental intergovernmental coordination functions, coordinated field personnel management, Upward Mobility, and the adverse action and employee grievance examining staff.
Office of the Administrator..	-20,000	Transfer of a budget analyst position to HSMHA Financial Management.

<u>Comparative transfer from:</u>

"Office of the Administrator..	136,000	Transfer of Deputy and staff due to the reorganization of HSMHA.

Health Services Delivery

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1963	$101,514,000	$101,477,000	$98,820,000	$98,820,000
1964	116,538,000	116,462,000	116,462,000	116,462,000
1965	142,536,000	142,436,000	143,064,000	143,064,000
1966	196,616,000	197,480,000	183,480,000	197,980,000
1967	242,521,000	242,271,000	242,271,000	242,271,000
1968	410,599,000	383,406,000	384,209,000	383,806,000
1969	513,476,000	454,847,000	457,847,000	456,347,000
1970	453,507,000	461,297,000	463,207,000	463,207,000
Trust fund transfers	4,320,000	4,320,000	4,320,000	4,320,000
1971	519,798,000	519,798,000	525,940,000	521,248,000
Trust fund transfers	4,320,000	4,320,000	4,320,000	4,320,000
1972	640,851,000	644,869,000	685,750,000	656,319,000
Trust fund transfers	4,519,000	4,519,000	4,519,000	4,519,000
Proposed supplemental	5,610,000			
1973	745,657,000			
Trust fund transfers	4,719,000			

Justification

Health Services Delivery

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits...	7,658	$102,116,000	7,678	$106,800,000	+20	+$4,684,000
Other expenses......	---	593,256,000	---	667,075,000	---	+738,000
Total..........	7,658	695,372,000	7,678	773,875,000	+20	+78,503,000

General Statement

This budget proposes a consolidated appropriation, Health Services Delivery, for HSMHA's health services programs which were supported previously by three separate appropriations: Comprehensive health planning and services, Maternal and child health, and Patient care and Special health services.

The proposed appropriation is consistent with the recent internal reorganization of the Health Services and Mental Health Administration. It reflects a functional grouping of the health services delivery programs and as such provides for improved coordination and administration. Not included in this grouping of health devlivery programs is the Indian health service appropriation which is presented to the Subcommittee on Department of Interior and Related Agencies and the Emergency health service appropriation which is heard by the Subcommittee on the Department of Treasury, Postal Service and General Government.

Comprehensive Health Services

The budget includes $90,000,000 for the States under the Partnership for Health formula grant program and $116,200,000 for 65 neighborhood health centers and 23 family health center projects.

The Federal funding of these centers supports the development of primary and ambulatory health services for inner city and rural areas lacking adequate services. Efforts will be continued to assist these centers to collect third party health insurance payments so that they can become self-sufficient.

The migrant health activity includes $23,750,000 for Health care for migrant and seasonal farmworkers, an increase of $5,800,000 over 1972. The 1973 program will focus on up-grading at least 50 existing projects strategically located along the migrant streams to improve quality of care and utilization.

Maternal and Child Health

In 1973, the budget includes $252,548,000 for Maternal and Child Health Services, an increase of $13,834,000 over 1972. Grants to States for maternal and child health services are being increased by $1,528,000 and for the care of crippled children by $2,628,000 to reduce infant mortality and to

continue and expand services for crippled children. These funds will provide for physicians' services to more than 500 thousand crippled children, prenatal and postpartum care to more than 400 thousand women, and family planning services to 850 thousand women. The projects grants program of $101,330,000 an increase of $9,322,000 over 1972, will provide comprehensive care services to 152,000 mothers, 53,000 infants and 546,000 children and youth in disadvantaged urban and rural areas.

Family Planning Services

The 1973 budget includes $139,011,000 for the National Center for Family Planning Services, an increase of $42,758,000 over 1972. This request will continue progress toward the President's goal of providing family planning services to women who need but cannot afford them. Project grants to State and local health departments and other public or nonprofit organizations will provide services to an estimated 2.2 million women in 1973 as compared to 1.5 million in 1972 and 700,000 in 1971.

Current estimates are that approximately 2.3 million additional women may be receiving services from other providers in 1973, including private physicians and voluntary organizations. When combined with the 2.2 million women to be served by projects funded by the National Center, a total of 4.5 million will be receiving services. This significant national effort will help reduce the dependency of many families presently burdened with the consequences of unwanted childbirth.

Patient Care and Special Health Services

The 1973 estimate for the PHS hospitals and clinics will maintain the same level of operation as in 1972. The number of primary PHS beneficiaries in the hospitals has continued its decline. In 1973 we estimate that 59 percent of the total patient load will represent primary beneficiaries as compared to 61 percent in 1971. During 1973 efforts will continue toward converting some of these facilities to community control in line with local health care needs and resources.

National Health Service Corps

In 1973, the Corps will accelerate placements of health personnel in Nation's health manpower shortage areas. Almost 600 physicians, dentists, nurses and other health professionals will be providing direct health care in these locations. These health personnel will provide support for a total of 175-225 communities with a total population of approximately 700,000 to 900,000 people.

Comprehensive Health Services

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits............	445	$8,327,000	445	$8,970,000	--	+$643,000
Other expenses...........	---	221,517,000	---	239,842,000	--	+18,325,000
Total..............	445	229,844,000	445	248,812,000	--	+18,968,000

Introduction

This activity encompasses a number of unique and interrelated programs designed to improve the delivery of health care to the American people. Comprehensive health services development, Migrant health, and support of Medicare programs - all move toward the improvement in the delivery of health care that we are seeking. One of the highest priorities is the support of 55 comprehensive health care centers and 118 migrant health projects. The centers and projects provide family-oriented primary care to population groups long without basic health services. The comprehensive health care centers provide basic health care primarily to the urban poor. The Migrant health program provides access to health services to migrant and seasonal farmworkers and their families. Emphasis is now on the improvement of the quality of those services. The quality of services provided through Medicare is aided through medical care standard development programs and through counseling and participation in the application of Medicare standards. States and communities are helped in maintaining quality of care in their health institutions through programs of training for their license inspectors and Medicare and Medicaid surveyors through the Nursing Home Improvement program.

Grants to States

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..............	--	$1,306,000	--	$1,306,000	--	--
Other expenses.............	--	88,694,000	--	88,694,000	--	--
Total.............	--	90,000,000	--	90,000,000	--	--

The formula grant authorized by Section 314(d) enables the States to provide more direct support to a broad range of public health programs at the State and local levels. The authority provides for flexibility in the use of these Federal funds in response to State needs. The States are using these funds to support communicable disease control programs such as venereal disease, tuberculosis and immunization activities (particularly rubella); chronic disease programs directed toward such major causes of death and disability as heart disease, cancer, diabetes, and stroke; environmental health services, including food and drug, industrial health, radiological health, sanitary engineering, air and water pollution; laboratory services; home health and public health nursing services, community mental health, including treatment of alcoholism, drug abuse, and suicide prevention.

A number of States use a portion of their allocation in developmental health activity. California has for some years provided State project support to communities for the organization, development, and operation of new and innovative health services, particularly community health services in urban or rural ghettoes and model cities areas.

The Missouri Division of Mental Health supports a crisis intervention program in Joplin serving two counties. A 24-hour-a-day program patterned after suicide prevention programs, serves a broader need to assist people with personal and emotional problems in addition to seeking to forestall suicide.

The mental health program of Kansas allocated all of its formula and matching funds to support new and innovative programs within the State, such as a therapeutic day school project, an adolescent walk-in clinic, a juvenile court cooperative group care program, and a family life education program.

Arizona is supporting the establishment and utilization of a pediatric nurse practitioner program in one county as a method of broadening its maternal and child health effort. In mental health, one of their programs in which State formula grant funds are used is in the prevention of mental illness through the early identification of high risk persons and the application of preventive psychotherapy.

One use of formula grant funds in American Samoa has been to extend dental health services into the elementary schools. Another has been to start a postgraduate course in public health nursing--a first in the medical history of American Samoa.

The State of Nebraska used some of its allotment to support health professionals assigned to local communities to carry out communicable disease and environmental health programs.

Pennsylvania uses formula funds to assist in carrying out a student intern project providing services to mental health, mental retardation, and related agencies. Undergraduate college students are placed in an agency for a year. They earn college credit through their universities and are paid a modest stipend for their services.

Expanded environmental health services is one of Maryland's uses of the grant. A sanitation inspection unit for nursing home facilities and expanded sanitary survey section of shellfish waters receive support from this use of the monies.

Virginia uses all its funds to assist in the operation of its local health departments for services rendered on the basis of the need of the individual locality.

In the District of Columbia these funds have enabled their community health services administration to further the concept of Neighborhood Health Centers which provide comprehensive health services to families within a short distance of their homes.

In 1972, funds authorized for evaluation are being used to continue to support a contract with the Association of State and Territorial Health Officers to develop and activate a uniform program reporting system for State health departments. This project will assist the State and Federal governments in planning and evaluation as a result of increased information which will lend itself to evaluation.

In 1973 we anticipate that the States will continue to support a broad range of health programs at the local level.

No increase is requested in this activity in 1973.

Health Services Grants

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses....	--	$103,913,000	--	$116,200,000	--	+$12,287,000

Project grants authorized under Section 314(e) of the Partnership for Health Legislation provide means to help upgrade the delivery of health services. First priority for awarding these grants is given to comprehensive health service programs providing primary care and a broad range of ambulatory services to medically underserved urban and rural neighborhoods. In 1973 these programs will provide comprehensive health services for about 1,280,000 persons, an increase of 330,000 over 1972.

Comprehensive Health Centers

The comprehensive health service program supported 55 comprehensive health centers, including nine neighborhood health centers transferred from OEO, and a limited number of developmental and supportive projects in 1972. These health care programs covered an eligible population of approximately 2,700,000 persons and provided services to an estimated 850,000 persons at a cost of $88,618,000. The centers are organized to deliver all ambulatory health care services and have arrangements to secure most needed specialty treatment. Improved management capability in the 55 comprehensive health centers in 1972 was encouraged through the support of ambulatory health care information systems and accounting systems. In addition, support was furnished to the centers to enable them to develop programs to increase their ability to obtain third party funding.

In 1973, $100,200,000 is requested to continue funding the existing comprehensive health programs, with $20,000,000 of this amount to be available for supporting 10 to 14 additional health centers previously funded by OEO. In total we expect these centers to provide services to over 1,000,000 people.

We are assisting health centers to improve their management capability and develop financial plans so they can recover increasing amounts of their cost of operation through third party payments. Where possible, emphasis is given on conversions to prepaid capitation and increasing the center's potential for becoming an HMO or an HMO component.

Family Health Centers

The Family Health Center Program, initiated in 1972 with $13,000,000, will continue our efforts to increase ambulatory health care resources in medically underserved urban neighborhoods and remote rural areas. These centers provide a basic package of health services on a prepaid capitation basis. Family health centers actively coordinate with other Federal planning and direct service programs at the national, regional and State levels to maximize the effects of planning, community relationships, funding allocations and staff competencies in a given geographic area. In 1973, an increase of $3,000,000 will provide for funding three new centers and for activating the operational phase of at least 10 developmental projects initiated in 1972. These new centers plus the 10 centers which began operating in 1972 will bring the total to 23 operating centers serving an estimated 230,000 persons.

Emphasis will continue to be placed upon efficient and effective methods of managing, organizing and financing health care services. Through these methods the family health center will become an integral part of the community medical care pattern and federal grant support can be released for resource building in other areas of critical health need.

Migrant Health Grants

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other expenses.......	--	$17,950,000	--	$23,750,000	--	+$5,800,000

Projects supported under this activity provide health care services to migrant agricultural laborers and seasonal farmworkers and their families. The purpose of this program is to raise the level of migrants' health to that of the general population, and to assure that migrants have access to ongoing community health services.

The problem of providing adequate health services to migrants and seasonal farmworkers and their families is closely related to the problem of insufficient health resources available to all rural residents. As more resources and financing mechanisms become available to support health care services for the general population, one aim of the Migrant Health Program will be to develop adequate services in migrant impact areas to meet the increased demand.

In 1972 the program initiated efforts to convert existing projects from their present grant method of financing services to a prepaid capitation system. An additional effort was made to assist projects in substantially upgrading the quality of their services and increasing their scope of service as well as increasing the numbers of persons served. It is estimated that there will be 460,000 patient visits in 1972, an increase of approximately 101,000 over 1971.

During 1972, 64 of the 118 projects reported the establishment of consumer boards. The remaining projects while having less formal mechanisms at this time are making efforts toward meeting the 1970 legislative mandate to show evidence of consumer participation in project activities.

In an effort to extend the concept of using indigenous personnel in the administration and delivery of health services in migrant projects, 90% of the projects have employed migrants or former migrants as paraprofessional staff members to assist in the delivery of services.

In addition, four of the seven comprehensive projects have Mexican Americans as project directors.

1973 Increases

In 1973, the program will maintain its efforts toward increasing the capacity and utilization of health services in the areas of major migrant populations. An increase of $2,800,000 is requested to cover increased continuation costs. A program increase of $3,000,000 is requested to accomplish the following purposes:

---An effort will be designed to provide 1,000 families, from one or more different areas, an appropriate health services benefit package through a prepaid capitation system capitalizing on existing migrant health projects as providers of service.

---This effort will provide an experience base with respect to the ability of established migrant health projects to cost out a service package and to collect third party payments. In addition, the effort would provide specific experience on the ability of migrants to effectively utilize available services provided under a prepaid delivery system spanning the migrants' work areas.

---A Uniform Cost Reporting and Accounting System will be implemented in 15 projects which have developed the potential capability to utilize third party reimbursement payment mechanisms. This effort will be needed in order to provide the framework to begin conversion from grant support to other funding approaches.

---In addition, the increase will be used to assist the remaining projects to become capable of converting from a grant method of financing to a prepaid capitation plan for delivering an acceptable benefit package, or to assist them to become a provider component of a prepaid health plan. It will also allow the projects to focus on improving the quality and utilization of services available. At least 50 existing projects strategically located along the migrant streams will be up-graded. This increase will also provide approximately 148,000 additional patient visits by migrants and seasonal farmworkers and their families bringing the total of patient visits in 1973 to more than 600,000. The patient visit increase will be accomplished through the support of primary health care projects located in areas of high migrant impact, interrelated with other health services in rural areas. In areas where provider organizations exist, the program will provide funds which can be used in a third party payment arrangement to assure that the migrants would receive care. In those rural areas where resources and/or services are not accessible to the migrants, the program will direct funds to develop programs that can provide an acceptable benefit package and attract resources to provide services through a variety of arrangements and payment mechanisms.

In order to have access to timely and more accurate program information on existing migrant health program activities to enable the program to judge more accurately the extent to which individual projects and the program as a whole are meeting their goals, emphasis will be placed on extending the information system designed and implemented on a limited basis in 1972 to a majority of projects funded in 1973.

