347

89th Congress
2d Session

JOINT COMMITTEE PRINT

FEDERAL PROGRAMS FOR THE DEVELOPMENT OF HUMAN RESOURCES

A COMPILATION OF REPLIES FROM DEPARTMENTS AND AGENCIES OF THE U.S. GOVERNMENT TO A QUESTIONNAIRE FORMULATED BY THE

SUBCOMMITTEE ON ECONOMIC PROGRESS

OF THE

JOINT ECONOMIC COMMITTEE
CONGRESS OF THE UNITED STATES

Volume 2. Part III (partial)

DECEMBER 1966

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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Food and Drug Administration

CONSUMER PROTECTION PROGRAM

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The program conducted by the Food and Drug Administration is directed toward protecting the consumer by insuring that: foods are safe, pure, and wholesome; drugs and therapeutic devices are safe and effective; cosmetics are safe; all of these products are honestly and informatively labeled and packaged; certain household chemical aids

carry adequate warning labels; dangerous and counterfeit drugs are not misused or illegally sold.

2. Operation

The consumer protection program is a direct Federal operation providing scientifically supported regulatory and advisory activities. The program is administered nationwide through 18 Food and Drug District offices and 9 Drug Abuse Control field offices. These offices conduct investigations, make scientific analyses and conduct research to insure the safety, purity, wholesomeness, and proper labeling of items under FDA regulation. They collaborate and coordinate with State and local authorities on these activities and work closely with them during major disasters such as floods and hurricanes. FDA also provides scientific and technological educational and informational materials to the public and to the regulated industries. FDA headquarters and field offices work together to provide training courses and materials to State and local authorities and to promote better Federal-State cooperation.

3. History

The program for consumer protection began in 1906 when the first Federal Food and Drug Act was passed. Enforcement of this Act, which was known as the Pure Food and Drug Law, was vested in the Bureau of Chemistry of the U.S. Department of Agriculture. The 1906 Act was completely rewritten in 1938 and since that time has been further strengthened by numerous amendments. The most important of these amendments are: the 1958 Food Additives Amendments, the 1960 Color Additives Amendments, the Kefauver-Harris Drug Amendments of 1962, and the Drug Abuse Control Amendments of 1965. In 1927, the Food and Drug Administration was established as a separate agency of the U.S. Department of Agriculture. In 1940, the Administration was transferred from the Department of Agriculture to the Federal Security Agency, which became the Department of Health, Education, and Welfare in 1953.

4. Level of operations. (See table 1.)

Program: Consumer protection program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Food and Drug Administration.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimates)	Fiscal year 1967 (estimates)
(a) Magnitude of the program—Secondary individual beneficiaries	192,000,000	195,000,000	197,000,000	199,000,000
(b) Applicants or participants, none				
(c) Federal finances:				
Total appropriation	$40,271,000	$51,245,000	$58,799,000	$67,534,000
Unobligated appropriations available [1]	$710,000	$14,193,000	$16,906,000	
Obligations incurred	$35,357,000	$41,159,000	$55,535,000	$84,379,000
Allotments or commitments made				
Certification (Fees account)	$2,337,000	$2,434,000	$2,779,000	$2,847,000
(d) Matching or additional expenditures, none				
(e) Number of Federal Government employees (field inspections and investigations, laboratory analysis, research, evaluation of medical and scientific data submitted by industry, industry and consumer education, general support) (man-years)	3,480	3,670	4,000	4,600

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*—Continued

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimates)	Fiscal year 1967 (estimates)
(f) Non-Federal personnel employed, none				
(g) Other measures of level or magnitude performance: [2]				
Number of establishments inspected	31,100	38,000	38,000	38,000
Number of inspections	34,400	42,753	43,000	46,500
Number of other inspections made (pesticides, hazardous substances, etc.)	12,800	13,619	14,000	15,000
Wharf examinations	14,000	15,250	17,000	20,000
Samples collected for examination, domestic and import	110,000	103,309	104,000	123,000
Laboratory analyses and other examinations field and headquarters laboratories	120,000	98,648	100,000	119,000

[1] This is primarily the balance available in the "Buildings and facilities" appropriation which is a non-year account.
[2] These are selected workloads and do not reflect total activities for the agency.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The Food and Drug Administration is organized to enhance coordination and cooperation both among its internal units and with units of the Department of Health, Education, and Welfare. Operation is under a Departmental manual system which FDA supplements as necessary to meet its special requirements.

FDA has entered into formal or informal working agreements with almost all agencies of the Federal government which influence, or receive information affecting the consumer protection program. These include the U.S. Department of Agriculture in such activities as the use and regulation of pesticides; the Federal Trade Commission regarding the advertising of products under FDA jurisdiction; the President's Committee on Consumer Interests on consumer informational activities; the Public Health Service on the interchange of research and drug information and other health matters; the Atomic Energy Commission concerning radioactivity; and, the Veterans' Administration on matters such as adverse drug reactions reporting.

Cooperation and assistance is regularly provided to State and local governments by FDA headquarters and field offices in a number of ways. These include training courses for State and local food and drug officials, response to specific requests as well as regular dissemination of a wide variety of technical, scientific and legal informational materials to such officials and working with them on scientific and investigational regulatory operations.

While FDA has no extensive foreign program it is involved in a voluntary international drug reaction reporting program in cooperation with the World Health Organization. In addition, FDA participates in the deliberations of the Codex Alimentarious Commission, a body which is jointly sponsored by the World Health Organization and the Food and Agriculture Organization, both part of the United Nations. The Commission seeks to promote fair international trade

practices in the interest of both the consumer and the producer. As part of the antibiotic certification program, FDA inspects and provides advice to manufacturers in 21 foreign countries. It also responds to inquiries and provides assistance to countries throughout the world. Assistance is given in the form of informational materials and scientific advice concerning various aspects of the consumer protection program.

FDA has mutual working arrangements with non-profit organizations and institutions; for example, conferences are jointly sponsored by consumer and industry associations and FDA. A specific example is the annual conference of the FDA and the Food Law Institute. Other examples are seminars and workships conducted by FDA in cooperation with universities, colleges and professional schools and such programs as the interchange of adverse drug reaction information with the American Medical Association. FDA is also represented at national and international meetings of scientific and professional societies which provides for the interchange of information.

8. Laws and regulations

Laws and regulations affecting the program:

Federal Food, Drug, and Cosmetic Act, as amended (52 Stat. 1040).

Tea Importation Act, as amended (29 Stat. 604).

Import Milk Act (44 Stat. 1101).

Federal Caustic Poison Act (44 Stat. 1406).

Filled Milk Act (42 Stat. 1486).

Federal Hazardous Substances Labeling Act (74 Stat. 372).

Department of Labor, and Health, Education, and Welfare Appropriation Act, 1966 (79 Stat. 589, 593).

Supplemental Appropriation Act, 1966 (79 Stat. 1133, 1140).

Code of Federal Regulations, Title 21—Food and Drugs.

Two volumes: Parts 1 to 129.

Part 130 to end.

Dates and citation for original laws and amendments:

March 2, 1883: Predecessor to the Tea Import Act prohibiting the importation of adulterated or spurious teas (22 Stat. 451).

March 2, 1897: Tea Importation Act (29 Stat. 604)—Provides for examination of tea at ports of entry.

March 1, 1899: An act to prevent importation of adulterated foods (30 Stat. 947).

June 30, 1906: Food and Drug Act of 1906 (34 Stat. 768)—The first Federal Food and Drugs Act.

May 16, 1908: Amendment to the Tea Importation Act allowing the importation of sub-standard tea, under bond, for use as an industrial raw material (35 Stat. 163).

August 23, 1912: Sherley Amendment (37 Stat. 416)—Prohibited labeling medicines with false and fraudulent therapeutic claims.

March 3, 1913: Gould Amendment (37 Stat. 732)—Required that definite quantity information appear on food packages.

July 24, 1919: Kenyon Amendment (41 Stat. 271)—Applied net weight labeling to wrapped meats.

May 29, 1920: An appropriation amendment to the Tea Import Act also provided for revision of the constitution of the Board of Tea Appraisers (54 Stat. 632).

March 4, 1923: Filled Milk Act (42 Stat. 1486)—Prohibited interstate traffic in milk or cream containing any fat other than milk fat.

March 4, 1923: An act to define butter (42 Stat. 1500).

January 18, 1927: Transferred to the Food and Drug Administration the duty to examine specimens of certain insecticides (44 Stat. 976).

February 15, 1927: Import Milk Act (44 Stat. 1101)—Provided for the issuance of permits for the importation of milk.

March 4, 1927: Caustic Poison Act (44 Stat. 1406)—Provided for warning labels and antidotes on 10 dangerous or corrosive substances packed in containers for household use.

July 30, 1930: McNary-Mapes Amendment (46 Stat. 1019)—Authorized promulgation of standards for canned foods, except meat and meat products and canned milk, and labeling to differentiate standard from substandard items.

June 22, 1934: Sea-food Amendment (48 Stat. 1204)—Provided for certification of sea-food packed in plants under continuous FDA inspection.

August 27, 1935: Amended the Sea Food Inspection Act (49 Stat. 871).

August 27, 1935: Amended the Filled Milk Act to authorize the promulgation of regulations (49 Stat. 885).

June 25, 1938: Federal Food, Drug, and and Cosmetic Act of 1938 (52 Stat. 1040)—Extended coverage to cosmetics and devices.

June 25, 1938: Required predistribution clearance of safety on new drugs.

June 25, 1938: Prohibited addition of poisonous or deleterious substances to foods, except where required or unavoidable.

June 25, 1938: Provided for tolerances for unavoidable or required poisonous substances.

June 25, 1938: Authorized standards of identity, quality, and fill of container for foods.

June 25, 1938: Authorized factory inspections.

June 25, 1938: Added the remedy of court injunction to previous remedies of seizure and prosecution.

June 23, 1939: Amended the Federal Food, Drug, and Cosmetic Act to temporarily postpone the effective date of some of the provisions (53 Stat. 853).

June 27, 1940: The Appropriations Act of 1940 also provided for the payment of fees by tea importers under the Tea Importation Act (54 Stat. 632).

June 30, 1940: Reorganization Plan Number IV transfers FDA and its functions from Department of Agriculture to the Federal Security Agency with the exception of those functions relating to the Insecticide Act of 1910 and the Naval Stores Act (54 Stat. 1237).

July 1, 1941: The Appropriations Act of 1941 also provided for the payment of fees by tea importers under the Tea Importation Act (55 Stat. 478).

December 22, 1941: Federal Food, Drug, and Cosmetic Act amended (55 Stat. 851) to require certification of the safety and efficacy of insulin.

March 2, 1944: An act defining and setting a standard of identity for dry milk solids (58 Stat. 108).

July 6, 1945: Federal Food, Drug, and Cosmetic Act amended (59 Stat. 463) to require certification of the safety and efficacy of penicillin.

March 10, 1947: Federal Food, Drug, and Cosmetic Act amended (61 Stat. 11) to require certification of the safety and efficacy of streptomycin.

June 24, 1948: Miller Amendment (62 Stat. 582)—Affirmed United States jurisdiction over products adulterated or misbranded after interstate shipment.

July 13, 1949: Federal Food, Drug, and Cosmetic Act amended (63 Stat. 409) to require certification of the safety and efficacy of aureomycin, chloramphenicol, and bacitracin.

October 18, 1949: Federal Food, Drug, and Cosmetic Act amended (63 Stat. 882) import actions to provide for charging the importer with costs incurred by FDA in supervising operations of bringing violative imported articles into compliance with the Act.

March 16, 1950: The Oleomargarine Act (64 Stat. 20)—Repealed oleomargarine taxes and amended the Federal Food, Drug and Cosmetic Act to set up controls for preventing public deception in the retail sale and serving of colored oleomargarine in both interstate and intrastate commerce.

October 26, 1951: Durham-Humphrey Amendment (65 Stat. 648)—Specifically required that drugs which cannot be safely used without medical supervision bear the prescription legend on the label and be dispensed only upon prescription.

April 11, 1953: Reorganization Plan Number I transfers FDA from the Federal Security Agency to DHEW (67 Stat. 631).

August 5, 1953: Amendment to the Federal Food, Drug, and Cosmetic Act changes the name of aureomycin to its chemical name chlortetracycline (67 Stat. 389).

August 7, 1953: Factory inspection Amendment (67 Stat. 476)—Clarified previous provision regarding mandatory factory inspection, and required the issuing to manufacturers of written reports on inspections and analysis of factory samples.

April 15, 1954: Hale Amendment (68 Stat. 54)—Simplified method of promulgating food standards where no controversy was involved.

July 22, 1954: Miller Pesticides Chemical Amendment (68 Stat. 511)—Changed procedures for the setting of safety limits for pesticidal residues on raw agricultural commodities and greatly strengthened consumer protection.

September 3, 1954: Amendment to the Federal Food, Drug, and Cosmetic Act which rewords the provisions of Section 307 dealing with subpoena power (68 Stat. 1239).

July 2, 1956: Nonfat Dry Milk (70 Stat. 486)—Amends definition of nonfat dry milk.

July 9, 1956: Amendment to the Federal Food, Drug, and Cosmetic Act, Section 402(c) which permits use of certain orange colors (70 Stat. 512).

August 1, 1956: Amendment to the Federal Food, Drug, and Cosmetic Act, Sections 401 and 701(e) simplifying the provisions for the promulgation of regulations under the act (70 Stat. 919).

August 31, 1957: Amendment to the Federal Food, Drug, and Cosmetic Act which provides for the disposition of certain condemned imported articles (71 Stat. 567).

August 28, 1958: Amendment to the Federal Food, Drug, and Cosmetic Act which abbreviates the record that is required in cases of judicial review of orders issued by FDA (72 Stat. 941).

September 6, 1958: Food Additives Amendment (72 Stat. 1784)—Prohibits use of food additives until promoter establishes safety and FDA issues regulations specifying conditions of use.

March 17, 1959: Amendment to the Federal Food, Drug, and Cosmetic Act permitting the use of certain colors on oranges pending further legislation (73 Stat. 3).

June 11, 1960: Amendment to the Federal Food, Drug, and Cosmetic Act to permit the use of certified as well as registered mail in situations where registered mail is called for in Section 505 of the Federal Food, Drug, and Cosmetic Act (74 Stat. 200).

June 29, 1960: Amendment to the Federal Food, Drug, and Cosmetic Act which requires a label declaration of the presence of pesticide chemicals on raw agricultural commodities which are shipped in interstate commerce (74 Stat. 251).

June 29, 1960: Amendment to the Federal Food, Drug, and Cosmetic Act revising provisions for judicial review of agency's orders under the Food Additives Amendment of 1958 (74 Stat. 255).

July 12, 1960: Federal Hazardous Substances Labeling Act (74 Stat. 372)—Requires prominent warning labeling on containers of hazardous household substances.

July 12, 1960: Color Additives Amendments (74 Stat. 397)—Allows FDA to set safe limits on the amounts of colors which may be used in foods, drugs, and cosmetics; and requires manufacturers to retest previously listed certifiable colors.

April 7, 1961: An amendment to the Food Additive provisions of the Federal Food, Drug, and Cosmetic Act which extends the transitional period for application of certain of the Food Additive provisions (75 Stat. 42).

May 24, 1962: Amendment to the Tea Import Act which establishes Tariff Schedules as listing exceptions to the prohibitions in the Tea Import Act (76 Stat. 77).

October 10, 1962: Kefauver-Harris Drug Amendment (76 Stat. 780)—Assures a greater degree of safety, effectiveness, and reliability in prescription drugs, and strengthens new drug clearance procedures.

October 3, 1964: Further amendments to the transitional provisions of the Food Additives Amendments of the Federal Food, Drug, and Cosmetic Act (78 Stat. 1002).

July 15, 1965: Drug Abuse Control Amendments (79 Stat. 226)—Protects the public health and safety by amending the Federal Food, Drug, and Cosmetic Act to establish special controls for depressant and stimulant drugs and counterfeit drugs, and for other purposes.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The consumer protection program affects almost all sections of the economy and its potential magnitude relates directly to changes in population and the gross national product. The program has a beneficial impact on the general environmental health of the population and affords broad protection against economic frauds and cheats.

It is estimated that approximately 25 percent of the consumer dollar is spent on commodities that are regulated by FDA. Economic benefits accrue to the public at large and to individuals as a result of educational activities directed toward assuring a better return to consumers on their expenditures. Additionally, regulatory and scientific activities, aimed at all types of FDA regulated industry, comprise an important part of the consumer protection program. All of these activities are believed to have a continuing constructive effect on the total economy because, in addition to protecting the consumer, they tend to protect reputable industry against abuses by unethical competition.

10. Economic classification of program expenditures. (See table 2.)

Program: Consumer protection program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Food and Drug Administration.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	31.0
Other	9.8
Total, Federal expenditures	40.8
Non-Federal expenditures financed by business enterprises [1]	2.3
Total expenditures for program	43.1

[1] This represents the amount paid by industry to FDA as reimbursement for the agency's certification of antibiotic drugs, insulin, pesticides, and color additives.

Office of Education

CONTENTS

I. GENERAL

The material presented in this report has been developed by the Office of Education in response to a request from the Subcommittee on Economic Progress of the Joint Economic Committee of the Congress. The description of the information requested is contained in the subcommittee's questionnaire of September 1965, Inquiry Relating to Human Resources Programs. Presentation of the material corresponds to the format prescribed in the questionnaire.

For the purposes of this report, all Office programs pertaining to research, demonstration, and dissemination are treated as one basic program. Each of the other programs of the Office which concern the development of human resources is discussed separately. A

few general comments pertaining to the report as a whole are noted below.

Program data

Many of the programs included in the report are new, having been authorized only in 1965, with some receiving final approval by the Congress shortly before this report was completed. Obviously, discussion of these cannot be as specific and detailed as that of older, more firmly established programs. Moreover, the detail of information requested in items 4 (level of performance) and 10 (economic classification of program expenditures) is not available for even some of the older programs. The Office is presently developing an expanded information system which will enable collection of current program data, including more meaningful measures of program performance, on a continuing basis.

Since personnel within a division or bureau often work on more than one program and since the bulk of OE salaries and administrative expenses are funded through a separate appropriation, the number of employees involved in the administration of some programs (as requested in item 4) and the amounts of their salaries and wages (item 10) can be only estimated. The financial data presented in the tables under item 4 show the disposition of funds appropriated by the Congress specifically for the program being discussed. The tables under item 10 include an estimated share of the OE administrative expenses that can be attributed to the program.

To help put the expenditures and outputs of these programs into the context of the total education activity in the United States, the reader should refer to OE publication Projections of Educational Statistics to 1974–75. This publication contains information about enrollments, teachers, facilities, and expenditures in the recent past as well as projections of the future.

Coordination arrangements

Item 7 under each program lists the coordination arrangements peculiar to that particular program. Arrangements applicable to OE programs generally are discussed below.

The Commissioner of Education provides overall direction and coordination of OE activities. To aid in these functions, standard practices are employed: biweekly staff meetings, bimonthly sessions devoted wholly to policy review and planning, and program reporting systems. Day-to-day coordination of programs is performed by the operating bureaus and staff offices.

The reorganization of the Office of Education in 1965 created three operating bureaus—the Bureau of Elementary and Secondary Education, the Bureau of Higher Education, and the Bureau of Adult and Vocational Education—and assigned to them responsibility for grant programs dealing with the same level of education. This grouping enables continuous, informal coordination and cross-fertilization of ideas among individuals working on different programs directed to similar problem areas. In some cases, common administration of several programs helps assure coordination of their purposes and policies. Planning and evaluation staffs now being set up in each bureau will further strengthen the coordination process.

In view of the interrelationships between research programs and the applicability of research findings to more than one level of education,

all research programs of OE were consolidated during the reorganization into the Bureau of Research. To make certain that the research supported by the Office is relevant to the needs of education and integrated into the overall planning and operations of the Office, several formal mechanisms have been created. These are described in detail in the report.

Staff units aid in the coordination process as follows:

The Office of the Associate Commissioner for International Education coordinates international activities administered by the Office and serves as a focal point for OE relationships with other agencies in the field of international education.

The Office of the Associate Commissioner for Federal-State Relations coordinates programs aimed at improving the leadership resources of State educational agencies.

The Office of Administration coordinates the OE budget and the financial aspects of grant programs.

The Office of Disadvantaged and Handicapped exercises staff review and serves as a central point of information and liaison with other agencies in connection with programs dealing with the education of the disadvantaged and handicapped.

The Office of Equal Educational Opportunities assures the compliance of educational agencies with the provisions of the Civil Rights Act and provides advisory services with respect to problems incident to desegregation.

The Office of the General Counsel, DHEW, coordinates the issuance of all program regulations.

The Office of Information coordinates the preparation and issuance of informational material about OE programs.

The Office of Legislation coordinates the legislative requirements of the Office.

The Office of Program Planning and Evaluation coordinates the planning and evaluation activities of OE components. It also develops long-range education goals and plans which help integrate the purposes and objectives of the Office's programs.

The Contracts and Construction Service is responsible for the negotiation and administration of all contracts and grant arrangements made by the Office of Education and provides legal and engineering services needed for construction programs.

The National Center for Educational Statistics collects, analyzes, and provides statistical data needed for planning, funds allotment, administration, and review of OE programs. It also coordinates reports requested from program participants and the public in order to assure comparability and consistency of information, eliminate duplication, and minimize reporting burdens of respondents.

The Office of Education uses a number of mechanisms to coordinate its programs with those of other Federal agencies:

The Office has developed a close rleationship with the National Science Foundation on science education matters involving fellowships, institutes, and curriculum development. The specific methods utilized to promote cooperation are generally of an informal nature, taking the form of information sharing and staff consultation on new programs. In the field of curriculum development, cooperation has been institutionalized by the appoint-

ment of an NSF staff member to the OE curriculum improvement review panel. NSF and OE staff members have conducted joint site visits to investigate the research potential of prospective research contractors. The Office and NSF jointly review and fund proposals relating to both agencies.

A formal working relationship has been established between OE and the Office of Economic Opportunity to coordinate antipoverty efforts. The agreement provides for a central contact in each agency; interchange of personnel; joint review of programs, policies and regulations; and joint funding of appropriate research projects. The Office of Disadvantaged and Handicapped serves as the contact point within OE; the Education Division of the community action program serves as the contact point in OEO. In addition there is continual consultation among operating personnel of the two agencies.

The Federal Interagency Committee on Education, established by Executive Order 11185 on October 16, 1964, with the Assistant Secretary for Education serving as Chairman, and the Commissioner of Education as a member, provides a means of coordinating the educational activities of executive branch agencies, preventing unnecessary duplication of activities, and resolving differences of opinion concerning policies and administrative practices affecting educational institutions.

The Committee on Academic Science and Engineering was set up in September 1965, under the auspices of the Federal Council for Science and Technology. The Committee meets monthly, directing its work toward the development of coordinated approaches to federally supported science and engineering education and research in universities in order to strengthen university science programs and to broaden the scientific base of the country.

An ad hoc committee has been created below the agency-head level to assist in coordinating the graduate education programs of the Office of Education, the National Space and Aeronautics Administration, the National Institutes of Health, the Atomic Energy Commission, and the National Science Foundation.

The Rural Development Committee seeks to provide leadership and uniform policy guidance to the several Federal agencies responsible for rural development program functions.

The President's Committee on Manpower and its various subcommittees offer means of coordinating Federal programs of guidance and counseling and manpower training.

The Interdepartmental Committee on Children and Youth was created to study and recommend programs which have a bearing on the physical, emotional, educational, and social well-being of children.

Since OE programs usually involve grants to States, local school districts, or colleges and universities, coordination arrangements must also be established with these groups. This is done through program regulations and through frequent consultation between representatives of these groups and OE personnel in Washington or in the field.

Coordination of the purposes and objectives of Office programs is also aided through the continuing dialogue carried on with the many professional organizations and public advisory committees concerned

with education. The information and advice received through these channels, along with the other coordination mechanisms mentioned above, help assure that OE programs consider the requirements of the various levels and areas of American education and that Federal efforts supplement and stimulate State, local, and private education efforts.

Legislation

A copy of most of the legislation affecting OE programs, which was requested in item 8 of the questionnaire, can be found in the Compendium of Statutes.[1] Recent legislative developments are summarized in Legislation Concerning Education and Training.[2]

Economic effects

Item 9 could be answered, for the most part, in only a general manner. The quantification of the economic impact of OE programs presents several problems. Because of the interaction of programs, specific outputs often cannot be related to specific inputs. Also, isolating the effects of Federal expenditures for education from those produced by the much greater expenditures of other groups (States, local school districts, and private institutions) is extremely difficult. Moreover, except in programs like the Manpower Development and Training Program, the time lapse between investment and dividend is too long to permit a direct cause/effect relationship to be established.

However, there can be no doubt that programs expending over $3 billion (fiscal year 1966) in developing the Nation's human resources have ultimately a sizable effect on the economy. Not only is the dollar amount spent by the Federal Government expanded through the Government multiplier, but it also helps stimulate another, more significant, expansion. This is the expansion resulting from technological improvement produced by individual innovators and a better educated, more productive working force in general. Without technological improvements, capacity of the economy to grow would be very limited, and much Federal spending would become inflationary rather than expansionary.

Along with the direct economic benefits produced by education there are certain byproducts accruing to society (e.g., the reduction in welfare and unemployment payments and a decrease in property loss due to crime and social conflict) which are assumed to result, at least partially, from investment in education, but which are equally difficult to relate to specific expenditures.

In addition to its contribution to the economic progress of the Nation as a whole, education has a significant payoff to individuals. Studies show that personal income and economic mobility have a high correlation with educational attainment. For example, college graduates earn during their lifetime an average of $180,000 more than individuals with only a high school diploma, while the lifetime earnings of high school graduates average $68,000 more than those of persons with only an eighth-grade education. To the degree that individuals living in certain regions or belonging to certain groups do not have the opportunities to attain higher levels of education, their potential

[1] Full title: A Compendium of Statutes Administered By, Delegating Authority To, Or Under Which Authority Has Been Delegated To The U.S. Office of Education, Department of Health, Education, and Welfare, Committee on Education and Labor, House of Representatives, July 1965.

[2] Legislation Concerning Education and Training, Committee on Education and Labor, House of Representatives, December 1965.

contribution to the economic system and their potential share in its benefits cannot be realized.

Given the nonavailability of specific data, the discussions presented in item 9 serve more as indications of the economic areas probably affected than as listings of actual, proved benefits. The Office is presently attempting to devise methods of measuring program effectiveness and identifying program benefits. Recognition of the need for work along these lines was largely responsible for the creation last year of the program planning and evaluation unit referred to earlier. Foremost among the tasks of this unit is the development of a planning-programing-budgeting system which will provide a framework for in-depth analysis of program inputs and outputs. In addition to this intramural activity, private research groups are being engaged to investigate the applicability of cost-benefit techniques to OE's work. It is expected that as a result of these various efforts, specific meaningful data about the effects of the Office's programs will be developed within a few years.

The material presented in this report deals mainly with the impact of the Office of Education's programs on the economy. Yet educational programs, whether supported by local, State, or Federal efforts, must be concerned with both economic and noneconomic aspects of our society—with improving the quality of American life, with expanding the opportunities for self-realization for all Americans, and with developing the full range of human resources. These are the goals toward which the programs of the Office of Education will continue to be directed.

II. PROGRAMS FOR ELEMENTARY AND SECONDARY EDUCATION

Education of Children of Low-Income Families

(The Elementary and Secondary Education Act of 1965—Title I)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To provide financial assistance to meet the special educational needs of educationally deprived children in areas with high concentrations of low-income families.

2. Operation

The money is allocated to counties on the basis of the number of school-age children from families earning less than $2,000 or receiving AFDC payments. Local public educational agencies submit proposals to the State educational agency for projects designed to meet the special educational needs of educationally deprived children. The State agency evaluates these proposals according to guidelines and criteria established by the U.S. Commissioner of Education and approves projects. Educationally deprived children enrolled in private schools as well as public schools may benefit from the program.

3. History

This program was initiated by title I of the Elementary and Secondary Education Act of 1965 (Public Law 89–10), signed into law by President Johnson on April 11, 1965. The major fiscal emphasis

is directed toward raising the educational achievement of deprived children. For this purpose, the Congress appropriated $775 million under title I for fiscal year 1966, the first year of the 3-year program.

4. Level of operations. (See table 1.)

Program: Education of children of low-income families.
Department or agency, and bureau or office: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (local projects)			30,000–50,000	30,000–50,000
(b) Applicants or participants: Local educational agencies (agencies)			18,000	18,000
(c) Federal finances:				
Unobligated appropriations available (millions)			[2] $959	$1,070.4
Obligations incurred (millions)			$959	$1,070.4
Allotments or commitments made (millions)			$959	$1,070.4
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)			80	80
(f) Non-Federal Government personnel employed (not available)				
(g) Other measures of level or magnitude of performance (pupils affected (millions))			6.5	7.5

[1] Not applicable.
[2] Includes $184,000,000 in fiscal year 1966 supplemental request.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Responsibility for the administration of the program is assigned to the Division of Program Operations of the Bureau of Elementary and Secondary Education. This Division works with State educational agencies.

The Division will coordinate the program with the National Teacher Corps which, when activated, will be administered by the same Bureau.

The legislation requires that a local school district submitting a request for grants under the program develop its request in cooperation with the local agency responsible for the community action program operating under the Economic Opportunity Act of 1964. In Washington, members of the Division have developed a close working relationship with the CAP staff of the Office of Economic Opportunity, which enables coordinated operations of the two programs in the poor areas of the Nation. In addition, staff review of the program is exercised by the Office of Disadvantaged and Handicapped, which provides a central point within OE for information and advisory services concerning educational components of antipoverty programs.

A National Advisory Council on the Education of Disadvantaged Children will review annually the operations of this program and related programs and make recommendations for their improvement to the President.

8. Laws and regulations

Title I of the Elementary and Secondary Education Act of 1965, enacted on April 11, 1965, as Public Law 89–10. For text of title I, see Compendium of Statutes, pages 56–63; for other titles of the act, pages 24–44.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—Title I of the ESE Act of 1965 is directly aimed at educationally deprived children in areas having high concentrations of families with incomes under $2,000. The program which it established can significantly alter the potential income of the participants. Innovative methods designed to raise the educational achievement of deprived students will help them break the cycle of poverty. The program should result in an increase in the students' future income and the consequent distribution of additional wealth to a population which is presently poor.

(*b*) *Worker placement and productivity.*—Adequately educated workers will be better equipped to cope with the labor market. Productivity and earnings should grow as workers' skills become marketable.

Increased quality in education should also result in an increase in worker mobility. Greater freedom of movement, enabling workers to seek out markets for skills, should also contribute to increased productivity and earnings.

(*c*) *Business and industrial organization and management.*—It is expected that the increase in demand for teaching aids will further the growth of an already expanding industry.

(*d*) *Other phases of economic activity.*—The program, aimed directly at areas which coincidentally have a high rate of unemployment, should help reduce the number of "hard-core unemployables." A reduction in unemployment would result in a decrease in welfare payments, thereby freeing funds for more productive use.

(*e*) *Geographic differentials.*—The formula for distribution of funds tends to distribute money to northern urban areas (35 percent of total) and southern rural areas (33 percent of total). For State distribution of fiscal year 1966 authorization, see table 2.

10. Economic classification of program expenditures

Not applicable. The program began operation in fiscal year 1966.

TABLE 2.—*Elementary and secondary educational activities, fiscal year 1966 authorization: Title I, assistance for educationally deprived children*

Area	Grants to local educational agencies	Grants for State administrative expenses	Total
United States and outlying areas	$1,164,320,614	$12,078,114	$1,176,398,728
50 States and the District of Columbia	1,141,034,202	12,078,114	1,153,112,316
Alabama	34,634,567	346,346	34,980,913
Alaska	1,797,914	75,000	1,872,914
Arizona	10,360,005	103,600	10,463,605
Arkansas	22,600,021	226,000	22,826,021
California	77,886,286	778,863	78,665,149
Colorado	9,755,134	97,551	9,852,685
Connecticut	7,196,504	75,000	7,271,504
Delaware	1,975,217	75,000	2,050,217
Florida	27,478,937	274,789	27,753,726
Georgia	37,342,341	373,423	37,715,764
Hawaii	2,374,944	75,000	2,449,944
Idaho	2,544,238	75,000	2,619,238
Illinois	61,112,154	611,122	61,723,276
Indiana	18,378,029	183,780	18,561,809
Iowa	18,652,957	186,530	18,839,487
Kansas	10,595,499	105,955	10,701,454
Kentucky	30,131,330	301,313	30,432,643
Louisiana	38,344,221	383,442	38,727,663
Maine	4,014,213	75,000	4,089,213
Maryland	15,249,238	152,492	15,401,730
Massachusetts	16,539,689	165,397	16,705,086
Michigan	34,733,765	347,338	35,081,103
Minnesota	24,530,168	245,302	24,775,470
Mississippi	30,894,244	308,942	31,203,186
Missouri	29,857,937	298,579	30,156,516
Montana	3,756,470	75,000	3,831,470
Nebraska	6,929,812	75,000	7,004,812
Nevada	949,969	75,000	1,024,969
New Hampshire	1,452,253	75,000	1,527,253
New Jersey	24,560,286	245,603	24,805,889
New Mexico	9,789,895	97,899	9,887,794
New York	109,670,427	1,096,704	110,767,131
North Carolina	52,826,063	528,261	53,354,324
North Dakota	5,219,893	75,000	5,294,893
Ohio	39,185,691	391,857	39,577,548
Oklahoma	17,393,688	173,937	17,567,625
Oregon	8,231,740	82,317	8,314,057
Pennsylvania	55,941,428	559,414	56,500,842
Rhode Island	4,039,555	75,000	4,114,555
South Carolina	27,478,721	274,787	27,753,508
South Dakota	6,936,594	75,000	7,011,594
Tennessee	32,206,225	322,062	32,528,287
Texas	77,525,099	775,251	78,300,350
Utah	2,853,159	75,000	2,928,159
Vermont	1,744,857	75,000	1,819,857
Virginia	30,619,294	306,193	30,925,487
Washington	10,757,118	107,571	10,864,689
West Virginia	16,991,225	169,912	17,161,137
Wisconsin	18,058,203	180,582	18,238,785
Wyoming	1,555,058	75,000	1,630,058
District of Columbia	5,381,927	75,000	5,456,927
Outlying areas	23,286,412		23,286,412

SCHOOL LIBRARY RESOURCES, TEXTBOOKS, AND OTHER INSTRUCTIONAL MATERIALS

(The Elementary and Secondary Education Act of 1965—Title II)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To provide financial assistance for the acquisition of school library resources, textbooks and other printed and published instructional materials for the use of children and teachers in public and private elementary and secondary schools.

2. Operation

Allotments are made to States on a formula basis (see act). To apply for a grant from its allotment, a State must submit an operational plan to the U.S. Office of Education. The State plan designates one State agency, usually the State department of education, which will be responsible for administering and supervising the entire program, and gives the criteria to be used in allocating funds. Materials are loaned to children and teachers in both public and private schools.

3. History

The Elementary and Secondary Education Act of 1965 (Public Law 89–10) was signed into law by President Johnson on April 11, 1965. Title II of the act is expected to assist States in providing a variety of high-quality instructional materials not previously available in sufficient quantity. Congress has appropriated $100 million under title II for fiscal year 1966, the first year of the 5-year program.

4. Level of operations. (See table 1.)

Program: School library resources, textbooks, and other instructional materials.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal 1966 (estimate)	Fiscal 1967 (estimate)
(a) Magnitude of the program (persons affected (millions))			40	40
(b) Applicants or participants: State educational agencies (agencies)			51	51
(c) Federal finances:				
Unobligated appropriations available (millions)			$100	$105
Obligations incurred (millions)			$100	$105
Allotments or commitments made (millions)			$100	$105
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years administering)			14	21
(f) Non-Federal Government personnel employed			(2)	(2)
(g) Other measures of level or magnitude of performance (schools receiving library resources)			90,000	90,000

[1] Not applicable.
[2] Not available.

5. Estimated magnitude of operation in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination is effected by the Division of Plans and Supplementary Centers of the Bureau of Elementary and Secondary Education. The Division works with the State agency designated to administer the State program. No other arrangements for coordination with governmental or nongovernmental units have, as yet, been deemed necessary.

8. Laws and regulations

Title II, the Elementary and Secondary Education Act of 1965, enacted on April 11, 1965, as Public Law 89–10. For text of the act, see Compendium of Statutes, pages 24–44.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—Title II of Public Law 89–10 focuses on providing school library books, textbooks, and other instructional materials through State agencies for children and teachers of public and private schools. Title III is designed to stimulate supplementary educational centers and programs of an innovative or exemplary character which are not available presently. Considered in isolation, those programs will have little measurable effect on personal income. But as a part of a general educational improvement program, they make a solid contribution toward producing better educated individuals whose future incomes will be higher than they would have been otherwise. Since fiscal 1966 is the first year of operation, data on these program operations are not yet available.

(*b*) *Worker placement and productivity.*—The better educated individual will find entrance into the labor market a much more rewarding experience, both personally and socially. He will be able to enter the market with relative ease and will find employment flexibility much more readily than the poorly educated person. His productivity should increase to an extent which cannot presently be measured.

(*c*) *Business and industrial organization and management.*—Effects on industrial organization, new business, and business competition will be seen in the increased production of book and textbook publishers and manufacturers of instructional equipment, particularly the audio-visual field. It is estimated that textbook sales in 1964–65, for grades K–12, amounted to $293 million and that library material sales were $70 million. The $100 million under title II should increase sales by over 25 percent. In addition, increased demand will probably be created in areas such as building materials, basic school equipment and furniture, visual and audio aids, programed instruction, television, electronic applications, and other types of supplemental tools of a kind which require imagination and inventiveness.

(*d*) *Other phases of economic activity.*—Increased demands for books and materials should produce the usual effects of increased production and sales. Such increases would also have positive effects on employment. Prices and wages will depend upon the fluidity of the labor market and ability to increase production quickly without creating bottlenecks.

(*e*) *Other benefits.*—If one group would benefit more than another, it would probably be the one presently low on the economic scale. Theoretically, it would be this group which, in the years to come, would find its economic position vastly improved because of an improved educational stature. This new status would result in a greater and more flexible labor marketability.

(*f*) *Geographic differentials.*—For State differentials, see table 2.

TABLE 2.—*Elementary and Secondary Education Act, title II: Grants to States for school library materials, etc.—Estimated fiscal year 1966 obligations*

State or outlying area	Estimated 1966 obligations
Total	$100,000,000
Alabama	1,734,277
Alaska	118,854
Arizona	815,164
Arkansas	937,854
California	9,308,483
Colorado	1,065,929
Connecticut	1,392,995
Delaware	256,903
Florida	2,604,055
Georgia	2,174,706
Hawaii	391,124
Idaho	370,581
Illinois	5,361,699
Indiana	2,528,237
Iowa	1,483,765
Kansas	1,146,723
Kentucky	1,549,486
Louisiana	1,922,905
Maine	525,829
Maryland	1,809,594
Massachusetts	2,622,125
Michigan	4,671,827
Minnesota	1,988,186
Mississippi	1,218,307
Missouri	2,309,246
Montana	382,828
Nebraska	775,144
Nevada	211,763
New Hampshire	$336,232
New Jersey	3,233,812
New Mexico	590,702
New York	8,293,725
North Carolina	2,435,404
North Dakota	347,300
Ohio	5,406,689
Oklahoma	1,266,877
Oregon	975,757
Pennsylvania	5,908,219
Rhode Island	427,974
South Carolina	1,320,035
South Dakota	386,888
Tennessee	1,826,346
Texas	5,345,745
Utah	587,662
Vermont	208,027
Virginia	2,095,347
Washington	1,591,758
West Virginia	924,800
Wisconsin	2,278,827
Wyoming	187,468
District of Columbia	345,817
American Samoa, Guam, Puerto Rico, Virgin Islands, Trust Territory of the Pacific	2,000,000

10. Economic classification of program expenditures

Not applicable. The program began operation in fiscal year 1966.

SUPPLEMENTARY EDUCATIONAL CENTERS AND SERVICES

(The Elementary and Secondary Education Act of 1965—Title III)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To stimulate and assist the advancement of elementary and secondary education through the provision of vitally needed educational services not available in sufficient quantity or quality, and through the development and establishment of innovative and exemplary programs to serve as models for regular school programs. The model programs may be in any area, such as guidance and counseling, remedial education, school health, physical education, recreation, performing arts, and psychological and social work services.

2. Operation

Local educational agencies submit project proposals simultaneously to the State educational agency and to the U.S. Commissioner of Education. Representatives of local cultural and educational resources participate in planning and carrying out the projects. Grants for the entire cost of approved projects are made by the Commissioner from State allocations. Each State has a base allocation of $200,000.

The remainder of the title III appropriation is allocated on the basis of a population formula (see act).

3. History

The Elementary and Secondary Education Act of 1965 (Public Law 89–10) was signed into law by President Johnson on April 11, 1965. Title III of the act authorizes a 5-year program of support for supplementary educational centers and services. Congress has appropriated $75 million for fiscal year 1966, the first year of this program.

4. Level of operations. (See table 1.)

Program: Supplementary educational centers and services.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program:				
Planning grants			700	1,000
Operations grants			300	1,000
(b) Applicants or participants: Local educational agencies			1,000	2,000
(c) Federal finances:				
Unobligated appropriations available (millions)			$75	$145
Obligations incurred (millions)			$75	$145
Allotments or commitments made (millions)			$75	$145
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years administering)			60	68
(f) Non-Federal Government personnel employed (man-years)			5,000	5,000
(g) Other measures of level or magnitude of performance (proposals received)			3,000	4,000

[1] Not applicable.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination of the program's operations within the Office of Education and with the local agencies is effected by the Division of Plans and Supplementary Centers in the Bureau of Elementary and Secondary Education.

Grants under this program are made to local educational agencies which have developed programs in cooperation with persons representing the cultural and educational resources of the area to be served, e.g., State educational agencies, institutions of higher learning, nonprofit private schools, libraries, museums, musical and artistic organizations, and educational radio and television stations. The application by the local agency must be reviewed by the State educational agency.

As directed by the act, the Commissioner has appointed an Advisory Committee on Supplementary Educational Centers and Services. This committee of eight members advises the Commissioner on the preparation of general regulations for administration of the program,

development of criteria for approval of applications, and action to be taken with regard to each application.

8. Laws and regulations

Title III of the Elementary and Secondary Education Act of 1965, enacted on April 11, 1965, as Public Law 89–10. For text of the act, see Compendium of Statutes, pages 24–44.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

For the economic effects of this program, see section 9 of preceding program, "School Library Resources, etc." Distribution of program funds by State is shown in table 2.

TABLE 2.—*Elementary and Secondary Education Act, title III: Supplementary educational centers and services—Estimated fiscal year 1966 obligations*

State or outlying area	Estimated 1966 obligations	State or outlying area	Estimated 1966 obligations
Total	$75,000,000	New Hampshire	$412,894
		New Jersey	2,326,965
Alabama	1,384,922	New Mexico	559,287
Alaska	285,285	New York	5,831,022
Arizona	729,975	North Carolina	1,863,654
Arkansas	847,491	North Dakota	425,588
California	5,996,364	Ohio	3,597,474
Colorado	854,131	Oklahoma	1,009,140
Connecticut	1,088,743	Oregon	825,256
Delaware	362,298	Pennsylvania	3,943,399
Florida	2,004,323	Rhode Island	488,792
Georgia	1,663,178	South Carolina	1,100,805
Hawaii	438,234	South Dakota	446,048
Idaho	442,524	Tennessee	1,472,890
Illinois	3,609,491	Texas	3,720,782
Indiana	1,823,414	Utah	553,474
Iowa	1,128,420	Vermont	337,187
Kansas	943,203	Virginia	1,652,988
Kentucky	1,272,427	Washington	1,201,226
Louisiana	1,409,927	West Virginia	827,281
Maine	530,937	Wisconsin	1,583,119
Maryland	1,338,701	Wyoming	317,541
Massachusetts	1,916,761	District of Columbia	440,713
Michigan	2,976,979	American Samoa, Guam, Puerto Rico, Virgin Islands, Trust Territory of the Pacific	1,500,000
Minnesota	1,399,113		
Mississippi	1,020,711		
Missouri	1,633,843		
Montana	443,556		
Nebraska	689,615		
Nevada	327,909		

10. Economic classification of program expenditures

Not applicable. The program began operation in fiscal year 1966.

INSTRUCTION IN CRITICAL SUBJECTS

(The National Defense Education Act—Title III)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To improve elementary and secondary education in such critical subjects as science, mathematics, history, civics, geography, economics,

modern foreign languages, English, and reading, by providing better equipment, materials, and State services.

2. Operation

Allotments to States are determined by formula (see act). Federal grants from the allotments are made to State educational agencies on a matching basis. To apply for a grant, a State educational agency must submit to the U.S. Commissioner a State plan, describing how it will use Federal funds for local projects to be approved by the State agency, for expansion and improvement of the State's supervisory services, and for administration of the State plan. To apply for remodeling and equipment funds, local educational agencies submit project proposals to the State educational agency, which administers the grants. Loans are negotiated with and paid directly by the Office of Education to private nonprofit elementary and secondary schools.

3. History

This program was initiated by title III of the National Defense Education Act of 1958 (Public Law 85–864). It has since been extended four times—in October 1961 (Public Law 87–344), in December 1963 (Public Law 88–210), in October 1964 (Public Law 88–665), and in November 1965 (Public Law 89–329), effective through June 30, 1968.

The 1963 amendments made the following principal changes in title III: Test grading equipment and specialized audiovisual equipment were authorized; American Samoa was allowed to participate; the definition of "local educational agency" was enlarged to include any public institution or agency which has administrative control of any public elementary or secondary school; the 1-year carryover provision was repealed; reallotment to other States of unused portions of State allotments was authorized.

Principal 1964 amendments to title III added history, civics, geography, English, and reading to the eligible subjects; increased the annual authorizations; increased the minimum annual State allotment for supervisory and related services and administration of the State plan; and provided that allotment ratios be promulgated biennially by the Office of Education. The Higher Education Act of 1965 added economics to the previously designated critical subjects and increased the authorization.

In the first 6 years of the program, States received a total of $223.6 million for equipment, materials, and minor remodeling and $13.1 million for supervision and administration. Both sums were matched with at least equal State or local expenditures. During the same period, States approved 306,941 local projects at a total estimated cost of $560.4 million. By July 1964, the States employed the full-time equivalent of 227 special supervisors in the eligible subjects, as against 33 before the National Defense Education Act was passed.

4. Level of operations. (See table 1.)

Program: Instruction in critical subjects.
Department or agency, and office or bureaus: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in millions]

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimate)	Fiscal year 1967 (estimate)
(a) Magnitude of the program (projects approved)	70,126	79,000	79,000	79,000
(b) Applicants or participants:				
State educational agencies	51	54	54	54
Nonprofit private schools	40	32	75	75
(c) Federal finances:				
Unobligated appropriations available	$84.1	$76.6	$88.2	$63.2
Obligations incurred	$81.4	$74.9	$88.2	$63.2
Allotments or commitments made	$84.1	$76.6	$88.2	$63.2
(d) Matching or additional expenditures [1]	$71.3	$77.2	$91	$103.2
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)	[2] 36	35	28	36
(f) Non-Federal Government personnel employed (State supervisors) [3]	227	227	265	275
(g) Other measures of level or magnitude of performance—Loans to nonprofit private schools:				
Applications received	44	35	85	85
Loans approved	40	32	75	75

[1] Matching funds necessary only under title III, sec. 303(a), of the act.
[2] Estimated.
[3] In science, mathematics, and modern foreign languages.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination of the program's operations is effected by the Division of Plans and Supplementary Centers and the Division of Program Operations of the Bureau of Elementary and Secondary Education.

The Divisions work with State educational agencies to which grants are made and with private nonprofit elementary and secondary schools to which loans are made.

8. Laws and regulations

Title III of the National Defense Education Act of 1958, enacted on September 2, 1958, as Public Law 85–864. For amendments and text of the act, see Compendium of Statutes, pages 163–176. The most recent amendment is title IV of the Higher Education Act of 1965 (Public Law 89–329).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—The equipment purchased under this program helps the student better grasp the subject area taught, by offering to him clear examples of practices in the subject (via science experiments, language labs, etc.). With a greater grasp of the field, and possibly a greater interest in the field, the student should be better prepared for a higher income occupation than might otherwise be possible.

(*b*) *Worker placement and productivity.*—Productivity should be raised for the same reasons as those given above.

(c) *Business and industrial organization and management.*—The school equipment industry has been stimulated as a result of title III. A number of small organizations have begun and grown as manufacturers of particular types of school apparatus. The audiovisual field in particular has been stimulated. Teaching aids, language laboratories, visual projection devices, and classroom television receivers have found a greatly expanded market. These new industries themselves have set off secondary repercussions and therefore have had a multiplied effect on the economy.

(d) *Geographic differentials.*—Tables 2 and 3 show State allotments in fiscal year 1965 and fiscal year 1966:

TABLE 2.—*National Defense Education Act, title III: Grants to States for acquisition of equipment and minor remodeling—Fiscal year 1965 obligations and estimated fiscal year 1966 obligations*

State or possession	1965 total obligations	1966 total estimated obligations [1]	State or possession	1965 total obligations	1966 total estimated obligations [1]
Total	$69,992,539	$79,200,000	Nevada	$92,120	$102,797
			New Hampshire	240,965	272,342
Alabama	1,106,953	2,030,242	New Jersey	1,494,421	1,793,579
Alaska	135,000	96,882	New Mexico	543,418	500,000
Arizona	783,374	225,000	New York	4,496,945	4,868,259
Arkansas	774,901	1,077,890	North Carolina	2,591,662	2,813,997
California	4,749,714	6,247,648	North Dakota	353,223	362,964
Colorado	876,883	816,970	Ohio	3,801,315	4,693,630
Connecticut	628,646	710,910	Oklahoma	1,143,641	1,153,472
Delaware	135,574	137,073	Oregon	809,193	787,605
Florida	2,005,855	2,315,638	Pennsylvania	4,237,149	4,491,895
Georgia	2,544,133	2,451,052	Rhode Island	282,713	314,007
Hawaii	485,610	236,009	South Carolina	1,441,158	1,577,873
Idaho	307,914	399,254	South Dakota	362,883	388,225
Illinois	2,871,234	3,541,125	Tennessee	1,600,000	2,075,005
Indiana	1,677,895	2,080,004	Texas	3,577,171	4,500,000
Iowa	1,209,954	1,233,936	Utah	624,006	587,336
Kansas	911,408	970,548	Vermont	180,553	198,426
Kentucky	1,267,975	1,500,000	Virginia	1,660,907	2,000,000
Louisiana	1,903,377	1,500,000	Washington	1,250,289	1,209,747
Maine	339,186	240,182	West Virginia	1,119,235	1,031,462
Maryland	1,322,373	1,287,627	Wisconsin	1,874,855	1,816,272
Massachusetts	1,546,958	1,531,545	Wyoming	146,864	159,552
Michigan	3,321,154	3,871,254	American Samoa	0	0
Minnesota	1,643,409	1,648,202	Canal Zone	0	0
Mississippi	600,000	1,200,000	District of Columbia	65,406	100,000
Missouri	1,359,973	1,599,030	Guam	12,500	50,000
Montana	264,181	300,000	Puerto Rico	575,166	1,340,000
Nebraska	611,147	623,534	Virgin Islands	30,000	50,000

[1] Amounts reflect anticipated reallotment of funds.

TABLE 3.—*National Defense Education Act, title III: Grants to States for supervision and administration—Fiscal year 1965 obligations and estimated fiscal year 1966 obligations*

State or possession	1965 total obligations	1966 total estimated obligations [1]	State or possession	1965 total obligations	1966 total estimated obligations [1]
Total	$4,530,623	$7,500,000	Nevada	$32,000	$50,000
			New Hampshire	21,837	50,000
Alabama	96,668	127,500	New Jersey	75,371	247,201
Alaska	15,000	50,000	New Mexico	50,000	52,357
Arizona	50,000	75,000	New York	682,105	718,935
Arkansas	51,000	88,687	North Carolina	98,550	225,000
California	379,313	396,350	North Dakota	30,000	50,000
Colorado	56,697	89,756	Ohio	90,000	200,000
Connecticut	112,233	117,003	Oklahoma	59,834	107,920
Delaware	30,949	50,000	Oregon	53,566	58,787
Florida	149,104	236,677	Pennsylvania	239,672	493,300
Georgia	140,000	204,087	Rhode Island	30,000	50,000
Hawaii	110,975	150,000	South Carolina	82,784	129,825
Idaho	20,481	50,000	South Dakota	29,000	50,000
Illinois	221,780	268,950	Tennessee	74,043	110,300
Indiana	38,785	174,000	Texas	185,614	487,423
Iowa	69,509	125,907	Utah	50,000	51,467
Kansas	44,233	82,500	Vermont	16,000	40,000
Kentucky	60,962	147,990	Virginia	35,000	150,000
Louisiana	109,335	172,031	Washington	88,813	142,859
Maine	28,000	50,000	West Virginia	56,465	87,262
Maryland	55,002	155,647	Wisconsin	62,626	94,653
Massachusetts	114,944	223,676	Wyoming	10,000	50,000
Michigan	50,000	200,000	American Samoa	0	0
Minnesota	105,277	165,620	Canal Zone	0	0
Mississippi	40,000	75,000	District of Columbia	20,000	50,000
Missouri	68,843	71,000	Guam	5,005	5,616
Montana	27,500	50,000	Puerto Rico	57,248	59,000
Nebraska	25,000	65,714	Virgin Islands	23,500	25,000

[1] Amounts reflect anticipated reallotment of funds.

10. Economic classification of program expenditures.[1] (See table 4.)

Program: Instruction in critical subjects.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 4.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	0.6
Grants to State and local governments	50.2
Loans to private schools	.4
Total, Federal expenditures	51.2
Non-Federal expenditures financed by State and local governments	77.2
Total expenditures for program	128.4

GUIDANCE, COUNSELING, AND TESTING

(The National Defense Education Act—Title V-A)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist in the establishment and maintenance of testing, guidance, and counseling programs in public elementary and secondary schools, junior colleges, and technical institutes, and testing programs in private schools.

[1] Estimated.

2. Operation

Funds are allotted to States on a formula basis (see act). Dollar for dollar matching is required. Grants are made to State educational agencies which have submitted approved State plans to the U.S. Commissioner of Education. These plans include descriptions of projected activities and an estimate of their need for funds. State agencies use a small portion of title V–A funds for their State-level activities and pay the major share to the school districts to help finance local guidance, counseling, and testing programs approved by the State. To request comparable testing services, nonpublic schools in 39 states submit applications directly to the U.S. Office of Education.

3. History

The National Defense Education Act (Public Law 85–864) was signed into law on September 2, 1958. It was extended three times: in October 1961 (Public Law 87–344); in December 1963 (Public Law 88–210); and in October 1964 (Public Law 88–665), effective until June 30, 1968. Originally, only secondary schools were eligible for participation in title V–A. The 1963 amendments included grades seven and eight. In 1964, eligibility was extended to all grades in elementary schools, junior colleges, and technical institutes.

During the first 6 years of the program, States have consistently overmatched Federal funds. The number of full-time equivalent counselors has increased from 12,000 to 29,275, with 80 percent of these working in programs approved under State plans for title V–A.

4. Level of operations. (See table 1.)

Program: Guidance, counseling, and testing.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimated	Fiscal year 1967 estimated
(*a*) Magnitude of the program: Students in schools with guidance and counseling programs (millions)	11.1	14	17	18
(*b*) Applicants or participants: State educational agencies	53	54	54	54
(*c*) Federal finances:				
Unobligated appropriations available (millions)	$15	$20.5	$24.5	$24.5
Obligations incurred (millions)	$15	$20.5	$24.5	$24.5
Allotments or commitments made (millions)	$15	$20.5	$24.5	$24.5
(*d*) Matching or additional expenditures (millions)	$154.6	$106.7	$200	$200
(*e*) Number of Federal Government employees administering, operating, or supervising the activity (administering)	[1] 37	[1] 35	23	30
(*f*) Non-Federal Government personnel employed	([2])	([2])	([2])	([2])
(*g*) Other measures of level or magnitude of performance:				
Pupil-counselor ratio	528:1	475:1	455:1	440:1
Tests administered (millions)	8.5	15	20	21
Secondary school counselors	27,275	[1] 31,000	32,500	34,000

[1] Estimated.
[2] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination of the program's operations is effected by the Division of Plans and Supplementary Centers of the Bureau of Elementary and Secondary Education. The Division works with the Bureau's Division of Educational Personnel Training, which administers the NDEA counseling institute program, to assure a coordinated Federal approach to the development of the Nation's school counseling program.

In making grants under the program, the Division works with State educational agencies and private nonprofit elementary and secondary schools.

8. Laws and regulations

Title V–A of the National Defense Education Act of 1958, enacted on September 2, 1958, as Public Law 85–864. For amendments and text of the current act, see Compendium of Statutes, pages 163–191.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—By directing students in their formative years, it is expected that the abilities and interests of students will better fit their future occupations. Also, through counseling, dropouts may be induced to finish high school. These two aspects of the program should increase the personal incomes of those involved in the program by helping them find more productive work.

(*b*) *Worker placement and productivity.*—Productivity is expected to be raised for the same reasons as those given above. Counselors have a direct bearing on the placement of students in fields which fit their skills and interest. By channeling students away from obsolete trades and into high potential areas, school counselors help alleviate technological unemployment.

(*c*) *Business and industrial organization and management.*—By having direction in choosing an occupation, a worker may be less prone to change jobs for other than economic reasons.

(*d*) *Geographic differentials.*—Table 2 shows the State allotments.

TABLE 2.—*National Defense Education Act, title V, pt. A: Guidance, counseling, and testing—Fiscal year 1965 obligations and estimated fiscal year 1966 obligations*

State or possession	1965 obligations	1966 total estimated obligations [1]	State or possession	1965 obligations	1966 total estimated obligations [1]
Total	$20,469,115	$24,500,000	Nevada	$49,997	$50,000
Alabama	396,887	470,611	New Hampshire	65,141	79,773
Alaska	50,000	50,000	New Jersey	638,892	781,675
Arizona	174,254	209,718	New Mexico	126,834	147,505
Arkansas	208,370	249,855	New York	1,688,528	2,025,432
California	1,783,398	2,171,432	North Carolina	553,877	654,741
Colorado	210,958	252,865	North Dakota	75,452	89,306
Connecticut	268,767	329,628	Ohio	1,102,239	1,308,478
Delaware	50,844	62,213	Oklahoma	261,415	304,041
Florida	554,790	666,782	Oregon	199,297	239,319
Georgia	477,546	574,968	Pennsylvania	1,170,828	1,389,757
Hawaii	79,327	93,821	Rhode Island	86,713	105,862
Idaho	84,556	96,831	South Carolina	308,017	365,752
Illinois	1,038,806	1,268,843	South Dakota	84,124	96,831
Indiana	516,387	625,140	Tennessee	410,266	490,178
Iowa	303,256	354,714	Texas	1,155,626	1,373,200
Kansas	239,000	282,467	Utah	121,204	144,996
Kentucky	352,007	416,927	Vermont	50,000	52,680
Louisiana	406,817	484,659	Virginia	471,528	558,913
Maine	106,126	125,931	Washington	330,446	383,814
Maryland	357,205	438,501	West Virginia	210,095	245,841
Massachusetts	520,709	630,157	Wisconsin	446,070	533,325
Michigan	916,242	1,087,723	Wyoming	50,000	50,000
Minnesota	391,628	466,597	American Samoa	0	0
Mississippi	281,650	332,639	Canal Zone	0	0
Missouri	442,175	531,319	District of Columbia	66,864	81,278
Montana	81,095	95,828	Guam	19,995	40,000
Nebraska	154,867	185,134	Puerto Rico	248,000	312,000
			Virgin Islands	30,000	40,000

[1] Amounts reflect a reallotment of funds.

10. Economic classification of program expenditures. (See table 3.)

Program: Guidance, counseling, and testing.

Department or agency; and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 3.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 0.3
Grants to State and local governments	17.3
Total, Federal expenditures	17.6
Non-Federal expenditures financed by State and local governments	[1] 106.7
Total expenditures for program	124.3

[1] Estimated.

INSTITUTES FOR COUNSELORS AND TEACHERS

(The National Defense Education Act—Titles V–B, XI)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To improve the qualifications of counselors in schools and colleges, teachers who are preparing to engage in the counseling and guidance of students in schools and colleges, and teachers of critical subjects in elementary and secondary schools.

2. Operation

Proposals for institutes are submitted by colleges and universities for approval by the U.S. Commissioner of Education. These are reviewed by outside consultants and rated in terms of the institution's ability to provide the necessary staff and facilities to conduct a high-quality institute program. Contract funds cover the operating costs of the institute and provide additional funds for payment of stipends to eligible enrollees.

Persons wishing to attend an institute apply to the director of that institute, who is responsible for selecting participants.

3. History

The institutes for counselors were established by title V–B of the National Defense Education Act of 1958. The most recent amendment (fiscal year 1964) extended the institutes to include personnel engaged in or preparing to engage in counseling in elementary schools, junior colleges and technical schools. Institute participants from nonprofit schools were made eligible to receive stipends.

At the beginning of the program, major emphasis was placed on short-term institutes for counselors. In succeeding years, an increased proportion of program funds has been used to establish regular session institutes for secondary school personnel with little or no previous counselor preparation. Current program emphasis is on the preparation of individuals for entry level work in counseling and guidance at all educational levels: elementary, secondary, and higher education.

The program of language institutes originated in title VI, section 611 of the National Defense Education Act of 1958. On December 18, 1963, the President signed legislation to broaden the scope of section 611 to include support of institutes for teachers of English as a foreign language. As of January 1965, some 17,000 teachers had attended 386 National Defense Education Act language institutes in the United States and other countries.

Under title XI of the 1964 amendments (Public Law 88–665) to the National Defense Education Act, the Commissioner was empowered to contract with institutions to conduct institutes for teachers of English, reading, history, geography, and disadvantaged youth, and for educational media specialists and school librarians. The first of these new institutes were conducted in the summer of 1965, and the institute program will continue for 3 years under the present law. The Higher Education Act of 1965 (Public Law 89–329) amended the act to include institutes in civics, economics, and industrial arts.

4. Level of operations. (See table 1.)

Program: Institutes for counselors and teachers.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(*a*) Magnitude of the program (institute participants) [2]	6,370	22,160	25,545	29,530
(*b*) Applicants or participants: Institutions of higher education (institutes operated)	142	552	637	721
(*c*) Federal finances:				
Unobligated appropriations available (millions)	$15	$37	$42.1	$47.3
Obligations incurred (millions)	$15	$37	$42.1	$47.3
Allotments or commitments made				
(*d*) Matching or additional expenditures				
(*e*) Number of Federal Government employees administering, operating, or supervising the activity (administering)	[3] 32	[3] 41	59	69
(*f*) Non-Federal Government personnel employed				
(*g*) Other measures of level or magnitude of performance:				
Counselor institute participants	1,902	1,733	1,560	1,530
Teacher institute participants	4,468	20,427	23,985	28,000

[1] Title XI undertook the duties previously assigned to title VI–B NDEA.
[2] For breakdown by type, see (*g*) Other measures.
[3] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination is effected through the Division of Educational Personnel Training of the Bureau of Elementary and Secondary Education. The Division works with the Bureau's Division of Plans and Supplementary Centers, which administers the guidance, counseling, and testing program authorized by the same act, to assure a coordinated Federal approach to the development of the Nation's school counseling program. In making grants, the Division deals directly with public and private colleges and universities.

8. Laws and regulations

Title V–B of the National Defense Education Act of 1958, enacted on September 2, 1958, as Public Law 85–864; title XI was added on October 16, 1964, by Public Law 88–665.

For amendments and text of the current act, see Compendium of Statutes, pages 163–191. The most recent amendment is section 467 of the Higher Education Act of 1965 (Public Law 89–329).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic impact of the institute program is similar to that discussed in earlier parts of this report. By upgrading the qualifications of teachers and counselors, the institutes help them to increase their potential income as well as their effectiveness in advising and teaching future members of the work force.

10. Economic classification of program expenditures. (See table 2.)

Program: Institutes for counselors and teachers.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 0.3
Grants to institutions of higher education for institutes and trainee allowances	26.0
Total, Federal expenditures	26.3
Non-Federal expenditures	----
Total expenditures for program	26.3

[1] Estimated.