The projects will also be encouraged to support efforts directed at training migrants for use as paraprofessional staff in ongoing projects and to enhance the training of policy board members in effectively fulfilling their roles.

Direct Operations

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	445	$7,021,000	445	$7,664,000	--	+$643,000
Other expenses........	--	10,960,000	--	11,198,000	--	+238,000
Total............	445	17,981,000	445	18,862,000	--	+881,000

The direct operations under this activity provide professional and technical assistance to States, communities, providers of health services, medical and health organizations and other Federal units.

This activity supports the staff that provides: (1) guidance on health care services essential to promote the utilization of improved methods of health services organization, delivery and financing at the community level in both urban and rural settings; (2) technical assistance and consultation to migrant health projects and other organizations which can contribute to the improvement of health services for the migrants and seasonal farmworkers and their families; and (3) the continuing responsibility of the Community Health Service to serve as the professional health resource of the Social Security Administration in the Medicare program. This latter responsibility provides the mechanism for defining and applying standards of quality for providers of service under Title XVIII of the Social Security Act. These standards are coordinated with those of the Title XIX (Medicaid) program to assure that the programs are consistent and do not adversely influence quality of care or the administration of these two programs.

To a large extent, the success of the Federal role in comprehensive health services is dependent upon the quality and responsiveness of staff in meeting State and community requests for assistance and for taking the initiative in coordinated actions leading to delivery of health services. The role of staff in the administration of comprehensive health centers goes far beyond just administration of individual grant programs. An extremely important aspect of this role is aimed at providing the positive kind of help required to make our health system more responsive and efficient. The following are examples of staff activities: assisting health centers to develop a strong management capability; developing component program activities; providing assistance in integrating and coordinating health center services with other services in the community; developing and applying techniques to assist the centers in becoming more self-sufficient; and evaluating project activities.

Comprehensive Health Services

Policy guidance, professional advice and technical assistance are rendered to comprehensive health center projects with emphasis on the development of organized primary care programs for those regions, communities, and population groups which do not have access to adequate primary health care.

A substantial proportion of staff and contract effort is devoted to providing expert back-up for HSMHA regional staff activity in improving the management capability and operational aspects of these comprehensive health centers as they become operational. Once such projects are established, extensive staff effort is required to assure an effective operation of health centers. The programs of these centers are so complex they require technical assistance from many different operational levels and on a wide variety of complex issues.

The staff assigned to the migrant health program provided consultation on health matters in health care, nursing, health education, hospital administration, nutrition, pharmacy and sanitation. Staff members also provide consultation on statistical reporting, project evaluation, general project administration, consumer participation and community organization.

In conformance with the new and comprehensive series of guidelines concerning the quality of medical care, the participation of consumers, and other aspects of the Migrant Health Program, 64 of the 118 projects reported the establishment of consumer boards.

In 1972, the new Family Health Center Program devoted considerable time and effort in the areas of staff recruitment, organization, business management design and implementation of prepayment schemes, and evaluation. Technical and program assistance to potential and funded projects was provided.

Continuing emphasis was placed on improving management of the comprehensive health centers through expansion of the site assessment activities and the provision of technical services in the administrative, financial and professional service areas. It is estimated that 12 comprehensive health centers will receive a complete site assessment followed by the development and implementation of corrective action plans to improve the efficiency of the centers and the quality of care furnished. Emphasis is being placed on moving positively toward improving management capacity to secure medicare, medicaid, private insurance, and other forms of reimbursement for services delivered through the centers.

In 1973, program emphasis will continue to be directed toward aiding the health centers in achieving a significant degree of financial independence through the garnering of additional third party reimbursements and other State and local support. Technical assistance will be provided to communities to aid them in developing community oriented health care programs. Considerable staff time will be required in connection with the transfer of OEO neighborhood health centers.

Nursing Home Improvement

Substantial efforts continued to be concentrated on the improvement of the quality of care in nursing homes as a major component of the implementation of the 1971 nursing home initiatives. This has included training health facility surveyors, short-term training of nursing home personnel, the initiation of demonstrations of consumer services programs, and provision of technical assistance to State and local programs.

Health facility surveyors or inspectors have the key responsibility for determining whether nursing homes comply with required standards for provision of care. These State inspectors are usually health professionals, well-prepared in their profession, but often lack specific training in the most effective techniques of surveying health facilities, recording and documenting findings, consultation, programming for facility improvements, and the changing requirements and standards of Federal health care programs.

A curriculum for university-based training was developed to provide full understanding of health facility components and the health care facility requirements and standards which have been established to protect and maintain the health of patients served by these facilities.

The capacity of three university-based programs was increased in 1972 together with the establishment of additional training programs in three new universities, to provide intensive, professionally-directed training for an additional 950 inspectors.

Surveyors often need an in-depth knowledge in many specialty areas, other than the one in which they were trained, to make a comprehensive, objective, and accurate evaluation of the compliance of a facility with Federal requirements under Titles XVIII and XIX and to assist the facility administrator in making needed improvements. In 1972, in-depth specialty courses were conducted at State and local levels for over 2,000 personnel concerned with inspection, in such areas as physical environment, physician services, nursing, medical records and social services.

This in-depth training experience has generated more interest in the overall program among the States. New prepackaged in-depth courses will be added during 1973 including social services, dietary services, administrative management and diagnostic services. It is expected that, with increased interest among States and the expanded subject material, the participation for 1973 will approximately double that of the 1972 activity.

An expanded and accelerated overall surveyor training effort will provide training for 1,050 inspectors in 1973 which, added to the 950 trained in 1972, will achieve our objective of upgrading the capacity of 2,000 nursing home inspectors employed by the States.

During 1972, a nationwide effort was initiated to improve the capabilities of the health personnel serving nursing home patients.

Staff efforts are currently underway for working with States and other multi-professional organizations as well as with physician, nurse and other individual disciplines in training efforts aimed at people who have day to day responsibilities for nursing home patients. Special efforts will also be made to develop activities which will bring about a better understanding of mental health problems on the part of nursing home personnel.

The short-term training programs for 1973 will give highest priority to rapid and effective achievement of objectives in fulfillment of the President's and the Department's commitments to the improvement of nursing homes in this country.

As part of the dynamics of program development, efforts will be directed to closely coordinated activities of State governments, State affiliates of professional societies, and organizations related to the facilities themselves, with the educational systems and institutions which can assist in the actual staging of short-term training programs.

These resources will be utilized to develop short-term training models that transmit principles and methods of gerontology and mental health practices to achieve a meaningful impact, as well as effective and viable long-term programs for the improved health, welfare, and mental health of nursing home patients.

Fiscal year 1973 funds will support short-term and in-service training to enhance the competence of thousands of professional and ancillary health personnel providing care and service to patients who utilize a nursing home for a part of their requirements for long-term care.

This estimate will continue the support for demonstration projects funded in 1972 to assist the States in establishing consumer service or investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual patients. The individual who is confined to an institution and dependent upon it is often powerless to make his voice heard.

These demonstrations are designed to show how governmental and voluntary organizations at both State and local levels can function to protect the nursing home patient's personal and property rights and improve the quality of his life while in a care facility.

Activities will continue to support responsibilities in professional and technical assistance to States, communities, providers of health services, medical and health organizations, and other Federal units and to further promote the Federal-State partnership for health.

Coordinators will be placed in all ten Regional Offices to work directly with Federal-State programs to assure effectiveness in the development, coordination, and implementation of short-term and in-service educational programs for long-term care personnel and survey improvement activities.

In addition to the primary concern for nursing home improvement, emphasis will be made on continuation of activities directed toward correcting deficiencies in facilities which receive Medicare and Medicaid reimbursements.

Projects will be supported in five States to correct the most serious provider deficiencies through programs of concerted action, developed through the collaboration of State health agencies (planning, licensure, certification, and construction) and related patient care provider organizations.

<u>Medical Care Standards and Consultation</u>

The Community Health Service supplies, in partnership with the Social Security Administration's Bureau of Health Insurance, the professional health expertise necessary for carrying out the Federal Government's responsibility for establishing, implementing, and evaluating Medicare standards and related policies.

In 1972, as a result of review and assessment of all Medicare requirements for providers of service and independent laboratories, the updating of regulations for hospitals, extended care facilities, home health agencies, and independent laboratories was completed. This major accomplishment was part of a general effort to clarify, on the basis of five years of Medicare program experience, provider requirements subject to misinterpretation and uneven enforcement and to standardize and improve the overall survey process. Survey report forms and surveyor guidelines for uniform application of the new and revised standards were prepared during 1972 and staffs of all regional offices and State agencies were oriented in the application of the new requirements. During 1973, the revised Medicare provider standards will have had the test of application by the State agencies, and areas in need of further clarification will be identified and appropriate revisions prepared.

To help insure effective application of Medicare quality standards, physicians, nurses, and other health services specialists assigned to regional offices provide continuing assistance and consultation to State Medicare agencies and regional Social Security staff. The resulting upgrading of facilities and services, in which the States are partners, has benefited persons of all ages, has strengthened State licensure statutes and regulations for health facilities, has had a positive effect on voluntary accrediting programs, and will provide the base for assurance of quality care in any national health program the Congress may enact.

Program review has become a major continuing process for evaluating the effectiveness of the application of the Medicare provider standards by State agencies. During 1972 and 1973, review teams composed of representatives of the Bureau of Health Insurance and the Community Health Service central and regional offices will conduct extensive reviews in each of the States, providing an in-depth evaluation of each State's Medicare certification operations. Year-

round evaluation of State agencies by regional office staff will be enhanced through quarterly visits and sample surveys of providers in each of the States. In 1973, the methodology for conducting program reviews will be modified to be more selective and responsive to the needs of regional offices and the State agencies they serve.

Consultation is provided to Social Security Administration on a continuous basis on questions concerning covered services under Medicare, professional ethics, appropriateness of fees, termination of provider status, emergency hospital claims, and the development of policy and procedures not related specifically to standards for providers or independent laboratories, but having an effect on quality or delivery of service.

The second administration of an examination for physical therapists not meeting Medicare's formal professional qualifications was conducted during 1972. The 1972 Social Security amendments will require the Secretary to provide a similar route to qualification for other health professionals and subprofessionals and in 1972 staff initiated a number of activities related to this: 1) review of related programs, both governmental and otherwise, which the Medicare program could benefit from; 2) development of intra-government agreements for use of existing examinations; and 3) contracting for an examination which would qualify waivered licensed practical nurses. In 1973, this program will be intensified to initiate action related to all appropriate personnel categories, and will include mechanisms to identify training needs of the examinees, in order that they may upgrade their skills.

Staff work will continue from 1972 into 1973 on a number of special activities, such as: (1) anticipated new authority to bar from Medicare participation any provider or supplier who abuses the program; (2) alternative approaches to the development of standards relating physicians' qualifications to the nature of services provided under the Medicare program; (3) consideration of alternative approaches to the problem of small, substandard rural hospitals; (4) the relationship between the two financing programs and grant-supported projects; (5) an evaluation of the impact of present nursing home standards on patient outcome and cost of care; and (6) anticipated new authority for advance Medicare approval of extended or home health care.

In 1973, emphasis will continue on Medicare quality control mechanisms of several kinds. Under a contract co-funded with BHI, we will have completed special training of State staff in clinical laboratory quality control, and the new regulations related to this will be in effect. Another 1972 contract provided for development of a prototype medical school curriculum on medical care appraisal. Seminars and other training in utilization review, as a follow-up on a series of training institutes in 1972, will be made available for providers, intermediaries, and physicians, and State staff will receive intensified training in this area.

Direct assistance and advice will continue to be provided to the Medical Services Administration, Social and Rehabilitation Service, on the development and implementation of regulations for skilled nursing homes, intermediate care facilities, utilization review, and medical review under the Title XIX (Medicaid) program. During 1972, Community Health Service regional offices worked closely with the Medical Services Administration in connection with the Nursing Home Improvement Program.

1973 Increases

In 1973, an increase of $988,000 is requested. This amount, partially offset by decreases of $38,000 for two less days of pay and $69,000 annualization of DHEW 1972 employment cutback, would provide $120,000 for program increase and $868,000 for mandatory items. The program increase would be used to initiate a

reporting system to collect information on the extent of health services obtained by migrants and seasonal farmworkers and their families. The mandatory items would cover annualization of 1972 new positions $443,000, annualization of the uniformed services pay increase, Public Law 92-129, dated September 29, 1971, $25,000, net costs of within grade and longevity increases $179,000 and increases for DHEW Working Capital Fund $95,000, HSMHA Service and Supply Fund $18,000 and FTS charges $108,000.

Maternal and Child Health

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	133	$2,633,000	133	$2,658,000	---	+$25,000
Other expenses........	---	236,081,000	---	249,890,000	---	+13,809,000
Total...........	133	238,714,000	133	252,548,000	---	+13,834,000

Introduction

The programs authorized under Title V of the Social Security Act are a major national resource for providing basic preventive maternal and child health services and for the location, diagnosis, treatment, and follow-up care of children with crippling or potentially crippling conditions, especially in rural areas and areas which are economically depressed. They respond to the serious deficiencies that exist in the amount and quality of care received by poor children as compared with middle class children which result in an excess of preventable deaths, illnesses and handicapping conditions among the poor.

The dual approach to services which the legislation provides--grants to States to strengthen and improve basic services especially in rural areas, and project grants targeted on low-income areas where there is heavy concentration of need--recognizes today's needs and permits some of the flexibility necessary to respond to them. The research and training programs, concentrating on finding new and improved ways to improve the delivery of services and on filling the manpower gap, round out the comprehensive approach provided by Title V legislation.

Section 513(b) provides that not exceeding one half of one percent of funds appropriated under the authority of Title V shall be available for evaluation by the Secretary of programs authorized under this title. In addition to grants and contracts, funds available for evaluation may also be used to finance consultative and other services related to evaluation purposes. Such consultative services would be performed under contract or through the use of experts and consultants.

Grants to States

Other expenses	1972 Amount	1973 Amount	Increase or Decrease
Maternal and child health services.................	$59,250,000	$60,778,000	+$1,528,000
Crippled children's services	62,272,000	64,900,000	+2,628,000
Total................	121,522,000	125,678,000	+4,156,000

The basic purposes of the maternal and child health and crippled children's services programs of grants to States are to (1) reduce infant mortality and otherwise promote the health of mothers and children, and (2) locate, diagnose, treat and provide follow-up care for children who are suffering from crippling or handicapping illnesses. In addition to providing grants to States on a formula basis, these programs also fund special projects of regional or national significance which contribute to improvement of the programs. Specialized program efforts are described in more detail under the appropriate activities.

Program Accomplishments

Training: In both the maternal and child health and crippled children's programs, States provide for training and use of paid subprofessional staff, with special emphasis given to employing low-income persons. Duties are tailored to the needs of the several programs and include work in casefinding, as nutrition aides, dental aides, home health advisors, and community services aides. As employment of such workers increases, new career opportunities will become available to persons who lack professional training. Training of professional personnel under the maternal and child health and crippled children's special project grants is also continuing. In 1971, more than 660 health-related professional personnel received training through institutions of higher education and State agencies. During 1972 and 1973 the numbers of professionals trained are expected to rise to 700 and 830 respectively.