EDUCATIONAL IMPROVEMENT FOR THE HANDICAPPED

(Public Law 85–926)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To improve the skills of teachers of handicapped children.

2. Operation

Grants are made by the Commissioner of Education to institutions of higher education and to State educational agencies, which in turn award fellowships, traineeships, and short-term traineeships to individuals who either are or are preparing to be, teachers, supervisors, speech correctionists, research workers, or other specialists in some aspect of the education of handicapped children.

Participating institutions of higher learning are responsible for insuring the eligibility of their award recipients. Participating State educational agencies are responsible for insuring that their award recipients and the courses they study meet the conditions of eligibility prescribed by the legislation and that the institutions offering the courses have acceptable, high-quality programs. Prospective recipients of awards apply directly to the participating institution or State educational agency.

3. History

This program was initiated by Public Law 85–926, enacted in fiscal year 1960, with a $1 million annual appropriation for the purpose of training leadership personnel in the education of the mentally retarded.

Public Law 87–276, enacted in fiscal year 1962, provided $1.5 million annually over a 3-year period for scholarships for prospective teachers of the deaf.

Title III, section 301 of Public Law 88–164 (Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) amended and expanded Public Law 85–926 to include teachers, trainers or supervisors of teachers, and other specialized personnel engaged in the education of hard of hearing, speech impaired, visually handicapped, seriously emotionally disturbed, crip-

pled, and other health impaired children, as well as mentally retarded children. At the expiration of Public Law 87–276, professional personnel engaged in the education of the deaf were included under this amendment.

The act was further amended by Public Law 89–105, dated August 4, 1965, increasing the appropriation each year to reach $37.5 million for the period ending June 30, 1969.

During the 4-year period, fiscal years 1961–65, grants to institutions of higher education and State educational agencies supported 11,262 fellowships and traineeships, approximately half of which were for persons working with the mentally retarded. In addition, 114 grants were made to strengthen institutional training programs.

4. Level of operations. (See table 1.)

Program: Educational improvement for the handicapped.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (grants) [1]	4,952	5,074	6,617	9,152
(b) Applicants or participants:				
State educational agencies	50	50	55	55
Institutions of higher education	154	193	210	225
(c) Federal finances:				
Unobligated appropriations available (millions)	$14	$14.5	$19.5	$24.5
Obligations incurred (millions)	$14	$14.5	$19.5	$24.5
Allotments or commitments made				
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)	[2] 23	[2] 37	38	38
(f) Non-Federal Government personnel employed (consultants)	43	33	34	35
(g) Other measures of level or magnitude of performance				
Grants for strengthening institutional programs	42	59	40	20
Individuals supported for full academic year	2,126	2,355	3,153	3,870
Individuals supported for summer programs	2,784	2,660	3,424	5,262

[1] For breakdown by type of grant, see (g) Other measures.
[2] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination of this program's operations is effected by the Division of Educational Personnel Training of the Bureau of Elementary and Secondary Education. In reviewing applications and making grants, the Division deals with State educational agencies and institutions of higher education.

Staff review of the program is exercised by the Office of Disadvantaged and Handicapped, which serves as a central information and contact point within OE and with other parts of DHEW for programs dealing with the education of the handicapped.

To advise the Commissioner of Education in carrying out his responsibilities, panels of consultants are convened. The consultants make

recommendations regarding the approval of applications and the distribution of funds in the various areas of the handicapped:

(*a*) Crippled and other health impaired.
(*b*) Deaf.
(*c*) Emotionally disturbed.
(*d*) Mentally retarded.
(*e*) Speech impaired and hard of hearing.
(*f*) Visually handicapped.
(*g*) Administrators of special education.

8. Laws and regulations

Enacted on September 6, 1958, as Public Law 85–926. For amendments and text of the current act, see Compendium of Statutes, pages 82–83. The most recent amendment, Public Law 89–105, was enacted on August 4, 1965.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—The personal incomes of two groups are affected by this program.

The direct beneficiaries are teachers, prospective teachers, and others involved in the education of the handicapped. Through special undergraduate and graduate training programs these individuals are able to develop highly needed professional skills and thereby qualify for higher paying positions. Over the first 7 years of this program, handicapped teacher fellowships have supported 11,349 students, and it is expected that 7,538 more will receive assistance through fiscal year 1966 moneys. Approximately $11,430,000 will be available in 1966 for this purpose.

A partial study, conducted on the 1,556 teachers of the deaf graduating from American universities between 1963 and 1965, shows that 78 percent (1,221) had received support through this program. Other evidence suggests that this percentage is typical of the handicapped field in general. Although some of the students earning graduate and undergraduate degrees in education of the handicapped might have been able to obtain comparable levels of training without this program, the support it has provided has been essential to the majority.

The ultimate beneficiaries of the program are handicapped children and youth. Increasing the number of teachers for the handicapped eventually will lead to higher incomes for the handicapped students too, as they gain the education and learn the skills requisite for higher paying jobs. Almost 10 percent of all school age children in the United States are numbered among the handicapped. Educational programs of the past left a majority of the handicapped inadequately prepared to achieve their full work potentials. Illustrative of this are the facts that almost five-sixths of the deaf adults work at ordinary manual jobs (as contrasted with 50 percent of the hearing population) and that over 50 percent of the hearing-impaired people in the United States have family incomes of less than $4,000 per year.

In recent years, there has been an awakening interest in providing the handicapped with better education. Special education enrollments in public schools increased 132 percent during the 10 years

following 1948. By 1963 there were 1,559,000 children attending special education programs in the Nation's public day schools and an additional 111,000 enrolled in public and private resident schools. With more and better teachers, this group undoubtedly will become more productive than their counterparts of the last generation.

(*b*) *Worker placement and productivity.*—It is estimated that 300,000 special education teachers would be needed to assure adequate "special student" programs this year. Of the 60,000 special teachers available, 30 to 60 percent are essentially untrained or acquiring training on a part-time basis. Because of this critical need, personnel receiving the training sponsored by this program have numerous opportunities for employment and advancement. Also, as a result of their training, they should become more productive in their work.

Investment in education for teachers of the handicapped earns an unusually high return since individuals choosing work in this field are especially devoted to their profession. Recent responses received from 415 individuals, who had received fellowships between 1959 and 1963 to become teachers of the mentally retarded, indicated that 95 percent of this group still are in education and doing work related to the handicapped. Many of these are now with universities where they are teaching others to become teachers of the handicapped.

Improving education of the handicapped can lead to direct increases in productivity by preparing additional productive workers for the labor force. Handicapped persons who have been trained for and matched to their jobs have proved themselves to be highly productive. As training programs increase in effectiveness, there will be some shifting of persons from care institutions, and possibly from specialized small "handicapped" industries, to large-scale industry, small business, and government.

(*c*) *Other phases of economic activity.*—The handicapped may either contribute to or burden the national economy. Aside from fulfilling a moral obligation, education of the handicapped represents a direct attack on unemployment and underemployment. Therefore preparation of teachers of the handicapped will indirectly reduce future welfare payments. Like most programs that provide training for the unemployed, it also creates the potential for noninflationary growth of the economy.

A final effect of the program is its minor but important role in strengthening the Nation's educational system. Not only does it help upgrade the teaching profession, but it also provides a modicum of direct financial support. Universities conducting teacher training programs in special education receive $2,000 for each senior traineeship, $2,500 for support of each graduate fellowship, and $75 per week for short-term special study institutes. This support is used to help defray university salaries and expenses. As a result of the 7,538 fellowships awarded through the program this year, operating budgets of American universities were increased by a total of $7,210,000. In addition, $840,000 was allocated to 55 State educational agencies to help them develop and administer their programs for the education of the handicapped.

10. Economic classification of program expenditures. (See table 2.)

Program: Educational improvement for the handicapped.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 0.3
Grants to institutions of higher education for program development, traineeships, and fellowships	10.7
Grants to state and local governments	3.1
Total, Federal expenditures	14.1
Non Federal expenditures	----
Total expenditures for program	14.1

[1] Estimated.

SCHOOL ASSISTANCE IN FEDERALLY AFFECTED AREAS

(Public Law 874)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To compensate school districts for burdens imposed on them by Federal activities and land ownership which result in an influx of schoolchildren whose parents live on or are employed on nontaxable Federal property.

2. Operation

Grants are made directly to eligible school districts under a formula which provides for payment of Federal dollars based on local costs per pupil. No matching is required. Applications are submitted by the local school districts to the Office of Education through the State educational agency. State agencies assist applicants in preparing applications, certify the accuracy of the data submitted, and provide information necessary for the calculations of payment rates. Data for verification of Federal property ownership and amounts of other Federal payments to be deducted from gross entitlements are obtained from the Federal agency having jurisdiction in the matter. Where no local educational agency is able to provide suitable free public education for children residing on Federal property, the Commissioner of Education is required to arrange for their education at full Federal expense by delegation of the responsibility to a local educational agency or to the Federal agency controlling the property on which the children live.

3. History

In 1949 the House Committee on Education and Labor began an investigation of the nature and extent of problems created for local communities by Federal activities. As a result of its findings, two major pieces of legislation emerged: Public Law 815 (discussed in the next section) to aid school construction in areas affected by Federal activities, and Public Law 874 to aid school operations in such areas.

Public Law 874 has been amended and extended numerous times. Most of the amendments either liberalized the basic provisions or were intended to meet specific problems. Assistance on behalf of children who live on Federal property with a parent employed on Federal property was made permanent by Public Law 85–620. The latest ex-

tension of the temporary provisions of the law by Public Law 89–10 provides authorization through fiscal year 1968. Public Law 89–313 amended the law to provide aid to schools in disaster-struck areas.

In 1951, the first year of the program's operation, 1,172 federally affected school districts were declared eligible for assistance. Over the years, the number of those eligible has gradually increased to nearly 4,100 schools, with an estimated attendance of 12.5 million pupils, now receiving Federal payments. In addition, funds are allocated to other Federal agencies to provide school services for over 45,000 children. Since the enactment of the program 15 years ago, almost $2.1 billion has been appropriated.

An extensive study of the Public Law 874 and Public Law 815 programs was authorized by the Congress in 1964. The report of the study, conducted by the Stanford Research Institute, was transmitted to the Congress in June 1965. The study[1] recommended a number of changes in the authorizing legislation to remove present inequities and to align Federal payments with actual financial burdens imposed by Federal activities in local school districts.

4. Level of operations. (See table 1.)

Program: School assistance in federally affected areas.
Department or agency, bureau or office: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimated	Fiscal year 1967 estimated
(a) Magnitude of the program (pupils affected) (millions)	1.9	2	2.15	1.5
(b) Applicants or participants: Local school districts and Federal agencies (number of grants received)	4,200	[1] 4,200	4,200	3,150
(c) Federal finances:				
Unobligated appropriations available (millions)	$320.7	$322	$347	$183.4
Obligations incurred (millions)	$301	$330.6	$347	$183.4
Allotments or commitments made				
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)	125	125	125	125
(f) Non-Federal Government personnel employed				
(g) Other measures of level or magnitude of performance				

[1] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Both this program and the school construction program discussed in the next section are administered by the Division of School Assistance in Federally Affected Areas of the Bureau of Elementary

[1] **Impacted Areas Legislation, Report and Recommendations, Print of the Committee on Labor and Public Welfare, U.S. Senate, August 1965.**

and Secondary Education. Division personnel deal with both State educational agencies and local school districts.

In addition, coordination is required with Federal agencies which operate schools for children living on Federal property (Veterans' Administration, Federal Aviation Agency, and the Departments of the Army, Navy, Air Force, and Interior).

8. Laws and regulations

Public Law 874, 81st Congress, enacted on September 30, 1950. For amendments and text of current law, see Compendium of Statutes, pages 44–53, 63–77. The most recent amendment is Public Law 89–313, enacted on November 1, 1965.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The school assistance program aids the educational efforts of the particular school districts qualifying for assistance. The general benefits of education and the effect of education on the economy have been discussed in other parts of this report. It should be pointed out here that although the 4,176 school districts eligible for aid in 1965 composed about 15 percent of the total number of school districts in the Nation, they contained 33 percent of the total public elementary and secondary school population. The $311 million of Federal aid they received amounted to 5.3 percent of their total current operating costs. In addition, 42,406 children residing on Federal property benefited from the $17 million allocated to other Federal agencies for their education.

Funds are spent under this program in every State and four territories. They are concentrated around military installations, many of which are in the coastal areas. For the distribution of funds by State, see table 2.

The report of the special study contains an economic analysis of the effect of Federal activity on the tax base and analysis of educational efforts of selected communities receiving aid through the programs discussed in this section and the next.

(NOTE.—In assessing the benefits of this program, it should be borne in mind that the purpose of the program is to compensate areas for burdens imposed on them by Federal activity, rather than to provide general aid to education. The study referred to above concluded that under the present legislation this purpose is not uniformly fulfilled in the areas receiving assistance.)

TABLE 2.—*Summary of entitlements, by State, titles I and III, Public Law 874, as amended, fiscal years 1965 and 1966*

State or territory	1965 actual	1966 estimate	State or territory	1965 actual	1966 estimate
Total	$330,561,932	$347,000,000	Nebraska	$4,138,073	$4,181,000
			Nevada	2,289,432	2,321,000
Alabama	6,886,664	7,100,000	New Hampshire	1,896,652	1,939,000
Alaska	9,610,686	10,340,000	New Jersey	7,954,215	8,467,000
Arizona	6,625,059	7,287,000	New Mexico	6,963,365	7,287,000
Arkansas	1,786,882	2,013,000	New York	8,671,825	9,092,000
California	52,579,489	53,687,000	North Carolina	7,815,275	8,253,000
Colorado	9,809,644	10,064,000	North Dakota	2,009,039	2,111,000
Connecticut	2,506,046	2,970,000	Ohio	7,649,397	7,869,500
Delaware	1,136,693	1,241,000	Oklahoma	9,156,765	9,922,000
District of Columbia	4,079,623	4,703,000	Oregon	1,420,466	1,665,500
Florida	10,688,273	11,429,000	Pennsylvania	6,973,657	7,530,000
Georgia	10,330,515	10,649,000	Rhode Island	2,539,519	3,123,000
Hawaii	6,381,530	6,940,000	South Carolina	5,402,016	5,760,500
Idaho	2,337,553	2,707,000	South Dakota	2,981,513	3,400,500
Illinois	6,224,130	6,277,000	Tennessee	3,676,936	3,839,500
Indiana	1,774,660	1,804,000	Texas	18,691,156	18,974,000
Iowa	1,323,240	1,384,000	Utah	3,808,242	4,185,000
Kansas	7,429,228	7,479,000	Vermont	57,553	69,000
Kentucky	5,127,753	6,073,000	Virginia	22,898,425	23,861,000
Louisiana	1,470,147	1,562,000	Washington	10,485,438	10,514,500
Maine	2,734,505	2,915,000	West Virginia	176,925	208,500
Maryland	13,919,837	14,326,000	Wisconsin	953,351	971,500
Massachusetts	9,507,270	9,853,000	Wyoming	1,239,189	1,423,000
Michigan	3,084,941	3,123,000	Guam	1,045,317	1,145,000
Minnesota	702,420	798,500	Puerto Rico	3,058,535	3,166,000
Mississippi	1,707,960	1,803,000	Virgin Islands	75,810	114,500
Missouri	3,794,482	3,817,000	Wake Island	144,810	173,500
Montana	2,930,806	3,088,500			

10. Economic classification of program expenditures. (See table 3.)

Program: School assistance in federally affected areas.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 3.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 1.3
Payments to other Federal agencies	[2] 16.6
Grants to State and local governments	294.8
Total Federal expenditures	312.7
Non-Federal expenditures	-----
Total expenditures for program	312.7

[1] Estimated.
[2] [Omitted from table 5 in pt. I of report.]

SCHOOL CONSTRUCTION IN FEDERALLY AFFECTED AREAS

(Public Law 815)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To aid the construction of school facilities in school districts having substantial increases in school enrollment as a result of Federal activities.

2. Operation

Grants are made directly to eligible school districts (see act) under a formula which bases the Federal payment on a portion of the cost

per pupil of constructing minimum school facilities. Applications for school construction assistance are submitted to the Office of Education through State educational agencies and contain the essential source data required for the determination of eligibility and payment. The State agency certifies that the data are correct and that the proposed project is in conformity with the overall State plans and requirements for the construction of school facilities. The State agency also provides the information required to calculate the average cost per pupil of construction of minimum school facilities in the State. Where no local educational agency is able to provide suitable free public education, the application is submitted by the appropriate Federal agency. No matching is required; however, Federal funds may be used only for the construction of "minimum" school facilities and local funds must be used for the remaining costs of a project.

3. History

In 1949, the House Committee on Education and Labor investigated problems created for school districts by Federal activities. As a result, Public Law 815 was enacted in September 1950, with an initial termination date of June 30, 1952. The act has had numerous amendments, mostly of a liberalizing nature, but the basic provisions, intent, and purpose have remained the same. Assistance on behalf of children who live on Federal property with a parent employed on Federal property was made permanent by Public Law 85–620. The latest extension of the temporary provisions of the law by Public Law 88–665 provides authorization through fiscal year 1966. Public Law 88–313 amended the law to provide aid to schools in disaster-struck areas.

Since the passage of Public Law 815 in 1950, nearly $1.2 billion has been appropriated to aid school construction in 1,900 school districts. With this sum plus State and local expenditures (approximately $715 million), a total of 58,000 classrooms and related facilities have been built for 1.8 million children.

4. Level of operations. (See table 1.)

Program: School construction in federally affected areas.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (classrooms provided)	707	3,092	2,700	1,000
(b) Applicants or participants: State educational agencies (projects filed)	331	360	368	121
(c) Federal finances:				
Unobligated appropriations available (millions)	$68.6	$105	$78.1	$37.1
Obligations incurred (millions)	$21.9	$77	$63.9	$25.1
Allotments or commitments made				
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)	31	31	31	31
(f) Non-Federal Government personnel employed				
(g) Other measures of level or magnitude of performance (pupils housed)	[1] 80,500	[1] 89,700	78,300	29,000

[1] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination of this program's operations is the same as that required under the "School Assistance" program discussed in the preceding section.

In addition, the Division of School Assistance is furnished technical engineering, legal, and construction assistance, including periodic inspections of construction progress, by the Department of Housing and Urban Development, both for schools constructed on Federal property and for schools constructed by local educational agencies. When a school is to be constructed on Federal property, the Department of Housing and Urban Development obtains an estimate of the construction costs and, after approval, hires the architect to prepare the plans and specifications, awards the contract, and supervises the construction.

8. Laws and regulations

Enacted on September 23, 1950, as Public Law 815, 81st Congress. For amendments and text of current law, see Compendium of Statutes, pages 67–80. The most recent amendment is Public Law 89–313.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

In addition to the indirect economic effects of this program (through its general contribution to education) there are direct effects on one particular sector of the economy—construction.

The more than $1.2 billion appropriated for this program since 1950 has been spread among 1,900 school districts to help build 58,000 classrooms. Compared with the total national expenditure for construction of public elementary and secondary schools during this period (approximately $40 billion), Federal aid granted under this program has accounted for approximately 3 percent. In any one of the areas receiving aid, building activity stimulated through the program might have a sizable impact on the area's economy.

The program's operations, like those of the school assistance program, are concentrated in the areas with military installations, predominantly the Western and Southern parts of the Nation. For distribution of program funds by State, see table 2.

(NOTE.—Assessment of the program's benefit should consider the intent of the program, i.e., the compensation of local school districts for burdens imposed on them by tax-exempt Federal activities The effect of the program should be to match burdens with equivalent Federal payments.)

TABLE 2.—*Summary of assistance for school construction, by State—Public Law 815, as amended, fiscal years 1965 and 1966*

State or outlying part (1)	1965 actual obligations (2)	1966 estimated entitlements (3)	State or outlying part (1)	1965 actual obligations (2)	1966 estimated entitlements (3)
Total	$77,000,030	$50,078,000	Nebraska	$794,477	$592,500
Alabama	1,030,830	789,900	Nevada	983,125	839,300
Alaska	4,046,231	987,400	New Hampshire	33,087	
Arizona	1,669,513	1,234,300	New Jersey	8,529	345,500
Arkansas	42,230	394,900	New Mexico	3,618,161	1,184,900
California	9,973,385	9,725,900	New York	1,013,785	987,400
Colorado	3,709,392	1,333,000	North Carolina	2,289,419	1,036,800
Connecticut		296,200	North Dakota	1,778,109	493,700
Delaware	715,799		Ohio	960,024	839,300
District of Columbia			Oklahoma	1,692,235	1,481,100
Florida	6,786,646	2,962,200	Oregon	123,428	197,500
Georgia	6,259,746	1,431,700	Pennsylvania	[1] −1,231	148,100
Hawaii		1,177,300	Rhode Island	663,344	98,800
Idaho	27,382	394,900	South Carolina	1,411,246	790,000
Illinois	987,746	444,300	South Dakota	439,067	493,700
Indiana	48,360	246,900	Tennessee	310,446	246,800
Iowa	9,348		Texas	2,477,461	1,721,700
Kansas	563,227	493,700	Utah	2,528,707	1,036,800
Kentucky	27,084	345,500	Vermont		
Louisiana	436,490	197,500	Virginia	10,152,380	4,295,200
Maine	602,363	197,500	Washington	260,167	1,283,600
Maryland	6,441,263	3,499,000	West Virginia		
Massachusetts	15,690	345,500	Wisconsin	184,505	197,500
Michigan	69,013	1,431,700	Wyoming	365,933	246,800
Minnesota		98,800	Guam		98,800
Mississippi		197,500	Puerto Rico	108,539	1,600,000
Missouri	141,021	493,700	Virgin Islands		
Montana	395,869	394,900	Wake Island	72,480	
			Technical services	793,979	708,000

[1] Adjustments from prior year obligations.

10. Economic classification of program expenditures. (See table 3.)

Program: School construction in federally affected areas.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 3.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 0.3
Payments to Housing and Urban Development Department	[2] 9.1
Grants to States and local governments	29.2
Total, Federal expenditures	38.6
Non-Federal expenditures	
Total expenditures for the program	38.6

[1] Estimated.
[2] [Omitted from table 5 in pt. I of report.]

NATIONAL TEACHER CORPS

(The Higher Education Act of 1965, title V–B)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To strengthen the educational opportunities available to children in areas having concentrations of low-income families, and to encourage college and universities to broaden their teacher preparation programs.

2. Operation

The Commissioner of Education is authorized to recruit experienced teachers and teacher-interns. The interns will be given 3 months' training, initially in colleges and universities, and then formed into teaching teams headed by an experienced teacher. Teaching teams and/or individual experienced teachers will be assigned to local educational agencies which request them and which are in low-income areas. The Corpsmen will perform certain teaching duties and also participate in additional training. All cost of the program and arrangements with the local agencies will be paid by the Federal Government. The Corpsmen will be under the complete control of the local school districts.

3. History

The National Teacher Corps was enacted as title V, part B of the Higher Education Act of 1965; $36,100,000 was authorized for fiscal year 1966 and $64,715,000 was authorized for fiscal year 1967. At the close of the 1st session of the 89th Congress, no funds had been appropriated.

4. Level of operations. (See table 1.)

Program: National Teacher Corps.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 estimated [2]	Fiscal year 1967 estimated [3]
(a) Magnitude of the program (teaching teams)			940	1,140
(b) Applicants or participants: Individuals (Corps teachers)			3,750	4,600
(c) Federal finances:				
Unobligated appropriations available (millions)			$13.2	$31.3
Obligations incurred (millions)			$13.2	$31.3
Allotments or commitments made (millions)				
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)			55	70
(f) Non-Federal Government personnel employed				
(g) Other measures of level or magnitude of performance				

[1] Not applicable.
[2] Based on fiscal year 1966 supplemental request for funds to cover recruitment and training of 3,750 Corps members.
[3] Fiscal year 1967 will provide salary compensation and other expenses for the 3,750 Corps teachers previously recruited and support for the recruitment and training of 850 new Corps members.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

This program will be administered to complement the program authorized by title I of the Elementary and Secondary Education Act of 1965 (see "Education of Children of Low-Income Families"). Coordination of the two programs will be effected within the Bureau of Elementary and Secondary Education.

In carrying out the program, the Bureau will deal with components of the Office of Economic Opportunity, institutions of higher education, and State and local educational agencies.

Staff review of the program will be exercised by the Office of Disadvantaged and Handicapped, which serves as a central point within OE for information and advisory services concerning educational programs designed to aid in the fight against poverty.

The act authorizing the National Teacher Corps requires the establishment of an Advisory Council on Quality Teacher Preparation. The Council will review the administration and operation of the Teacher Corps and the Fellowships for Teachers program and make recommendations for their improvement.

8. Laws and regulations

Title V–B of the Higher Education Act of 1965, enacted on November 8, 1965, as Public Law 89–329.

Regulations have not yet been issued.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The National Teacher Corps is expected to stimulate and encourage college graduates (*a*) to enter the teaching profession, and (*b*) to teach where they are particularly needed—in city slums and areas of rural poverty.

The economic effects of the Corps operations will be very similar to those of title I of the Elementary and Secondary Education Act of 1965 (see "Education of Children of Low-Income Families").

10. Economic classification of program expenditures

Not applicable. No funds have as yet been appropriated.

Fellowships for Teachers

(The Higher Education Act of 1965—Title V–C)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To improve the quality of the education of persons who are pursuing or plan to pursue a career in elementary or secondary education.

2. Operation

The Office of Education will entertain proposals from institutions of higher education interested in providing graduate Federal fellowship programs for experienced or prospective teachers. Advisers will help in selecting the programs to be funded. The act requires an equitable distribution of the fellowships throughout the States.

Prospective fellows will apply to the institutions with approved programs. In addition to the fellowship awarded to each individual, the institutions where they are studying will receive $2,500 per fellow. The act also provides for grants to colleges and universities to help develop and strengthen their teacher education programs.

3. History

This fellowship program was enacted as title V, part C of the Higher Education Act of 1965. The act provided for $40 million and 4,500 fellowships for fiscal year 1966. Actual appropriations amounted to $20 million ($5 million for improving teacher education and $15 million for fellowships). This is expected to make possible approximately 900 fellowships for experienced teachers and 1,300 for new teachers.

Meetings were held during December of 1965 with college and university officials to acquaint them with the provisions of the law and plans for the program.

4. Level of operations. (See table 1.)

Program: Fellowships for teachers.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Elementary and Secondary Education, and Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(*a*) Magnitude of the program (fellowships)			2,354	5,800
(*b*) Applicants or participants: Institutions of higher education (institutions)			100	125
(*c*) Federal finances:				
Unobligated appropriations available (millions)			$20	$42.5
Obligations incurred (millions)			$20	$42.5
Allotments or commitments made				
(*d*) Matching or additional expenditures				
(*e*) Number of Federal Government employees administering, operating, or supervising the activity (administering)			10	10
(*f*) Non-Federal Government personnel employed				
(*g*) Other measures of level or magnitude of performance (teacher education programs supported)			50	50

[1] Not applicable.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The administration of this program is divided between two bureaus. The Bureau of Elementary and Secondary Education administers fellowships for experienced teachers. The Bureau of Higher Education administers the fellowships for prospective teachers. Both Bureaus administer the grants to institutions for the improvement of their teacher education offerings. The two Bureaus work closely together to assure continuing coordination, especially during the initial stages of program development.

The Advisory Council on Quality Teacher Preparation, created by the act, will review the administration and operation of this and similar programs of teacher education and recommend to the Commissioner ways of improving their effectiveness.

Other mechanisms for coordination will be the same as those discussed in the "Graduate Fellowships" program.

8. Laws and regulations

Title V–C of the Higher Education Act of 1965, enacted on November 8, 1965, as Public Law 89–329.

No regulations have as yet been issued.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic effects of this program will be very similar to those listed in the sections dealing with "Institutes for Counselors and Teachers" and "Graduate Fellowships."

In addition, approximately 20 percent of the funding will be used to assist teachers who have been displaced as a result of school desegregation actions and who wish to upgrade their teaching skills and to continue teaching in new locations.

The main effect of the program will be to improve the quality of teaching in the elementary and secondary levels by encouraging experienced teachers to enter graduate programs and by attracting college graduates to pursue teaching careers.

10. Economic classification of program expenditures

Not applicable. The program began operation in fiscal year 1966.

III. PROGRAMS FOR HIGHER EDUCATION

Higher Education Facilities

(The Higher Education Facilities Act of 1963)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To help in constructing and improving academic facilities at colleges, technical institutes, and universities in order to meet existing needs, and to keep pace with mounting student enrollment.

2. Operation

The Higher Education Facilities Act of 1963, as amended by the Higher Education Act of 1965, is a Federal program providing grants and loans to assist eligible colleges, universities, and technical institutes in financing the construction of academic facilities needed to expand their enrollment capacity or capacity to carry out on-campus extension and continuing education programs. It offers matching grants to both public and private undergraduate institutions under title I, with special provisions for public community colleges and technical institutes (sec. 103) and for graduate schools and centers under title II. Loan funds are available under title III to assist construction of facilities by any of these types of institutions.

The Office of Education administers the undergraduate grants section of this program through designated State commissions. A State commission, in accordance with criteria prescribed by Federal statutes and regulations, assigns priorities to institutional applications for proposed projects and determines the Federal share in each case (up to 40 percent for the public community colleges and technical institutes

and up to 33⅓ percent for other institutions). Of the funds appropriated for title I, 22 percent are allotted among the States for public community colleges and technical institutes, and the remaining funds are allotted among the States for institutions other than public community colleges and technical institutes; however, a State commission may request that funds not applied for by institutions in either group by January 1 be transferred to the other group of institutions.

The section of this program authorizing grants for construction of facilities for graduate education is directly administered by the Office of Education. Awards are made on a matching basis of up to one-third of the costs to applicant institutions by the Commissioner of Education on the advice of the Advisory Committee on Graduate Education which was established under the Higher Education Facilities Act.

The loan provisions of this program are administered solely by the Office of Education. A loan plus other Federal funds used may not exceed 75 percent of the eligible development cost of a construction project. Interest on loans may not exceed 3 percent.

Through a special arrangement with the Community Facilities Administration of the Department of Housing and Urban Development, architectural-engineering services in field operations are provided by that agency.

3. History

Fiscal year 1965 saw the first funds made available under the Higher Education Facilities Act of 1963 which provided grants and loans to higher education institutions for the construction of academic facilities.

By November 1964 plans submitted by State commissions for undergraduate construction projects had been approved by the Commissioner of Education for half of the States, and by the end of March 1965 plans had been approved for all the States, the District of Columbia, and Puerto Rico. From an appropriation of $50.6 million, grants totaling $47.4 million were made to 98 public community colleges and technical institutes during fiscal year 1965. An appropriation of $179.4 million enabled 168 public 4-year institutions and 209 private institutions to receive grants totaling $177 million. These grants under title I ranged from $5,573 to $3,770,269.

During fiscal year 1965, 69 graduate institutions received grants totaling $60 million for 85 projects for the construction of graduate academic facilities under title II of the act. The 85 approved project grants will help pay for the construction of 26 libraries; 23 social science, education, and related facilities; 15 physical science and mathematics buildings; 9 buildings in engineering and environmental fields; 7 facilities in the fine arts and humanities; and 5 in the biological sciences and agriculture. Grants made under this program serve the following objectives: an increased supply of highly qualified personnel needed in higher education, industry, and Government; improvement of existing graduate schools and cooperative graduate centers; assistance to institutions for the establishment of excellent schools and centers of these types; and the attainment of a wider geographical distribution of graduate facilities.

From an appropriation of $169.3 million for loans under title III: Loans for Construction of Academic Facilities, loans totaling $107.7

million were made to 112 private and 7 public institutions. These loans ranged from $51,000 to $2,994,000.

The facilities which these Federal grants and loans will help to construct will cost an estimated total of $1.37 billion. Although much of the non-Federal funding was committed in advance of the availability of Federal funds, it is believed that these funds have stimulated approximately one-half of the total construction to which they were contributed.