Mentally retarded children: The maternal and child health and crippled children's programs currently support in whole or in part 150 mental retardation clinics in which 57,000 children and their families received diagnostic and counselling services; 20 cytogenetic diagnostic and counselling programs; and 15 special clinics for children with multiple handicaps. The services include diagnosis, evaluation of a child's capacity for growth, the development of a treatment and management plan, interpretation to parents and follow-up care and supervision.

A major effort in the prevention of mental retardation continues to be in relation to phenylketonuria (PKU). MCHS continues to work with State health departments in developing the necessary laboratory facilities to detect families with the condition and assisting States to provide special diets and follow-up programs. During 1970 approximately 90 percent of the newborns in the 50 States and District of Columbia were screened. This screening effort by the States, supported through MCHS, turned up approximately one confirmed case for every 16,000 live registered births.

Nutrition services: As an integral part of the maternal and child health and crippled children's programs, nutrition services are provided through well-child clinics, pediatric clinics, group care facilities and school health programs. Currently over 500 nutrition personnel are employed by State and local agencies.

These personnel play a major role in assisting low-income families to develop a better understanding of normal as well as therapeutic diets. Their activities are contributing to the prevention or elimination of malnutrition in many families.

1. Maternal and child health services

States use Federal funds, together with State and local funds, for prenatal and postpartum care in rural areas where mothers may receive clinical services including family planning services and home visits by public health nurses; for well-child clinics where mothers can bring children for examination, immunizations, and competent advice. Such measures have been instrumental in the reduction of maternal and infant mortality.

Funds are used to provide medical, dental and nursing services for school health examinations and immunizations. These projects are primarily located in rural areas.

Major support for dental services for children through State health departments continues to be from maternal and child health funds. For many basic maternal and child health programs the development and extension of family planning services continue to be a priority in 1972 with special emphasis on the provision of services to pregnant adolescents.

Among the more significant services provided through the maternal and child health services program are the following:

	1971 Provisional	1972 Estimate	1973 Estimate
Mothers receiving prenatal and postpartum care in maternity clinics......................	334,000	400,000	400,000
Women receiving family planning services.....................	752,000	752,000	752,000
Public health nursing visits made on behalf of:			
Mothers....................	566,000	566,000	566,000
Children...................	3,290,000	3,290,000	3,290,000
Children attending well child clinics......................	1,500,000	1,500,000	1,500,000
Children receiving screening tests for:			
Vision.....................	8,977,000	10,000,000	10,000,000
Hearing....................	5,677,000	6,250,000	6,250,000

1973 Program: Funding proposed for 1973, which includes an increase of $1,528,000 over 1972, is expected to continue support of essential services provided through this program and maintain the high level of excellence in quality of such services.

2. Crippled children's services

State crippled children's agencies use their funds especially in rural areas, to locate handicapped children, to provide diagnostic services, and then to see that each child gets the medical care, hospitalization, and continuing care by a variety of professional people that he needs. Fewer than half of the children served have orthopedic handicaps. The rest include epilepsy, hearing impairment, cerebral palsy, cystic fibrosis, heart disease, and many congenital defects. Clinics are held periodically by State crippled children's agencies. Some clinics are mobile and travel from place to place; others are held in permanent locations. Any parent may take his child to a crippled children's clinic for diagnosis.

Within the last two decades, the number of children using the crippled children's program has more than doubled. In 1950, there were 214,405 children served, while in 1971 the number served was approximately 485,000. More than a third of the children served were new admissions to the crippled children's program. The number of children who received physicians' services in clinics increased (2.1 percent) as did the number who received other physician's services (7.2 percent). The number of children requiring hospital inpatient care decreased (3.8 percent) as did the number of children who received convalescent home care (14.0 percent).

Among the specific services provided through this program are the following:

Number of Children	1971 Provisional	1972 Estimate	1973 Estimate
Receiving physicians' services.....	485,000	500,000	500,000
Receiving hospital inpatient care..	82,000	82,000	82,000
With multiple handicaps...........	90,000	90,000	90,000
With congenital heart disease......	33,000	33,000	33,000

1973 Program: The additional $2,628,000 proposed for 1973 will help States meet the rising costs of providing care for crippled children. Increased costs in the crippled children's program are due not only to the average annual increase in medical care costs but also to the fact that the more effective treatment methods are now more complicated technically and more costly.

Project Grants

Other expenses	1972 No.	1972 Amount	1973 No.	1973 Amount	Increase or Decrease No.	Increase or Decrease Amount
Maternity and infant care:						
Comprehensive centers	56	$42,675,000	56	$46,332,000	--	+$3,657,000
Intensive care of infants............	8	753,000	8	900,000	--	+147,000
Children and youth.....	59	47,400,000	59	52,842,000	--	+5,442,000
Dental health of children.............	17	1,180,000	17	1,256,000	--	+76,000
Total............	140	92,008,000	140	101,330,000	--	+9,322,000

These programs provide comprehensive medical care to poor and near-poor mothers and children who might otherwise not receive such services. Efforts are particularly focused on those who live in urban slums.

The comprehensive maternity and infant care (M&I), and children and youth (C&Y) projects together with related neighborhood health centers are making it possible for community health organizations to develop new and imaginative methods of reaching out to the people in slum areas, decentralizing services into neighborhoods, reducing crowding in tax-supported hospitals by paying for care in voluntary hospitals, and establishing well-organized systems of providing comprehensive health programs for casefinding, prevention, health supervision, and treatment.

These programs, for the most part, are being carried out in areas where there are few physicians in private practice and where existing clinics are grossly overcrowded. In these areas they are creating new resources and changing existing methods of delivering health services in order to be responsive to the needs of the people. Of the 115 comprehensive M&I and C&Y projects now in operation almost one-third are involved in cooperative efforts with other Federal programs. Two-thirds are located in city slum areas. Over 1,600 community aides are employed through these projects.

In 1973 and future years, emphasis will be on coordination of existing maternal and child health programs with other Federal-State-local sponsored service and financing mechanisms. The M&I and C&Y projects are Health Maintenance Organization prototypes incorporating several of the basic characteristics of Health Maintenance Organizations. They are a form of group practice, but broader than the usual group practice model in that they include the services of nutritionists, social workers, public health nurses, and aides. Prevention is a major emphasis and patients are enrolled in a system of continuing health supervision rather than one which responds only to episodic illnesses. The services are prepaid through tax funds and the staff is salaried. The additional resources available for FY 1973 will help to expand and broaden the existing centers and to facilitate their collaboration with other health providers and financing systems.

1. Maternity and infant care

Comprehensive maternity and infant care projects: This program, begun in the spring of 1964, now has 56 projects in operation in large and middle-sized cities and in rural areas. These projects are located in 35 States, the Dictrict of Columbia and Puerto Rico. While more than 60 percent of the maternity and infant care projects serve cities of 100,000 inhabitants or more, projects are also located in rural and urban-rural populations in such States as Alabama, Georgia, Florida, Arkansas, Idaho and others. All the projects serve localities which in the past showed much higher infant and maternal mortality rates than the Nation as a whole.

	1971 Provisional	1972 Estimate	1973 Estimate
Admissions for services:			
Mothers........................	141,000	144,000	152,000
Cumulative since start of program......................	877,000	1,021,000	1,173,000
Infants........................	47,000	49,000	53,000
Women receiving family planning services........................	134,000	134,000	134,000

Approximately 60 percent of all women admitted for maternity care in the projects during fiscal year 1971 (the most recent year for which complete data is available) were black, 20 percent were white, and the rest were of other origin. The large proportion of black women reflects the central-city, metropolitan location of the projects as well as the predominance of blacks in the medically indigent segment of the urban population.

Thirty-nine percent of all women admitted for maternity care in fiscal year 1971 had become pregnant out-of-wedlock. This figure varied from 87 percent in those under 15 years of age to 25 percent in those 35 years and older. The large proportion of out-of-wedlock pregnancies in part comes from the greater reported incidence of such pregnancies in low-income populations and from emphasis on the part of projects in reaching this particular high-risk group either through neighborhood canvassing or through referral agreements with schools and other community agencies.

Significant contributions to recent reductions in the Nation's infant mortality rate have been made through the maternal and child health program and the comprehensive maternity and infant care projects. For the Nation as a whole, infant mortality decreased almost 24 percent during the period 1960-70. Almost three-fourths of that decrease occurred during the four-year period 1966-70.

Reports submitted by specific projects show these reductions in infant mortality rates per 1,000 live births in these major cities:

	From		To		Decrease
	Year	Rate	Year	Rate	%
National rate....................	1965	24.7	1970	19.8	19.8%
Cities with major maternity and infant care projects:					
Baltimore, Md.	1965	26.8	1970	25.1	6.3
Houston, Texas	1965	28.0	1970	20.0	28.6
St. Louis, Mo.	1965	44.4	1970	31.1	30.0
Chicago, Ill.	1965	33.6	1970	27.7	17.6

The impact of the maternity and infant care projects on infant mortality can be measured in many ways, among them:

a. The increased number of women who request help early in pregnancy so that they get the most benefit from prenatal care. This trend is shown by the fact that for M&I projects as a whole, the percentage of new maternity patients seen during the first trimester of pregnancy was 23.0 in 1971 as compared with 18.8 in 1970, an increase of 4.2 percent in one year.

b. Some projects are making marked reductions in the number of mothers being delivered without any prenatal care. In Greenville, S. C., the proportion dropped from 25 percent in 1967 to 5.9 percent in 1970.

1973 Program: The request of $46,332,000, an increase of $3,657,000 provides for increased support of 56 ongoing projects. About one-fourth of the expenditures under this program represent hospital costs and one-half, salaries and services of medical and other staff.

Intensive care projects for high-risk infants: Specialized care for infants born at high risk (prematurely born or with other conditions detrimental to their normal growth and development) provides another means of combating high infant mortality rates. Such infants usually require both intensive care during their hospital stay and follow-up attention during the first year. A large number of studies in this country and others have shown that a considerable degree of effectiveness in reducing the mortality rate among high-risk infants can be achieved through the use of special intensive care units or centers. These provide increased medical and nursing supervision, care by personnel specially trained in such fields as treatment of cardiopulmonary failure and respiratory distress in newborns, and use of special equipment as needed.

In 1973, the $900,000 requested, an increase of $147,000 over the 1972 level, will continue support of the five ongoing projects initiated in 1970 and three new projects initiated in 1972.

2. Children and youth

The "Children and Youth" project grants support comprehensive health care for children in areas where low-income families are concentrated. Projects provide screening, diagnosis, preventive services, correction of defects and after-care (both medical and dental). Services are coordinated with the programs of the State or local health, welfare and education departments and with related programs

of the Office of Economic Opportunity and other programs in HSMHA. The treatment services available under the program are provided only to children from poor families who would not otherwise receive such care.

There were 59 operating children and youth project units as of June 30, 1971, serving areas in which approximately 3,653,000 children and youth under age 21 live. Sixty-seven percent of the projects and 87 percent of the registrants are from cental city areas. The grantees are about equally divided between health departments and medical schools with their affiliated teaching hospitals.

A breakdown by race shows that 64 percent of registrants are black, 32 percent are white, 4 percent are of other races. Girls outnumber boys in each of the ethnic categories. Median age for registration was about 5 years. The age group 5 to 9 has the highest percentage of registered children, followed by the 1 to 4 age group. Most projects focus their efforts on children between the ages of 0-14. At least one-fourth of the new registrants has had an acute medical care episode before initial health assessment. The number of registrants with acute episodes of care decreases dramatically after provision of comprehensive health care services has begun.

Since the beginning of the program there has been a marked decrease in the percentage of registrants needing hospitalization. Figures comparing 1968, 1969 and 1970 are:

Year	No. of Hospital Admissions	No. of Hospital Days	% of Registrants Hospitalized	Average Length of Stay
1968	15,100	113,100	7.73	7.48
1969	15,400	111,800	4.50	7.27
1970	15,238	97,500	4.09	6.40

Accompanying the decrease in hospitalization rates is a decrease in annual average per capita costs:

Average Annual Cost per Child

1968	$201.26
1969	162.47
1970	149.82

This demonstrates that child health services which emphasize prevention pay off among the poor as well as among private patients. There is a consistent decrease in illness and in the need for hospital care.

Screening for correctable defects is one important program objective. For the year ending June 30, 1971, of the 65,000 children screened for visual impairments 14,404 failed the test. Of the 63,500 children who had hearing tests in this same year, 5,800 failed. Projects also offer special screening programs to detect diseases that are more common in their particular community, such as lead poisoning and sickle cell disease. In a cooperative effort between the Chicago Board of Health, the State Health Department, OEO, and the children and youth program, 116,261 children were screened for lead poisoning over a 3-year period in the Chicago area, and of these over 10,000 had abnormally high lead levels indicative of excessive exposure.

In order to more effectively serve their communities, the projects have involved parents in the overall planning and implementation of Services. Forty-three percent of the projects have developed community advisorv boards, although this is not mandated by law.

Some of the projects are able to utilize the services of medical personnel such as interns and residents, who are in a rotational program from educational institutions such as medical schools and teaching hospitals. Thirty-nine projects report a total of 1,641 persons working in this capacity, either full- or part-time.

1973 Program: The request of $52,842,000 for 1973, an increase of $5,442,000 over 1972, provides for the effect of rising medical care costs and for expansion of the 59 operating projects. It also provides funds to study the feasibility of converting children and youth projects to Health Maintenance Organizations on a prepaid capitation basis.

3. Dental health of children

The Child Health Act of 1967 authorized a program of special project grants to promote the dental health of children. Up to 75 percent of the cost may be paid from comprehensive projects serving school and preschool children from low-income families. These are located particularly in areas with concentrations of low-income families. These projects can employ dental personnel without professional training, as well as dental hygienists.

Dental disease in children is common; however, the plight of the rural or disadvantaged child is most serious. While approximately one-half of all children under 15 in the country have never been to a dentist, this percentage is higher for children in rural areas. It rises to 75 percent of the children living in families with incomes under $2,000. Sixty-six percent of the children in families with incomes under $4,000 have never been to a dentist, compared to 40 percent in families with an income of $4,000 or more.

The 1971 appropriation provided for initiation of this program to provide comprehensive dental care to 10,000 children. Coverage included first grade children only as the first increment in a program aimed at full coverage of all eligible children in grades 1 through 12. Each year services will be continued for these children and a new group of 5 and 6 year olds will be added. The advantage of the incremental approach is that less professional time is required to carry out preventive and corrective measures than to correct neglected and advanced dental problems. Children become familiar with dental procedures at an early age, thus are less likely to avoid such procedures as they grow older. This approach emphasizes preventive and continuing dental health supervision. It is expected that 21,000 children will receive treatment under this program with funds appropriated in 1972.