4. Level of operations. (See table 1.)

Program: Higher education facilities.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (approved projects):				
Title I (undergraduate grants)		516	1,137	1,137
Title II (graduate grants)		85	85	85
Title III (loans)		133	135	250
(b) Applicants or participants (colleges and universities):				
Title I		475	1,000	1,000
Title II		69	69	69
Title III		119	122	215
(c) Federal finances:				
Unobligated appropriations available (millions)		$462.3	[2] $638.3	$722.7
Obligations incurred (millions)		$393.7	[2] $638.3	$722.7
Allotments or commitments made, title I only (millions)		$230.0	$463.6	$453.0
(d) Matching or additional expenditures (millions)		[3] $983.7	[3] $1,611.0	[3] $1,665.0
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years)		[4] 34	62	84
(f) Non-Federal Government personnel employed (persons)		[4] 40	50	50
(g) Other measures of level or magnitude of performance				

[1] No funds were appropriated for fiscal year 1964.

[2] Includes $5,600,000 unused 1965 funds which were reallotted for 1966 and $230,000,000 authorized but unappropriated for 1964 which was appropriated for 1966.

[3] Estimated matching expenditure by colleges and universities in accordance with sec. 107, 202, and 303 of the Higher Education Facilities Act of 1963.

[4] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(a) *Within the bureau, division, or office.*—The program is administered by the Bureau of Higher Education of the Office of Education; the undergraduate facilities and loan programs are directly administered by the Division of College Facilities and the graduate facilities program by the Division of Graduate Programs. There is continuing day-to-day coordination of the program between these two divisions.

The operation of the loan program under title III is coordinated with the operation of the grant programs under both titles I (undergraduate) and II (graduate) on occasions when both grant and loan funds are sought. These titles have the common objective of helping

colleges and universities accommodate the rapidly growing numbers of young people who aspire to a higher education. Although each program handles its applications separately, plans are currently being developed to place all pertinent data on punchcards, enabling the facility programs to operate more efficiently.

(*b*) *With other Federal Government departments or agencies.*—Through an agreement with OE, the Community Facilities Administration (CFA) regularly provides construction and contracting data needed in the planning of these programs. CFA also gives architectural and engineering assistance to the programs by inspecting the construction of academic facilities.

The Department of Labor has provided written information on the demand and supply of highly trained personnel needed by community, industrial, Government, research, and teaching professions. These reports are available to the staff in evaluating applications.

An Advisory Committee was established by law to advise the Commissioner on the action to be taken on each title II (graduate) application and also on policy matters for that program. Membership of other Government organizations on the Committee includes one representative from the Office of Science and Technology, Executive Office of the President, and another representative from the National Science Foundation. There is close coordination of applications with the National Science Foundation, the National Institutes of Health, and the National Aeronautics and Space Administration in cases where applications have been filed for grants for the same facility with more than one agency.

(*c*) *With State governments or their instrumentalities.*—Many applications are from State institutions. Some of these institutions are located in States having building authorities which construct the facilities. A State commission reviews proposed projects under title I and forwards them to the Commissioner for final approval.

(*d*) *With local government or communities.*—Some applications are from institutions of a municipal government.

(*e*) *With nonprofit organizations or institutions.*—All institutions awarded grants or loans under this program are private or public nonprofit institutions.

(*f*) *With others.*—In evaluating applications, the Bureau obtains the advice and assistance of non-Government, academic, professional people, who serve as consultants under temporary civil service appointments. These individual are from colleges and universities around the country and are recognized leaders in their respective academic fields.

8. Laws and regulations

The Higher Education Act of 1963, enacted on December 16, 1963, as Public Law 88–204. See Compendium of Statutes, pages 99–116 for a copy of the act.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic effects of the higher education facilities program can be examined in at least two ways: The first assesses its impact on the

total economy and the second reviews its regional or local effects. In terms of the national economy, this facilities program has the indirect effect of contributing to the gradual improvement of the educational level of the labor force and citizenry. It is generally acknowledged that educational expenditures are one of our economy's most productive long-term investments.

The effects of the Federal facilities program on the economy of a region or locality can be substantial. The degree of impact depends primarily on the size of the program relative to that of the community involved. A large construction project in a small town, particularly if the town is in a depressed area, would have substantial shortrun influence on employment, personal income, worker migration, etc. In addition, indirect effects on the community, such as increased sales and rising prices, might occur. The longrun effects of a completed educational facility would include an increase in consumers (students), a permanent increase in jobs, and an additional and positive attraction in the community. All of these consequences, however, would tend to be reduced in situations where the facilities program constituted but a small portion of the economic activities of the region involved.

While the precise effects of the graduate facilities program on the economy cannot be measured, the expansion of graduate education in the United States will unquestionably have the effect of increasing the supply of highly skilled people who can make a substantial economic contribution at a high level of income and productivity. The effect of the program on research and development will also be substantial, since the expansion of graduate education will mean an expansion of research facilities in science, engineering, and other fields in many parts of the United States, with a beneficial effect on both regional and national economies. The effect should be to stimulate the growth of existing businesses and industries and to bring about the creation of new economic enterprises.

10. Economic classification of program expenditures. (See table 2.)

Program: Higher education facilities.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 0.6
Grants to State commission to administer title I	1.3
Loans to institutions (title III)	1.7
Total, Federal expenditures	3.6
Non-Federal expenditures financed by individuals and nonprofit organizations	[2] 1.6
Total expenditures for program	5.2

[1] Estimated.
[2] Estimated matching expenditures by institutions of higher education in accordance with sec. 303 of the Higher Education Facilities Act pertaining to title III loans for construction projects.

College Work-Study

(The Economic Opportunity Act of 1964—Title I–C)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To provide financial assistance to institutions of higher education for the support of part-time employment opportunities for financially needy college students, particularly students from low-income families.

2. Operation

The Office of Education administers Federal grants to colleges and universities. These will finance up to 90 percent of student wages in work-study programs through August 1967, and 75 percent thereafter. The colleges arrange for work opportunities either on campus or in nonprofit organizations off campus.

All public and private nonprofit institutions of higher education, including junior colleges, which are accredited by a nationally recognized accrediting agency may participate in the work-study program. Other institutions may be eligible for participation under provisions of section 441 of the Higher Education Act of 1965.

A student may work under the work-study program for not more than 15 hours in any week in which classes are in session, and not more than 40 hours in any other week (summer or other vacation periods). A student may work on campus for the college in a variety of ways—as a laboratory assistant or library aid, in food service or in grounds maintenance. Off campus he may work in activities such as those supported by a community action program of the Economic Opportunity Act or in other activities in health, education, recreation, and welfare.

3. History

Title I–C of the Economic Opportunity Act of 1964, enacted on August 20, 1964, as Public Law 88–452, authorized grants to institutions of higher education to assist in the operation of work-study programs of part-time employment for students. By February 1965 the first students were employed under this program, and by the end of spring the program covered work-study projects in 674 colleges and universities. At that time grants totaled more than $12 million, and the number of students from low-income families employed in part-time jobs under the program had reached 38,015.

The program continued to expand in fiscal year 1966 with 783 institutions of higher education approved for 1965 summer programs and 1,120 approved for 1965 fall programs. An estimated 40,000 students in summer programs and more than 100,000 in fall programs benefited from college work-study programs.

In 1965 the act was amended by the Economic Opportunity Act Amendments and by the Higher Education Act. These amendments transferred the authority to administer the program from the Director of the Office of Economic Opportunity to the Commissioner of Education and established a basis for expanding the number of student and institutional participants.

4. Level of operations. (See table 1.)

Program: College work-study.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in millions]

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (thousands of students)		[2] 188	[2] 320	[2] 450
(b) Applicants or participants (colleges and universities)		[3] 1,120	[3] 1,600	[3] 1,700
(c) Federal finances:				
Unobligated appropriations available [4]		$55.7	[5] $100	$134.1
Obligations incurred [4]		$54.9	$100	$134.1
Allotments or commitments made		$55.7	$100	$134.1
(d) Matching or additional expenditures		$6.1	$11.1	$25.5
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years)		15	42	42
(f) Non-Federal Government personnel employed (persons)		[6] 1,120	[6] 1,600	[6] 1,700
Consultants		8	8	8
(g) Other measures of level or magnitude of performance (off-campus projects)		493	1,300	[7]

[1] Not applicable.
[2] Maximum number of student participants in spring, summer, and fall programs for the respective calendar year. The actual total number of students participating will be less, for many participate in programs in 2 or all of these periods during the year.
[3] Institutional participants for calendar year—Spring, summer and fall.
[4] The fiscal years 1965 and 1966 appropriation and obligation figures do not include OEO transfer funds for salaries and expenses. (Fiscal year 1965 appropriation, $242,000; obligations, $170,000. Fiscal year 1966 estimated appropriation and obligations, $666,000.)
[5] Includes unobligated appropriation carried over from fiscal year 1965; appropriation for fiscal year 1966 is $99,100,000.
[6] Estimated on basis of an average of 1 full-time college administrator at each participating college.
[7] Unknown.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(a) *Within the Bureau, Division, or Office.*—The college work-study program is administered by the Division of Student Financial Aid, Bureau of Higher Education, Office of Education. The program information and operations are closely coordinated with the national defense student loan, educational opportunity grants, and the low-interest insured student loan and interest subsidy programs which are also administered by this Division.

(b) *With other Federal Government departments or agencies.*—Staff review of the program is exercised by the Office of Disadvantaged and Handicapped, which serves as a central information and contact point within OE and with the Office of Economic Opportunity for programs dealing with the education of the disadvantaged.

(c) *With nonprofit organizations or institutions.*—The program requires direct contact with public and private nonprofit institutions of higher education. The liaison required with nonprofit off-campus organizations employing students is largely the responsibility of the participating institutions.

8. Laws and regulations

Title I–C of the Economic Opportunity Act of 1964, enacted on August 20, 1964, as Public Law 88–452. See Compendium of Statutes, pages 285–315 and 11–14, for a copy of the act and extensions. For other amendments see the Economic Opportunity Amendments of 1965 and the Higher Education Act.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—

1. Long range: The program will have its impact on both the parental income of the present and near future and the student recipients' income over the better part of a half century. Some parental income that otherwise would have been encumbered by borrowings for educational expenses will be freed for the purchase of goods and services. The effects on the personal income of students participating in work-study programs will be of a greater magnitude. The Department of Labor estimates that whereas the lifetime earnings of a male high school graduate are $272,600, those of college graduates are $452,000. Thus college students benefiting from the program have the potential to achieve much higher income levels than would be possible without the college degree.

2. Short range: The program's support of part-time employment opportunities will assure to the participating college students additional income to meet, in part, the increasing costs of higher education.

(*b*) *Worker placement or productivity.*—

1. Long range: College graduates not only increase their earning power through higher education but they move, generally, into highly skilled professional careers in which critical manpower shortages have existed for a long time. Thus the addition of new teachers, health personnel, engineers, scientists, social workers, and those in other professions not only contributes to the economy, but helps overcome manpower shortages that impede national progress.

2. Short range: Increasing the number of jobs available to students which are not available to the general public tends to draw students away from some of the jobs which they have previously held in the community; e.g., working as gas station attendants or clerking in stores. These jobs then become available to the general public.

(*c*) *Business and industrial organization and management.*—

1. Long range: Each year, with the injection of additional highly trained college graduates into the work world, business and industrial organizations and management receive the stimulation and support of talented young people whom they can train to carry on their work.

2. Short range: None immediately observable.

(*d*) *Other phases of economic activity.*—

1. Long range: See (*a*), (*b*), and (*c*) above.

2. Short range: The basic wage established in this program is $1.25 per hour. Since this is significantly higher than the wages previously paid to many college students, the total wage for student employment will probably continue to be increased. The effect cited in (*b*) above will also tend to raise the wage level.

(*e*) *Other benefits.*—Benefits to the individual and to the country's economic and social advance are indicated above. In addition, colleges and universities themselves are strengthened and enabled to expand through the enrollment of more students. Furthermore, colleges are aided in getting worthwhile work accomplished which they have had to defer for lack of funds.

(*f*) *Geographic differentials.*—None readily observable. The program is operating in all States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

10. Economic classification of program expenditures. (See table 2.)

Program: College work-study.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	[1] 0.1
Payments for wages under work-study program	[2] 22.6
Total, Federal expenditures	22.7
Non-Federal expenditures financed by individuals and nonprofit organizations	[3] 2.5
Total expenditures for program	25.2

[1] OEO transfer funds.

[2] These payments are made to institutions of higher education. In the national income accounts, they are classified as a grant to State and local governments when the payment is made to a State or local public university and as a transfer payment when payment is made to a private institution.

[3] This sum represents the estimated amount spent in matching funds in accordance with sec. 124 of the Economic Opportunity Act of 1964.

LANGUAGE DEVELOPMENT

(The National Defense Education Act—Title VI)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To provide for the establishment and operation of centers to further teaching of modern foreign languages not generally taught in this country, and to provide for studies necessary for a full understanding of the areas in which such languages are commonly used. Also, to pay stipends to individuals undergoing advanced training in such modern foreign languages, who will, upon completion of their training, be available for teaching a modern foreign language in an institution of higher education or for other service of a public nature.

2. Operation

Under section 601(a), title VI of the National Defense Education Act, Federal funds support on a matching basis (up to 50 percent) instruction in modern foreign languages and related area studies. Contracts are made with colleges and universities to provide new or expanded programs for graduate and undergraduate students at language and area centers in modern foreign languages where instruction has not been adequate or sufficiently available.

Under section 601(b), title VI of the National Defense Education Act, Federal funds provide fellowships for advanced training in neglected language and related area studies for students preparing for college teaching, Government service, or other service of a public nature. Fellowships are awarded for the study of those languages which the Commissioner of Education has determined to be needed by individuals in the Federal Government, business and industry, and education in the United States. More than 100 languages have been so designated as critical and needed. The list includes all official national languages and languages of major regional and cultural significance, except French, German, Italian, and peninsular Spanish, which currently are widely taught in the United States.

3. History

The concept of language and area studies developed rapidly in the period after World War II. By the middle of the 1950's, there was a small but significant number of these programs on American campuses. Both their importance and the need for immediate strengthening of foreign studies were recognized by the Congress in its enactment of title VI of the National Defense Education Act.

The act provided for the support of comprehensive programs of instruction dealing with world regions in close integration with the study of the modern languages spoken in each region. As of June 30, 1965, Federal support has provided for the establishment of 98 of these National Defense Education Act language and area centers located at colleges and universities throughout the country. Instruction in nearly 100 modern foreign languages is offered by these centers. However, support has been limited, so far, to centers which concern only the so-called non-Western areas of the world (regions other than Western Europe).

The modern foreign language fellowship portion of this program is designed to help meet the critical national need for individuals equipped with knowledge and skills in modern foreign languages and related studies. Graduate fellowships constitute the major part of this program. Between 1959 and 1963 only graduate fellowships were awarded. However, since 1963 awards have also been made to undergraduates for intensive summer study, after a year of introductory study in the language; and since 1962 a limited number of postdoctoral fellowships have been awarded to faculty members of liberal arts colleges to prepare them to participate in undergraduate programs of non-Western studies. From 1959 to 1965 inclusive, 6,288 awards have been made: 5,505 for graduate fellowships, 681 for undergraduate stipends, and 102 for postdoctoral fellowships. In academic year 1965–66, 1,727 awardees will receive training at 67 institutions in 64 critical languages and related area studies.

4. Level of operations. (See table 1.)

Program: Language development.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 [1] estimate	Fiscal year 1967 [1] estimate
(a) Magnitude of the program:				
Centers	55	98	98	106
Fellowships (individuals)	1,074	1,727	1,915	2,175
(b) Applicants or participants				
Centers participants (colleges and universities)	34	61	61	69
Fellowships (applicants for study grants)	3,519	3,834	4,000	4,250
(c) Federal finances:				
Unobligated appropriations available (millions)	$6.2	$10.4	$11.2	$12.7
Obligations incurred (millions)	$6.2	$10.4	$11.2	$12.7
Allotments or commitments made				
(d) Matching or additional expenditures:				
Centers (millions)	[2] $2.6	[2] $4.9	[2] $5.1	[2] $5.8
Fellowships				
(e) Number of Federal Government employees administering, operating, or supervising the activity:				
Centers (man-years)	[3] 5	[3] 7	[3] 8	[3] 8
Fellowships (man-years)	[3] 8	[3] 10	[3] 10	[3] 10
(f) Non-Federal Government personnel employed:				
Centers faculty (persons)	[4] 715	[4] 1,260	[4] 1,310	[4] 1,464
Centers consultants (persons)	4	4	5	6
Fellowships consultants [5] (persons)	30	30	25	25
(g) Other measures of level or magnitude of performance:				
Centers (enrollments [6])	40,000	49,000	54,000	([7])
Summer programs (approved programs)	22	19	24	25

[1] Forward financing.
[2] With the required 50 percent university matching contribution, these are minimum figures; since many universities provide more than 50 percent (some more than 80 percent) the total size of the investment is substantially higher.
[3] Plus administrative support.
[4] Full and part time.
[5] Paid to attend 3-day evaluation meetings.
[6] Enrollments in all courses at centers. (These figures do not represent the actual number of students since each student may be enrolled in several courses.)
[7] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) *Within the bureau, division, or office.*—The language development program is administered by the Division of Foreign Studies, Bureau of Higher Education, Office of Education. There is continuing informal coordination of activities of this program with related sections of the Division of Foreign Studies, such as the Overseas Projects Section. The Overseas Projects Section administers the graduate fellowship program and the faculty fellowship program under section 102(b)(6) of the Fulbright-Hays Act (Public Law 87-256). Purposes, policies, operational procedures and financing methods are communicated by various internal organizational arrangements such as distribution lists, reading files, meetings, etc.

(*b*) *With other units of the department or agency.*—There is informal coordination and cooperation existing with the Bureau of Elementary and Secondary Education on language institutes and the Bureau of Research, Division of Higher Education Research, on related research and study projects. The Contracts Branch of the Contracts and Construction Service and the Office of Administration are involved with the financial and fiscal management of the awards.

(*c*) *With other Federal Government departments or agencies.*—Coordination and cooperation is actively sought and informal liaison estab-

lished with the following Federal Government agencies: Department of State, Agency for International Development, Peace Corps, National Science Foundation, National Institutes of Health.

(*d*) *With State governments or their instrumentalities.*—The program administrators respond to inquiries concerning this program which are received from various State education departments, which wish to consider possible implications of the program related to such items as program planning and evaluation, design of language programs, and its relevance to teacher training.

(*e*) *With nonprofit organizations or institutions.*—The institutions with which the Office of Education negotiates operational plans and administers contracts for the establishment of language and area centers, and for which language fellowship programs are approved, are public or private nonprofit institutions of higher education.

(*f*) *With others.*—

(1) An advisory committee for the national defense language development program, composed of eminent representatives from various professions, was established under the NDEA to advise on policy matters arising in the administration of the program.

(2) The various professional organizations and foundations maintain an active interest in this program and informal liaison has been achieved.

8. Laws and regulations

Title VI of the National Defense Education Act of 1958, enacted on September 2, 1958, as Public Law 85–864. See Compendium of Statutes, pages 181–182 for a copy of the title, as amended.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—Recipients of language fellowships and participants in language and area center programs have higher potential personal incomes than would be the case without this advanced and specialized training. This is true in government, business, and teaching; for not only does the person become a more valuable employee or teacher, but there is an expanding market for persons competent in these languages.

(*b*) *Worker placement and productivity.*—This program has a substantial effect on the job placement of its participants, for while the market for persons trained in languages is widely expanding, the supply is scarce. Trained personnel usually have a wider variety of positions open to them, and, due to their training, are highly qualified and productive workers.

(*c*) *Business or industrial organization and management.*—The effect on business is indicated by the fact that during the past year or two business has been taking an increasing and more active interest in persons with this kind of training. The long-term effects of the program on the development of American international trade are important and will provide the stimulus for new business enterprises or expansion of old ones.

(*d*) *Geographical differentials.*—Not every State and not even every area or region of the country has a center, but because of student mobility, particularly at the graduate level, every area of the country

is served, though certainly not adequately. Fellowships are available nationally without differentiation by region.

(*e*) *Gross national product.*—It cannot be identified.

10. Economic classification of program expenditures. (See table 2.)

Program: Language development.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	0.4
Grants to institutions	2.3
Fellowships	3.8
Total, Federal expenditures	6.5
Non-Federal expenditures financed by:	
Individuals and nonprofit organizations	[1] 2.3
Total expenditures for program	8.8

[1] Estimated. With the required 50 percent university matching contribution, these are minimum figures; since many universities provide more than 50 percent (some more than 80 percent), the total size of the investment is substantially higher.

GRADUATE FELLOWSHIPS

(The National Defense Education Act—Title IV)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To provide fellowships for graduate students planning to teach in institutions of higher education, and to assist in strengthening graduate education.

2. Operation

The Commissioner allots NDEA title IV fellowships to approved programs in graduate institutions. The university selects the fellows who are paid stipends and dependency allowances by the Federal Government for up to 3 years of study leading to the Ph. D. degree. The stipends are for $2,000 the first year, $2,200 the second, and $2,400 the third, with an additional annual payment of $400 for each dependent. The university is given a grant of $2,500 each academic year for each student who is pursuing a course at that universtity with a NDEA graduate fellowship.

3. History

The graduate fellowship program was established as a part of the 1958 National Defense Education Act. It was designed to help meet the growing need for college and university teachers caused by increasing enrollments.

The act as passed in 1958 allowed for 1,500 fellowships per year. It was amended in October 1964 to permit more vigorous Federal action by doubling the number of fellowships to 3,000 for fiscal year 1965, doubling it again in fiscal year 1966, for a total of 6,000, and increasing it to 7,500 in fiscal years 1967 and 1968. The 1964 amendments also allow the Commissioner to award some of the fellowships to existing programs which are neither new or expanded. This modification permits support of departments having the capacity to enroll additional students with existing staff and facilities.

Under the NDEA graduate fellowship program the Federal Government has helped to prepare a significant number of qualified teachers to meet increasing enrollments in higher institutions by awarding fellowships for study in 177 colleges and universities to 11,500 graduate students from 1958 through 1965. Approximately half of the total expenditures of $179.4 million during this period has gone to the fellows for stipends and dependency allowances; the remainder to the participating graduate schools to help cover the cost of the program.

4. Level of operations. (See table 1.)

Program: Graduate fellowships.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (fellows)	[1] 4,255	[1] 5,883	[1] 10,494	[1] 15,000
(b) Applicants or participants (universities)	161	167	171	175
(c) Federal finances:				
Unobligated appropriations available (thousands)	$21,200	$31,740	$55,961	$81,957
Obligations incurred (thousands)	$21,197	$31,359	$55,961	$81,957
Allotments or commitments made				
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years)	9	18	24	35
(f) Non-Federal Government personnel employed,[2] consultants and advisory committee members (persons)	48	84	84	84
(g) Other measures of level or magnitude of performance:				
Approved graduate fellowship programs	694	905	2,100	2,400
Fellows receiving stipends for summer programs		2,350	5,400	9,445

[1] Academic year fellowships 1964–65; 1965–66; 1966–67; 1967–68, respectively.

[2] Personnel at the universities where NDEA fellows are pursuing their studies spend some time administering this program. It is impossible to estimate how many man-years are involved here.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(a) *Within the bureau, division, or office.*—The graduate fellowship program is administered by the Division of Graduate Programs, Bureau of Higher Education, Office of Education. Within the Division and Bureau, information coordination is part of the day-to-day operations. It is planned to coordinate this program with the graduate facilities program—which is also administered by the Division of Graduate Programs—by joint meetings of the advisory committees for the programs to discuss mutual problems in the evaluation of proposals for strengthening graduate academic programs and for building graduate facilities.

(b) *With other Federal Government departments or agencies.*—Federal fellowship program administrators meet on an informal basis approximately twice a year to discuss mutual problems.

(c) *With nonprofit organizations or institutions.*—NDEA graduate fellowships are allotted to doctoral programs in private or public nonprofit institutions of higher education.

(*d*) *With others.*—An advisory committee on the NDEA graduate fellowship program was established under the act to advise on policy matters related to the administration of the program and to consider the program in the context of total Federal involvement in the support of graduate education.

8. Laws and regulations

Title IV of the National Defense Education Act of 1958 enacted on September 2, 1958, as Public Law 85–864. For amendments and text of the current act, see Compendium of Statutes, pages 163–191.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—A recipient of an NDEA graduate fellowship by obtaining a doctoral degree, has a higher potential personal income than would be the case without the degree. This is true in both industry and teaching. If, however, a person leaves a position in industry to obtain a doctoral degree and pursues a career in college teaching, his income level may be below that which he would achieve through a career in business or industry.

(*b*) *Worker placement and productivity.*—The Ph. D. earned by NDEA fellows provides them with the "union card" necessary for entrance into the field of college or university teaching. The doctoral degree is often required for promotion or appointment to positions above the rank of instructor.

(*c*) *Business or industrial organization and management.*—This program, by increasing the number of persons holding doctoral degrees, eases the manpower shortage of persons with advanced degrees. Although NDEA fellowships are awarded to those planning a career in college teaching, the easement of the manpower shortage in college teaching will have the same effect on industry by freeing greater numbers of persons with advanced degrees for service in industry and business.

(*d*) *Geographic differentials.*—Title IV of the NDEA particularly specified that graduate programs for which NDEA fellowships are awarded must substantially further the objectives of increasing the facilities throughout the Nation for the graduate training of college or university level teachers and of promoting a wider geographical distribution of such facilitities throughout the Nation. For study during fiscal year 1967, for example, fellowships have been allocated to 171 institutions in 49 States and the District of Columbia.

There are already many fellowship programs, public and private, which permit the student to go to the institution of his choice. These have resulted in a high concentration of fellowship holders in relatively few institutions. The NDEA graduate fellowship program has strengthened and helped to insure graduate training in areas of the country where help is badly needed and contributed to a better geographical balance in providing graduate education.

(*e*) *Gross national product.*—Education is one of the deepest roots of economic growth. Through its direct effect on the quality and adaptability of the working population and through its indirect effects on the advance of science and knowledge, education is the ultimate source of much of our increased productivity. Improvement in the quality of education now available and expansion of the capacity of an

educational system that increasingly feels the pinch of demands it is not equipped to meet are major aims of the graduate fellowship program. The Federal Government, through such programs, helps to insure a more adequate flow of resources into education; insures greater opportunities for graduate students; helps to advance the quality of education at the undergraduate and graduate level; and will thus add immeasurably to the economic growth of our Nation.

10. Economic classification of program expenditures. (See table 2.)

Program: Graduate fellowships.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 0.1
Payments to institutions	[2] 20.7
Total, Federal expenditures	20.8
Non-Federal expenditures	
Total expenditures for program	20.8

[1] Estimated wages and salaries.
[2] Payments to institutions to be disbursed to NDEA fellows and payments to institutions to pay the cost of administering the program.

NOTE.—In national income terminology the payments to private nonprofit institutions are classified as a transfer payment. Those payments which are made to public institutions are classified as grants.

NATIONAL DEFENSE STUDENT LOANS

(The National Defense Education Act—Title II)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To enable higher education institutions to provide low-interest loans to college students.

2. Operation

The Federal Government contributes up to 90 percent of the total amount for the establishment of national defense student loan funds at American institutions of higher learning.

All public and private nonprofit institutions of higher education, including junior colleges, which are accredited by a nationally recognized accrediting agency may participate in the national defense student loan program. Other institutions may be eligible for participation under provisions of section 461 of the Higher Education Act of 1965.

Undergraduate and graduate students attending school full time or half time, who need money to go to college, may borrow from student loan funds. Loan amounts during an academic year are limited to $1,000 for undergraduate and $2,500 for graduate students. Total loans for individual students are limited to $5,000 for undergraduate study and $10,000 for undergraduate and graduate work combined.

Repayment to the lending institution extends over a 10-year period beginning 9 months after the borrower ceases full- or half-time study. Interest at 3 percent starts to accrue at the beginning of the repayment period. For borrowers who become teachers, a "teacher forgiveness"

cancellation was established at the rate of 10 percent (plus interest) for each year of teaching, up to a maximum of 50 percent. Borrowers teaching in an elementary or secondary school in a district eligible for assistance pursuant to title II of Public Law 81–874 may receive cancellation at the rate of 15 percent (plus interest) for each year up to a maximum of an additional 50 percent.

3. History

At the time of the enactment of the National Defense Education Act in 1958, the Nation faced a critical shortage of manpower in the fields of education, science, mathematics, engineering, and modern foreign languages. At the same time, talented high school graduates with high potential in these and other fields were not going on to college, many because they could not afford the rising cost of higher education. The national defense student loan program was designed to assist qualified financially needy students to pursue higher education in certain fields, and to provide more professionally trained people to meet the Nation's requirements. The act has been amended subsequently to provide loans to needy students in all fields of study, without the original special preferences.

Since the program became operational 7 years ago, more than 890,000 students attending 1,700 colleges and universities in all 50 States have borrowed approximately $800 million. The average annual loan during the first full year of the program was $438. In 1965 the average loan was $522. In fiscal year 1965, over 319,000 loans were made totaling some $166.6 million. Since the beginning of the program, $14.2 million has been canceled under the "forgiveness" features for borrowers who become teachers.

4. Level of operations. (See table 1.)

Program: National defense student loans.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate [1]
(a) Magnitude of the program (thousands of student borrowers)	247	319	400	
(b) Applicants or participants (colleges and universities)	1,574	1,616	1,704	
(c) Federal finances:				
Unobligated appropriations available (millions)	$121.2	$145	$179.3	
Obligations incurred (millions)	$108.4	$130.4	$179.3	
Allotments or commitments made (millions)	$108.4	$130.4	$179.3	
(d) Matching or additional expenditures (millions)	$12	$14.4	$19.9	
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years)	[2] 26	[2] 34	[2] 37	
(f) Non-Federal Government personnel employed (man-years)	[3] 1,574	[3] 1,616	[3] 1,704	
(g) Other measures of level or magnitude or performance:				
Canceled loans for teachers [4] (persons)	[4] 62,807	[4] 95,000	[4] 150,000	
Obligations for:				
Loans to educational institutions	$898,975	$1,088,711	$1,600,000	
Cancellation of student loans	$263,781	$516,398	$650,000	

[1] Not available at this time.
[2] Does not include persons serving in the field.
[3] Estimated on the basis of 1 person per participating institution.
[4] These are estimated cumulative figures showing the number of partial loan cancellations for borrowers who have become teachers.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) *Within the bureau, division or office.*—Administration of the NDEA student loan program, within the Division of Student Financial Aid, Bureau of Higher Education, Office of Education, is conducted in close cooperation with the college work-study program, the educational opportunity grant program, and the low-interest insured loan and interest subsidy program. This cooperation is also maintained at the level of the nine regional representatives of the Bureau of Higher Education.

(*b*) *With other units of the department or agency.*—Within the Department of Health, Education, and Welfare, the program officers are in frequent contact with the Public Health Service, concerning problems arising in connection with the operation of the health professions student loan and the nursing student loan programs, both administered by that agency.

(*c*) *With nonprofit organizations or institutions.*—Not only does the program operate through participating public or private nonprofit institutions of higher education to which the act delegated the major administrative responsibilities, but representatives of the higher education community frequently serve the program in an advisory capacity as consultants and panel members.

8. Laws and regulations

Title II of the National Defense Education Act, enacted on September 2, 1958, as Public Law 85–864. See Compendium of Statutes, pages 167–172, for reprint of the title and some amendments. Also see the Higher Education Act, for recent amendments.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Effects on personal income.*—The Department of Labor estimates that the lifetime earnings of a male college graduate are $452,000, and those of a high school graduate $272,600. Thus NDEA loans help persons, who would not otherwise be able to obtain a higher education, increase their potential earning capacity.

(*b*) *Effects on placement or productivity of workers.*—College graduates not only increase their earning power through higher education, but they move, generally, into highly skilled professional careers in which critical manpower shortages have existed for a long time. Thus, the addition of new teachers, health personnel, engineers, scientists, social workers and those in other professions not only contributes to the economy, but helps overcome manpower shortages that impede national progress.

(*c*) *Effects on business or industrial organization and management.*—Each year, with the injection of additional highly trained college graduates into the work world, business and industrial organization and management receive the stimulation and support of talented young people they can train to carry on their work.

(*d*) *Other benefits.*—In addition to the above benefits to the individual and to our country's economic and social advance, colleges and universities themselves are strengthened and enabled to expand through the enrollment of more students. To the business community surrounding the college benefits also flow from this growth—to its hotels, service industries, transportation and recreational facilities.

(*e*) *Pertinent geographic differentials.*—The national defense student loan program is in operation in every State and territory in the United States. Thus its impact is nationwide but difficult to measure geographically because of the mobility of most people.