1973 Program: The total request of $1,256,000, an increase of $76,000 over the 1972 amount, is expected to provide dental care for 22,000 children in 1973.

Research and Training

Other expenses	1972		1973		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Training............	33	$15,071,000	33	$15,357,000	--	+$286,000
Research............	68	6,035,000	68	6,035,000	--	---
Total.........	101	21,106,000	101	21,392,000	--	+286,000

1. Training

The major purpose of this program has been to support training in University-Affiliated Centers for the Mentally Retarded in an effort to improve and expand the supply and competence of personnel working with children with multiple handicaps and their families. The primary objective of these centers is to carry the concept of a coordinated multidisciplinary multiservice approach to the problem of mental retardation forward into a training program. This training program is charged with turning out professionals who not only have the clinical competency in their own discipline but who, as a result of their training, have an appreciation of the roles and contributions of an array of other disciplines and can fit their own skills and function into such a coordinated group approach. The centers offer a complete range of services for mentally retarded and multiply handicapped children.

During fiscal year 1971, the 19 University-Affiliated Centers (4 new in 1971) which had training support from this program provided long-term training for over 300 professional health personnel and short-term training for 3,600 graduate and undergraduate trainees.

The major impact of the 19 centers during 1971 continued to be in raising levels of teaching and service and influencing a variety of basic curriculum changes in the affiliated degree-granting departments, colleges and universities. Colleges for example, are using the centers to train their students and give degree recognition for the training the centers provide. Over 16,000 children and their families were evaluated to select the appropriate teaching situations for students enrolled in the program. Excellent quality health care was provided to the children selected for this program.

In 1972 a new program under Section 511 is being initiated to train obstetrical and pediatric health manpower. This is a new training program not associated with the training efforts of the 19 centers previously described. It is expected that approximately 150 nurse midwives, pediatric nurses and other physicians' assistants will be trained in 1972.

1973 Program: The 1973 amount requested, $15,357,000, will support improved staffing levels for the existing university-affiliated centers and also support continuation of the new training programs initiated in 1972.

2. Research

The basic purpose of this research grant program is to contribute to improving the health of mothers and children of the Nation. In consonance with that objective, it aims to improve the operation, functioning, and general usefulness and effectiveness of maternal and child health and crippled children's services. The concern is with mothers and children in all classes of our society with high

priority given to special problems for those segments of the population not receiving adequate health care.

Some examples of areas being or to be investigated are: health status of and health services for mothers and children in urban and rural communities; new approaches to providing maternity health services; methods of increasing the effectiveness of child health programs, especially services for school-aged children and for mentally retarded children; prevalence of handicapping conditions; cost of services; evaluation of the effectiveness of programs; nutrition; and programs and services for teenage parents.

Special emphasis is being given to studies of the need for and feasibility and effectiveness of comprehensive health care programs in which maximum use is made of health personnel with varying levels of training. The purpose of the research project entitled "Allied Health Worker Utilization in Maternity Care," for example, was to determine how physicians who specialize in obstetrics-gynecology use allied health workers in maternity service. About half the respondents endorsed the concept of greater use of maternity nurses and agreed in general on the tasks to be delegated, while about one-fourth were negative or opposed and the remaining fourth were uncommitted or neutral. Obstacles to such delegation were an increase in physician's liability and the lack of well-qualified maternity nurses.

1973 Program: The 1973 request of $6,035,000 would continue support of 68 ongoing research efforts in the broad field of maternal and child health and crippled children's services.

Direct Operations

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	133	$2,633,000	133	$2,658,000	---	+$25,000
Other expenses........	---	1,445,000	---	1,490,000	---	+45,000
Total..........	133	4,078,000	133	4,148,000	---	+70,000

The Maternal and Child Health Service staff are concerned with (1) administration of grants for medical care services, research and training grants; (2) technical assistance and consultation to States, localities and organizations; (3) development and issuance of standards and guidelines for services to mothers and children; and (4) evaluation and analysis of program performance and potential. The special emphasis placed in 1971 on providing consultation and advice to State and local agencies is being continued in 1972. Special effort is also being directed to assisting States in meeting the legislative requirements to provide family planning services Statewide by 1975.

1973 Program: MCHS staff will continue consultation and evaluation efforts and will continue to concentrate on monitoring of grant activities, improved management of services, and provision of technical assistance and guidance to States and communities. Mandatory costs associated with within-grades, reclassifications, and central services charges account for the total increase of $70,000 in 1973. The staff will continue its current high rate of productivity in providing technical assistance and consultation to grantees, States and localities, and in implementing policies related to capitation and third party payments.

Family Planning

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.	70	$1,024,000	87	$1,407,000	+17	+$383,000
Other expenses.	--	95,229,000	--	137,604,000	--	+42,375,000
Total	70	96,253,000	87	139,011,000	+17	+42,758,000

Introduction

Family planning services are defined as those educational, comprehensive medical and social services necessary to enable individuals to determine freely the number and spacing of their children. An estimated 20 percent of all births in the United States are unwanted by either the husband or wife or both. The proportion of unwanted births is significantly higher among the poor for whom contraceptive information and services are less available than for others. This lack of information and services causes unwanted pregnancies which result in numerous health, social and economic problems, and deny individuals the right to control their own fertility.

To remedy the situation, the President has declared it a national goal that family planning services should be available by 1975 to all who want, but cannot afford them. The Federal responsibility is to provide leadership in meeting this goal. About 2.9 million individuals were receiving services by the end of 1971, through all public and private means. The major responsibility to more than double the nationwide capacity to deliver family planning services by 1975 rests with the Department of Health Education and Welfare, primarily with the National Center for Family Planning Services. The National Center for Family Planning Services, as the lead agency within the Health Services and Mental Health Administration for the delivery of family planning services, administers a program of project grants and contracts for the support of family planning clinics, the training of family planning workers, the development and distribution of family planning educational materials, and for research and technical assistance to improve the delivery of family planning services. These programs are designed to accomplish the President's goal by focusing and coordinating efforts to reach the maximum number of people with quality services as rapidly as possible.

Project Grants and Contracts

	1972 Amount	1973 Amount	Increase or Decrease
Other expenses.	$94,815,000	$137,024,000	+$42,209,000

Included in this subactivity are project grants and contracts for the delivery of family planning services; project grants and contracts for the training of allied and other health personnel for work in family planning clinics; and project contracts for education, research, technical assistance and planning and evaluation as described below:

(1) Family planning services

	1972 Amount	1973 Amount	Increase or Decrease
Project grants and contracts for family planning services:			
Project grants.	$87,875,000	$129,875,000	+$42,000,000
Project contracts.	625,000	625,000	--
Total	$88,500,000	$130,500,000	+ 42,000,000

Support for the delivery of family planning services is provided through project grants authorized under Title V of the Social Security Act and Title X of the Public Health Service Act. These grants, which are administered by regional office staff, are made to State and local health departments, hospitals, universities, community agencies and other public or nonprofit groups. Family planning services include comprehensive medical services composed of physical examiniations, medical history, laboratory tests, contraceptive supplies and referral for other health service needs.

In addition to those medical services directly relevant to family planning and contraception, clinics provide services for the detection, diagnosis and referral of other major health problems, such as breast and cervical cancer, venereal disease, and among black patients only, sickle cell disease. Other services include patient education and counseling and social services, such as transportation and babysitting to facilitate patients' use of family planning services.

The mandate of the National Center is to provide comprehensive family planning services to the millions of individuals who, for many reasons, are denied access to these services, with priority on services for persons from low income families. The acceptance of these services is purely voluntary, and does not affect the recipient's eligibility for other services. Priority is placed on locating services in areas with high concentrations of persons in need of family planning services and high rates of maternal and infant sickness and death. In addition, consideration is given to integrating family planning projects within existing health systems. Many projects supplement programs of State and local health departments or other Federal programs to avoid duplication of effort and provide a base for more comprehensive services.

During FY 1972, grants totalling $87,875,000 will support about 325 projects whose total capacity for services will be about 1.5 million people, more than doubling the service capacity funded through 1971. To guide program development and funding during FY 1972, the Center has established several priorities. The priorities are based on a concern for the timely development of programs against the five-year goal, utilizing the project grant which is particularly suited to support the creation and initial expansion of a capacity to provide family planning services into which other sources of continuing financial support can be channeled. This is particularly true for specific groups and areas for which the traditional means of health care delivery are not generally available. Specifically, these priorities are:

1. To ensure geographic and administrative coverage of the entire United States by developing plans and identifying service providers and full-time administrators for areas such as states or metropolitan areas.
2. To establish and enforce minimum program standards for medical services, administration and staffing;
3. To maximize the extent to which financial resources other than those available through the National Center are utilized; and
4. To increase the availability of services to rural residents, low-income whites, people who have achieved their desired family size, adolescents, and those with no children.

During 1972, 75 OEO projects were transferred to the National Center. Liaison with OEO, the Maternal and Child Health Service and other providers of services was maintained to ensure the most effective utilization of all family planning resources. The Center will continue to support project contracts totalling $625,000 in both 1972 and 1973 for the delivery of family planning services to American Indians.

Of the total 1973 program level of $129,875,000 for family planning project grants, approximately $114,875,000 will be for the continuation and expansion of 325 prior-year awards, including $27,000,000 for program expansion. Ten million dollars is included for the transfer of approximately 75 additional on-going projects from OEO and $5,000,000 is included to initiate about 25 new projects. In 1973, the estimated 425 projects will provide service capacity for approximately 2.2 million women. At least one project will be operating in each state, as well as Puerto Rico, The Virgin Islands and Guam.

Priority will be given to the expansion of existing programs including the development of services in additional locations within the service area, such as additional cities and counties within a statewide project. It is crucial that the basic capacity to deliver services be established throughout the country in 1973 so that the national goal can be achieved.

Efforts will be made to involve all elements of the health services delivery system in the provision of family planning services, and to make family planning a basic component of all comprehensive health programs. This will include providing family planning services in public and private hospitals, comprehensive health centers and neighborhood health centers. It is estimated that 90 percent of the services needed for family planning can be provided by existing health facilities. All projects will be encouraged to seek other sources of financial support, particularly for the support of

continuing care through third-party reimbursements, including private insurance and public programs such as Medicaid.

The $10,000,000 for the funding of an estimated 75 OEO family planning projects throughout the nation reflects the Administration's policy of having successful OEO projects transferred to operating agencies once they are established. Although all of the projects to be transferred have not yet been identified, priority will be given to transferring programs which are jointly funded by OEO and the National Center for Family Planning Services and projects which have accomplished their development and demonstration purposes. The National Center is currently working with the OEO to facilitate this second round of transfers so that program continuity will be ensured.

The following table shows the estimated number of projects, women served, and funding of family planning project grants to be supported by the National Center in 1972 and 1973:

Project grants funded in the Fiscal Year	1972 Estimate		1973 Estimate		Increase or Decrease	
	No.	Amount	No.	Amount	No.	Amount
Continuation projects	265	$75,875,000	325	$114,875,000	+60	+$39,000,000
OEO projects to be transferred	--	--	75	10,000,000	+75	+10,000,000
New project grants	60	12,000,000	25	5,000,000	-35	-7,000,000
Total	325	87,875,000	425	129,875,000	+100	+42,000,000
Number of women served*		1,500,000		2,200,000		+700,000

*Estimated on the basis of $60 per woman per year

Current estimates indicate that approximately 2.3 million additional women may be receiving services from other providers of services in 1973, including private physicians and voluntary organizations. When combined with the 2.2 million women to be served by projects funded by the National Center, a total of 4.5 million women in need of subsidized services will be receiving them. Thus, at the end of the third year of the five-year effort, well over two-thirds of the total estimated need for subsidized family planning services will have been met. This significant national effort will greatly help reduce the dependency of many families presently burdened with the consequences of unwanted childbirth.

(2) Training and Education

	1972 Amount	1973 Amount	Increase or Decrease
Project grants and contracts for training and education			
Training grants.	$2,000,000	$2,000,000	--
Training contracts. . . .	1,000,000	1,000,000	--
Education contracts. . . .	700,000	909,000	$+209,000
Total.	3,700,000	3,909,000	+209,000

The rapid establishment of a network of family planning service programs requires the availability of trained manpower, the absence of which is a major impediment to the development of many health programs. The crucial efforts to remove this as a constraint include training additional family planning workers, creating new categories of health workers, and special efforts to demonstrate the most effective utilization of manpower resources.

Project grants and contracts totalling $3,000,000 in 1972 will be used for the development of a short-term training capacity to train approximately 2,200 personnel who will assist in the delivery of family planning services. Priority will be given to the development of training capacity at regional and state levels to provide training for all categories of service delivery personnel. Emphasis will be on training administrators for improved management and program development, and training selected individuals from family planning projects to assume the role of trainers within their own projects. In an effort to improve the delivery of services in rural areas and promote effective manpower utilization, special training programs will develop the clinical service delivery skills of physicians' assistants, nurse clinicians, public health nurses, and nurse midwives.

Special studies to improve the tools available for family planning training programs will be further developed in 1972. It has become crucial that all materials currently used in family planning training be reviewed to determine their effectiveness, to make the best materials more widely available and to determine where new materials should be developed. In addition, new methods for evaluating the effectiveness of various training approaches will be developed as a tool for administrators responsible for implementing training programs. Models for training will be developed to assist new projects in initiating training efforts and established projects to improve programs.

During 1973, the $3,000,000 training grants and contracts program will concentrate upon the improvement and strengthening of the regional and state training capacities developed during the preceding year. A major training objective will be to continue to gain a high multiplier effect by training selected project level personnel to provide family planning service delivery training at the local level. The development of a minimum training capability within each project will thereby be achieved. Program areas to receive the greatest attention will include program and project management, with emphasis upon skills in personnel, office management, record keeping, budgeting and accounting, planning and evaluation, clinic management, community relations

and education, and staff training. The training program will also continue to develop new manpower categories such as family planning assistants and nurse clinicians to assume increasing responsibility for the delivery of services previously accomplished by physicians and nurses alone. Continued emphasis will be placed on the effective utilization of existing categories of manpower such as nurse-midwives, nurse clinicians and physicians' assistants so that they might assume responsibility for many of the more routine medical procedures.

Education - The broad objectives of the education program of the Center range from providing information to a variety of family planning personnel at all levels to increase their awareness of the family planning field, to assisting in the implementation of effective education components of operating family planning programs. These efforts are intended to give direct support to NCFPS service projects in the development of provider and patient oriented education programs, and to extend and improve the understanding, knowledge and commitment of the total community to the potential benefits of effective family planning services.

In 1972 a variety of activities will be supported to improve awareness and knowledge of family planning at all levels. Special efforts will be made, through studies, surveys and workshops to extend and improve knowledge about special patient groups such as adolescents and minorities, in order to develop improved education programs responsive to their needs. Further studies are needed to learn more about the specific barriers which may prevent people from controlling their own fertility. For example, in-depth studies are needed of the attitudes of individuals of varying characteristics toward specific methods of family planning and toward various sources of service in order that education, medical and social services might take such attitudes into consideration in planning the actual services to be offered.