10. Economic classification of program expenditures. (See table 2.)

Program: National defense student loans.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services: Wages and salaries	[1] 0.6
Cancellation of student loans	4.6
Contributions to student loan funds	129.8
Loans to institutions	1.1
Total, Federal expenditures	136.1
Non-Federal expenditures financed by:	
Individuals and nonprofit organizations	[2] 14.4
Total expenditures for program	150.5

[1] Estimated.
[2] Based on ⅓ matching funds provisions (NDEA, sec. 204).

LOW-INTEREST INSURED LOAN AND INTEREST SUBSIDY PROGRAM

(The Higher Education Act of 1965—Title IV–B—and the National Vocational Student Loan Insurance Act of 1965)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To aid the States and nonprofit private organizations in the establishment of adequate low-interest loan insurance programs for students attending higher education institutions or postsecondary technical and vocational schools with special assistance for students from families having an adjusted annual income of less than $15,000.

2. Operation

The program operates through State or private nonprofit guarantee agencies with the use of moneys for loan purposes supplied by commercial lending institutions. The Federal Government provides funds to pay a portion of the interest charges on postsecondary vocational and college student loans made under this program. Federal funds are also provided as advances to State and nonprofit private guarantee agencies to establish or strengthen such loan programs. The legislation provides for Federal guarantee of such loans in the event that all demands are not met by the other agencies within a State.

3. History

This program was authorized by the Higher Education Act of 1965 (title IV, pt B) and the National Vocational Student Loan Insurance Act of 1965. Congress appropriated $10 million for fiscal year 1966, the first year of the program, for the use of the higher education portion of the program only. It is anticipated that the vocational education part of the program will be funded also, and that both parts will be in operation by September 1966.

4. Level of operations. (See table 1.)

Program: Low-interest insured loan and interest subsidy program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 [2] estimate	Fiscal year 1967 estimate
(a) Magnitude of the program: Students receiving loans			315,000	830,000
(b) Applicants or participants:				
Student loan recipients for whom interest payments are made			315,000	830,000
State and other guarantee agencies (agencies)			20	55
(c) Federal finances:				
Unobligated appropriations available (millions)			$11	$48
Obligations incurred (millions)			$11	$48
Allotments or commitments made (millions)			$8	$11
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (persons)			35	46
(f) Non-Federal Government personnel employed:				
Members of advisory councils			16	16
(g) Other measures of level or magnitude of performance:				
Loans insured by Federal Government			6,000	11,000
Commercial lending institutions			[3]	[3]

[1] Not applicable.
[2] 1966 is the 1st year for which funds were authorized for this program.
[3] This is expected to be a measure of magnitude, but the data are not yet available since the program is not in operation at this time.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation.

(a) *Within the bureau, division or office.*—The program is administered by the Division of Student Financial Aid, Bureau of Higher Education, Office of Education. There is constant, day-to-day coordination of information and activities with the national defense student loan, college work-study, and educational opportunity grants programs, also administered by the Division. In addition, coordination also takes place within the Office of Administration.

(b) *With other units of the department or agency.*—The program requires coordination with the Public Health Service (DHEW) which administers the Health Professions Educational Assistance Act of 1963.

(c) *With State governments or their instrumentalities.*—The program requires direct contact and coordination with State governments,

which have or will operate a State guarantee loan program, and with any private nonprofit loan guarantee agency.

(*d*) *With nonprofit organizations or institutions.*—The students who will benefit from the program are attending either public or private nonprofit institutions of higher education or postsecondary vocational/technical schools. Information on the program will be channeled through these institutions.

(*e*) *With business enterprises.*—The program requires direct contact with the banking and credit community.

(*f*) *With others.*—Advisory councils for the program will be established in accordance with the Higher Education Act of 1965 and the National Vocational Student Loan Insurance Act of 1965. (See also (*c*).)

8. Laws and regulations

Title IV-B of the Higher Education Act of 1965 enacted on November 8, 1965, as Public Law 89–329, and The National Vocational Student Loan Insurance Act of 1965, enacted on October 22, 1965, as Public Law 89–287.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—In making long-term credit available, the low-interest insured loan and interest subsidy program lowers an economic barrier to higher and postsecondary vocational/technical education for all youth who have the ability and desire to pursue such education. In so doing, the program will have its impact on both the parental finances of the present and near future and the student recipients' income over the better part of a half century. Parental income that otherwise would have been encumbered by borrowings for educational expenses will be freed for the purchase of goods and services. The effects on the personal income of students receiving loans will be of a greater magnitude. The Department of Labor estimates that whereas the lifetime earnings of a male high school graduate are $272,600, those of a college graduate are $452,000. Thus, college students benefiting from the program have the potential to achieve much higher income levels than would be possible without the college degree. Those trained in vocational schools obtain similar economic benefits. Skilled vocational technicians as a rule receive higher wages than unskilled workers and generally benefit from more regular employment.

(*b*) *Placement and productivity.*—College graduates and vocationally trained persons not only increase their earning power through advanced education, but also become more productive and valuable employees. They move generally, into highly skilled professional and semiprofessional technical careers in which critical manpower shortages exist. The addition of this education and vocationally trained manpower not only contributes to the economy, but helps overcome manpower shortages which impede national progress.

(*c*) *Business and industrial organization and management.*—With the addition of greater numbers of educated and trained persons, business and industrial organizations receive the stimulation and support of talented young people whom they can train to carry on their work.

(*d*) *Other phases of economic activity.*—This program will have a generally beneficial economic effect due to the greater number of

well-educated citizens promoting a higher standard of living. An outlay of a comparatively small amount of money by the Federal Government will make a very large amount of commercial credit available. The expenditure of $21 million, for example, would pay 3 percent per annum of the interest on $700 million of commercial loans. The program utilizes commercial credit from the private sector rather than the public sector.

(*e*) *Other benefits.*—In addition to the benefits outlined above, institutions of higher education and of postsecondary vocational/technical education will be strengthened and enabled to expand through the enrollment of more students. Moreover, the business community within the immediate environs of these institutions will benefit from the increase in the purchase of goods and services by these additional students.

(*f*) *Geographic differentials.*—None readily observable.

(*g*) *Gross national product.*—See (*a*) and (*d*) insofar as this can be ascertained.

10. Economic classification of program expenditures

Not applicable. This program was not in operation in fiscal year 1965.

Educational Opportunity Grants

(The Higher Education Act of 1965—Title IV–A)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To provide, through institutions of higher education, educational opportunity grants to assist in making available the benefits of higher education to qualified high school graduates of exceptional financial need, who for lack of financial means of their own or of their families would be unable to attend college without such aid, and to provide funds to identify these potential grant recipients and to encourage them to pursue a higher education.

2. Operation

The Federal Government contributes 100 percent of the total amount for the awarding of educational opportunity grants by colleges and universities. The program operates on the basis of an agreement executed between the Commissioner of Education and the college or university concerned. Technical and program assistance is provided by the regional offices as well as the headquarters staff in Washington.

All public and nonprofit institutions of higher education, including junior colleges, which are accredited by a nationally recognized accrediting agency or association may participate in the educational opportunity grant program. Other institutions may be eligible for participation under special procedures established under the Higher Education Act of 1965.

Qualified high school graduates of exceptional financial need who show evidence of academic or creative promise and who either have been accepted for enrollment as full-time students at grant recipient institutions of higher education or are in good standing and in full-time attendance at such institutions are eligible to receive educational opportunity grants. These grants range in amounts from $200

to $800 for each academic year of undergraduate study for a maximum of 4 years, the amount of each stipend being governed by the parental contribution, the cost of the college education, and the amount of additional student financial aid being received. An additional award of $200 may be given to those students who ranked in the upper half of their college class during the preceding academic year.

The Commissioner of Education may also enter into contracts with State and local educational agencies and other public and nonprofit organizations and institutions for the purpose of:

(*a*) Identifying qualified youths of exceptional financial need and encouraging them to complete their schooling,

(*b*) Publicizing existing forms of student financial aid, and

(*c*) Encouraging secondary school and college dropouts of demonstrated aptitude to reenter educational programs.

3. History

This is a new program authorized under title IV–A of the Higher Education Act of 1965. Congress has appropriated $60 million for fiscal 1966, the first year of the program. By the beginning of the academic year 1966–67, it is estimated that there will be 115,000 grant recipients in over 1,600 institutions of higher learning in the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

4. Level of operations. (See table 1.)

Program: Educational opportunity grants.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 [2] estimate	Fiscal year 1967 estimate
(*a*) Magnitude of the program (students)			115,000	220,000
(*b*) Applicants or participants (colleges and universities)			1,600	1,600
(*c*) Federal finances:				
Unobligated appropriations available (millions)			$60	$122
Obligations incurred (millions)			$60	$122
Allotments or commitments made (millions)			$58	$119.5
(*d*) Matching or additional expenditures				
(*e*) Number of Federal Government employees administering, operating, or supervising the activity			30	32
(*f*) Non-Federal Government personnel employed			[3] 1,600	[3] 1,600
(*g*) Other measures of level or magnitude of performance: Funds to identify educational talent (millions)			[4] $2	[4] $2.5

[1] Not applicable.
[2] 1966 is the 1st year for which funds were authorized for this program.
[3] Estimated on the basis of 1 full-time administrator at each college.
[4] Included in the appropriations and obligations totals noted in (*c*) above.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) *Within the bureau, division, or office.*—This program is administered by the Division of Student Financial Aid, Bureau of

Higher Education, Office of Education. It is tightly tied to the national defense student loan program under sections 402(1) and 407(b) of the Higher Education Act of 1965 pertaining to student financial aid "packaging" and the transfer of grant funds to be included as part of the Federal capital contribution in the NDEA program. Moreover, there will be many instances in which grant recipients will be given employment under the college work-study program in order to meet their full financial needs. All of this activity requires extremely careful coordination within the Division of Student Financial Aid.

(*b*) *With other units of the department or agency.*—Financial coordination takes place within the Office of Administration. In addition, the Office of Disadvantaged and Handicapped is concerned with OE and OEO programs dealing with the education of the disadvantaged and handicapped.

(*c*) *With other Federal Government departments or agencies.*—This program is coordinated with the Office of Economic Opportunity's "upward bound" project. In part, this coordination consists of alerting institutions to make provisions in their grant requests for the inclusion of needy students enrolled in or to be enrolled in "upward bound" programs.

(*d*) *With State and local agencies.*—There is coordination and direct contact with State and local educational agencies under section 408 of the Higher Education Act of 1965 which authorizes the Commissioner of Education to enter into contracts, not to exceed $100,000 per year, with State and local educational agencies and other public or nonprofit organizations and institutions for the purpose of encouraging full utilization of this program of opportunity grants.

(*e*) *With local governments or communities.*—See (*d*), above.

(*f*) *With nonprofit organizations or institutions.*—The program requires direct contact with public and private nonprofit institutions of higher education, for it will operate on the basis of agreements executed between the Commissioner of Education and these institutions.

8. Laws and regulations

Title IV–A of the Higher Education Act of 1965, enacted on November 8, 1965, as Public Law 89–329.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Personal income.*—The program will have its impact on the student recipients' income over the better part of a half century due to the higher potential incomes of college graduates contrasted with those of high school graduates. The Department of Labor estimates that whereas the lifetime earnings of a male high school graduate are $272,600, those of a college graduate are $452,000.

(*b*) *Worker placement and productivity.*—College graduates not only increase their earning power through higher education but they move, generally, into highly-skilled professional careers in which critical manpower shortages have existed for a long time. Thus the addition of new teachers, health personnel, engineers, scientists, social workers, and those in other professions not only contributes to the economy, but helps overcome manpower shortages that impede national progress.

(*c*) *Business and industrial organization and management.*—Each year, with the injection of additional highly trained college graduates into the work world, business and industrial organization and management receive the stimulation and support of talented young people they can train to carry on their work.

(*d*) *Other phases of economic activity.*—See (*a*), (*b*), and (*c*) insofar as this can be ascertained.

(*e*) *Other benefits.*—In addition to the above benefits to the individual and to our country's economic and social advance, colleges and universities themselves are strengthened and enabled to expand through the enrollment of more students. Moreover, the business community within the immediate environs of these institutions benefits from the increase in the purchase of goods and services by these additional students.

(*f*) *Geographic differentials.*—None readily observable. The program will be operating in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

(*g*) *Gross national product.*—See (*a*) preceding.

10. Economic classification of program expenditures

Not applicable. This program was not in operation in fiscal year 1965.

Strengthening Developing Institutions

(The Higher Education Act of 1965—Title III)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist in raising the academic quality of developing institutions by supporting cooperative arrangements between colleges for strengthening their programs and by awarding fellowships to encourage highly qualified graduate students and junior faculty members at major colleges and universities to teach at developing institutions.

2. Operation

Under title III of the 1965 Higher Education Act, colleges and universities can apply directly to the Commissioner of Education for grants to pay part of the cost of cooperative arrangements with other institutions or with other agencies for strengthening their academic programs or their administration (faculty exchange, joint use of facilities, new curriculums, etc.). They may also apply to the Commissioner for grants for the support of teaching fellowships. The Commissioner and his Advisory Council on Developing Institutions will establish procedures and policies for determining priorities and for administering the program. In the case of teaching fellowships, the maximum stipend is set at $6,500 plus an additional $400 for each dependent.

3. History

This is a new program authorized by title III of the Higher Education Act of 1965, signed into law on November 8, 1965, as Public Law 89–329. Congress has appropriated $5 million for fiscal year 1966, the first year of the program.

4. Level of operations. (See table 1.)

Program: Strengthening developing institutions.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 [2] estimate	Fiscal year 1967 estimate
(a) Magnitude of the program:				
Cooperative programs (approved applications)			[3] 110	[3] 660
National teaching fellowships (fellows)			30	180
(b) Applicants or participants: Institutions (colleges and universities)			[4] 220	[4] 1,320
(c) Federal finances:				
Unobligated appropriations available (millions)			$5	$30
Obligations incurred (millions)			$5	$30
Allotments or commitments made				
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (persons)			15	21
(f) Non-Federal Government personnel employed: Advisory Council on Developing Institutions (members)			8	8
(g) Other measures of level or magnitude of performance:				
Approved institutional relationships [5] (programs)			45	270
Approved faculty programs [6]			65	390

[1] Not applicable.
[2] Fiscal 1966 is the 1st year for which funds were authorized for this program.
[3] See (g) below for type of program.
[4] Minimum figure assuming only 2 institutions per each cooperative project.
[5] This includes cooperating relationships, consortia relationships, ad hoc relationships, and intra-institutional relationships.
[6] This includes visiting scholar programs, graduate fellowship education, faculty exchange, research and training internships, and administrator training programs and institutes, but not the national teaching fellowships.

5. Estimated classification of program expenditures

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) *Within the bureau, division, or office.*—The program will be administered by the Division of College Support of the Bureau of Higher Education, Office of Education. There will be continuing informal coordination of information and activities of this program with related programs in the Bureau.

(*b*) *With other units of the department or agency.*—The fellowship portions of the program will be coordinated with other USOE fellowship programs in DHEW.

(*c*) *With nonprofit organizations or institutions.*—All institutions awarded grants under this program are private or public nonprofit institutions of higher education. There will be continuing cooperation with higher education institutions and organizations having similar programs.

(*d*) *With others.*—An Advisory Council on Developing Institutions was established in accordance with the provisions of the Higher Education Act (title III). The membership includes one representative of each Federal agency having responsibilities with respect to developing institutions, together with eight other members appointed by the Commissioner of Education. It will advise the Commissioner with respect to policy matters arising in the administration of this program.

8. Laws and regulations

Title III of the Higher Education Act of 1965, enacted on November 8, 1965, as Public Law 89–329.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Prior to implementation of title III, assessment of the likely economic effects of the program must necessarily be limited to subjective appraisal. Even when operational data become available, objective evaluation of program results will be limited because of their inherent complexity, interrelation, lack of measurability, and long-term nature.

The economic consequences of the developing colleges program can be considered in three categories: (1) benefits to the economy as a whole because of the greater number of well-educated citizens promoting a higher standard of living; (2) benefits to communities because of the presence of stronger educational enterprises; and (3) possible benefits to society as a result of changes in the occupational mix of graduates from developing institutions aided by the program.

It is recognized that well-educated people make positive contributions to society. Helping small isolated colleges raise their standards of education constitutes an important step in increasing the supply of quality graduates to meet the demand. Educational expenditures for smaller and inferior colleges may be expected to provide the initial stimulus for expanded and continuing growth.

Raising the academic quality of a college is likely to have a positive effect on a community's economy. Certainly the vitalization of an isolated institution struggling for survival should increase and upgrade job opportunities, alter consumption patterns, add to gross expenditures, and in general increase commercial attractiveness. The developing colleges program may in certain instances serve as a catalyst for long-term regional improvement.

Helping developing institutions loosen curricular and other restraints imposed by academic isolation will allow students to enroll in disciplines previously denied. The occupational mix of graduates will then be altered by the increased span of course offerings and no doubt will improve in favor of those academic fields in greatest demand.

10. Economic classification of program expenditures

Not applicable. This program was not in operation in fiscal year 1965.

Improving Undergraduate Instruction

(The Higher Education Act of 1965—Title VI)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To improve the quality of undergraduate classroom instruction in selected subject areas by providing grants for the acquisition of equipment and minor remodeling and by supporting short-term workshops and institutes for those persons engaged in the use of educational media equipment or preparing to be specialists or librarians for educational media.

2. Operation

Funds are provided on a matching basis to higher education institutions for the purchase of laboratory and other instructional equipment and materials and closed circuit television equipment. A State

commission (whose State plan must be approved by the Commissioner of Education) receives applications, determines priorities, and establishes the Federal share—up to 50 percent or, in hardship cases, up to 80 percent. The State commission forwards applications to the Commissioner for final approval. Funds for approved projects are paid directly to the institution.

The Commissioner is authorized to arrange with institutions, through grants or contracts, for the conduct of workshops and institutes for persons using or planning to use educational media materials. Regulations and procedures with regard to workshops and institutes will be issued by the Office of Education.

3. History

This new program was authorized by title VI of the Higher Education Act of 1965, signed into law on November 8, 1965, as Public Law, 89–329. Congress has appropriated $15 million for fiscal year 1966, the first year of the program, for equipment grants. No money has been appropriated for workshops and institutes.

4. Level of operations. (See table 1.)

Program: Improving undergraduate instruction.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Higher Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 [2] estimate	Fiscal year 1967 estimate
(a) Magnitude of the program:				
Approved proposals for:				
Equipment projects			314	314
TV projects			40	30–40
Institutes and workshops			0	35
(b) Applicants or participants (colleges and universities)			300	315
(c) Federal finances:				
Unobligated appropriations available (millions)			$15	$17.0
Obligations incurred (millions)			$15	$17.0
Allotments or commitments made (millions)			$15	$14.5
(d) Matching or additional expenditures (millions)			[3] $15	[3] $14.5
(e) Number of Federal Government employees administering, operating, or supervising the activity (persons)			9	18
(f) Non-Federal Government personnel employed				
(g) Other measures of level or magnitude of performance: Institutes and workshops (attendees)			0	990

[1] Not applicable.
[2] Fiscal year 1966 is the 1st year for which funds were authorized for this program; there was no appropriation for pt. B of title VI (workshops and institutes) for fiscal year 1966.
[3] Based on a Federal contribution of 50 percent of project costs, although in some cases the Federal share may be 80 percent (sec. 604(b)).

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(a) *Within the bureau, division, or office.*—This program will be administered by the Divisions of College Support and College Facilities, Bureau of Higher Education, Office of Education. There will be continuing informal coordination of the information and activities of

this program between these divisions and with related programs in the divisions and Bureau.

(*b*) *With other units of the department or agency.*—There will be informal coordination between this program and the equipment program of the National Institutes of Health (HEW).

(*c*) *With State governments or their instrumentalities.*—The equipment part of this program is administered through State commissions, which may or may not be those which administer title I (facilities grants) of the Higher Education Facilities Act of 1963.

(*d*) *With nonprofit organizations or institutions.*—Institutions to be awarded grants under this program are public or private nonprofit institutions of higher education.

(*e*) *With business enterprises.*—There will undoubtedly be cooperation between the State commissions and the educational equipment industry.

8. Laws and regulations

Title VI of the Higher Education Act of 1965, enacted November 8, 1965, as Public Law 89–329.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

It is estimated that the 2,208 institutions of higher education in the country spent roughly $0.4 billion for equipment in fiscal year 1964–65. If one-fourth of these purchases were for laboratory, special instructional, and audiovisual equipment, then the colleges and universities spent approximately $100 million in 1964–65 for title VI type equipment. For fiscal year 1965–66, $15 million was appropriated for title VI, and it can be assumed that this will prompt even larger total expenditures.

In addition to the more general benefits derived from aiding higher education, expenditures under title VI will have the unique influence of enlarging the educational equipment market and stimulating the industry concerned.

10. Economic classification of program expenditures

Not applicable. This program was not in operation in fiscal year 1965.

College Library Assistance and Related Programs

(The Higher Education Act of 1965—Title II)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist and encourage institutions of higher education in the acquisition of books, periodicals, documents, magnetic tapes, phonograph records, audiovisual materials, and other related materials for library purposes; to assist institutions of higher education in training persons in librarianship; to support research and demonstration projects relating to the improvement of libraries or the improvement of training in librarianship; and to assist the Library of Congress in acquiring and making available library materials published throughout the world which are of value to scholarship.

2. Operation

The different purposes of this title are carried out as follows:

(*a*) Acquisition of library materials: Grants to institutions of higher education and combinations of such institutions. Three types of grants are authorized:

(1) Basic grants of not to exceed $5,000 for each institution and each branch of such institution located in a different community. These grants are on a 50–50 matching basis.

(2) Supplemental grants of not to exceed $10 for each full-time student (or equivalent) enrolled in the institution. No matching is required for these grants.

(3) Special purpose grants to institutions of higher education or combinations of such institutions. These grants are on a 75 percent (Federal)–25 percent (institution) matching basis.

(*b*) Training in librarianship: Grants to institutions of higher education. No matching is required.

(*c*) Research and demonstration projects: Grants to or contracts with institutions of higher education and other public or private agencies, institutions, and organizations, except that grants may be made only to nonprofit agencies, organizations, or institutions. No matching is required for these grants or contracts.

(*d*) Transfer of funds to the Library of Congress for the acquisition of materials and for making such materials available.

3. History

This program was authorized by title II of the Higher Education Act of 1965, but no funds have been appropriated for it. Informational meetings have been held throughout the country to discuss all parts of the act.

4. Level of operations. (See table 1.)

No funds have been appropriated for title II. The following table reflects funds being requested for fiscal year 1966 and fiscal year 1967.

Program: College library assistance and related programs.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67* [1]

Measure and unit	Fiscal year 1964 [2]	Fiscal year 1965 [2]	Fiscal year 1966 estimate [3]	Fiscal year 1967 estimate
(*a*) Magnitude of the program:				
Traineeships			241	800
Library grants			2,000	1,758
(*b*) Applicants or participants: Institutions of higher education (grant applications)			2,500	4,700
(*c*) Federal finances:				
Unobligated appropriations available (millions)			$11	$28.7
Obligations incurred (millions)			$11	$28.7
Allotments or commitments made				
(*d*) Matching or additional expenditures [4] (millions)			$10	$8.1
(*e*) Number of Federal Government employees administering, operating, or supervising the activity (man-years)			5	13.3
(*f*) Non-Federal Government personnel employed [5]				
(*g*) Other measures of level or magnitude of performance:				
Short-term training institutes supported			3	10
Regular session training programs supported			4	20

[1] Excludes funds transferred to the Library of Congress and funds for research and demonstration projects.
[2] Not applicable.
[3] Based on fiscal year 1966 supplemental request.
[4] Matching expenditures required only for basic and special purpose grants.
[5] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) *Within the Office of Education.*—Coordination of the program's operations will be effected by the Division of Library Services and Educational Facilities of the Bureau of Adult and Vocational Education. The Division also administers the library services and construction program discussed in another part of the report. The research and demonstration grants will be administered by the Bureau of Educational Research. (See "Educational Research" for coordination arrangements pertaining to research and demonstration.)

It is expected that aspects of the new program will be coordinated within the Office of Education with the units administering programs for higher education, school library books, and teacher training.

(*b*) *With other Federal agencies.*—Coordination and cooperation with the Library of Congress will be carried out in connection with the functions to be performed by that agency.

(*c*) *With other groups.*—Coordination and cooperation will be carried out with institutions of higher education, combinations of such institutions, public and private agencies, institutions, and organizations participating in the various grant and contract programs. Institutions of higher education and combinations of such institutions are required to share in the financing of certain activities as indicated in item two, above.

The act directs the Commissioner of Education to appoint an Advisory Council on College Library Resources which will recommend criteria for the making of supplemental and special purpose grants.

8. Laws and regulations

Title II of the Higher Education Act of 1965, enacted on November 8, 1965, as Public Law 89-329.

Regulations have not yet been issued.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The program is not expected to have any direct effect on the economy. Assistance to education, training, and research should contribute indirectly to economic improvement.

10. Economic classification of program expenditures

Not applicable. The program was not in operation in fiscal year 1965.

IV. PROGRAMS FOR ADULT AND VOCATIONAL EDUCATION

Vocational Education

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To develop and improve vocational education.

2. Operation

All programs pertaining to vocational education are administered by the Division of Vocational and Technical Education in the Bureau of Adult and Vocational Education.

A field staff has been assigned to the nine regional field offices of the Department of Health, Education, and Welfare. The field representatives serve as direct representatives of the Office of Education in providing assistance to States in all program functions and responsibilities created by the various vocational education acts.

Grants are made to the States, largely on a matching basis; according to the allotment formula stipulated by the legislation. The actual implementation and operation of vocational education programs is the responsibility of the State boards for vocational education and local boards of education.

3. History

The Federal, State, and local programs of vocational education were first implemented with the passage of the Smith-Hughes Act, Public Law 64–347 (February 23, 1917). This act emphasized the need for occupational training in the broad fields of agriculture, trades and industry, and for home economics education. The act provides an annual appropriation of $7.1 million.

Subsequent changes and new acts include:

1936: George-Dean Act, Public Law 74–673 (June 8, 1936) provides for training in agriculture, trades and industry, home economics, distributive occupations, and vocational guidance. This act provides an annual appropriation of $12 million. This act was amended by Public Law 79–586.

1946: "Vocational Education Act of 1946" (George-Barden Act), Public Law 79–586 (August 1, 1946) provides for increasing the authorization for training in agriculture, trades and industry, home economics, distributive occupations, and vocational guidance; authorizes preemployment classes for less than 9 months per year and 30 hours per week for persons over 18 years of age who have left a full-time school; and authorizes an annual appropriation of $28.5 million.

1956: Public Law 84–1027 (August 8, 1956) adds the fishery trades and industries to the vocational categories in the Vocational Education Act of 1946 (George-Barden Act). Authorizes an annual appropriation of $375,000 for vocational education in these trades and industries and in the distributive occupations.

1956: The Health Amendments Act of 1956, Public Law 84–911 (August 2, 1956) amends the George-Barden Act by adding title II, which specifies practical nurse training for inclusion under the act. Authorizes $5 million a year. The title was originally for 5 years, but in 1961 it was extended to June 30, 1965, and now has been made permanent.

1958: The National Defense Education Act, title VIII, Public Law 85–864 (September 2, 1958) amends the George-Barden Act by adding title III which authorizes $15 million a year to train highly skilled technicians. The title was originally for 4 years, but it was subsequently extended to June 30, 1964, and now has been made permanent.

1961: The Panel of Consultants on Vocational Education was named by the Secretary of the Department of Health, Education, and

Welfare at the request of President Kennedy to study the Nation's needs in the fields of vocational and technical education. The Panel spent several months collecting and studying the problems and needs of occupational training and in November 1962 submitted a report which included specific recommendations.

1963: Largely as a result of the Panel's recommendations, on December 18, 1963, the Congress passed the Vocational Education Act of 1963, Public Law 88–210. Funds to carry out the act's provisions were first appropriated in September 1964.

The Act gives authority for two separate appropriations. First, it authorizes a permanent program (in addition to the permanent programs authorized in the Smith-Hughes and George-Barden Acts); secondly, it authorizes funds for two 4-year programs.

Permanent programs of vocational education were established for—

(*a*) Persons attending high school.

(*b*) Persons who have completed or left high school but are free to study full time in preparing for a job.

(*c*) Persons who have already entered the labor market but need training or retraining, either to hold their jobs or to get ahead, but who are not already receiving training allowances under the Manpower Development and Training Act of 1962, the Area Redevelopment Act, or the Trade Expansion Act of 1962.

(*d*) Persons who have handicaps—academic, socioeconomic, or other—which prevent them from succeeding in the regular vocational education program.

In addition, funds were authorized for the construction of area vocational education school facilities and for ancillary services and activities to assure quality in all vocational education programs.

Four-year authorizations were made for (*a*) work-study programs for vocational education students and (*b*) residential vocational education schools.

Although programs under this act could not be implemented until State plans were developed and approved subsequent to the passage of the appropriations act, evidence from States indicates substantial changes in program direction and in the planning and construction of essential area vocational education facilities. Moreover, there has been a dramatically increased interest in providing vocational and technical education for all persons of all ages in all communities.

4. Level of operations. (See table 1.)

Program: Vocational education.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 1.—*Level of operations or performance, fiscal year 1966–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimated	Fiscal year 1967 estimated
(a) Magnitude of the program: Trainees (thousands)	4,566.4	5,263.2	5,789.5	5,800
(b) Applicants or participants: State boards of vocational education (State boards)	54	54	54	54
(c) Federal finances:				
Unobligated appropriations available [1] (millions)	$56.9	$176.6	$249.9	$238.4
Obligations incurred (millions)	$56.8	$168.2	$249.9	$238.4
Allotments or commitments made (millions)	$56.9	[2] $168.6	[3] $241.9	[3] $226.9
(d) Matching or additional expenditures (millions)	$277.8	$630.8	$737	$740
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)	83	85	85	95
(f) Non-Federal Government personnel employed [4]	86,675	118,744	167,679	163,355
(g) Other measures of level or magnitude of performance				

[1] Includes permanent appropriation of $7,100,000 under Smith-Hughes Act.
[2] $8,000,000 appropriated under the Appalachian Regional Development Act of 1965 not allotted by State formula.
[3] $8,000,000 for Appalachian Regional Development Act and $3,500,000 for residential vocational schools not allotted by State formula.
[4] Includes State and local supervisory staff and teachers.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination is effected through the Division of Vocational and Technical Education of the Bureau of Adult and Vocational Education. The Division administers all of OE's occupational training programs, including those authorized by the Manpower Development and Training Act and the Area Redevelopment Act, so that their operations are coordinated.

In carrying out these programs, the Division deals with State boards of vocational education, colleges, universities, and other public and nonprofit agencies and institutions.

Various units of the Public Health Service provide advice to the Division and local communities pertaining to subprofessional training in the health occupations included in the vocational education program.

To advise the Commissioner on matters pertaining to vocational and technical education the Advisory Committee on Vocational Education has been established. The Committee consists of 12 members drawn from the fields of education, labor, management, and the general public as well as representatives from the U.S. Departments of Labor, Commerce, and Agriculture.

In addition, a review council to be appointed by the Secretary of Health, Education, and Welfare will evaluate the vocational education programs in 1966 and periodically thereafter.

8. Laws and regulations

See Compendium of Statutes, pages 209 to 254, for legislation pertaining to vocational education. See also answer to question 3.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The productive skills and the creativity of the American people have been major factors in the great economic achievements of the United States. The ability to produce has been closely allied with the system of education. Preparation of individuals for occupational competency through vocational education can materially assist the national economy in this period of technological, economic, and social change. However, education for employment has not always been equally available to many young people and adults.

The Vocational Education Act of 1963 provides new directions and a broad philosophy of vocational education. Its goal is to furnish readily accessible vocational training or retraining which meets "the needs of persons of all ages in all communities of the State" and "which is realistic in the light of actual or anticipated opportunities for gainful employment."

With the implementation of the Vocational Education Act of 1963, the programs of vocational and technical education have shown considerable increase in the number of persons served, and the varieties and quality of offerings. Considerable emphasis has been placed not only in vocational programs for persons attending high school, but also for persons who have completed or left high school and who are available for full-time study in preparation for entering the labor market; persons who have entered the labor market and who need training or retraining; and persons who have academic, socio-economic, or other handicaps.