Projects will be initiated in 1972 to disseminate educational materials to selected audiences including potential deliverers of medical, educational, referral and other supportive services. New educational materials will be developed and evaluated for use in multiple settings, such as hospitals and private doctor waiting rooms as well as family planning clinics.

The increase of $209,000 in 1973 will enable the Center to develop and evaluate new education materials and promote the use of education methods which have proven their usefulness. A major objective in 1973 will be to utilize the information derived from studies to develop and introduce educational programs for hard-to-reach groups based on a sound understanding of their levels of knowledge and attitudes toward family planning services.

(3) Services Delivery Improvement

	1972 Amount	1973 Amount	Increase or Decrease
Project contracts for services delivery improvement.	$2,615,000	$2,615,000	--

Special studies and programs are being supported by the Center to develop and improve its ability to mount a coordinated program responsive to national priorities and to significant regional and local variations. These programs, supported under project contracts, are in the areas of operational research, planning, evaluation and technical assistance.

Operational Research - This program seeks to develop the most effective methods for the delivery of family planning services, and to apply the most modern research techniques to the solution of operational problems.

In 1972, the operational research program is directed toward the exploration of new techniques for serving the "hard-to-reach" segments of the population in need of services. Extension of services into rural areas will be explored in several studies. These studies will document existing rural delivery approaches, identify major barriers to services, design alternative models for delivery of services and, in a controlled situation, evaluate various delivery mechanisms such as mobile clinics, private physician programs, and free-standing clinics. Studies also will be supported which will use and compare a wide variety of program designs responsive to the needs of the adolescent. Other studies will seek ways to improve the accessibility of services through establishment of alternative delivery settings. One project, for instance, will test the feasibility of providing services at work sites to reach the many low income workers who cannot, because of both job and family responsibilities, easily avail themselves of services provided elsewhere.

Planning - Activities are supported at the national, regional, state and local level to provide program managers with the demographic, analytical and procedural tools for designing future program efforts.

During 1972, the Center will continue its efforts in defining the scope, strategies, policy requirements, resources and needs of a nationwide services delivery program. The need to plan alternative levels of program implementation led to the development in 1972 of separate regional profiles which itemize for each of the ten DHEW regions detailed data and strategy implications. A detailed update and assessment of program progress will be initiated in the Spring of 1972, the first point at which significant new data and program information will be available. This will form the basis for the more detailed analysis and update of the five year plan in January of 1973, the midpoint in the five year mandate for the nationwide delivery of family planning services.

Evaluation - The development of methods and data for determining progress and identifying problems in implementing program objectives is crucial. At all levels of program implementation effective decisions depend directly on the availability and analysis of current information on program status and impact and on the effectiveness of various operating techniques and strategies.

A joint OEO/HEW evaluation project identifying and comparing detailed data from selected projects on utilization of services, patient characteristics and clinic operations, will be completed in the Spring of 1972. On January 1, 1972, the National Center for Health Statistics began the final phase of implementation of the National Reporting System for Family Planning Services, which includes all DHEW funded projects among others. This will form one of the core elements of the evaluation effort, by providing continuing data on the number and characteristics of all family planning patients.

A high priority in 1972 will be the development of an evaluation process built upon project monitoring concepts. Projected phases include assessment of evaluation needs at all levels of program management; identification of existing evaluation activities; development of program specific evaluation concepts; definition of project performance criteria; field-testing of the resulting evaluation process; preparation of technical assistance manuals for application of this process at various operating levels; and installation of the evaluation system in selected areas. This process is being designed to provide a common framework within which project evaluation will become an ongoing activity at the national, regional and the project levels.

Technical Assistance -- Special efforts are supported to provide outside consultation to directly assist local communities in the development and implementation of specific aspects of effective delivery of family planning services. These cover a range of activities, including: development of mechanisms for area-wide coordination of delivery programs; implementation of effective consumer participation activities; the improvement of project management skills; the development of effective coordination with other Federal agencies providing family planning services; and the improvement of communication skills and attitudes in providing services to ethnic groups. These activities, initiated in 1971, will be expanded to assist additional projects in 1972.

In 1973, studies will be continued to improve the delivery of services to people with problems of access to health services such as adolescents and rural people in general. Planning and evaluation data will be used to meet the immediate requirements of family planning administrators primarily at the regional, State and local levels. The project evaluation process will be further refined and fully implemented across all levels of program administration. The Center's technical assistance efforts in 1973 will concentrate on improving project management and assisting in the orderly expansion of services in given geographic areas.

Direct Operations

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	70	$1,024,000	87	$1,407,000	+17	+$383,000
Other expenses	--	414,000	--	580,000	--	+166,000
Total.	70	1,438,000	87	1,987,000	+17	+549,000

The direct operations subactivity provides staff and operating funds necessary for program development and administration of the programs of the National Center for Family Planning Services. During 1972, 60 new project grants totalling $12,000,000 million were awarded, 75 OEO projects totalling $10,000,000 were transferred to the National Center and project grants and contracts totalling $6,315,000 for training, education, and services delivery improvement related to family planning were awarded.

Priority in 1972 was given to staffing regional and central office programs in line with their increased responsibilities for program development and monitoring. By the end of 1972, the regional office staff will have awarded project grants totalling almost $88,000,000 to about 325 grantees serving approximately 1.5 million women. Efforts were also focused on the improvement of the organizational and management structure of the Center. Special training and orientation was provided to the many new staff members who were assuming major responsibilities for the achievement of program goals. A major step forward was begun in 1972 toward measuring the accomplishment of program objectives through project evaluation. The Five-Year Plan was updated to reflect the latest analyses of census data and information from the National Center for Health Statistics Patient Reporting System.

The 17 additional positions requested in 1973 will be used to strengthen both regional and central office program management capabilities and to provide increased technical assistance to grantees. In the regions, priority will be given to providing the basic program and management staff necessary to develop and evaluate family planning projects on a decentralized basis including the development of alternative funding sources. A total of ten positions are requested to strengthen the regional offices in these areas. The remaining seven positions will be used in the central office to strengthen program management, especially in relation to assisting grantees and regional office staff in the areas of training, education, and technical assistance.

An increase of $549,000 is requested for direct operations in 1973. Of this amount, $233,000 is for the first year costs of the 17 new positions, $267,000 is to annualize the costs of the new 1972 positions, $28,000 for the cost of within grade increases; $28,000 for the increased cost of FTS and the HSMHA Service and Supply Fund; and $2,000 is to annualize the costs of the 1971 Commissioned Officer pay increase. These increases are partially offset by a built-in decrease of $9,000 for two days less pay in 1973.

National Health Service Corps

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..................	637	$6,994,000	637	$9,518,000	--	+$2,524,000
Other expenses..............	--	7,123,000	--	5,285,000	--	-1,838,000
Total....................	637	14,117,000	637	14,803,000	--	+686,000
Budget authority.........		11,200,000		8,418,000		
Reimbursements...........		---		6,385,000		

The National Health Service Corps represents a new approach in the Federal effort to improve the health care of people residing in medically underserved areas of this country. For the first time, Public Health Service physicians, dentists, nurses and other health professionals will be providing direct health care to persons living in an area where existing health manpower resources are inadequate to provide this care.

The Administration has stated, "It is a matter for public concern that too many of you live in areas where there are critical shortages of health personnel." The Corps was formed to help alleviate this situation.

"In over 120 counties, comprising over eight percent of our land area, there are no private doctors -- and the number of such counties is growing."

"A similar problem exists in our inner cities. In some areas of New York, for example, there is one private doctor for every 200 persons but in other areas the ratio is one to 12,000. Chicago's inner city neighborhoods have some 1,700 fewer physicians today than they had ten years ago."

In the preamble of the law, there is explicitly identified a major goal of the whole program -- to get Corps assignees to stay in the areas to which they are assigned after the completion of their service with the Corps. If we are to have any success at all with this goal, we must develop community patterns which are natural and cooperative. Our assignees must be a real part of community life. They must, however, have the administrative and professional backup which they need to remain as fully effective health professionals. We will supply this, partly through the Corps' own resources and partly through the resources of the community and the region itself. If we are to build systems which will be self-sustaining and which will outlast the need for the Corps, then the community must develop its own complete system. One small aspect of this system is the building of an economic base for an independent, post-Corps medical or dental practice. Thus the provision for collection of fees, from individuals or third-party payers as necessary, is an important part of the general effort at effective system-building. Only in this way can the Corps achieve long term success in overcoming the "emergencies" which led to its creation. The 1973 request is based on anticipated reimbursements of $6,385,000.

During the course of 1972, the following significant steps were accomplished:

---Appointment of the National Advisory Council on Health Manpower Shortage Areas and convening of its first meeting December 4-5, 1971. Support for the Council for 1973 is covered in this request.

---Regulations governing the policies and procedures of all aspects of the program, e.g., criteria for community participation, conversion of assignees to status of private practitioners, and the collection of fees for services have been prepared and published.

---Advice and assistance to communities, and processing of their requests for assignees. Of the first 122 requests received and processed, 18 were evaluated, the sites visited and finally selected for manpower assistance. As of December 31, 1971, 494 requests have been received and are in various steps of processing and development. It is incumbent on staff working with community groups to encourage them to set realistic goals and to assure that assignees are effectively linked to other provider units in a way that fosters the development of effective and efficient systems for care. In some cases, a physician will not be warranted in light of the overall need. In such cases, the community will be assisted in determining the most appropriate type of health personnel and arrangements.

---A major goal of the program, in addition to the assignment of health professionals to such areas, is the encouragement of National Health Service Corps assignees to stay in the areas to which they were assigned after completion of service. To this end, a careful program of matching by the assignees and the communities is being developed, as well as the development of educational linkages to maximize the chances of retention of such persons in the communities.

---A total of approximately 240 health professionals, including doctors, dentists, nurses and other allied health personnel will have been recruited, oriented and assigned to communities in critical need of health services. Teams vary in size from two to seven health professionals. It is estimated that approximately 60 communities serving approximately 600,000 people will be reached.

---To ensure that program goals and objectives are being met, an evaluation component utilizing 1/2% funds has been approved; it will evaluate consumer acceptance, effectiveness of the matching process, attitudinal changes in assignees and communities and the factors related to establishment and growth of medical practices in medically underserved areas.

1973 Program

This request would allow for recruitment of an additional 337 health professionals for a total of 577. This number would provide support for a total of 175-225 communities with a total population of approximately 700,000 - 900,000 people.

No program increase is requested for this activity. However, we are requesting a net increase of $686,000 to cover mandatory items. The mandatory items include $547,000 for continuation pay costs for commissioned officer medical positions, $148,000 for net costs of within grade increases and $139,000 for annualization of the uniformed services pay increase, Public Law 92-129, dated September 29, 1971. These increases are partially offset by decreases of $23,000 for two less days of pay and $125,000 annualization of DHEW 1972 employment cutback.

Patient Care and Special Health Services

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..........	5,890	$74,603,000	5,890	$75,628,000	---	+$1,025,000
Other expenses..........	---	31,422,000	---	31,777,000	---	+355,000
Subtotal.......	5,890	106,025,000	5,890	107,405,000	---	+1,380,000
Deduct quarters and subsistence charges...	---	-299,000	---	-299,000	---	---
Total..........	5,890	105,726,000	5,890	107,106,000	---	+1,380,000
Reimbursable obligations		-17,223,000		-17,114,000		+109,000
Direct obligations........		88,503,000		89,992,000		+1,489,000

Introduction

This program furnishes health care to the legal beneficiaries of the Public Health Service. Major beneficiary groups are American seamen, Coast Guard and PHS Commissioned Corps personnel, and persons afflicted with leprosy. On a reimbursable basis, medical care is also provided to Federal employees in PHS health units. In addition, Coast Guard personnel are provided medical and dental services at various Coast Guard locations.

1. Inpatient and outpatient care. - The primary purpose of this activity is to provide for the comprehensive health care of its beneficiaries. The budget for 1973 will permit operation of the eight PHS general hospitals, 30 outpatient clinics and the National Leprosarium at Carville, La. It will also fund contracts with about 250 private physicians and with other Federal and non-Federal facilities to furnish health care to the legal beneficiaries of the Public Health Service.

2. Coast Guard medical services. - This activity provides PHS personnel to staff Coast Guard infirmaries, dispensaries and sick bays at shore stations, air stations, and on board vessels. Contract care is also provided in civilian or Federal facilities. Coast Guard medical services has also developed programs in industrial, underwater and aviation medicine, and in environmental sanitation. The current emphasis is on establishing programs to detect and rehabilitate drug abusers and to set up treatment centers at Cape May, New Jersey and Alameda, California to rehabilitate persons with minor psychological disorders.

3. Federal employees. - This activity provides consultation to and surveys of Federal agencies, upon request, on the conduct of Federal employees' occupational health programs. Federal employee health programs are operated for Federal agencies on a reimbursable basis, on request. In 1973, it is expected that 95 health units operating under this activity will provide occupational health services to an estimated 160,000 Federal employees.

4. Payment to Hawaii. - Grants are made to Hawaii to defray the cost of care and treatment of persons afflicted with leprosy. The average daily patient load is expected to be 158 in 1973, as compared with 164 in 1972 and 166 in 1971.

Inpatient and Outpatient Care

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits...............	5,479	$68,975,000	5,479	$69,888,000	---	+$913,000
Other expenses...........	---	26,561,000	---	26,714,000	---	+153,000
Subtotal.............	5,479	95,536,000	5,479	96,602,000	---	+1,066,000
Deduct quarters and subsistence charges........	---	-299,000	---	-299,000	---	---
Total.................	5,479	95,237,000	5,479	96,303,000	---	+1,066,000
Reimbursable obligations..		-13,223,000		-13,110,000		+113,000
Direct obligations....		82,014,000		83,193,000	---	+1,179,000

The primary mission of this program is to provide comprehensive health care to PHS beneficiaries. The major beneficiary groups are American seamen, Coast Guard and PHS Commissioned Corps personnel, and persons with leprosy. The largest single category of beneficiary is the American seamen, comprising approximately 50% of the inpatient load in PHS general hospitals. On a reimbursable basis, health care is also provided to foreign seamen and beneficiaries of other Federal agencies in PHS hospitals.

In addition to providing direct health care services, the hospitals are actively participating in the improvement of health services in the local communities. Over 600 professional and sub-professional employees and 2,400 individuals from the communities receive clinical training both in these facilities and through affiliations and auxiliary training programs. Emphasis is given to training of disadvantaged groups. Community involvement has increased through sharing available medical capabilities and health care resources where reimbursements or reciprocal services are received from the communities.

The PHS hospitals have been experiencing a continuing decline in inpatient workloads and are now operating at less than maximum capacity. The facilities have, however, become important community health resources. Recognizing the potential of further increasing the value of these facilities to the communities and to assure maximum utilization, we are conducting studies to determine the feasibility of converting them from Federal to local control. During 1973 emphasis will be placed on converting as many of these facilities as possible, in order to permit communities more latitude in utilizing the excess capacity to meet local needs.

The net increase of $1,179,000 is comprised of an increase of $2,283,000 for built-in costs of continuing the 1972 level of hospital and clinic operations, offset by a decrease of $1,104,000 which reflects this program's share of an HEW-wide personnel reduction.

Coast Guard Medical Services

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.............	151	$2,490,000	151	$2,591,000	---	+$101,000
Other expenses.............	---	2,312,000	---	2,514,000	---	+202,000
Total..............	151	4,802,000	151	5,105,000	---	+303,000

The budget estimate provides for medical services to Coast Guard personnel aboard their vessels and at their air and other shore stations. It also provides for care in contract medical facilities, hospitalization in Federal facilities other than those operated by the Public Health Service, and emergency medical treatment in non-contract facilities as authorized by law. Not included are costs funded by the Coast Guard such as space, utilities, medical and dental equipment, mobile dental units, furniture, office appliances, and pay and travel allowances of Coast Guard personnel assigned to the program.

Medical facilities at Coast Guard units are classified as infirmaries, dispensaries, or sick bays. The larger shore units have infirmaries staffed with medical and dental officers of the Public Health Service. Dispensaries are facilities at intermediate size shore units at which either or both medical and dental officers are assigned to duty. Sick bays are facilities aboard vessels and at smaller shore units. Sick bays are usually manned by hospital corpsmen, but vessels may have a medical officer assigned. The Coast Guard operates one accredited hospital, located at the Coast Guard Academy, New London, Connecticut.

Full-time medical, dental, and ancillary staff are assigned where sufficient concentration of personnel exist to make operation of such facilities economical to the Government. Small concentrations of personnel are provided medical and dental care by local contract physicians and dentists. Mobile dental units manned with Public Health Service dental officers are also used to provide dental services to personnel in remote areas. The major problem of the Coast Guard program is provision of adequate medical and dental care to personnel widely dispersed in numerous small units, many of which are geographically and medically isolated.

The budget increase for medical services for the Coast Guard in the amount of $303,000 provides for built-in items of expense: statutory salary increases, price increases for contract medical care, and increased cost of medical supplies.

Federal Employees

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits..................	260	$3,138,000	260	$3,149,000	---	+$11,000
Other expenses...............	---	1,349,000	---	1,349,000	---	---
Total.....................	260	4,487,000	260	4,498,000	---	+11,000
Reimbursable obligations..		-4,000,000		-4,004,000		-4,000
Direct obligations........		487,000		494,000		+7,000

Responsibility for Federal employee health is assigned to the Public Health Service under P.L. 79-658, August 8, 1946 (5-USC-7901), and the Bureau of the Budget Executive Circular No. A-72, June 18, 1965.

The services authorized include emergency diagnosis and treatment of injury or illness occurring during working hours; pre-employment examinations; inservice examinations determined necessary by the Department or agency head; administration of treatments and medications under certain circumstances; preventive services to appraise and report work environment health hazards; health education, and specific disease screening examinations and immunizations; and referral to private physicians, dentists, and other community health resources. The specified goal is the provision of these services for all Federal employees who work in groups of 300 or more.

The Division of Federal Employee Health has established the following objectives:

a. To provide consultation on the organization and establishment of employee health services to any Federal agency requesting advice; to provide standards and criteria for the furnishing of such employee health services; and, when requested, to assist agencies of the Government in the evaluation of such services.

b. To organize, administer, and operate Federal employee health services for participating Federal agencies on a reimbursable basis.

The requested increase of $7,000 in appropriated funds and $4,000 in reimbursable funds are for built-in items of expense. In 1973, it is expected that 95 health units operating under this activity will provide occupational health services to an estimated 160,000 Federal employees.

Payment to Hawaii

	1972 Amount	1973 Amount	Increase or Decrease
Other expenses, total.....	$1,200,000	$1,200,000	---

In accordance with 42 U.S.C. 255, funds under this activity are to be used for payments to the State of Hawaii for care and treatment of persons afflicted with leprosy. For the past several years, $1,200,000 has been appropriated each year to assist Hawaii in defraying the expenses relating to this care and treatment. We are requesting no change in the amount for 1973.

It should be noted that reimbursement is based on actual expenses so that the requested amount will not be paid unless it is actually needed. Any expenses above the $1,200,000 are borne by the State of Hawaii.

The table below shows the estimated average daily patient load, patient days, per diem cost, and appropriation requests for 1972 and 1973.

	1972	1973
Average daily patient load...	164	158
Patient days.................	59,936	57,758
Per diem cost..............	$32.37	$32.47
Total cost and net requirements.....................	$1,940,000	$1,875,000
Appropriation request......	1,200,000	1,200,000

Regional office central staff

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	250	$4,549,000	250	$4,543,000	--	-$6,000
Other expenses......	--	738,000	--	738,000	--	--
Total..........	250	5,287,000	250	5,281,000	--	-$6,000

This staff is located in the 10 Regional Offices. These are direct operational arms of HSMHA and serve as focal points for the packaging of multiple program efforts to meet community needs. Such needs encompass, but are not limited to, comprehensive health planning, resource development, disease control and collaborative endeavors for the improvement of health service in States and communities. Regional Office functions fall into the following broad categories:

1. Operational planning.

2. Technical assistance and consultation to:

   a. Plan and evaluate comprehensive health services in the States and communities within the Region.

   b. Aid State and community organizations in the provision of high quality health services.

   c. Fill gaps in existing community health services (including provision of grant funds for start-up costs).

   d. Assist State and local agencies to effect HSMHA goals in the delivery of health services.

3. Manage Federal grant funds as outlined in the authorities delegated to the Regional Offices.

To carry out these HSMHA Regional Office responsibilities, the Regional Health Director has a Central or "core" staff of capable individuals unencumbered by categorical loyalties reporting directly to him. Such a "core" staff gives the Regional Health Director the flexibility to react effectively to the needs of the Region's citizens and the objectives of a decentralized health delivery system.

In 1973 a net decrease of $6,000 occurs. This is composed of $11,000 for annualization of the uniformed services pay increase, Public Law 92-129, dated September 29, 1971, and $116,000 net costs of within grade increases, offset by decreases of $12,000 for two less days of pay and $121,000 annualization of DHEW 1972 employment cutback.

Program direction and management services

	1972		1973		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits........	233	$3,986,000	236	$4,076,000	+3	+$90,000
Other expenses........	---	1,445,000	---	2,238,000	---	+793,000
Total...........	233	5,431,000	236	6,314,000	+3	+883,000

This activity includes program leadership and direction and staff services including administrative management, program planning, and evaluation.

The immediate office of the Director is responsible for planning, directing, coordinating, and administering the Health services delivery programs.

Administrative management is responsible for the development, coordination, direction, and assessment of management activities. It directs such services as financial, personnel, and contract management.

Planning activities focus on annual work plans, the longer-range goal-oriented planning system and encompases efforts in program analysis and evaluation, as well.

A net increase of $883,000 is requested for 1973. This amount includes program increases of $649,000 for the Upward Mobility Program, $45,000 and three positions to administer the expanded family planning program and several built-in increases amounting to $189,000.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Comprehensive health services - Grants to states (PHS Act, Section 314(d))

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$90,000,000	$165,000,000	--	$90,000,000

Purpose: Formula grants are awarded to State health and mental health authorities to assist the States in providing and maintaining adequate public health services in accord with priorities and goals established by the States.

Explanation: A plan for the provision of public health and mental health services is required from each State. Grant allocations are based on a State's population and per capita income, with the restriction that States make available at least 15% of the funds for the support of mental health activities, and at least 70% for the provision of health services at the local level. The Federal share ranges from 33 1/3% to 66 2/3% based on population and per capita income.

Accomplishments in 1972: State health and mental health agencies have utilized their funds to assist in the support of a broad range of basic health programs provided at the State and local level. Among these ongoing activities that provide health services to both the general population of the States and to high risk groups within the States are communicable disease control, environmental health programs (including food and drugs, radiological health, sanitary engineering, and vector control), laboratory services, vital statistics, nursing services, and a variety of community mental health services. Some States have used the flexibility of these funds to support new approaches to the delivery of these health programs, and others have expanded into new areas of services for their State health agencies, such as family planning, dental and medical care clinics.

Objectives for 1973: The 1973 budget request would allow the States to continue the same level of support for their State plan programs as in 1972. A large number of States distribute the grant funds through systems of formula or project grants to local health jurisdictions.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purposes and Accomplishments

Activity: Comprehensive health services - health services grants (PHS Act, Section 314(e))

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$103,913,000	$157,000,000	--	$116,200,000

Purpose: This program provides an effective means for upgrading and expanding the capacity of the ambulatory health services delivery system, and permits the Federal Government to be more responsive to health needs of limited geographic scope or of special regional or national significance, and for developing and initially supporting new health service programs and related training.

Explanation: Grants are awarded to support comprehensive health service programs which provide primary care and a broad range of ambulatory services.

Accomplishments in 1972: In 1972, 55 comprehensive health centers (including nine health centers transferred from OEO) and component projects provided primary care and ambulatory services to an estimated 850,000 persons. These projects covered an eligible population of approximately 2,700,000 persons.

It is estimated that the new Family Health Centers programs established in 1972 will have 20 centers in the planning stage and 10 operational centers serving about 100,000 persons.

Each center will have an agreed upon package of health benefits for each enrollee under prepaid capitation arrangements. The location of centers will be consistent with the development of health maintenance organizations on a short- or long-range basis. The experience with this unique type of health center will provide models by which previously existing health centers developed under different criteria and conditions may be converted to prepayment and health maintenance organization status.

Objectives for 1973: Emphasis in 1973 will be placed on continued improvement in the management of existing comprehensive health centers, the quality of health care provided, operation of uniform accounting systems, development of financial plans by the centers to aid them in developing a broad base financial support and eventual self-sufficiency, and the utilization of medical audits. The program of shifting mature OEO health center projects into this activity will also be carried on in 1973.

Continued priority will be placed on assisting health centers to convert to prepaid capitation arrangements and increase collections from third party payers. It is expected that these actions will result in reduced Federal grant requirements and in opportunities for enhancing the use of project grant funds in improving or expanding health services.

The increase of $3,000,000 for Family Health Centers would allow 10 developmental projects initiated in 1972 to become operational and fund three new centers. These new operational projects will serve an additional 130,000 persons for a total of 23 centers serving approximately 230,000 persons.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Comprehensive health services - Migrant health grants (PHS Act, Section 310)

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$17,950,000	$30,000,000	--	$23,750,000

Purpose: To provide health care services to migrant agricultural laborers and seasonal farmworkers and their families in order to raise the level of their health to that of the general population.

Explanation: Project grants are made to finance part of the costs (no specific matching requirement) of establishing family health services clinics and to improve the health services and health condition of agricultural migrant workers and their families by providing primary health care services organized to maintain their health as well as to treat their illnesses.

Accomplishments in 1972: Emphasis was placed on existing projects in initiating activities designed to convert their current grant method of financing to a prepaid capitation system. Existing projects were encouraged to expand their scope of services. It is estimated that there will be 460,000 patient visits in 1972, an increase of 101,000 over 1971.

Objectives for 1973: Continuing emphasis will be placed on: (1) converting existing projects from grant support to other funding mechanisms; (2) improving the quality of services provided to migrants and seasonal farmworkers and increasing the number of persons served; and (3) methods to integrate migrants into a comprehensive system of care in rural areas which are responsive to their unique needs.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Comprehensive health services - Direct operations

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
445	$17,981,000	Indefinite	445	$18,862,000

Purpose: This activity provides continuing professional and technical assistance to States, communities, providers of health services, medical and health organizations and other Federal units for the development of specialized programs in comprehensive health and resources improvement.

Explanation: The direct operating programs under this activity provide services to the regional and specialized program staff for support of the comprehensive health services grant programs. This activity also provides for the development of specialized programs related to medical care administration, including the professional health aspects of Title XVIII of the Social Security Act.

Accomplishments in 1972: Major emphasis was placed on initiating the new Family Health Centers program. A continuing objective has been improving management of the comprehensive health centers and migrant health projects through the provision of technical services in the administrative, financial and professional service areas. Emphasis is also being placed on moving positively toward improving management capacity to secure medicare, medicaid, private insurance, and other forms of reimbursement for services delivered through the centers.

A major new initiative has been the President's program for improving general conditions of the Nation's nursing homes and extended care facilities. The health facility survey improvement program provided training for 275 State surveyors and, utilizing an accelerated program of university-based training courses, an additional 950 surveyors/inspectors will be trained. The goal is 2,000 trained surveyors by February 1973. A second element in the President's program is short-term training for those health personnel who are furnishing services to patients in nursing homes. Thousands of health personnel actually working in nursing homes are being reached through this initial effort. A third priority is on demonstrations in five States to assist in developing consumer investigative units designed to provide a mechanism for nursing home patients to have an advocate to protect their basic rights.

Substantial staff assistance was given to the Social and Rehabilitation Service in the enforcement of Medicaid requirements for nursing homes. As a result of review and assessment of all Medicare requirements for providers of service and independent laboratories, the updating of regulations for hospitals, extended care facilities, home health agencies and independent laboratories was completed. Survey report forms and surveyor guidelines for uniform application of the new and revised standards were prepared and staffs of all regional offices and State agencies were oriented in the application of the new requirements.

Objectives for 1973: Program emphasis will continue to be directed toward aiding health centers in achieving a significant degree of financial independence through the garnering of additional third party reimbursements and other State and local support and moving toward prepayment systems wherever feasible.

Technical assistance will be provided to cities and neighborhoods to aid them in developing community oriented health care programs.

The health facility surveyor improvement program, utilizing the university-based training program, will train 775 State surveyors. This number, plus those trained in 1972, would achieve the President's overall objective of training a total of 2,000 surveyors in an eighteen-month period.

Short-term training program will continue to be emphasized and will support training for professional and ancillary health personnel providing services for patients in nursing homes.

Continued support will be provided to State-sponsored consumer investigative units. These demonstrations will be supported in both governmental and voluntary settings and will attempt to demonstrate activities on both State and local levels.

Program review has become a major continuing process for evaluating the effectiveness of the application of the Medicare provider standards by State agencies. In 1973, the methodology for conducting program reviews will be modified to be more selective and responsive to the needs of regional offices and the State agencies they serve.

The program increase of $120,000 would be used to initiate a migrant health service reporting system. The information collected would be used to evaluate the adequacy and effectiveness of health services offered migrant workers.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Maternal and child health--Grants to states (Social Security Act as amended through 1967, Sections 503 and 504)

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$121,522,000	Indefinite by activity[1/]	---	$125,678,000

Purpose: The basic purposes of these grants to States are to (1) reduce infant mortality and otherwise promote the health of mothers and children, (2) locate, diagnose, and treat children who are suffering from crippling or other handicapping illnesses.