Of the 190,957 graduates from the secondary vocational education programs in fiscal year 1964, estimated figures indicate that 109,911 were directly employed in a trade for which they had been trained, 21,230 were employed in a field related to their training, and 59,816 continued their education. Of the 61,699 graduates from the post-secondary vocational education programs, estimated figures indicate that 43,736 were directly employed in a trade for which they had been trained, 14,008 were employed in a field related to their training, and 3,955 continued their education. The total expenditures for this education were $332,785,114—$55,026,874 Federal funds and $277,758,240 State and local funds. The training offered at the secondary level is designed on the basis of known facts—facts concerning employment opportunities, types and numbers of persons needing vocational and technical education, what employers desire in the way of preemployment preparation of the workers they hire, and the opportunities employers seek for their workers who may need updating and upgrading training; consequently, there is a high percentage of placement. The average annual income of the persons who completed their programs is $4,078; the total estimated earnings of these graduates in their first year of entry into the labor market are $553,460,596.

To serve all the people in our communities better, there has been a nationwide increase in the construction of area vocational schools. In fiscal year 1965, 125 area vocational schools were built or remodeled at a total cost of $55,117,893. These buildings have had an impact on the economic aspects of the construction trades and the manufac-

turing units whose research and technology are utilized in these school buildings. The educational facilities upon completion are fully equipped with initial equipment to meet the requirements for which the programs have been designed. There has developed between the educators and the equipment manufacturers a joint research endeavor to design and develop equipment comparable to industrial units in all aspects. This research and the purchase of equipment have also been major economic factors throughout the country. To staff these area vocational schools, many teacher training institutions have increased their staffs and in many instances revised their curriculum offerings to aid in overcoming the need for trained vocational instructors. Both these additions and the completely new educational facilities require many new instructors and supporting staffs.

Instructors are demonstrating their ability to develop curriculum offerings in sufficient depth and scope to train and retrain individuals to meet the employment needs of business and industry. As these cooperative endeavors among educators, workers, and industry develop, they have their effect on the stability of employment, which in time will affect wages, costs, production, and sales. These, in turn, will have a bearing on the rate of growth of the gross national product.

10. Economic classification of program expenditures. (See table 2.)

Program: Vocational education.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 1.3
Grants to State and local governments	143.0
Total Federal expenditures	144.3
Non-Federal expenditures financed by State and local governments	630.9
Total expenditures for program	775.2

[1] Estimated wages and salaries.

MANPOWER DEVELOPMENT AND TRAINING*

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To upgrade the occupational and basic skills of unemployed and underemployed youth and adults.

2. Operation

The Nation's manpower development and training program is administered jointly by the Department of Labor and the Department of Health, Education, and Welfare. Responsibility of the two departments in administering this legislation is summarized by the following five-stage process: (1) Survey of skills required; (2) referral of persons for training; (3) planning and development of the training

*The data included in this section pertain to the institutional training program authorized by the Manpower Development and Training Act and administered by the Department of Health, Education, and Welfare.

NOTE.—This program is also included in the Labor Department report on the manpower development and training program.

program; (4) conduct of the training program; and (5) placement and followup of those persons who have completed training. Steps 1, 2, and 5 are within the jurisdiction of the Department of Labor; steps 3 and 4 are responsibilities of the Department of Health, Education, and Welfare.

Institutional training, which represents the bulk of the training activity, is the responsibility of the Secretary of Health, Education, and Welfare. This training is administered by the Department's Office of Education, through agreements with the State vocational education agency. The State agency, under the guidance of the Department of Health, Education, and Welfare, arranges for appropriate training to be given in either public or private training facilities.

Within the Division of Vocational and Technical Education of the U.S. Office of Education, a special staff has been assigned to develop procedures and to carry out program operations. This staff provides assistance to State vocational education agencies in curriculum design, training program development, production of teaching materials, and related educational activities. A field staff has been organized, with regional representatives in the nine field offices of the Department. These persons function as direct representatives of the Office of Education in training project review sessions and in implementing policy and regulations. They provide professional guidance and assistance in the manpower training program to State vocational training agencies and other types of training agencies. The initiative for starting manpower training projects usually comes from the community—either from the employment office, schools, or civic groups. Manpower advisory committees made up of leaders from school organizations, community groups, industry, and management and labor also aid in planning. The determination of occupations for which training is needed and in which job opportunities are available is made by a local office of the State employment service, in cooperation with employers and trade unions in the area.

As training proceeds, school officials submit reports on the attendance and performance of each trainee to the local or State employment security office. These reports comprise the basis for payment to eligible trainees of a weekly training allowance provided under the act. At completion of training, the local employment office provides services to place the graduates, thus completing a series of cooperative efforts at many governmental levels and involving many agencies, both public and private.

2. History

Prompted by the knowledge that advances in technology are displacing more and more workers every year and that the number of the consistently unemployed in the Nation is not, in an affluent society, to be tolerated, on March 15, 1962, Public Law 87–415, the Manpower Development and Training Act, was enacted. In August 1962, funds became available to implement the provisions of the act and program operations began. Two months later the first amendment to the basic legislation was enacted, Public Law 87–729, October 1, 1962. This amendment dealt with unemployment benefits under the Railroad Unemployment Insurance Act paid to persons receiving training allowances while in manpower training. By the end of 1962, 430 training projects accommodating 16,157 trainees were approved. These

projects were located in 192 different communities in 49 States. Of those authorized for training, at year's end 6,315 persons had commenced training. The program showed promise of becoming an increasingly effective weapon in the Nation's war on poverty and unemployment.

The Department's role in the manpower training program broadened in 1963, to cover 2,455 new training projects. In that year the program was extended to the District of Columbia, Puerto Rico, and the Virgin Islands. People were being trained in more than 500 different occupational titles. In 1963, in addition to institutional training programs which comprise the bulk of manpower training activity, a second type of project was initiated—workers were to be given on-the-job training at employers' establishments. A third type of project was also started that year, experimental and demonstration in nature. This latter program is aimed at developing new techniques in the occupational training of disadvantaged groups and in their selection, counseling, and referral to training.

After a year of training operations, some deficiencies were noted in the original legislation which the Congress subsequently corrected by enacting Public Law 88–214, the second amending action to the Manpower Development and Training Act of 1962. Certain amendments reflected the fact that two groups, the illiterate and semi-literate and the out-of-school/out-of-work youths 16–18 years of age, comprise together one-quarter of the unemployed. The amendment provided for the Secretary of Labor to refer for the attainment of basic education skills those eligible persons who without such training would be unable to pursue occupational training. It also authorized a special program for the testing, counseling, selection, and referral of youths 16 years of age or older, for occupational training and further schooling. In addition, the amended act authorized the extension of the manpower program to July 1966.

In 1964, there were ongoing manpower programs in all of the 50 States, plus Puerto Rico, Guam, the Virgin Islands, and the District of Columbia. Institutional training projects were approved for 114,665 trainees, denoting steady growth of the program from the 1962 figure of 16,157 trainees approved.

On April 26, 1965, President Johnson signed Public Law 89–15, The Manpower Act of 1965. This amending action to the original 1962 act extended the scope of the program to permit refresher or reorientation courses for unemployed or underemployed professional persons. The payment of training allowances was extended from a 72-week-maximum to 104 weeks in recognition that persons with little education require more time in training to become employed and that some of the new highly technical occupational fields require more extensive training. It also extended the Federal Government's share of retraining costs to the 100-percent level until July 1, 1965, instead of requiring one-third matching by States, as originally envisioned. The amended act also repealed section 16 of the Area Redevelopment Act and placed training activities under the Manpower Act. No State matching will be required for training in redevelopment areas.

By the end of fiscal year 1965, a total of 331,420 trainees were approved, approaching the goal of providing assistance for 400,000 persons in the first 3 years of the program. Some 5,755 institutional

training projects were approved and training was being conducted in 400 different occupational fields.

4. Level of operations. (See table 1.)

Program: Manpower development and training.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (trainees approved)	114,665	157,149	175,000	125,000
(b) Applicants or participants: State boards of vocational education	54	54	54	54
(c) Federal finances:[1]				
Unobligated appropriations available (millions)	$82.5	$131	$132.8	$96.9
Obligations incurred (millions)	$82.4	$130.1	$132.8	$96.9
Allotments or commitments made				
(d) Matching or additional expenditures[2] (millions)				$10.5
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)	93	128	156	154
(f) Non-Federal Government personnel employed[3]	460	575	620	500
(g) Other measures of level or magnitude of performance				

[1] Includes funds for program administration.
[2] 10 percent matching expenditure required of States beginning fiscal year 1967.
[3] Includes State and local personnel involved in the occupational training in redevelopment areas program.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Basic responsibilitity for the Manpower Development and Training Act and similar legislation is assigned jointly to the U.S. Department of Labor and the Department of Health, Education, and Welfare.

Operating responsibility for the DHEW part of the program is assigned to the Division of Vocational and Technical Education of the Bureau of Adult and Vocational Education, within which the operations of the MDTA program are coordinated with other training programs—adult basic education, vocational education, and, previously, occupational training in redevelopment areas.

In developing institutional training programs on the local level the division, through HEW regional representatives, works with State vocational education agencies, State employment bureaus, private and public educational and training institutions, labor unions, and business organizations.

A DHEW-Labor coordinating committee helps coordinate the activities of the two departments in the discharge of their responsibilities under the MDTA. Regional representatives of the two departments work together in reviewing training proposals submitted by State agencies.

Cooperative arrangements have also been established with the Departments of Commerce, Interior, and Agriculture, the Office of Economic Opportunity, and the Small Business Administration to develop training programs in areas of their special interest and authority.

There are also various manpower advisory committees on the local, State, regional and national level with whom DHEW field representatives and the Division of Vocational and Technical Education cooperate to assure an effective institutional training program.

8. Laws and regulations

The Manpower Development and Training Act enacted on March 15, 1962, as Public Law 87–415. For amendments and text of current act, see Compendium of Statutes, pages 144–159.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The Manpower Development and Training Act has not and cannot of itself solve our problem of unemployment, with its accompanying social ills. It is, however, a vital part of a cluster of Federal legislation which seeks to attack the problem of some 4 million unemployed citizens in a society of abundance.

By the end of fiscal year 1965, an estimated 122,000 individuals had completed training and were graduated from institutional programs under the Manpower Act.[1] Since the inception of the program the placement record for those completing training has been around 72 percent. Of the group immediately employed, more than 90 percent were placed in jobs directly related to the training they had received.[2]

What might be the impact on the economy of this number of individuals who entered the economic stream of the country? One study conducted by the Department of Health, Education, and Welfare suggests that the cost of manpower training is really an investment with accruing benefits.[3] A sample of 12,696 persons was drawn from those who had received occupational training since the start of the manpower program. At the time of enrollment all of these people were unemployed—they were an economic liability. Analysis of the sample indicated that:

(*a*) In 1 year of employment the average trainee can be expected to earn $4,180, or $3,135 more than it cost to train him.

(*b*) An investment of $13.3 million in training is expected to result in gross earnings of over $148 million in 5 years.

(*c*) Every dollar spent in training the group should return $2.24 a year in gross earnings to the Nation's economy.

This study does suggest that the manpower program is paying for itself; however, its validity depends on the assumptions made, especially that all trainees will remain employed throughout their work lives.

The average MDTA trainee earns more money after training than he did prior to enrolling. A nationwide evaluation conducted late in 1964 involved a national sample of 1,000 trainees who completed institutional training during the year.[4] A comparison of pretraining and posttraining earnings showed increased average earnings for 40 percent of the sample. Another 26 percent started work after training below their average wage levels before they became unemployed.

[1] "Manpower Development and Training Program: Status of Institutional Training." Sept. 1962–July 1, 1965. USDL, BES. July 16, 1965.
[2] "Education and Training: The Bridge Between Man and His Work." Apr. 1, 1965.
[3] "The Economics of Training the Unemployed." Leroy A. Cornelsen. School Life, Oct. 1964.
[4] "Manpower Research and Training Under the MDTA of 1962." Mar. 1965.

The remaining 34 percent returned to gainful employment at about the same income level attained earlier. Median pretraining earnings for all trainees, institutional and OJT, were $67 per week, compared with $73 after training. Median earnings of male institutional trainees, when the survey was made, were $13 per week higher than for women. Significantly, nearly half of the trainees surveyed had already received a promotion and/or wage increase. For the most part, they credited their MDTA training for their advancement.

The institutional training program not only provides unemployed and underemployed workers with usable work skills, but in the process helps them to climb the rungs of the occupational ladder.[5] Before entrance into training, only 2 percent of the trainees performed work of a professional, semiprofessional, technical, or managerial nature. Yet 10 percent of all MDTA trainees are being trained in some occupation in that broad grouping. This trend of upward mobility applies to both men and women.

There are ongoing manpower programs in all 50 States and in Puerto Rico, Guam, the Virgin Islands, and the District of Columbia. Ten States account for more than 50 percent of all approved trainees: California, New York, Illinois, Pennsylvania, Michigan, Ohio, Massachusetts, Connecticut, Missouri, and Kentucky. With the exception of the last two, these are heavily industrial States. In view of wide geographical dispersion of the programs and the large number of trainees, both the number of projects and the number of trainees will conform roughly to the population and industrial distribution of the Nation.[6]

In September 1965, the Department of Health, Education, and Welfare analyzed trainee data tabulated on the basis of the urban or rural classification of the county of residence.[7] Using the Census definition (i.e., if 50 percent or more of the population of the county reside in towns of 2,500 or over, the county is classified as urban) it was ascertained that 78.7 percent of the trainees reported in fiscal year 1965 were classified as urban residents, with 21.3 percent from rural areas. The analysis further revealed that there is a greater concentration of training in the skilled and semiskilled occupations for persons from rural areas, while among persons from urban areas over three times as many are being trained in unskilled occupations as in skilled and semiskilled occupations. Nonwhite trainees from rural areas are less well represented in the subprofessional, clerical, and sales training courses than nonwhites from urban areas.

In evaluating the impact of a program, a different perspective can be afforded by supposing what might happen if that effort were non existent. A recent study has underscored the necessity of making an increased effort to provide training programs for American workers. It stresses that approximately 20 million persons, of the more than 52 million studied, are high school dropouts without any formal training. It estimates that if the present pace of education and training continues, the Nation can anticipate having 32 million adult, non-high-school graduates in the labor force in 1975.[8] These figures (projections) seem more critical in the light of an economy that is

[5] Ibid.
[6] "Education and Training: The Bridge Between Man and His Work." Apr. 1, 1965.
[7] Staff paper. New MDTA Data. Sept. 7, 1965, Mrs. Jean Williams.
[8] "Formal Occupational Training of Adult Workers." USDL, 1965.

reflecting technological change at a rapid rate. The 1965 Amendments to the Manpower Act acknowledged this trend and made provisions for extending training benefits to a younger age group.

It has been stated that the absence of a manpower policy can affect the economy in many ways: Possible jobs may not become actual ones, the burden of social and welfare costs will increase, and the malaise that will set in for those condemned to deprivation will permeate society with adverse economic and political tensions.[9] Statistics can be assiduously gathered detailing increased unemployment and welfare costs, but it is impossible to quantify the human misery of those denied, for whatever reason, the means of earning a living.

10. Economic classification of program expenditures. (See table 2.)

Program: Manpower development and training.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	[1] 1.1
Other	[2] 89.1
Total, Federal expenditures	90.2

[1] Estimated.
[2] Includes some funds to private organizations for training programs.

NOTE.—In the national income accounts payments to State and local educational and vocational institutions under the manpower development and training program are classified as a purchase of goods and services. Training allowances made to trainees are considered a transfer payment to individuals. Payments to State offices for administration are classified as grant.

OCCUPATIONAL TRAINING IN REDEVELOPMENT AREAS*

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To provide job opportunities in those areas which have experienced substantial unemployment over a considerable period of time and which have been designated as redevelopment areas by the Secretary of Commerce.

2. Operation

Administration of the Area Redevelopment Act rests with the Department of Commerce. However, specific responsibilities are assigned to the Departments of Labor; Health, Education, and Welfare; Agriculture; Interior; and Housing and Urban Development; and to the Small Business Administration. The act places direct responsibility on the Secretary of Labor to provide direction and assistance in identifying occupational training and retraining needed by jobless workers and by employers in redevelopment areas. The Secretary of Health, Education, and Welfare is responsible for making available the

[9] "Education and Training: The Bridge Between Man and His Work." Apr. 1, 1965.
*The above comments and those following pertain to training programs authorized by Public Law 87-27, May 1, 1961, sec. 16. and, subsequent to the repeal of sec. 16 of that act, Public Law 89-15, Apr. 26, 1965, title II, pt. C, sec. 241.

NOTE.—This program is also included in the Labor Department report in the section on redevelopment areas.

needed training facilities through the State vocational education agencies and assisting in the development of training programs. Training projects are worked out with the participation of the Employment Service, area economic development groups, and school authorities.

3. History

In 1961, the Congress enacted the Area Redevelopment Act (Public Law 87–27). The catalyst for this legislation was that which almost 10 months later prompted the Manpower Development and Training Act, i.e., the knowledge that our country could not afford the persistent unemployment rate which it had been experiencing. The legislation further acknowledged that problems of economically distressed areas throughout the country needed to be tackled on a more massive scale and in a more integrated manner than heretofore.

Section 16 of the act authorized $4,500,000 annually for training programs in redevelopment areas to extend to June 30, 1965. At the end of the first 8 months of operation, 147 occupational training projects had been approved (286 separate courses) for 9,074 trainees.

By the end of fiscal year 1963, the program had been extended to include redevelopment areas in 42 States; occupational training was provided for 13,754 trainees.

Fiscal year 1964 showed a slight decrease in the number of training projects established, with a consequent decrease in the number of trainees served. This was attributed to training activity then being carried out under provisions of the Manpower Development and Training Act.

Early in 1965, it was recommended that the occupational training provisions of the Area Redevelopment Act be carried out by the Secretaries of Labor and of Health, Education, and Welfare according to the Manpower Development and Training Act. Training in redevelopment areas would continue in cooperation with the Secretary of Commerce and would carry full Federal financing. This was predicated on the belief that MDTA could provide more diversified opportunities in occupational training than the provisions of ARA. It had also become increasingly important to incorporate area redevelopment training projects into comprehensive State planning for manpower development. This could be facilitated under the Manpower Development and Training Act.

On April 26, 1965, the Congress enacted the Manpower Act of 1965 (Public Law 89–15). Significant among the amendments was the transfer of ARA training activities to the Manpower Act, effective July 1, 1965.

4. Level of operations. (See table 1.)

Program: Occupational training in redevelopment areas.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67* [1]

Measure and unit	Fiscal year [1] 1964	Fiscal year 1965	Fiscal year 1966 estimate [2]	Fiscal year 1967 estimate [2]
(a) Magnitude of the program (trainees approved)	11,603	10,217		
(b) Applicants or participants: State boards of vocational education (State boards)	41	35		
(c) Federal finances: [3]				
Unobligated appropriations available (millions)	$3.5	$3.3		
Obligations incurred (millions)	$3.4	$3.2		
Allotments or committments made				
(d) Matching or additional expenditures				
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)	16	16		
(f) Non-Federal Government personnel employed [2]				
(g) Other measures of level or magnitude of performance				

[1] These data pertain to the training programs authorized by Public Law 87-27, May 1, 1961, sec. 16, and, subsequent to the repeal of sec. 16 of that act, Public Law 89-15, Apr. 26, 1965, title II, pt. C, sec. 241, effective July 1, 1965.
[2] This information is included above under Manpower Development and Training Act, Office of Education.
[3] Includes funds for program administration.

5. Estimated level in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination arrangements for this program are the same as those listed under the manpower development and training program with one addition: an Interagency Review Panel, with representatives from the Departments of Labor, Commerce, and Health, Education, and Welfare gives final approval to training projects in redevelopment areas.

8. Laws and regulations

Section 16 of the Area Redevelopment Act, enacted on May 1, 1961, as Public Law 87–27. (Incorporated into the Manpower Development and Training Act by the Manpower Act of 1965, Public Law 89–15, enacted on April 26, 1965. See Compendium of Statutes, pages 143–159.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects [1]

From November 1961 to July 1, 1965, under section 16 of the Area Redevelopment Act a total of 1,053 training projects had been approved for 44,988 trainees. By July of 1965 an estimated 28,200 individuals had completed occupational training under ARA.

Major occupations in which people were being trained are as follows: Nurse's aid, machine-tool operator, clerk-stenographer and stenographer, welder (all types), farm machinery operator, and boot and shoe production worker. The average training cost is computed to be $569.

[1] See also "Economic Effects" of the manpower development and training program in the preceding section.

States having over 1,400 trainees approved are as follows: Michigan, 4,965; Pennsylvania, 3,915; West Virginia, 3,138; Oklahoma, 2,313; New Jersey, 2,270; Kentucky, 1,847; Illinois, 1,674; North Carolina, 1,502; Ohio, 1,501; and Rhode Island, 1,458.

In studying the characteristics of ARA trainees it may be noted that since the inception of the program more women have been trained (52.7 percent of all trainees) than men (47.3 percent of all trainees). This differs from the manpower development and training program in which men have consistently outnumbered women in training programs.

Under the ARA more trainees have not been classified as the family head or as head of household (63.1 percent of total trainees); only 36.9 percent of the trainees were categorized as heads of households.

A further study of the characteristics of ARA trainees indicates that 43.6 percent of the trainees had been unemployed 27 weeks and over; only 23.4 percent were unemployed less than 5 weeks. The majority of ARA trainees were classified in the 22 to 44 age group, with 52.7 percent of the trainees in that category. Persons under 19 years of age constituted 14.6 percent of the total number of trainees.

Area redevelopment training programs have repeatedly demonstrated their usefulness in assisting communities to attain economic recovery. A major role has been taken by training programs in reducing one of the greatest bottlenecks to economic recovery: the absence of skills needed to attract industry. Increased gainful employment of citizens added income to economically depressed areas; individuals were removed from public welfare; and the training activities in depressed regions offered assurance that businesses moving into the region would have a source of skills which their endeavors required.

10. Economic classification of program expenditures

Total Federal expenditures for this program in fiscal year 1965 were $3 million.

(NOTE.—In the national income accounts the training allowances are considered a transfer payment to individuals. Payments to State and local vocational and educational institutions are considered a purchase of goods and services. Payment to State offices for administration are considered a grant.)

ADULT BASIC EDUCATION

(The Economic Opportunity Act of 1964—Title II–B)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To improve the basic reading and writing skills of adults unable to find employment because of their functional illiteracy.

2. Operation

The adult basic education program, part of the war against poverty, is administered by the Office of Education under delegation from the Office of Economic Opportunity. It is a federally operated program providing grants to the States for adult basic education. These grants represent a 90-percent Federal share of expenditures, with the State's share representing 10 percent in matching funds. Grants are

used to assist local educational agencies in establishing programs and pilot projects in adult basic education, to assist with the actual costs of adult instruction, and to assist State educational agencies to improve their technical and supervisory services to adult basic education.

3. History

The adult basic education program was established by the Economic Opportunity Act of 1964, enacted on August 20, 1964. Funds for the program became available in March of 1965. Prior to that time, however, with the aid of the Ford Foundation and the individual States, training workshops were held throughout the country. Program regulations were issued in March.

By the end of January 1966, 43 States had won final approval of their adult basic education plans and received their funds. Six States were notified that their plans were in substantially approvable form while the plans of four additional States were under review.

A county-by-county survey of State education agencies revealed that as of the end of 1965, 197,000 persons were enrolled in State programs. Based on estimates from the States, total fiscal year 1966 enrollment is projected at over 258,000, more than triple the expected response to the program. These figures indicate that the States' share of program expenditures will exceed the 10-percent matching requirement.

4. Level of operations. (See table 1.)

Program: Adult basic education.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in millions]

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (classes)	----------	[2] 1,900	15,216	20,000
(b) Applicants or participants: State educational agencies	----------	15	55	55
(c) Federal finances:				
Unobligated appropriations available [3]	----------	$19	$30.4	$30
Obligations incurred [3]	----------	$4.2	$30.4	$30
Allotments or commitments made	----------	$18.6	$29.6	$29.2
(d) Matching or additional expenditures	----------	[2] $.4	$4.8	$3
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years administering)	----------	4.9	20	31
(f) Non-Federal Government personnel employed (persons)	----------	20	19,793	20,000
(g) Other measures of level or magnitude of performance (trainees)	----------	37,991	258,000	300,000

[1] Not applicable.
[2] Estimated.
[3] Includes funds for program administration.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Funds for this program are appropriated to the Office of Economic Opportunity which transfers them to the Office of Education.

Operating responsibility for the program is assigned to the Division of Adult Education Programs of the Bureau of Adult and Vocational Education. The Division works with other Bureau elements administering the MDTA program to effect a coordinated approach to adult training programs.

Staff review of the program is exercised by the Office of Disadvantaged and Handicapped which serves as a central point within OE for information, advisory services, and liaison with OEO with respect to educational components of economic opportunity programs.

On the broad question of aid to undereducated adults, members of the Division of Adult Education Programs are working with an interagency coordinating committee from OEO and the Department of Labor. The goal is to coordinate all resources and assure their most efficient use.

In administering grants, the Division deals with State education agencies.

8. Laws and regulations

Title II–B of the Economic Opportunity Act of 1964, enacted on August 20, 1964, as Public Law 88–425. (See Compendium of Statutes, pages 285–315.) Public Law 89–253, enacted on October 9, 1965, amended the act.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The initial funding of an adult basic education program did not take place until March 1965, and only 14 State programs were funded by the close of that fiscal year. The normal length of a program is approximately 8 months per level, with three levels being included in most programs. Accordingly, information about the program's benefits and economic effects is not available.

A data collection system is being developed by the Office of Education and the Office of Economic Opportunity to gather personnel information about participants in the State programs. It is hoped that this information will permit an evaluation of the adult basic education program in terms of the items listed in question 9.

In general, it can be assumed that the program will improve the economic standing of individuals completing basic education courses since it will increase their chances of getting and retaining employment.

10. Economic classification of program expenditures. (See table 2.)

Program: Adult basic education.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 0.1
Grants to State and local governments	3.3
Total, Federal expenditures	3.4
Non-Federal expenditures financed by: State and local governments	.4
Total expenditures for program	3.8

[1] Estimated.

Library Services and Construction

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To extend and improve public library services and to aid in the construction of public libraries.

2. Operation

The Library Services and Construction Act program is a direct Federal operation, consisting of grants to the States, administered by the Library Services Branch at the Office of Education headquarters. Professionally trained and experienced librarians, in the position of library extension specialists, work out of Washington to provide the State library administrative agencies with guidance and technical assistance. State plans for the use of funds for services and for construction are submitted to the U.S. Commissioner of Education for approval.

Each State receives an allotment of Federal funds based on its population. This allotment must be matched by the State with funds from State or local sources. The required matching ratio is determined by the State's per capita income, with a maximum Federal share of total expenditures being 66 percent, the minimum being 33 percent. Allotted funds that are not required by any State may be reallotted by the Commissioner to States which require additional Federal funds.

3. History

State library extension agencies reported in 1956 that 75 percent of the U.S. population was considered to have either inadequate or no local public library service.[1] Although the need for greatly expanded and improved public library service existed at all population levels, the needs of rural areas were the greatest.

In recognition of this need, the Congress responded with the passage of the Library Services Act in 1956. This program authorized a maximum of $7.5 million in Federal funds for each of 5 years to enable the States and territories to extend and improve public library services in areas under 10,000 population. The Library Services Act was extended through fiscal 1966, and between 1956 and 1964 $50.6 million in Federal funds were made available. State and local expenditures for the same period totaled $114.1 million.

During the 8-year Library Services Act program the intended goal of stimulating "the States and local communities to increase library services available to rural Americans" [2] was realized. All regions of the country reported increases in local and State funds, ranging from 99 percent in the Southeast to 156 percent in the North Atlantic.

Despite the substantial gains made by the rural grant programs, public libraries continued to lag behind the demands placed upon them. Even the large, well-established urban libraries were unable to cope with the new, heavier, and more complex demands on their resources.

[1] The U.S. Department of Health, Education, and Welfare. Office of Education. "State Library Extension Services; A Survey of Resources and Activities of State Library Administrative Agencies, 1955-56." Washington: U.S. Government Printing Office, 1960 (OE-15009, miscellaneous No. 37) pp. 3, 23.

[2] President Eisenhower, at the signing of the library services bill, June 19, 1956.

Of particular concern was the obsolete and dilapidated condition of most public libraries. Estimates from the States in 1964 indicated an immediate need of 20 million square feet of new public library construction.

Therefore, in 1964 the original act was amended to encompass all areas, whether rural or urban, which had no library service or which had inadequate service. A new title for the construction of public libraries was added. The amended Library Services and Construction Act began operating in fiscal 1965 with $25 million for services under title I, and $30 million for construction under title II.

4. Level of operations. (See table 1.)

Program: Library services and construction.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimated	Fiscal year 1967 estimated
(a) Magnitude of the program:				
Services (millions of books added)	2.4	3.9	6.5	7
Construction of library space (millions of square feet added)		5.4	5.4	5.4
(b) Applicants or participants:				
State library administrative agencies	[1] 54	[1] 54–[2] 52	55	55
Local communities		363	400	400
(c) Federal finances:				
Unobligated appropriations available (millions)	$7.5	$55	$55	$57.5
Obligations incurred (millions)	$7.4	$54.9	$55	$57.5
Allotments or commitments made (millions)	$7.5	$55	$55	$57.5
(d) Matching or additional expenditures (millions)	$20.6	$150.2	$189.2	$195
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years administering)	4.7	9.5	9.5	9.5
(f) Non-Federal Government personnel employed	86	[3] 674	705	710
(g) Other measures of level or magnitude of performance				

[1] Agencies submitting plans for library services.
[2] Agencies submitting plans for library construction.
[3] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination required is effected by the Division of Library Services and Educational Facilities of the Bureau of Adult and Vocational Education. The Division also administers the college library assistance program authorized by the Higher Education Act of 1965. In arranging for grants, the Division deals with State library administrative agencies.

The advisory committee on the library services program has been created to provide the Commissioner with advice and recommendations pertaining to this program.

8. Laws and regulations

The two main pieces of legislation affecting the program are the Library Services Act, enacted on June 19, 1956, as Public Law 84–597, and a later amendment adding construction to the act, enacted on

February 11, 1964, as Public Law 88–269. For amendments and text of the current act, see the Compendium of Statutes, pages 197–204.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The salaries paid at the State and local levels to the over 600 professional librarians who are engaged in the full operation of the Library Services and Construction Act equal or exceed the prevailing levels of comparable positions within the State. The wages spent in the States help to increase consumption of goods and services.

Improved public library services help individuals prepare themselves for better jobs by providing aid in the selection of books and materials necessary for further class study and by exposing individuals to new ideas and techniques which stimulate them to seek retraining.

This particular aspect of "exposure" is being increasingly emphasized in the culturally and economically deprived areas of the Nation, in the Appalachian States as well as in the poverty-stricken neighborhoods of our metropolitan areas. Efforts are being made not only to provide better service to people coming into the libraries, but to go out into the communities to determine needs and means of satisfying them. A nonreading, uneducated public is not a productive public, but one which drains the country's resources. The contribution that these programs are having on national economic development is difficult to measure statistically.

Building activity has been stimulated in 48 States and 3 territories through the construction part of the program. Approximately $60 million (including expenditures from States and local communities) is being made available annually for this purpose.

A breakdown of the State allotments under the fiscal year 1966 program appears in table 2.

TABLE 2.—*Federal allotments and required matching expenditures from State and local sources*

[The Library Services and Construction Act, fiscal year 1966 (Public Law 88-269)]

States and outlying parts	Title I, public library services		Title II, public library construction		Matching ratio	
	Federal allotment	State and local matching	Federal allotment	State and local matching	Federal percentage	State percentage
Total	$25,000,000	$26,132,581	$30,000,000	$31,581,237		
Alabama	454,452	234,111	543,258	279,860	66.00	34.00
Alaska	124,540	173,047	112,073	155,724	41.85	58.15
Arizona	241,289	194,802	264,660	213,670	55.33	44.67
Arkansas	293,816	151,360	333,312	171,706	66.00	34.00
California	1,805,367	2,824,966	2,308,865	3,612,820	38.99	61.01
Colorado	290,309	304,952	328,728	345,309	48.77	51.23
Connecticut	375,081	697,498	439,523	817,335	34.97	65.03
Delaware	148,424	297,829	143,289	287,526	33.26	66.74
District of Columbia	182,892	371,326	188,337	382,381	33.00	67.00
Florida	637,260	487,648	782,183	598,546	56.65	43.35
Georgia	527,841	311,200	639,175	376,840	62.91	37.09
Hawaii	168,658	174,910	169,734	176,027	49.09	50.91
Idaho	172,392	114,450	174,615	115,925	60.10	39.90
Illinois	1,193,838	1,805,755	1,509,614	2,283,386	39.80	60.20
Indiana	605,896	604,443	741,191	739,414	50.06	49.94
Iowa	399,202	345,856	471,048	408,100	53.58	46.42
Kansas	336,386	294,259	388,950	340,240	53.34	46.66
Kentucky	429,650	244,416	510,842	290,605	63.74	36.26

TABLE 2.—*Federal allotments and required matching expenditures from State and local sources*—Continued

States and outlying parts	Title I, public library services		Title II, public library construction		Matching ratio	
	Federal allotment	State and local matching	Federal allotment	State and local matching	Federal percentage	State percentage
Louisiana	$453,397	$254,373	$541,880	$304,015	64.06	35.94
Maine	205,168	143,579	217,452	152,176	58.83	41.17
Maryland	436,435	558,629	519,710	665,220	43.86	56.14
Massachusetts	658,637	917,427	810,122	1,128,432	41.79	58.21
Michigan	948,841	981,660	1,189,411	1,230,550	49.15	50.85
Minnesota	470,415	423,061	564,122	507,335	52.66	47.35
Mississippi	336,335	173,263	388,883	200,334	66.00	34.00
Missouri	568,713	587,208	692,595	715,119	49.20	50.80
Montana	173,214	140,921	175,689	142,934	55.14	44.86
Nebraska	253,134	231,426	280,141	256,116	52.24	47.76
Nevada	130,954	259,138	120,455	238,362	33.57	66.43
New Hampshire	165,853	149,337	166,068	149,530	52.62	47.38
New Jersey	758,265	1,138,821	940,333	1,412,264	39.97	60.03
New Mexico	203,189	133,942	214,865	141,639	60.27	39.73
New York	1,920,933	3,120,886	2,459,907	3,996,542	38.10	61.90
North Carolina	594,357	342,523	726,111	418,452	63.44	36.56
North Dakota	168,622	117,178	169,687	117,918	59.00	41.00
Ohio	1,153,175	1,196,887	1,456,469	1,511,676	49.07	50.93
Oklahoma	352,626	240,421	410,175	279,658	59.46	40.54
Oregon	291,908	300,919	330,818	341,031	49.24	50.76
Pennsylvania	1,328,187	1,336,180	1,685,205	1,695,346	49.85	50.15
Rhode Island	193,257	192,101	201,884	200,676	50.15	49.85
South Carolina	358,519	184,691	417,877	215,270	66.00	34.00
South Dakota	173,838	118,180	176,504	119,992	59.53	40.47
Tennessee	487,040	273,604	585,851	329,112	64.03	35.97
Texas	1,139,425	851,185	1,438,499	1,074,602	57.24	42.76
Utah	196,636	151,270	206,300	158,704	56.52	43.48
Vermont	142,303	108,142	135,289	102,812	56.82	43.18
Virginia	530,427	380,490	642,555	460,922	58.23	41.77
Washington	409,583	435,789	484,616	515,624	48.45	51.55
West Virginia	301,862	186,192	343,827	212,077	61.85	38.15
Wisconsin	528,780	502,181	640,403	608,189	51.29	48.71
Wyoming	135,813	140,006	126,807	130,722	49.24	50.76
American Samoa	27,176	14,000	22,843	11,768	66.00	34.00
Guam	32,274	16,626	29,508	15,201	66.00	34.00
Puerto Rico	354,933	182,844	413,190	212,855	66.00	34.00
Virgin Islands	28,483	14,673	24,552	12,648	66.00	34.00

10. Economic classification of program expenditures. (See table 3.)

Program: Library services and construction.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 3.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 0.5
Grants to State and local governments	26.1
Total, Federal expenditures	26.6
Non-Federal expenditures financed by State and local governments	78.3
Total expenditures for program	104.9

[1] Estimated wages, salaries.

EDUCATIONAL TELEVISION FACILITIES

(Public Law 87–447)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist (through matching grants) in the construction of educational television broadcasting facilities.

2. Operation

Eligible recipients under the program (public school system, college or university, State educational television agency, or nonprofit corporation) apply directly to the Secretary of Health, Education, and Welfare for grants for the acquisition and installation of transmission equipment for educational television broadcasing. Grants for activation of new stations are made on a 50–50 matching basis; those for expansion of existing stations are made on the same basis, except that credit for 25 percent of the cost of existing facilities may be given. No more than $1 million may be granted to any one State. Not more than 15 percent of any grant may be used to connect two or more stations. The Secretary of HEW approves all applications, but he has delegated the technical processing of applications to the Office of Education.

3. History

This program was established by Public Law 87–447 on May 1, 1962, and the first appropriation was made on May 17, 1963. Since that time over $29 million of the $32 million authorized through fiscal year 1967 has been appropriated. A total of $13,917,510 has been obligated to construct 37 new stations and to expand 36 existing ones. Applications totaling $9,140,223 are currently pending. Applications which exceed the $1 million statutory limitation have been received from five States.

Total applications received represent 43 States (including Washington, D.C., and Puerto Rico). The 73 grants approved (to date) were made in a total of 35 States (including Washington, D.C., and Puerto Rico). Through the grant program seven States were able to activate their first educational television stations.

By the end of fiscal year 1966, 50 percent more ETV stations will be in operation as a result of this program than were operating prior to passage of Public Law 87–447. The following table reflects other comparative results of the program:

	1963 (June 30)	1965 (Dec. 1)
Number of ETV stations in operation	79	112
Total population in reception area	(1)	128,000,000
Number of students in reception area (all levels of instruction)	[2] 25,000,000	35,000,000
Number of States having at least 1 ETV station	33	40

[1] Less than 100,000,000.
[2] Approximately.

4. Level of operations. (See table 1.)

Program: Educational television facilities.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (ETV equipment grants) [1]	33	29	48	50
(b) Applicants or participants:				
State government agencies	3	4	19	3
Local school districts	8	6	5	20
Nonprofit community corporations	11	6	14	24
Institutions of higher education	11	13	10	3
(c) Federal finances: [2]				
Unobligated appropriations available (millions)	$7.84	$12.90	$15.41	$3.30
Obligations incurred (millions)	$5.33	$5.26	$15.41	$3.30
Allotments or commitments made				
(d) Matching or additional expenditures (millions)	$3.63	$4.30	$9.10	$7.74
(e) Number of Federal Government employees administering, operating, or supervising the activity (administering)	13	13	13	13
(f) Non-Federal Government personnel employed				
(g) Other measures of level or magnitude of performance				

[1] For breakdown by grantee, see (b) Applicants or participants.
[2] Includes funds for program administration.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination and cooperation with other programs and agencies are implicit in the bifurcated administration of the ETV facilities program and can be summarized as follows:

(a) *Within the Department of Health, Education, and Welfare.*—Processing of all applicants is done in the Educational Television Branch of OE's Bureau of Adult and Vocational Education. This processing requires frequent liaison with the Office of General Counsel and the Financial Standards Section, Finance Branch. Recommendations with respect to grant action, policy determinations, and working procedures are transmitted from the Branch, through the Associate Commissioner, BAVE, to the Commissioner of Education for transmittal to the Secretary. Final grant approvals are made by the Secretary, HEW, and postgrant administration is again referred to the ETV Facilities Branch.

(b) *With other Federal agencies.*—

(1) Federal Communications Commission: Each applicant must be processed in close cooperation with the FCC to coordinate with that agency's regulatory requirements on broadcasting. Recommendation to award an HEW grant is contingent on award of a construction permit or other authorization by the FCC.

(2) Appalachian Regional Commission: Procedures are currently under development to provide for interagency cooperation with respect to applicants who request supplemental grants for ETV projects under section 214 of the Appalachian Regional Development Act.

(3) National Aeronautics and Space Administration: The Applied Technology Section of NASA is being consulted on the possible use of satellite relay for ETV interconnection.

(c) *With State agencies.*—The ETV branch cooperates with designated State ETV agencies in the review of applications under provisions of State educational television planning.

(*d*) *With other groups.*—In processing applications and performing postgrant administration, the ETV branch deals with colleges and universities and nonprofit foundations and associations engaged in educational television broadcasting.

In addition, program administrators seek cooperation of and rely on information supplied by the National Association of Educational Broadcasters on such matters as program progress, development of needs for educational television, and future expansion needs of ETV.

8. Laws and regulations

Part IV of title III of the Communications Act of 1934, enacted on May 1, 1962, as Public Law 87–447. (See Compendium of Statutes, pp. 19–22.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

With the exception noted below, it is not possible to describe the effects of the educational television facilities program in "economic" terms. Information normally available in administration of the program does not relate to such factors as personal income, placement or productivity of workers, or employment factors.

The only identifiable economic impact of the ETV facilities program is in the construction and manufacturing sectors. Expenditure of the full authorization provided under the act plus matching amounts from State and local sources will result in the purchase of goods and services in these two sectors totaling $64 million, spread throughout the United States and the territories.

Through its use as a medium of communication and instruction educational television, itself, not only aids the educational process (which, in turn, has a beneficial effect on the economy) but also enables a more efficient use of limited educational resources. It can be expected that with the expansion and improvement of educational television throughout the Nation the great potential of this medium for providing vocational and technical training for the general public will be increasingly exploited with economic benefits accruing to individuals and the Nation as a whole.

10. Economic classification of program expenditures. (See table 2.)

Program: Educational television facilities.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services	[1] 0.2
Grants	[2] 2.7
Total, Federal expenditures	2.9
Non-Federal expenditures financed by:	
State and local governments	.7
Individuals and nonprofit organizations	.9
Others	2.7
Total expenditures for program	7.2

[1] Estimated wages and salaries.
[2] Includes grants to State ETV agencies and local school districts.

COMMUNITY SERVICE AND CONTINUING EDUCATION

(The Higher Education Act of 1965—Title I)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist in the solution of community problems such as housing, poverty, government, recreation, employment, youth opportunities, transportation, health, and land use by strengthening community service programs of colleges and universities.

2. Operation

Allotments are made to States on the basis of population. Any State desiring to participate in the program must designate a State agency or institution to develop and administer a State plan, which must be approved by the Commissioner of Education. Each State allocates Federal funds to institutions of higher education in the State to provide new, expanded, or improved community service programs. In fiscal years 1966 and 1967, Federal funds may be used to pay 75 percent of the cost of developing and carrying out a State plan. Federal funds may be used to pay 50 percent of such costs in fiscal years 1968, 1969, and 1970.

3. History

The program was initiated by title I of the Higher Education Act of 1965, enacted on November 8, 1965. Ten million dollars have been appropriated for title I for fiscal year 1966.

4. Level of operations. (See table 1.)

Program: Community services and continuing education.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Adult and Vocational Education.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in millions]

Measure and unit	Fiscal year 1964 [1]	Fiscal year 1965 [1]	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (projects supported)			400	800
(b) Applicants or participants: State agencies			55	55
(c) Federal finances:				
Unobligated appropriations available			$10	$20
Obligations incurred			$10	$20
Allotments or commitments made			$10	$20
(d) Matching or additional expenditures			$3.3	$6.7
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years administering)			10	20
(f) Non-Federal Government personnel employed [2]				
(g) Other measures of level or magnitude of performance:				
Colleges and universities participating (institutions)			200	250
Adults participating in programs (persons)			100,000	200,000

[1] Not applicable.
[2] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination of the program's operations will be effected by the Bureau of Adult and Vocational Education.

Since the projects which may be carried out under title I may be concerned with a wide range of community problems and university extension or continuing education offerings, it is expected that there will be many opportunities for coordination and cooperation as indicated below.

(*a*) *Within the Office of Education.*—Purposes and operations of the program might be coordinated with adult education programs, vocational and technical education programs, manpower development and training programs, area redevelopment programs, and programs for the handicapped, construction of educational facilities, work-study, and research.

No specific devices have been developed to date to promote such coordination.

(*b*) *With other units of the Department of Health, Education, and Welfare.*—Program operations might be coordinated with the Public Health Service, Water Pollution Control Administration, and Vocational Rehabilitation Administration.

No specific devices have been developed to date to promote such coordination.

(*c*) *With other Federal Government departments or agencies.*—Recent legislation has provided several other Government departments and agencies with activities closely related to title I. Therefore, it is expected that this program will be conducted with coordination and cooperation of at least the following departments or agencies: Agriculture, Commerce, Defense, Labor, Interior, State, Housing and Urban Development, and the Office of Economic Opportunity.

The need for coordination and cooperation was taken into consideration by the Congress in establishing the National Advisory Council on Extension and Continuing Education, which was directed to provide the Commissioner of Education with advice in the preparation of regulations and policy matters arising in the administration of title I. The Council is also required to review the administration and effectiveness of all federally supported extension and continuing education programs.

(*d*) *With State governments or their instrumentalities.*—Coordination and cooperation will be maintained in each participating State with a State agency or institution which has been designated by State authorities to develop and administer the State plan for carrying out the program.

(*e*) *With other groups.*—The cooperation of communities, nonprofit organizations, and institutions of higher education will also be needed to fulfill the purposes of this new program.

8. Laws and regulations

Title I of the Higher Education Act of 1965, enacted on November 8, 1965, as Public Law 89–329.

Regulations have not yet been issued.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

This program is specifically directed toward the solution of community problems. Improved conditions within a community are expected to result in a corresponding improvement in its economy. In addition, through continuing education programs adults can upgrade their skills or learn new ones and, thus, improve their economic security. There is, however, no basis for estimating the specific economic effects resulting from this program.

10. Economic classification of program expenditures

Not applicable. The program was not in operation in fiscal year 1965.

V. PROGRAMS FOR EDUCATIONAL RESEARCH

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To broaden the knowledge and improve the quality of education by stimulating and supporting research, survey, demonstration, and dissemination projects in the field of education.

2. Operation

Research programs of the Office of Education are administered by the Bureau of Research. The Bureau receives proposals from colleges, universities, organizations, State educational agencies, and individuals for extramural research and research-related projects and programs. Proposals are evaluated by Bureau staff and by field readers and consultants outside the Office of Education. After approval by the Commissioner, a grant or contract is negotiated and awarded. Projects are monitored by the Bureau of Research. Projects and programs conducted through educational laboratories will be directed by laboratory staffs in conjunction with the Office of Education and within established program guidelines.

The Bureau of Research also stimulates research projects or programs in those areas which it has identified as needing special attention or development.

3. History

The educational research program is composed of a variety of smaller programs, each of which was established by a specific legislative authorization.

The first program began in 1954 with the enactment of the Cooperative Research Act (Public Law 83–531) which authorized the Commissioner of Education to enter into cooperative arrangements with colleges, universities, and State educational agencies for research, surveys, and demonstrations in the field of education. For its first 4 years, the program supported only basic and applied research and emphasized the area of mental retardation. Subsequently, the program was enlarged to include field demonstrations, developmental projects, curriculum study centers, a small contracts program, and a curriculum improvement program.

With the passage of title IV of the Elementary and Secondary Education Act of 1965 (Public Law 89–10), the cooperative research program was broadened to provide for grants as well as contracts, extend the eligibility for support, authorize the development and support of training programs for research, give the program authority to disseminate the results of research, and authorize funds over a 5-year period for constructing and equipping educational research facilities. Based on this expanded authority, a national program of educational laboratories was created. These laboratories are new institutions which, through the initiative and cooperative planning of scholars, school personnel, and representatives of various other groups interested in education, conduct research and research-related activities, and assure educational improvements by implementation of research.

The National Defense Education Act of 1958 (Public Law 85–864), as amended, provides authorization for other research programs. Title VI (sec. 602) authorizes research in more effective methods of teaching modern foreign languages and related area studies, and development of specialized materials for use in such teaching. Part A of title VII authorizes research and experimentation in the educational uses of television, radio, motion pictures, and other communications media. Part B of the same title complements part A by authorizing studies on and the production of materials for dissemination of information regarding the new media.

Public Law 85–905 (amended by Public Law 87–715), "Captioned Films for the Deaf," provides for research in the use of educational and training films for the deaf, for the production and distribution of training films and captioned films, for the training of persons in the use of films for the deaf, and for the operation of a loan service of captioned films.

Public Law 88–164 increased the commitment to improved education for handicapped children. Title III, section 302, of this law authorizes the award of grants for research and demonstration projects relating to the education of mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, emotionally disturbed, crippled, or otherwise health-impaired children. Public Law 89–105 provides for the construction, equipping and operation of a facility for research, research training, surveys, and demonstrations in the field of handicapped children, and for the dissemination of information derived from such research and related activities.

The Vocational Education Act of 1963 (Public Law 88–210) authorizes grants for research and training programs and for experimental, developmental, or pilot programs designed to meet the special vocational educational needs of youth, particularly those in economically depressed communities.

Title V, section 503(a)(4) of the Elementary and Secondary Education Act of 1965 allows the State departments of education to identify research as one of their needs and therefore to use part of their title V allotment for conducting, sponsoring, or cooperating in educational research and demonstration programs and projects. Title V broadens the possibilities for State agencies to engage in research since the funds may be used for research specifically aimed at a State need.

The Higher Education Act of 1965 (Public Law 89–329), title II, part B, section 224, authorizes the Commissioner to make grants to

institutions of higher education and other public or private nonprofit agencies, institutions, and organizations for research and demonstration projects relating to the improvement of libraries or of training in librarianship, and for the dissemination of information derived from such research and demonstrations. The Commissioner is also authorized to provide by contracts with public or private agencies, organizations, or institutions for the conduct of such activities.

In addition to its other support programs, the Office also administers a program in certain foreign countries for research of significance to American education. Excess foreign currencies generated from the sale of surplus commodities abroad are used for this purpose. The program is authorized by Public Law 83–480.

Under the authority of the legislative acts cited above, a variety of research activities aimed at the improvement of the whole educational process are now being supported, as follows:

Individual research projects are producing new teaching methods and more meaningful textbooks and instructional materials which encourage self-directed learning in all subject areas, expecially in English, mathematics, foreign languages, and science.

To permit further expansion of research, training grants, institutes, workshops, and program development grants are being awarded which will increase the number of educational researchers, strengthen the research resources of small institutions, bring about a broader geographical distribution of research capability, and encourage better balanced research activities in those institutions already engaged in research efforts.

Nine research and development centers, federally supported but university operated, have so far been established, each concentrating its efforts in a particular area of educational research such as teacher training, urban education, the effects of psychological and cultural differences on the learning process, and the organization of higher education.

The educational laboratories now being established will carry on comprehensive programs of research, development, and dissemination serving the educational needs of the Nation as well as of the region in which they are located.

The relationships between educational research and development and other educational agencies are being strengthened so that each can aid the other in formulating and executing their responsibilities.

Out of these efforts, some continuing from previous years, others initiated this past year, a new kind of educational system is emerging. It is designed to recognize obsolescence and to incorporate innovation on a continuing basis. This system is drawing upon some of the best educational, scientific, cultural, and other resources of the Nation. All parts of the education community will eventually participate in this new system. Once a commitment to quality has been made, and once the means of achieving that goal have been identified, research in education will be pursued and informed by all parts of the intellectual community and by every discipline within that community.

4. Level of operations. (See table 1.)

Program: Educational research.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Educational Research.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (projects approved) [1]	716	1,090	1,528	1,695
(b) Applicants or participants:				
State educational agencies (projects approved)	55	96	166	175
Local school districts (projects approved)	7	16	141	155
Individuals (projects approved)	28	26	19	30
Institutions of higher education (projects approved)	579	899	1,177	1,305
Other (projects approved)	47	53	25	30
(c) Federal finances:				
Unobligated appropriations available (millions)	$20.1	$38.2	$101	$117.7
Obligations incurred (millions)	$19.7	$36.1	$101	$117.7
Allotments or commitments made				
(d) Matching or additional expenditures (millions)	$2.8	$8.2	$12.6	$14.1
(e) Number of Federal Government employees administering, operating, or supervising the activity (man-years)	47	136	260	285
(f) Non-Federal Government personnel employed (persons)	3,526	6,843	12,578	15,000
(g) Other measures of level or magnitude of performance:				
Proposals submitted	1,746	2,692	4,619	5,230
Regional labs supported			8	12
Research centers supported	2	4	9	11

[1] For breakdown, see participants listed under item (b).

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(a) *Within the Bureau of Research.*—The Bureau of Research is organized to encourage coordination and cooperation among its internal units and with the other bureaus of the Office of Education. Three of the divisions of the Bureau of Research correspond directly to the Bureaus of Elementary and Secondary Education, Higher Education, and Adult and Vocational Education. Thus, the exchange of information about research programs is greatly facilitated between the operating programs of these bureaus and the Bureau of Research.

To assure internal coordination the programs of each of the divisions are reviewed weekly by division directors and Bureau staff personnel meeting as a committee. Special units assigned to the Office of the Associate Commissioner circulate information about proposal allocations, procedures, fiscal and budget matters, and other related items to all Bureau units.

(b) *Within the Office of Education.*—An internal review committee works to assure interbureau coordination and cooperation. This committee consists of a representative from each of the four bureaus of the Office of Education as well as the division directors of the Bureau of Research. A representative from the Office of the Commissioner also is a member of the committee. The internal review committee is responsible for making final recommendations to the Commissioner regarding specific research and research-related projects and programs to be supported, as well as formulating and recommending new policies and procedures.

(c) *With other Federal agencies.*—The Bureau of Research exchanges with the National Science Foundation information and recommenda-

tions on programs and on individual projects which may be of interest to either agency.

Coordination of programs between the Office of Education and the Office of Economic Opportunity is provided by Bureau of Research staff members who work closely with research components of OEO on project formulation, proposal review, and joint funding of programs of mutual interest.

Research programs in vocational education are coordinated with those of the Office of Manpower, Automation, and Training, Department of Labor, by an interchange of research proposals and a continuing dialog between the members of the two staffs.

The Bureau of Research conducts research in foreign countries with funds from the Public Law 480 excess foreign currency program. These projects are coordinated both through the State Department and the local embassy in the country in which the research is conducted.

The Inter-Agency Committee on Education includes, among its concerns, matters of research coordination.

Another interdepartmental committee, the Foreign Area Research Coordinate Group, coordinates Government-sponsored research in foreign areas and international education.

(*d*) *With State governments.*—The largest single program of the Bureau, the cooperative research program, has encouraged and supported the research activities of State educational agencies, including, for example, the funding of 151 research projects conducted by State departments of education in the last 3 years. Information from the vocational education part of the Bureau's programs is regularly exchanged with State boards of vocational education. Twenty-three State vocational education research coordinating units have been established through this program.

(*e*) *With local governments.*—The national program of educational laboratories which is now being developed includes provisions for communities and local school districts, among others, to participate in the activities of the laboratories. In addition to this participation, local communities or organizations may make application to the research programs of the Bureau of Research.

(*f*) *With nonprofit organizations.*—Nonprofit organizations and institutions are eligible for grants or contracts as appropriate. The Bureau of Research maintains contact with such organizations through professional associations and other channels.

(*g*) *With business enterprises.*—Business enterprises are eligible to participate, through contracts, in the research programs of the Bureau. The increasing interest and contributions of business to education make contacts with them an important area which receives special attention through bulletins, speeches, special purpose meetings, etc.

(*h*) *With other groups.*—Various advisory groups aid the educational research program as follows:

(1) The Research Advisory Council is the major advisory group on the long-range policy of the cooperative research program. Under the council, panels have been established for arts and humanities, reading, curriculum improvement, demonstration, educational processes, English, environment, psychological processes, and research and development centers. Members of the panels evaluate research proposals in their area as to the soundness of the design, the possibilities

of securing productive results, and their relationship to similar educational research already completed or in process.

(2) The Advisory Committee on New Educational Media, established by title VII of the National Defense Education Act of 1958, makes recommendations to the Commissioner on research projects and other matters relating to the utilitization or adaptation of television, radio, motion pictures, or related media of communication for educational purposes.

(3) The Advisory Committee on Research and Demonstration in the Education of Handicapped Children, established by Public Law 85–926, advises the Commissioner as to criteria for evaluating proposals, areas in which research and demonstration need to be stimulated and encouraged, and distribution of funds between the areas of the handicapped and between research and demonstration. Panels of consultants have been created for the following areas: crippled and special health, deaf, emotionally disturbed, mentally retarded, speech impaired and hard of hearing, and visually handicapped.

8. Laws and regulations

Legislative authority for the Office of Education's research program is shown below in order of enactment. Except where noted, the laws along with their legislative histories and amendments are included in the Compendium of Statutes.

(*a*) Agricultural and Trade Development and Assistance Act of 1954, enacted on July 10, 1954, as Public Law 480, 83d Congress. (For amendments and extensions see Compendium of Statutes, pp. 119–122.)

(*b*) Cooperative Research Act, enacted on July 26, 1954, as Public Law 531, 83d Congress (Compendium of Statutes, pp. 7–10).

(*c*) Titles VI and VII of the National Defense Education Act of 1958, enacted on September 2, 1958, as Public Law 85–864 (Compendium of Statutes, pp. 182–183).

(*d*) Captioned Films for the Deaf, enacted on September 2, 1958, as Public Law 85–905 (Compendium of Statutes, pp. 81–82). Amended by Public Law 89–258, 79 Stat. 983, on October 19, 1965.

(*e*) Title III of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, enacted on October 31, 1963, as Public Law 88–164 (Compendium of Statutes, pp. 86–87).

(*f*) Title V of the Elementary and Secondary Education Act of 1965, enacted on April 11, 1965, as Public Law 89–10 (Compendium of Statutes, p. 35).

(*g*) Title II–B of the Higher Education Act of 1965, enacted on November 8, 1965, as Public Law 89–329.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

There are compelling economic and social reasons for investing in educational research. Few economists, for example, would dispute the fact that money spent on research and development is the key to product improvement. Education is one of the most productive investments a society can make, but research and planning in this field will increase its yield even more and, in the long run, affect all sectors of the economy and result in increased GNP.

While there is common agreement among experts as to the long-run value and need for research in education, tools for measuring the effects of research or even isolating the effects so that they can be measured have yet to be developed. Moreover, since the research programs of the Office of Education were established less than 10 years ago and research expenditures have been relatively small, the economic effects have not yet had a large nationwide impact. Even if economists could account for "other things being equal" outside the sphere of educational expenditures, it would still be difficult to determine which kinds of educational expenditures are causally related to specific economic results. (Will the size of a pupil's future salary be related to his studying the new math developed through research, going to school in a modern building, or being able to attend college on a Federal loan, or all three, or none?)

Leaving aside the problem of measurement, it is possible to point out some of the relationships between educational research and the economy. One aspect of this is the growing interplay between research and industrial firms which promises to be of mutual benefit to both business and education. Increasingly the private industrial sector is recognizing all parts of education, not only technical or vocational, as being directly relevant to its interests. Private enterprise is also increasing its interest in the market which education offers for a spectrum of products, all of which are designed to contribute to better education. The interchange of information and interests, and the coordination of these efforts, will alter the pattern of research in education which has previously been directed and conducted almost exclusively by professional educators. The ingenuity and talents of the private sector, both stimulated and utilized by educational research, are developing new materials and new devices which augur a significant change in educational practices.

The most important economic contribution of educational research is, of course, its development of more efficient uses of human resources. As a result of advances through research, children are already learning more at earlier ages. For example, first graders are now learning fundamentals of economics and algebra, and fifth graders are studying mathematical logic usually taught in college. Ideally, research efforts to provide each child with individualized instruction tailored to his own needs and talents will result in each child learning as much as he can, as soon as he can, and as quickly as he can.

The Office's research program, in particular the educational research laboratories now being established, will result in continued improvement in the efficiency of the Nation's educational system. The interest in, and the ability to cope with, the problems which are being researched means that for the first time every level of American education will have available to it the means to effect its own improvement and renewal. Efforts such as these will create a new and more effective partnership in the improvement of American education. The fact that colleges and universities, State educational agencies, and local schools may be both beneficiary and participant in this effort will make the administration of research much more responsive to the needs of education and should result in more rapid improvement in education, contributing to the greater economic and social progress of the Nation.

10. Economic classification of program expenditures. (See table 2.)

Program: Educational research.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Office of Education; Bureau of Educational Research.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchase of goods and services:	
Wages and salaries	[1] 0.9
Other	[2] 19.5
Total, Federal expenditures	20.4
Non-Federal expenditures	[3] 8.0
Total expenditures for program	28.4

[1] Estimated
[2] Includes payments for research work preformed on contract and grants to State and local governments, institutions of higher education, and nonprofit organizations.
[3] Includes some expenditures by State and local governments as well as by individuals and nonprofit organizations.

Vocational Rehabilitation Administration

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The Vocational Rehabilitation Administration is the focal point in the Department of Health, Education, and Welfare for administration of programs to achieve the vocational rehabilitation of physically and mentally disabled persons and their greater utilization in suitable, gainful employment.

The overall objective is to provide the leadership and the means for furnishing vocational rehabilitation services to all the disabled who need and can be expected to benefit from such services.

Within this objective these are the five main missions of the Vocational Rehabilitation Administration:

To build State vocational rehabilitation agency programs of services for the disabled;

To increase rehabilitation knowledge and techniques and their application to practice;

To increase the Nation's supply of trained rehabilitation manpower which will continue to be in severe shortage;

To increase and improve the physical plants for serving the disabled, including rehabilitation facilities and workshops, training settings, specialized clinics, and other special facilities; and

To educate the general public and specific publics—such as employers, researchers, public and voluntary agencies, and the disabled themselves—about vocational rehabilitation of the disabled and to disseminate available rehabilitation knowledge.

The Vocational Rehabilitation Administration estimates that among the millions of our citizens who are disabled, there are over 3.5 million persons of working age who could be rehabilitated to employment. Each year an additional 450,000 people join the group who are disabled and who could be restored to useful activity and work through vocational rehabilitation services. With the added authority and opportunities provided by the Vocational Rehabilitation Act Amendments of 1965, there is a strengthened commitment to press forward to the

central objective of furnishing rehabilitation services to all who need and can use them.

2. Operation

The Vocational Rehabilitation Administration is a Federal agency in the Department of Health, Education, and Welfare. The agency has a headquarters staff and regional staff in the nine HEW regional offices. The Vocational Rehabilitation Administration staff has responsibility for exercising leadership in vocational rehabilitation and for administering the various authorities provided in the Vocational Rehabilitation Act as amended.

Specialist staff of the Vocational Rehabilitation Administration, including regional staff who are supervised by headquarters staff, provide technical assistance to applicants and grantees, the bulk of which are State vocational rehabilitation agencies and nonprofit public and voluntary organizations such as universities, rehabilitation centers, and sheltered workshops.

At the core of the Vocational Rehabilitation Administration's responsibility is the program of grants to States to support the provision of a wide range of vocational rehabilitation services to disabled persons and a program for licensing blind persons to operate vending stands on Federal and other property. Basic support grants are distributed to the State vocational rehabilitation agencies under a statutory formula. Starting in fiscal year 1966, States also receive project grants for special innovation efforts. States have been receiving grants for extension and improvement projects which will be phased out, to be supplanted by the innovation project grants provided under the new 1965 legislation.

The Vocational Rehabilitation Administration also administers a program of grants to support research, demonstration, and training to improve rehabilitation knowledge and techniques and to increase the supply of professionally trained rehabilitation personnel. It carries responsibility for research, research training, and the interchange of rehabilitation experts and other special rehabilitation activities overseas.

The Vocational Rehabilitation Administration also cooperates with the Social Security Administration in disability determinations and determinations of vocational rehabilitation potential under the Social Security Act and in providing rehabilitation services to disabled applicants and beneficiaries; with the Bureau of Employees' Compensation, Department of Labor, in providing rehabilitation services for disabled Federal employees; and with the Public Health Service in the administration of grants for rehabilitation facilities under the Hill-Burton Medical Facilities Survey and Construction Act.

In addition, the Vocational Rehabilitation Administration maintains continuing liaison with numerous agencies of the Federal Government; with the Department of Labor in connection with the selective placement activities of the Employment Service and with the manpower development and training program; with the President's Committee on Employment of the Handicapped; with the Office of Economic Opportunity; and with the various other agencies in the Department of Health, Education, and Welfare, with regard to all activities involving the disabled and their vocational rehabilitation, such as special education, vocational education, health, welfare, and social insurance.