Explanation: Grants are made to States on a formula basis and to State agencies and public or non-profit agencies 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 the maternal and child health services and crippled children's services formula grant programs one-half of the amount appropriated in each case is apportioned among the States on a population-related formula basis and must be matched dollar for dollar. From the remaining half of the appropriation, specified amounts are reserved for special project grants and the balance is then apportioned by formula (in inverse population and per capita income ratio) among the States. Matching is not required for funds awarded from the second half of the appropriation.

Accomplishments in 1972: The 1972 program continues to provide a variety of health services to mothers and children, including the following:

	Estimate
Mothers receiving prenatal and postpartum care in maternity clinics	400,000
Women receiving family planning services	752,000
Children attending well-child conferences	1,500,000
Crippled children receiving physicians' services	500,000
Clinics for the mentally retarded	150

Objectives for 1973: Additional funds proposed for 1973 will help meet the rising costs of locating, diagnosing, treating and providing follow-up care for crippled children. Approximately 500,000 children will receive physicians' services under the crippled children's program. Maternal and Child Health Services grants will continue to provide care in maternity clinics to about 400,000 women, family planning services to about 752,000 women, and dental services to 1,300,000 children.

1/ Authorization for all programs under Title V, Social Security Act, is $350,000,000.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Maternal and child health--Project grants (Social Security Act as amended through 1967, Sections 508, 509, and 510)

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$92,008,000	Indefinite by activity[1/]	---	$101,330,000

Purpose: The basic purpose of this program is to provide comprehensive health care to poor and near-poor mothers and children who might otherwise not receive such services.

Explanation: Project grants are awarded on a 75% Federal, 25% matching basis in the following areas: (1) to State and local health agencies and to other public or non-profit private agencies, for comprehensive maternity care and specialized care of infants born at high risk (Sec. 508); (2) to State and local agencies, medical schools, and teaching hospitals for comprehensive health care of children and youth (Sec. 509); and (3) to State and local health agencies and other public or non-profit private agencies, institutions, or organizations for comprehensive dental services for children and youth (Sec. 510).

Accomplishments in 1972: The 1972 program has been designed to provide a variety of services to poor and near-poor mothers and children in order to improve their health status. The following are some of the services provided and estimates of number of individuals reached:

	Estimate
Admissions for comprehensive services:	
Mothers	144,000
Infants	49,000
Women receiving family planning services	134,000
Children registered for comprehensive health care	504,000
Children cared for in dental projects	21,000
Health aides employed by projects	1,600
Number of comprehensive projects funded (Maternity and infant care and children and youth projects)	115

Objectives for 1973: The 1973 program is planned to increase the level of services anticipated for 1972 in the maternity and infant care and children and youth projects, and to expand services in the dental care program. It will also provide for studying the feasibility of converting children and youth projects to Health Maintenance Organizations on a prepaid capitation basis. Estimated numbers to receive services are as follows:

1/ Authorization for all programs under Title V, Social Security Act, is $350,000,000.

	Estimate
Admissions for comprehensive services:	
Mothers	152,000
Infants	53,000
Women receiving family planning services	134,000
Children registered for comprehensive health care	547,000
Children cared for in dental projects	22,000
Health aides employed by projects	1,600
Number of comprehensive projects funded (Maternity and infant care and children and youth projects)	115

The maternity and infant care projects are continuing to exert influence on decreasing infant mortality rates in cities where large projects are located. For example, in Houston, Texas, the infant mortality rate dropped from 28.0 in 1965 to 20.0 in 1970; in Chicago, Illinois, from 33.6 to 27.7; and in St. Louis, Missouri, from 44.4 to 31.1. All these cities have large projects.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Maternal and child health--Research and training (Social Security Act as amended through 1967, Sections 511 and 512)

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$21,106,000	Indefinite by activity[1/]	---	$21,392,000

Purpose: These programs are designed to improve health and medical services to mothers and children through applied research and through training of personnel involved in providing health care and related services for mothers and children, particularly mentally retarded and multiply-handicapped children.

Explanation: Primary effort has been given to support of training in university-affiliated centers for the mentally retarded. These centers provide specialized clinical training in a multidisciplinary setting for physicians and other health personnel who focus their activity on the multiply-handicapped child. Grants to public or non-profit institutions of higher learning provide support for faculty, traineeships, services, clinical facilities and short-term institutes and workshops. Research grants and contracts are made with public or other non-profit institutions of higher learning and public or non-profit private agencies and appropriate research organizations. The research effort is concerned with mothers and children in all classes of our society, with high priority given to special problems for those segments of the population not receiving adequate health care.

Accomplishments in 1972: The training program provides staffing support for a total of 19 university-affiliated mental retardation centers in geographically dispersed areas. The primary effort of these centers has been to support advanced training of professionals in maternal and child health fields. In addition to supporting training for over 300 individuals in 1971 these centers offer a complete range of services for mentally retarded and multiply-handicapped children. The 1972 program also provides for training of up to 150 nurse midwives, pediatric nurses and other physicians' assistants. This newly initiated program is separate from the training efforts of the university-affiliated centers. The research program, through its 68 projects, is focusing on improving health and medical services to mothers and children. Two of its major undertakings concentrate on evaluation and assessment of the comprehensive medical care projects.

Objectives for 1973: The 1973 budget continues support of the 19 university-affiliated centers for the mentally retarded and sustains the annual level of long-term training at about 450 individuals.

1/ Authorization for all programs under Title V, Social Security Act, is $350,000,000.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Maternal and child health--Direct operations

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
133	$4,078,000	Indefinite	133	$4,148,000

Purpose: This activity provides staffing resources and operating funds essential to implementing program requirements of the Maternal and Child Health Service.

Explanation: The Maternal and Child Health Service staff are concerned with (1) administration of grants for medical care service, research and training grants; (2) provision of technical assistance and consultation to States, localities and organizations; (3) development and issuance of standards and guidelines for health services to mothers and children; and (4) evaluation and analysis of program performance and potential.

Accomplishments in 1972: In 1972 MCHS staff will continue consultation and evaluation efforts undertaken in 1970 and will concentrate on monitoring of grant activities, provision of technical assistance and guidance to States (with special emphasis on simplified State plans) and communities and to improved management resources. Program monitoring and analysis includes overview of 450 service, research and training projects in addition to supervision of the two discrete State grant programs.

Objectives for 1973: Mandatory costs associated with within-grades, reclassifications, and central services charges amount for the total increase of $70,000 in 1973. Staff will continue its current high rate of productivity in providing technical assistance and consultation to grantees, States and localities, and in implementing policies now proposed relative to capitation and third party payments.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Family planning - Project grants and contracts. (Social Security Act as amended, Title V, Sections 508 and 512, and Public Health Service Act as amended, Title X.)

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
--	$94,815,000	1/	--	$137,024,000

1/ Total authorization for all programs under Title V, Social Security Act in 1973 is $350,000,000. The authorization is indefinite by activity with the specification that not less than 6 percent of the funds shall be for family planning services. The National Center is requesting $19,000,000 for family planning project grants under this authorization in 1973. See earlier section on authorizing legislation for discussion of amounts authorized and requested under Title X, Public Health Service Act.

Purpose: The primary mission of the family planning service program is to insure that individuals are free to choose the number and spacing of their children and thereby improve maternal and child health. The goal is to provide, by 1975, a full range of high quality family planning services to all women who might want such services but cannot obtain them.

Explanation: Project grants are made under Title V, Social Security Act and Title X, Public Health Service Act to State and local health departments and other public or non-profit private organizations to provide family planning services. Project grants under Title V of the Social Security Act are for up to 75 percent of the cost of the project, while those under Title X of the Public Health Service Act have no specified matching requirements. Title X of the Public Health Service Act 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 education materials.

Accomplishments in 1972: Approximately 60 new grants totalling almost $12,000,000 will be awarded and 75 OEO projects totalling $10,000,000 will be transferred to the National Center in 1972, bringing the total number of active projects to 325. The number of women who will receive family planning services from all projects funded through 1972 will total approximately 1,500,000 when the projects are fully operational. Project grants and contracts totalling $6,315,000 will be awarded for the development of training programs, the development and distribution of educational materials related to family planning and for operational research and technical assistance to improve the delivery of family planning services.

Objectives for 1973: The family planning project grants program for 1973 is designed to increase the number of people receiving family planning services to approximately 2,200,000 persons when all projects are operational. This will be accomplished through expansion of existing projects and development of new

projects. Included in the total are an estimated additional 75 OEO projects totalling $10,000,000 and serving about 200,000 persons. Project grants and contracts will be awarded to train allied health and other personnel for service in family planning clinics, to educate and inform families about voluntary family planning, to develop improved family planning educational materials, and to carry out studies designed to improve the delivery of family planning services.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health Services delivery

Program Purpose and Accomplishments

Activity: Family planning-Direct operations

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
70	$1,438,000	Indefinite 1/	87	$1,987,000

1/ Section 301, Public Health Service Act

Purpose: The direct operations activity provides staff and operating funds necessary for program development and administration of the programs of the National Center for Family Planning Services, including the administration of the decentralized service project grant program in the ten DHEW regions.

Explanation: Staff of the National Center administer project grants and contracts for the provision of family planning services, the training of family planning workers, operational research, and for family planning education activities. In addition, central office staff provide technical assistance to the regional offices, as well as current and potential grantees, in administering the service delivery grant program, and developing and implementing policies and program plans for the areas of training, education, operational research and technical assistance.

Accomplishments in 1972: Efforts in 1972 were concentrated on the development of improved policies and guidelines, improving program management and the recruitment and training of new staff. The first Five-Year Plan for Family Planning Services was updated, 60 new project grants totalling approximately $12,000,000 were awarded, $10,000,000 in OEO projects were transferred to the Center, and a $6,315,000 project grants and contracts program for training,education, and services delivery improvement related to family planning was implemented.

Objectives for 1973: The seventeen new positions for the central and regional office staff are requested to provide the program development and management capacity to program the additional service grant funds. Continued priority will be given to staffing the regional offices which assist local communities in the development and expansion of family planning services and in developing support staff in central office for the services, training, research and education programs.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: National health service corps (PHS Act, Section 329)

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
637	$14,117,000	$30,000,000	637	$14,803,000

Purpose: The assignment of personnel to areas with critical medical manpower shortages and to encourage health personnel to practice in areas where shortages of such personnel exist.

Explanation: This activity provides for the direct assignment of health personnel to areas with critical health manpower shortages. Where practical, the team approach will be utilized in the assignment of health personnel.

Accomplishments in 1972: Initial emphasis was placed on appointment of the National Advisory Council on Health Manpower Shortage Areas; development of regulations, policies and procedures, criteria for community participation and fee collection and submission to Treasury; and the provision of technical assistance to community groups to encourage them to set realistic goals to assure that assignees were effectively linked to other provider units in a way that fostered the development of effective and efficient systems for care. In cases where a physician was not warranted, the community was assisted in determining the most appropriate type of health personnel for the community.

A mere compilation of a list of candidates and random selection was not sufficient. In an effort to assure success, assignees were "matched" with the communities to which they were assigned.

A total of approximately 240 health professionals (including doctors, dentists, nurses and other allied health personnel) were recruited, oriented and assigned to approximately 60 communities in critical need of health services. Two to seven health professionals were assigned to communities with an average team size of four.

Objectives for 1973: This request would allow for recruitment of an additional 337 health professionals for a total of 577. This number would provide support for a total of 175-225 communities with a total population of approximately 700,000 - 900,000 people.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Inpatient and outpatient care (PHS Act, Sections 301, 311, 321, 322, 324, 326, 328, 331, 332, 502, 504, 33 U.S.C. 763c and 42 U.S.C. 253a)

1972		1973		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
5,479	$82,014,000	Indefinite	5,479	$83,193,000
Obligations				
5,479	$95,237,000		5,479	$96,303,000

Purpose: The primary purpose of this program is to provide for the comprehensive health care of American seamen, Coast Guard and PHS Commissioned Corps personnel, and persons with leprosy. On a reimbursable basis, health care is also provided to foreign seamen and beneficiaries of other Federal agencies in PHS hospitals.

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. Medical care is also provided to beneficiaries of other Federal agencies on a reimbursable basis.

Accomplishments in 1972: Health care was made available to an estimated 492,000 beneficiaries with an estimated 1,800 average daily inpatient load and a total of 1,758,000 outpatient visits to PHS facilities. Contract care in other Federal and non-Federal facilities averaged 100 inpatients per day; in addition, 63,000 outpatient visits were made to private physicians. Direct funding supported approximately 92 clinical and 56 health service research projects with 40 other research projects funded by grants and reimbursements. Community involvement was mainly through training affiliations, and local OEO and Department of Labor programs for the unemployed. PHS health care resources were integrated further into communities through sharing available medical capabilities where reimbursements or reciprocal services were received from the community.

Objectives for 1973: Studies have indicated that the most effective alternative for assuring efficient uses of the PHS facilities within the communities may involve converting these facilities to community control. If, after further reviews and refinements of community proposals, this is found to be so, comprehensive health care for primary beneficiaries would be provided through service agreements with these community controlled facilities and other health resources, as necessary. In 1973, we hope to convert as many of these facilities as possible. The Carville leprosarium will continue to provide for treatment of leprosy.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Coast Guard medical services (PHS Act, Section 326 as amended)

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
151	$4,802,000	Indefinite	151	$5,105,000

Purpose: The Coast Guard medical program, under the direction of the Chief Medical Officer, U. S. Coast Guard, provides for the delivery of direct health care to personnel aboard its vessels and at its shore and air stations. Coast Guard personnel are also provided inpatient, outpatient and emergency medical care and services on a contractual basis in areas without PHS facilities or in cases needing special care.

Explanation: Appropriated funds are used to finance a system of medical facilities classified as infirmaries, dispensaries, and sick bays. Where sufficient concentrations of personnel exist, large infirmaries with full-time medical, dental, and ancillary staff provide comprehensive care to authorized beneficiaries. Smaller concentrations of personnel are served by dispensaries and sick bays which may have medical and dental officers assigned or may be staffed by Coast Guard hospital corpsmen. In many instances, small concentrations of personnel are provided health care by local contract physicians, dentists, and hospitals, as well as through utilization of Federal medical facilities where available. The Coast Guard operates one accredited hospital, located at the Coast Guard Academy.

Accomplishments in 1972: In 1972, care is being made available to approximately 54,200 Coast Guard personnel (active duty and retired), and 81,300 dependents. Outpatient medical and dental visits by all beneficiary classifications will be in excess of 500,000 for the year. A total of approximately 14,000 inpatient days are anticipated in Coast Guard medical facilities. Programs are being established to provide both detection and rehabilitation of personnel with problems related to drug abuse. Facilities to deal with the rehabilitation of personnel with minor psychological disorders are being established at the two major recruit training centers located at Cape May, New Jersey and Alameda, California. Contracts for inpatient care in non-PHS hospitals will account for an additional 84 average daily patient load; and agreements with local physicians will account for an additional 18,750 visits.

Objectives for 1973: Objectives in 1973 will be to meet the needs of an increased beneficiary population of approximately 139,000. Programs started in prior years will be continued and expanded to the extent possible. Included are programs related to aviation medicine, underwater medicine, industrial medicine, and environmental sanitation. Efforts to improve the effectiveness of health care delivery in pursuit of the above stated objectives will continue.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Federal employees (P.L. 79-658, August 8, 1946, 5 USC 7901)

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
260	$ 487,000	Indefinite	260	$ 494,000
Obligations				
260	$4,487,000		260	$4,498,000

Purpose: This activity provides upon request consultation to and surveys of Federal agencies on the conduct of Federal employees occupational health programs, and operates selected programs for 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 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. The Public Health Service also provides, under reimbursable authority, direct clinical health services to other Federal agencies on request.

Accomplishments in 1972: In 1972 over 100 consultations to Federal agencies, executive boards, and associations were provided on the evaluation and establishment of Federal employee health activities. By the end of 1972, health care services will have been provided to 160,000 Federal employees in 95 facilities.

Objectives for 1973: This activity will permit maintenance of employee health activities at the same level reached by 1972, providing approximately 100 consultations to Federal agencies and operating 95 health units providing services to 160,000 Federal employees.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Patient care and special health services -- Payment to Hawaii (PHS Act, Section 331)

1972		1973		
			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 afflicted with leprosy.

Explanation: The appropriated funds are paid as a reimbursement of actual expense to the Department of Health of Hawaii to assist in that care and treatment in its facilities. Any expenses above the appropriated funds are borne by the State of Hawaii.

Accomplishments in 1972: Care will have been provided to an estimated daily average of 164 inpatients. This is a continuation of the decreasing inpatient load of recent years. Of the total program costs estimated to be $1,940,000, the share borne by Hawaii is $740,000.

Objectives for 1973: The average daily patient load is expected to be 158 in 1973. The total program requirements are estimated to be $1,875,000, of which the Federal government will pay $1,200,000.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Regional office central staff

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
250	$5,287,000	Indefinite	250	$5,281,000

Purpose: This activity supports the Regional Health Directors and their central staffs which are concerned with the coordination and interrelation of the various program activities of HSMHA and the implementation of those programs in the regional offices.

Explanation: The regional office central staff includes: (1) a comprehensive health planning unit that provides leadership in the development and operation of programs for the conduct and improvement of comprehensive State and areawide health planning; (2) a grants management unit which provides centralized support for all HSMHA grants that have been decentralized to the regions; and (3) a special projects unit which manages an information system providing data on areas of special interest to each particular region.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Health services delivery

Program Purpose and Accomplishments

Activity: Program direction and management services

1972			1973	
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
233	$5,431,000	Indefinite	236	$6,314,000

Purpose: This activity provides for the overall planning, direction and administration of the broad scope of programs of the Health service delivery appropriation.

Explanation: It includes program planning and evaluation activities which focus on program, operational, and legislative planning. Administrative management is responsible for the development, coordination, direction, and assessment of management activities. It directs such services as financial, personnel, and contract management.

Health Services Delivery

Allocations of Grants for Comprehensive Public Health Services 1/

	1971 Actual	1972 Allocation	1973 Estimate
Alabama	$1,787,800	$1,723,400	$1,689,500
Alaska	388,100	394,100	397,600
Arizona	918,600	933,600	952,200
Arkansas	1,143,500	1,111,900	1,085,900
California	6,539,900	6,662,100	6,753,800
Colorado	1,030,300	1,063,300	1,081,200
Connecticut	1,233,000	1,237,600	1,242,900
Delaware	476,200	477,700	479,400
District of Columbia	543,600	530,700	516,600
Florida	2,561,700	2,675,100	2,767,600
Georgia	2,074,400	2,023,400	2,011,200
Hawaii	569,000	555,100	548,600
Idaho	580,200	572,900	572,000
Illinois	3,839,900	3,845,300	3,845,200
Indiana	2,062,300	2,077,000	2,113,800
Iowa	1,278,200	1,284,600	1,292,800
Kansas	1,111,700	1,090,500	1,072,000
Kentucky	1,569,700	1,559,200	1,557,500
Louisiana	1,774,700	1,743,800	1,716,600
Maine	670,400	673,700	672,000
Maryland	1,540,500	1,580,100	1,599,400
Massachusetts	2,081,400	2,139,800	2,149,800
Michigan	3,213,600	3,223,600	3,289,500
Minnesota	1,587,000	1,610,800	1,627,100
Mississippi	1,365,200	1,302,400	1,243,200
Missouri	1,938,500	1,951,800	1,950,100
Montana	557,000	557,600	557,300
Nebraska	811,400	812,600	821,600
Nevada	446,200	452,600	459,000
New Hampshire	551,900	559,500	568,400
New Jersey	2,597,300	2,597,100	2,589,400
New Mexico	689,600	693,200	690,200
New York	6,063,300	6,011,200	5,976,200
North Carolina	2,337,200	2,272,700	2,227,000
North Dakota	536,900	533,900	542,400

Health Services Delivery

Allocations of Grants for Comprehensive Public Health Services (cont'd) 1/

	1971 Actual	1972 Allocation	1973 Estimate
Ohio	$3,949,000	$3,921,000	$3,919,000
Oklahoma	1,263,400	1,264,800	1,260,400
Oregon	1,009,000	1,026,300	1,049,400
Pennsylvania	4,360,800	4,351,000	4,310,800
Rhode Island	607,300	617,500	624,500
South Carolina	1,422,200	1,364,500	1,332,200
South Dakota	546,900	551,600	552,100
Tennessee	1,887,800	1,846,800	1,825,700
Texas	4,389,800	4,376,200	4,380,500
Utah	698,300	702,500	710,600
Vermont	458,700	461,600	465,600
Virginia	1,995,300	1,979,200	1,960,000
Washington	1,428,500	1,442,500	1,454,700
West Virginia	1,042,200	1,017,200	977,400
Wisconsin	1,767,800	1,822,700	1,857,500
Wyoming	413,300	418,700	420,000
Guam	351,500	307,700	304,000
Puerto Rico	2,063,300	2,109,500	2,058,500
Virgin Islands	265,700	265,700	265,700
American Samoa	265,700	265,700	265,700
Trust Territory of the Pacific Islands	443,300	453,400	446,700
TOTAL	89,100,000	89,100,000	89,100,000
Evaluation Amount 2/	900,000	900,000	900,000
Grand Total	90,000,000	90,000,000	90,000,000

1/ Allocations are awarded to States based on population and per capita income with a minimum program requirement.

2/ Authorized by P.L. 91-296

HEALTH SERVICES DELIVERY

Allocations of Grants for Maternal and Child Health Services

Actual and Estimated Awards [1/]
Fiscal Years 1971-73

State	1971 Actual	1972 Estimate	1973 Estimate
Alabama................	$1,247,908	$1,238,285	$1,273,000
Alaska.................	195,461	186,495	187,900
Arizona................	425,974	434,434	434,100
Arkansas...............	673,478	694,603	712,400
California.............	2,834,834	2,828,154	2,917,600
Colorado...............	494,248	469,248	490,100
Connecticut............	475,448	494,721	505,200
Delaware...............	201,995	211,196	213,300
District of Columbia...	247,008	247,944	251,100
Florida................	1,604,726	1,659,093	1,650,400
Georgia................	1,654,810	1,635,785	1,654,500
Guam...................	158,028	158,164	158,700
Hawaii.................	245,422	245,080	248,200
Idaho..................	234,870	234,870	246,200
Illinois...............	1,668,815	1,624,459	1,728,700
Indiana................	1,089,353	1,258,011	1,323,700
Iowa...................	680,398	691,122	730,600
Kansas.................	483,732	479,770	500,300
Kentucky...............	1,133,396	1,149,085	1,173,700
Louisiana..............	1,361,208	1,336,337	1,374,100
Maine..................	356,076	330,076	342,800
Maryland...............	1,098,384	1,063,730	1,084,900
Massachusetts..........	838,403	847,061	848,100
Michigan...............	1,926,890	1,884,356	1,967,000
Minnesota..............	905,063	910,103	934,900
Mississippi............	1,085,847	1,052,599	1,077,700
Missouri...............	1,020,062	1,074,037	1,107,700
Montana................	222,453	226,685	229,200
Nebraska...............	346,591	346,379	360,700
Nevada.................	200,211	202,707	204,600
New Hampshire..........	262,881	229,881	232,500
New Jersey.............	1,046,999	1,061,487	1,106,900
New Mexico.............	340,026	325,026	338,600
New York...............	2,649,381	2,651,940	2,650,400
North Carolina.........	1,908,325	1,887,202	1,922,500

HEALTH SERVICES DELIVERY

Allocations of Grants for Maternal and Child Health Services (cont'd.)

State	1971 Actual	1972 Estimate	1973 Estimate
North Dakota...........	216,561	216,561	218,800
Ohio....................	2,201,112	2,260,887	2,358,700
Oklahoma...............	602,965	606,840	625,400
Oregon.................	536,415	534,555	554,900
Pennsylvania...........	2,522,102	2,522,102	2,617,900
Puerto Rico............	1,638,916	1,646,229	1,694,800
Rhode Island...........	273,072	250,431	253,700
South Carolina.........	1,142,005	1,127,632	1,153,500
South Dakota...........	182,917	223,592	229,400
Tennessee..............	1,236,805	1,214,192	1,245,800
Texas..................	2,577,513	2,584,320	2,604,700
Utah...................	435,724	404,862	423,300
Vermont................	230,921	195,331	197,000
Virgin Islands.........	157,002	157,002	157,500
Virginia...............	1,371,581	1,325,581	1,350,100
Washington.............	791,559	794,386	836,700
West Virginia..........	761,498	624,050	649,600
Wisconsin..............	1,004,099	997,099	1,037,400
Wyoming................	204,043	181,723	183,000
Total distribution by formula 1/.........	49,405,514	49,237,500	50,574,500
Special projects for mentally retarded children............	4,749,325	4,750,000	4,750,000
Other special projects.	5,033,872	5,262,500	5,453,500
Total..............	59,188,711	59,250,000	60,778,000

1/ (a) One-half of the amount appropriated for each year is apportioned among States on the basis of a uniform grant of $70,000 and an additional grant in proportion to the number of live births in the State. Amounts awarded must be matched dollar for dollar.

(b) The remaining half, after being reduced by the amounts reserved for the two categories of special projects, is apportioned by formula. Each State receives an amount which varies directly with the number of urban and rural births in the State and inversely with State per capita income. No State receives less than $70,000 and rural live births are given twice the weight of urban births.

(c) The 1972 and 1973 figures represent tentative apportionment of the amount requested.

HEALTH SERVICES DELIVERY

Allocations of Grants for Crippled Children's Services

Actual and Estimated Awards 1/
Fiscal Years 1971-73

State	1971 Actual	1972 Estimate	1973 Estimate
Alabama	$1,233,750	$1,270,900	$1,334,500
Alaska	190,886	183,600	187,400
Arizona	453,155	460,400	489,900
Arkansas	764,797	766,700	802,000
California	2,525,849	2,702,900	2,820,100
Colorado	447,187	524,900	556,900
Connecticut	506,134	531,000	550,300
Delaware	218,463	215,600	219,300
District of Columbia	220,212	227,900	231,300
Florida	1,412,687	1,485,100	1,566,300
Georgia	1,532,393	1,570,200	1,647,100
Guam	273,999	229,200	154,900
Hawaii	320,945	341,600	248,500
Idaho	276,339	276,300	292,800
Illinois	1,528,560	1,721,700	1,797,800
Indiana	1,241,567	1,393,500	1,461,800
Iowa	754,187	854,300	894,100
Kansas	559,493	586,300	611,300
Kentucky	1,183,600	1,235,600	1,306,100
Louisiana	1,256,709	1,256,900	1,316,900
Maine	336,140	339,000	356,100
Maryland	723,483	802,400	843,400
Massachusetts	789,336	871,400	912,300
Michigan	1,737,632	1,925,700	2,013,700
Minnesota	956,268	1,072,700	1,127,800
Mississippi	1,079,784	1,066,600	1,115,700
Missouri	1,065,628	1,162,600	1,219,900
Montana	289,988	246,300	261,000
Nebraska	399,551	436,300	460,400
Nevada	266,705	253,900	208,100
New Hampshire	243,654	239,600	245,300
New Jersey	981,662	1,047,100	1,094,700
New Mexico	330,493	378,000	364,000
New York	2,245,364	2,393,200	2,505,200
North Carolina	1,974,387	2,028,000	2,133,000

HEALTH SERVICES DELIVERY

Allocations of Grants for Crippled Children's Services (cont'd.)

State	1971 Actual	1972 Estimate	1973 Estimate
North Dakota	242,699	258,700	274,500
Ohio..................	2,206,790	2,397,400	2,510,000
Oklahoma..............	666,832	721,000	759,000
Oregon................	533,302	559,500	591,700
Pennsylvania..........	2,368,601	2,598,500	2,717,100
Puerto Rico...........	1,465,042	1,599,500	1,581,400
Rhode Island..........	250,764	256,900	262,100
South Carolina........	1,115,709	1,132,400	1,185,600
South Dakota..........	248,501	265,600	278,800
Tennessee.............	1,285,940	1,370,400	1,439,500
Texas.................	2,561,876	2,765,400	2,904,500
Utah..................	297,465	322,100	343,100
Vermont...............	207,827	202,300	206,000
Virgin Islands........	148,560	151,100	150,700
Virginia..............	1,424,748	1,417,200	1,487,700
Washington............	689,782	779,600	805,000
West Virginia.........	717,319	708,400	740,200
Wisconsin.............	1,049,513	1,203,600	1,262,300
Wyoming...............	171,983	186,000	188,400
Total distribution by formula 1/.........	47,974,240	50,993,000	53,037,500
Special projects for mentally retarded children.............	4,998,967	5,000,000	5,000,000
Other special projects.	5,624,412	6,279,000	6,862,500
Total.............	58,597,619	62,272,000	64,900,000

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.

(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 1972 and 1973 figures represent tentative apportionment of the amount requested.

New Positions Requested
Fiscal Year 1973

Family Planning	Grade	Number	Annual Salary
Direct Operations			
Health Educator.	GS-14	1	$21,960
Grantee Training Specialist.	GS-13	1	18,737
Program Analyst.	GS-12	1	15,866
Operations Analyst	GS-11	1	13,309
Program Analyst.	GS-11	4	53,236
Program Analyst.	GS- 9	2	22,092
Clerk Typist	GS- 5	2	14,638
Clerk Typist	GS- 4	4	26,175
Clerk Typist	GS- 3	1	5,828
		17	191,841
Program Direction and Management Services			
Program Analyst	GS-11	1	15,866
Clerk Typist	GS- 4	1	6,545
Clerk Typist	GS- 3	1	5,828
		3	28,239
Total new positions, all activities		20	220,080