3. History

The program for vocational rehabilitation of the disabled, now 45 years old, is one of the oldest grants-in-aid programs for providing services to individuals. The program had its start in 1920 when President Wilson signed the Smith-Fess Act. This first act provided for services limited to counseling, job training, artificial limbs and other prosthetic appliances, and job placement. The initial appropriation of $750,000 for payments to States cooperating in vocational rehabilitation of persons disabled in industry was raised to $1 million for the fiscal years 1922–24. The Federal Board of Vocational Education was responsible for this program.

Authorization for the program was temporary, requiring renewal in succeeding years. The first permanent authorization for this program came with the Social Security Act in 1935, which recognized the importance of rehabilitation in a program for economic security. The Social Security Act also included authorization for appropriations to extend and strengthen the Federal-State program of vocational rehabilitation by providing for both increased grants to States and increased support for Federal administration.

World War II forced reexamination of this essentially small-scale program, and in 1943 major amendments to broaden the program were passed. Vocational rehabilitation then for the first time could provide (1) medical, surgical, and other physical restoration services to eliminate or reduce disabilities; and (2) services for persons whose disability was mental illness or mental retardation. This law also brought into the vocational rehabilitation program for the first time the separate State agencies serving the blind. The concept of rehabilitation was significantly broadened by this law's definition of vocational rehabilitation services as "any services necessary to render a disabled individual fit to engage in a remunerative occupation."

The cost of rehabilitation services under the 1943 act was shared under an arrangement whereby the Federal Government paid (1) the full cost of rehabilitating the war disabled, (2) half the cost of rehabilitating other disabled persons and (3) the full cost of administering the program, including guidance and placement services. This system replaced the 50–50 sharing arrangement previously in effect.

By the early 1950's it had become apparent that the program was being held back, partly by the financing system and partly by lack of authority for supporting research, training of professional staff, and development of rehabilitation facilities. In 1954 the legislative authority was overhauled to remedy these deficiencies. New financing provisions with variable matching were designed to give greater financial support to States with relatively large population and relatively small per capita income. The Federal share varied from 50 percent to 70 percent, and the national average was about three Federal dollars to two State dollars.

The 1954 amendment authorized grants to encourage support of research into better rehabilitation and demonstration projects through which new knowledge could be applied in communities across the country. These grants go to public and private nonprofit organizations such as State rehabilitation agencies, voluntary organizations, universities and rehabilitation facilities.

Training grants to increase the supply of trained manpower in the professional fields involved in rehabilitation were also authorized by the 1954 amendments.

These amendments also initiated use of Federal grant funds to support establishment of rehabilitation facilities and workshops, i.e., alteration of existing buildings and equipment, and—in the case of rehabilitation facilities—initial staffing.

The next major forward step was the 1965 Vocational Rehabilitation Act Amendments, which had three major emphases:

1. The new provisions in the Vocational Rehabilitation Act Amendments, in concert, are designed to put the public vocational rehabilitation program on a scale of operation which it should attain in this coming decade.

2. The new provisions aim to strengthen the program's ability to tackle and solve the problems of rehabilitating the very difficult cases, the severely disabled.

3. These provisions also are drawn to make possible a direct drive to build more rehabilitation facilities and workshops and, equally important, to strengthen those now operating.

More specifically, the 1965 revisions of the Vocational Rehabilitation Act provide for:

(*a*) The broadening of the base of the Federal-State program to take into the program not only more of the disabled, but also a greater spread of the severe disabilities.

(*b*) The liberalization of Federal financial support of certain portions of the program to match State money more favorably with Federal funds so as to put State vocational rehabilitation agencies in better position to secure State appropriations for their programs.

(*c*) A multifaceted, comprehensive program of grants to improve and strengthen the workshops of the Nation.

(*d*) A rehabilitation facilities construction program directed primarily to construction of vocationally oriented facilities.

(*e*) A concerted effort to remove and prevent architectural barriers which impede the rehabilitation of the handicapped.

(*f*) Special projects grants to allow quick, responsive focus on particular program areas, such as the mentally retarded, the victims of heart disease, cancer and stroke, cerebral palsy, and similar groups of the disabled, and for statewide planning.

(*g*) Extended training of professional rehabilitation staff.

(*h*) The establishment of intramural programs of rehabilitation research and data assembling and dissemination.

The Vocational Rehabilitation Administration also has new responsibility under the 1965 medicare provisions, which included new authority making funds available to the State vocational rehabilitation agencies to pay for rehabilitation services for OASDI beneficiaries and restore them to work and to effect savings for the trust funds.

The Correctional Rehabilitation Study Act of 1965, provides authority for the Vocational Rehabilitation Administration to grant Federal funds to help finance a 3-year coordinated study and report on manpower needs in the correctional field.

4. Level of operations. (See tables 1.1 through 1.13.)

Because of the different activities encompassed in the vocational rehabilitation program, the answer to this question has been divided into segments in order to give a clearer picture of the total program.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Vocational Rehabilitation Administration.

TABLE 1.1.—*Program: Sections 2 and 3 of the Vocational Rehabilitation Act*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 [1]	Fiscal year 1967 estimate
(a) Magnitude of program (people rehabilitated)	119,708	134,859	168,500	207,500
(b) Applicants or participants: State Government agencies (participants)	90	90	91	91
(c) Federal finances (annual appropriations): Unobligated appropriations available	$88,788	$100,100	$163,500	$239,000
Obligations incurred	$86,778	$99,285	$163,500	$239,000
(d) Matching or additional expenditures for program	[illegible]	[illegible]	[illegible]	[illegible]
(e) Number of Federal employees [2]				
(f) Non-Federal personnel (employees)	7,155	8,250	11,000	13,600
(g) Other measures or level of magnitude of performance (number of people served)	399,852	441,338	562,000	690,000

[1] Includes pending supplemental appropriation.
[2] See statement on salaries and expenses, table 1.12.

TABLE 1.2.—*Program: Expansion of rehabilitation services*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (number of projects)			60	100
(b) Applicants or participants: State government agencies and other nonprofit institutions and agencies [1] (grantees)				
(c) Federal finances: Unobligated appropriations available			$3,000	$6,300
Obligations incurred			$3,000	$6,300
(d) Matching or additional expenditures for the program			$333	$700
(e) Number of Federal employees [2]				
(f) Non-Federal personnel [3]				
(g) Other measures or level of magnitude of performance [3]				

[1] New program; information not available for breakdown between these 2 categories.
[2] See statement on salaries and expenses, table 1.12.
[3] Information not available.

TABLE 1.3.—*Program: Statewide planning grants for development of comprehensive vocational rehabilitation programs in each State*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (number of projects)			21	33
(b) Applicants or participants: State vocational rehabilitation agencies or other designee appointed by the Governor (grantees)			21	33
(c) Federal finances: Unobligated appropriations available			$2,000	$3,200
Obligations incurred			$2,000	$3,200
(d) Matching or additional expenditures for the program			(1)	(1)
(e) Number of Federal employees [2]				
(f) Non-Federal personnel [3]				
(g) Other measures or level of magnitude of performance [3]				

[1] Not applicable.
[2] See statement on salaries and expenses, table 1.12.
[3] Information not available.

TABLE 1.4.—*Program: Construction grant program*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program:				
Construction grants				40
State planning grants for rehabilitation facilities			20	54
(b) Applicants or participants: State government agencies and other nonprofit institutions and agencies [1] (grantees)				
(c) Federal finances:				
Unobligated appropriations available			$1,500	$4,500
Obligations incurred			$1,500	$4,500
(d) Matching or additional expenditures for the program [2]				
(e) Number of Federal employees [3]				
(f) Non-Federal personnel [4]				
(g) Other measures or level of magnitude of performance [4]				

[1] New program; information not available.
[2] New program; information not available. Federal matching rate varies by program.
[3] See statement on salaries and expenses, table 1.12.
[4] Information not available.

TABLE 1.5.—*Program: Workshop improvement program*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (workshop improvement projects)			60	160
(b) Applicants or participants: State and public and other nonprofit institutions and agencies [1]				
(c) Federal finances:				
Unobligated appropriations available			$1,310	$4,000
Obligations incurred			$1,310	$4,000
(d) Matching or additional expenditures for the program [2]				
(e) Number of Federal employees [3]				
(f) Non-Federal personnel [4]				
(g) Other measures or level of magnitude of performance [4]				

[1] New program; information not available.
[2] New program; information not available. Federal share of cost up to 90 percent.
[3] See statement on salaries and expenses, table 1.12.
[4] Information not available.

TABLE 1.6.—*Program: Training service projects to workshops and rehabilitation facilities*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (number of workshops and rehabilitation facilities assisted)				35
(b) Applicants or participants: State and public and other nonprofit institutions and agencies (grantees)				35
(c) Federal finances:				
Unobligated appropriations available				$2,000
Obligations incurred				$2,000
(d) Matching or additional expenditures for the program [1]				
(e) Number of Federal employees [2]				
(f) Non-Federal personnel [2]				
(g) Other measures or level of magnitude of performance [2]				

[1] New program; information not available. Federal share of cost of each project is 90 percent.
[2] See statement on salaries and expenses, table 1.12.
[3] Information not available.

TABLE 1.7.—*Program: Research and demonstration activities under section 4 of the Vocational Rehabilitation Act*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967 estimate
(a) Magnitude (projects)	371	385	437	449
(b) Applicants:				
State (projects)	75	77	87	90
Other (projects)	296	308	350	359
(c) Federal finances:				
Appropriations available	$15,180	$17,070	$20,570	$21,850
Obligations incurred	$15,179	$17,069	$20,570	$21,850
(d) Matching	$6,038	$5,150	$5,760	$5,500
(e) Number of Federal employees [1]				
(f) Non-Federal personnel [2]				
(g) Other measures or level of magnitude of performance [2]				

[1] See statement on salaries and expenses, table 1.12.
[2] Information not available.

TABLE 1.8.—*Program: Training activities under sections 4 and 7 of the Vocational Rehabilitation Act*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program: [1]				
Long-term:				
Teaching grants	409	399	444	479
Traineeships	3,236	3,722	4,520	5,173
(b) Applicants or participants (grantees):				
State government agencies [2]	66	75	86	80
Other nonprofit institutions and agencies	203	218	249	235
(c) Federal finances:				
Unobligated appropriations available	$16,565	$19,810	$24,800	$29,800
Obligations incurred	$16,528	$19,770	$24,800	$29,800
(d) Matching or additional expenditures for the program [3]	$3,374	$3,865	$4,007	$4,920
(e) Number of Federal employees [4]				
(f) Non-Federal personnel [5]				
(g) Other measures or level of magnitude of performance [5]				

[1] Excludes short-term training activities.
[2] Includes State agencies for the blind.
[3] These are estimated figures. It is estimated that grantee's share of the total cost of project averages 45 percent of the teaching grant except State agency inservice training grants for which the State agency's share is 10 percent.
[4] See statement on salaries and expenses, table 1.12.
[5] Information not available.

TABLE 1.9.—*Program: Research and training center program*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (centers)	6	15	17	17
(b) Applicants or participants:				
State Government agencies [1] (grantees)		3	3	3
Other nonprofit institutions and agencies (grantees)	6	12	14	14
(c) Federal finances:				
Unobligated appropriations available	$2,965	$4,085	$7,575	$8,575
Obligations incurred	$2,965	$4,084	$7,575	$8,575
(d) Matching or additional expenditures for the program	$1,760	$2,236	$3,266	$3,619
(e) Number of Federal employees [2]				
(f) Non-Federal personnel [3]				
(g) Other measures or level of magnitude of performance [3]				

[1] In conjunction with universities.
[2] See statement on salaries and expenses, table 1.12.
[3] Information not available.

TABLE 1.10.—*Program: International activities—Special foreign currency program*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of program:				
Projects	65	79	99	117
Experts to and from United States	[1] 29	[1] 58	[1] 82	[1] 87
Trainees (in United States) and visitors	104	125	135	140
(c) Federal finances:				
Unobligated appropriations available [2]	$4,426	$3,662	$3,503	$4,000
Obligations incurred	$2,768	$2,209	$3,503	$4,000
Domestic support foreign currency program [3]	$100	$100	$100	$100
(e) Number of Federal employees [4]				

[1] Rehabilitation research experts from United States for consultation or projects: 1964, 14; 1965, 30; 1966, 40; 1967, 41.
[2] Foreign currencies.
[3] U.S. dollars.
[4] See statement on salaries and expenses, table 1.12.

TABLE 1.11—*Program: Correctional Rehabilitation Study Act*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (project) [1]			1	1
(b) Applicants or participants: Other nonprofit institution			1	1
(c) Federal finances:				
Unobligated appropriations available			$500	$800
Obligations incurred			$500	$800
(d) Matching or additional expenditures for the program			$128	$272
(e) Number of Federal employees [2]				
(f) Non-Federal personnel [3]				
(g) Other measures or level of magnitude of performance [3]				

[1] 1st and 2d year of 3-year study.
[2] See statement on salaries and expenses, table 1.12.
[3] Information not available.

TABLE 1.12.—*Program: Salaries and expenses*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967
(c) Federal finances:				
Unobligated appropriations available	$2,905	$3,232	$4,050	$5,381
Obligations incurred	$2,800	$3,107	$4,050	$5,381
(e) Number of permanent Federal employees [1]	250	268	351	414

[1] Includes all permanent employees of the VRA. It is not feasible to provide a breakdown of these employees among the several VRA programs.

TABLE 1.13.—*Program: Rehabilitation of disability beneficiaries—Paid from social security trust funds*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (rehabilitants)			6,500	7,500
(b) Applicants or participants (grantees):				
State government				
Agencies				
(c) Federal finances:				
Transfer from Social Security Administration trust funds			$6,000	$14,000
Obligations incurred			$6,000	$14,000
(d) Matching or additional expenditures for the program [1]				
(e) Number of Federal employees [2]				
(f) Non-Federal personnel [3]				
(g) Other measures or level of magnitude of performance [3]				

[1] Not applicable.
[2] See statement on salaries and expenses, table 1.12.
[3] Information not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) *Within your bureau, division, or office.*—Within the Vocational Rehabilitation Administration, coordination and cooperation among the divisions is assured through the following means: close supervision of activities by division chiefs; direct coordination of interdivisional activities by the Assistant Commissioners; and finally, direct review and supervision of all activities in the Office of the Commissioner. Maximum utilization is made of advisory committees and outside consultation where required.

(*b*) *With other units of your department or agency.*—There follow some examples of coordination and cooperation between the Vocational Rehabilitation Administration and other parts of the Department of Health, Education, and Welfare:

1. In the areas of services to individuals—Welfare Administration (Children's Bureau): As early as 1943, a cooperative agreement was developed with the Children's Bureau and issued to States as a guide to collaboration in serving crippled children approaching the age for vocational planning. The Vocational Rehabilitation Administration participation in the Interdepartmental Committee on Children and Youth alerts States to developing needed programs. States are afforded an opportunity to learn of major anticipated developments of import for vocational rehabilitation and are encouraged to collaborate with State crippled children's programs to assure optimum vocational adjustment for disabled youths.

Bureau of Family Services: Methods used include cooperating agreements and guides for States, State plan requirements, cooperative projects, inservice training for State and local staff, advising States of recent national developments and plans, and active liaison in operational and policy matters. Inservice training: VRA has supported training workshops to increase the skills of State and/or

local public welfare and vocational rehabilitation personnel in cooperative planning and services. Liaison on operations and policies: Active staff liaison includes consultation in handling of operational questions and in development of policies affecting vocational rehabilitation of public assistance recipients.

Office of Education: Both the Vocational Rehabilitation Administration and the Office of Education recognize the fact that the two agencies have a joint responsibility in seeing that handicapped children and youth are provided necessary rehabilitation services. This cooperative relationship has been strengthened by legislative programs affecting both agencies. The Vocational Education Amendments of 1963 provide additional and improved training programs for both youth and adults, including the disabled, in need of vocational skills. The Elementary and Secondary Education Act of 1965 provides among other things for the identification of many more handicapped children and thus sets the stage for increasing cooperation between vocational rehabilitation and special education programs.

At the present time, interagency conferences are being held to establish written guidelines so as to emphasize and blueprint procedures to effect an extension of special education-vocational rehabilitation programs at the State and local boards of education and the State divisions of vocational rehabilitation to incorporate joint programing as a regular and ongoing policy, and to extend these services to all handicapped youth.

A summary of regional reports relative to vocational rehabilitation-special education cooperative programs for the first quarter of fiscal year 1965 indicates that 33 States involving some 287 individual school districts have such an agreement. Planned expansion should result in new programs in an additional six States in the next few months and in all States in the near future.

U.S. Public Health Service, military rejectees: Utilizing funds transferred to the Department of Health, Education, and Welfare from the Office of Economic Opportunity, the Vocational Rehabilitation Administration and the Public Health Service jointly developed and implemented a program of screening, referral, and followup services to young men rejected for medical reasons at the 73 Armed Forces examining stations. The program was designed by State and Federal health and rehabilitation personnel based on experience gathered in pilot projects sponsored by both VRA and PHS. A joint staff, composed of personnel from both agencies, is responsible for orientation and training of field personnel and for program surveillance.

The Vocational Rehabilitation Administration is also participating with the Department of Defense, the Selective Service System, the Department of Labor, and the Public Health Service in an Interdepartmental Committee on Military Rejectees. This committee was formed to coordinate all Federal programs for young men rejected for military service.

Mentally retarded: Vocational Rehabilitation Administration collaborates with the Division of Hospital and Medical Facilities, Public Health Service, in implementing the grant programs authorized under Public Law 88–164 for the construction of university-affiliated facilities for the mentally retarded. This has involved formal review of grant applications and participation in site visits to university applicants.

At both the regional and central office levels, the Vocational Rehabilitation Administration staff cooperate with the Public Health Service's Mental Retardation Branch in implementing the program of grants to States for comprehensive planning in mental retardation authorized under Public Law 88-156 and the Social Security Amendments of 1965. VRA personnel serve on the committees which review the grant applications, and provide critical comment on those aspects of the plans which concern rehabilitation. VRA also joins in site visits to selected States to assist PHS in consulting with State officials on planning.

Migrant labor: The Public Health Service initially convened this committee to develop improved interagency programs to serve the migrant worker and his family. Later, as the Migrant Health Branch was developed to administer the migrant health grants this group served in a consultant and supportive capacity. VRA staff have had a continuing involvement on this advisory group and have demonstrated by research and demonstration projects the vocational rehabilitation needs and medical deficits of migrants. State vocational rehabilitation agencies have been encouraged wherever possible to provide vocational rehabilitation services to migrants.

Social Security Administration: The Vocational Rehabilitation Administration maintains a continuous liaison with Social Security Administration in two program areas. The first relates to the SSA disability insurance program which was established by the Social Security Amendments of 1954, and under which State vocational rehabilitation agencies (in all but five States) by agreement with SSA make determinations of disability in the cases of individuals applying for disability benefits. All persons applying for disability benefits by law, also must be referred for necessary vocational rehabilitation services. The purpose of the liaison function is to insure coordination in relationships with the State agencies in the interests of advancing Federal program objectives in both of these activities.

The second program, as authorized by the Social Security Amendments of 1965, relates to payments from the trust funds for the cost of providing vocational rehabilitation services to social security disability beneficiaries.

2. In research: An informal system of communication is maintained between relevant parts of VRA, the National Institutes of Health and the Bureau of State Services of the Public Health Service. The abstracts of projects on rehabilitation topics are routinely supplied to the study sections of VRA by the Science Information Exchange which also supplies VRA abstracts to relevant study sections in NIH. In this way the same or similar projects submitted to different study sections are identified and sources of overlap discovered.

In addition, there is regular contact between the various VRA study sections, the PHS Bureau of State Services, and NIH study sections, including those on cardiovascular disease, health services research, neurology, general medicine, and surgery. The executive secretaries of NIH study sections are always invited to appropriate VRA study section meetings. Also invited are the Medical Director of the Neurological and Sensory Disease Service Branch of the Bureau of State Services; the Chief of Research Grants of the Division of Chronic Diseases, Bureau of State Services; and the Chief of Grants Programing and Coordination in the same Division. The VRA study

sections executive secretaries are in turn invited to meetings of those parts of PHS.

There have been several interagency projects. Currently, a project approved for support by both PHS and VRA is one at the Barrow Neurological Institute of St. Joseph's Hospital in Phoenix, Ariz., on a regional program for the habilitation and rehabilitation of patients with epilepsy and related neurological disabilities. The project is to be handled as two complementary separately funded parts, both contributing to the functioning of a regional center for the rehabilitation of the epileptic and other neurological disorders. The VRA contribution is focused on the vocational rehabilitation aspects.

(c) *Some examples of coordination and cooperation with other governmental agencies:*

1. In the area of service to individuals—Veterans' Administration: As early as 1946 a joint statement of principles of cooperation was developed between the Veterans' Administration and the Office of Vocational Rehabilitation, applicable to the vocational rehabilitation of veterans not covered by VA legislation.

Civil Service Commission: Vocational Rehabilitation Administration collaborates closely with the Director, Employment Program for the Handicapped and other key staff of the Civil Service Commission and its regional offices in implementing the program of Federal employment of the handicapped. This collaborative relationship is particularly vital to the program for Federal employment of the mentally retarded, which is jointly operated by the Civil Service Commission and the State-Federal program of vocational rehabilitation.

Department of Housing and Urban Development: VRA and the Public Housing Administration are jointly planning for ways of broadening collaboration by local public housing authorities and State vocational rehabilitation agencies.

Bureau of Indian Affairs: A cooperative relationship agreement was developed with the Office of Indian Affairs, Department of the Interior, in 1947. A revised agreement with the Bureau of Indian Affairs was effected in 1962 for the guidance of State rehabilitation agencies in meeting the disability problems of Indians.

Department of Labor: Cooperative programs involving the VRA and the U.S. Department of Labor are based on the interest of both agencies in the training and employment of handicapped persons. Written agreements, liaison, and cooperative working relationships have been developed between VRA and the Department of Labor, between VRA and individual bureaus within the Department of Labor, and between their State and local constituents. Such relationships are in operation between the Vocational Rehabilitation Administration and the following:

A. Office of Manpower, Automation, and Training. This office was established after passage of the Manpower Development and Training Act of 1962. Arrangements have been made whereby VRA reviews and furnishes comments to OMAT on all MDTA projects involving handicapped persons.

B. The Bureau of Apprenticeship and Training. Cooperative relationships have been established between the BAT and the State vocational rehabilitation programs. Most recently, we have developed joint projects involving employment of the mentally retarded in

industrial laundries and retail chainstores. We have also cooperated with the BAT in developing programs for the placement and training of personnel employed in rehabilitation facilities.

C. Bureau of Employment Security. The Vocational Rehabilitation Administration has a written agreement with the Bureau of Employment Security to increase the number of handicapped persons placed in productive employment. The Vocational Rehabilitation Administration issued as early as 1956 a detailed plan for all State vocational rehabilitation agencies to implement national policies and procedures established between the VRA and the Bureau of Employment Security. We are currently negotiating with BES to review and update these agreements.

D. Bureau of Employees Compensation. The VRA also has a long-standing agreement with the Bureau of Employees Compensation. Of particular significance is the provision for the prompt referral of disabled civil employees of the United States and disabled individuals who apply for benefits under the Longshoreman's and Harbor Workers Compensation Act. Copies of this agreement have been furnished by VRA to all State agencies.

E. President's Committee on Employment of the Handicapped. The VRA Act contains the appropriation authority for support of the activities of the President's Committee on Employment of the Handicapped and provides that the Secretary of Labor, Secretary of HEW, and the Chairman of the President's Committee shall cooperate in developing and recommending methods to assure maximum utilization of services in promoting job opportunities and placement for handicapped persons. On the national level all three agencies maintain a continuing close liaison in the development of national plans and the preparation of procedural guidelines and informational materials for use by State and local affiliates. At the State level, State vocational rehabilitation and employment service agencies have written cooperative agreements which include provision for direct involvement of Governors and local committees in the employment of the handicapped.

2. In the area of training: The Division of Training maintains close liaison with similar programs in other Federal Government departments or agencies, for example, those in the Office of Education, the Children's Bureau, the National Institute of Mental Health and other divisions within the Public Health Service, the Department of Justice and the Labor Department. There are no formal agreements but there is a constant exchange of information and frequently joint planning and implementation of a training program. Training programs for personnel have been planned jointly with the U.S. Bureau of Prisons and short-term training courses have been cosponsored and jointly financed by the Public Health Service and the Vocational Rehabilitation Administration, for example, the National Stroke Conference, a conference on cardiac work evaluation units and an institute on the rehabilitation of the narcotic addict.

3. In research: In cases where another Federal department or agency has common interests with VRA, liaison is maintained and information exchanged between the two agencies. The Research and Demonstration Division, for example, maintains contact with the Office of Manpower, Automation and Training of the Department of Labor, offering consultation on OMAT projects of interest to VRA. Close contact is

maintained with the U.S. Bureau of Prisons in that a number of VRA projects are being initiated to study the vocational rehabilitation of Federal public offenders.

4. In the area of rehabilitation facilities and workshops: The Rehabilitation Facilities Division maintains close liaison with the Wage and Hour and Public Contracts Division of the Department of Labor relative to certification of sheltered workshops. There is also a recurring relationship with the President's Committee on Employment of the Handicapped concerning problems of workshop employment and architectural barriers. Since residential facilities for the handicapped may be constructed adjacent to sheltered workshops, this Division also coordinates with the Federal Housing Administration.

5. In the area of international activities: The program of the VRA Division of International Activities works cooperatively with the Department of State and the International Office of the Department of Labor. The approval of rehabilitation research projects and communications relating to project operation pass through the Office of the Science Adviser, Department of State, where purposes are determined to be in accord with U.S. foreign policy. The Division receives rehabilitation trainees from other countries whose support is provided by the United Nations fellowship program and the foreign training program of the Agency for International Development. These trainees are referred by the Department of State through its Agency for International Development. The Division cooperates also with the Bureau of Educational and Cultural Exchange of the Department of State by arranging or participating in arranging the programs for leaders and specialists brought by the Bureau of the United States to study and observe rehabilitation activities. The Division also cooperates through the exchange of information on rehabilitation activities of mutual interest with the International Labor Organization, as well as the World Health Organization. Evidences of this cooperation are seen in the ILO recommendation 99 endorsed by the International Labor Conference of 1955 and the companion resolution of the International Labor Conference in June 1965 reporting on 10 years of activity under resolution 99.

(*d*) Under the Vocational Rehabilitation Act, the program must be administered through the vocational rehabilitation agency. Thus, the major focus of all of our efforts is directed to help each State vocational rehabilitation agency build the strongest possible program.

(*e*) The Vocational Rehabilitation Administration has no direct responsibility for working with local community agencies except as they may qualify as a grantee under one of our programs or as we may provide assistance through the State vocational rehabilitation agencies to expand and strengthen local rehabilitation programs.

(*f*) *With Foreign Governments or International Organizations.*—The Vocational Rehabilitation Administration, with the assistance of and through the American Embassies, maintains on-the-spot negotiations when indicated with members of the Ministries, Departments or other appropriate parts of the national governments of other countries in relation to the initiation and operation of international rehabilitation research projects. For example, VRA has planned projects with the Ministry of Social Affairs of the United Arab Republic and assisted representatives of the Ministry in interpreting proposed research undertakings to selected sponsors, such as the orthopedic department.

of the University of Cairo, and the opthalmological department of EinShams University.

In Poland, the cooperation of project sponsors is achieved through primary planning with the Coordinating Council in the ministry of Health and Social Welfare, and in India through the India Council of Medical Science.

(*g*) *Voluntary Agencies.*—The Vocational Rehabilitation Administration has developed relationships with many voluntary organizations devoted to problems of specific illness and disability. These relationships include provision for joint research procedures, training and research grants, the provision for films and educational materials, and cooperative in-service training programs.

An example of this cooperative relationship is the agreement between the Vocational Rehabilitation Administration and the American Heart Association.

(*i*) *With Other Organizations.*—The Vocational Rehabilitation Administration maintains cooperative working arrangements with a number of international voluntary organizations through such activities as the regular exchange of information, participation in programs, special undertakings, and when appropriate, through the payment of membership dues. The Vocational Rehabilitation Administration staff takes part in the annual or special meetings of international organizations and calls upon international organizations to participate in the training programs of foreign nationals. Some principal international organizations with which the Vocational Rehabilitation Administration maintains cooperative working relationships are the Bureau of Social Affairs, United Nations; the International Society for Rehabilitation of the Disabled, the World Rehabilitation Fund, Inc.; the American Foundation for the Overseas Blind; and the World Veterans Foundation.

8. Laws and regulations

The two lists below include (1) the major Federal laws in effect which relate to the Federal-State program of vocational rehabilitation and (2) all Federal laws relating to this program from its inception to the present.

List I: Current Federal legislation.—The major Federal laws currently in effect which relate to the Federal-State program of vocational rehabilitation are:

1. Vocational Rehabilitation Act (29 U.S.C. ch. 4) as amended by:
   (*a*) Section 2 of Public Law 565, 83d Congress (Vocational Rehabilitation Amendments of 1954):
      Section 2—grants to States for basic support of vocational rehabilitation services.
      Section 3—grants to States for the extension and improvement of vocational rehabilitation services.
      Section 4—grants for research, demonstration, and training.
   (*b*) Amendments to the Vocational Rehabilitation Act since 1954:
      Act of August 1, 1956, section 16 of Public Law 896, 84th Congress, 2d session, extension of provisions of Vocational Rehabilitation Act to Guam.
      Public Law 85–198, amendments to exempt physicians enrolled in residency training program in physical medicine

and rehabilitation from the 2-year limitation on receipt of a Vocational Rehabilitation Administration traineeship and permit them to receive a traineeship for as long as 3 years.

Public Law 86–70, Alaska Omnibus Act, in connection with Alaska's statehood, amendments of financing provisions for Alaska's basic support program under section 2 of the Vocational Rehabilitation Act.

Public Law 86–624, Hawaii Omnibus Act, in connection with Hawaii's statehood, amendments of financing provisions for Hawaii's basic support program under section 2 of the Vocational Rehabilitation Act. Section 47g of this law affected Alaska's basic support program during the fiscal years 1962 through 1965.

Public Law 88–605 (appropriation act) amendment to authorize as State funds for matching purposes, contributions of funds made by private organizations or individuals to a State to assist in meeting the cost of establishment of a public or other nonprofit workshop or rehabilitation facility, where the contributor imposes a condition limiting the use of such funds to establishment of such workshop or facility.

(*c*) Public Law 89–333 which provides for an improved and expanded program of services for handicapped individuals under liberalized Federal financing. It also provides for increased and expanded Federal financial participation in research and training and project development. Attention is also given to special problems such as architectural barriers, and correctional rehabilitation.

2. International Health Research Act of 1960 (22 U.S.C. ch. 30): Public Law 86–610 and section 104(k), Agricultural Trade Development and Assistance Act of 1954 as amended (7 U.S.C. 1704 foreign currency program)—legislation in connection with administration of an international research program for the purpose of enhancing rehabilitation research within the United States and over the world.

3. Randolph-Sheppard Vending Stand Act: Public Law 732, 74th Congress, as amended (20 U.S.C. ch. 6A)—provides that qualified blind persons licensed by a designated State agency shall be given preference to operate vending stands on Federal and other property.

4. Rehabilitation facilities construction provisions of title VI of the Public Health Service Act as amended by section 3(A) of Public Law 88–413, Hospital and Medical Facilities Amendments of 1964 (42 U.S.C. ch. A, subch. IV)—in connection with construction and modernization of hospital and other medical facilities, authorized appropriations for construction of public or other nonprofit rehabilitation facilities.

5. Disability benefits provisions of the Social Security Act as amended (42 U.S.C. 421, 422)—in connection with the disability determination provisions of the Social Security Act, authorized agreements whereby responsibility is assigned to State vocational rehabilitation agencies for evaluating the disability and rehabilitation potential of each person who applies for disability benefits under OASDI and also requires referral of such persons to the State agency for necessary vocational rehabilitation services.

6. Public Welfare Amendments of 1962 (42 U.S.C. 303, 603, 1203, 1323, 1383)—use of State vocational rehabilitation agencies by State

welfare agencies in furnishing vocational rehabilitation services to assistance recipients or applicants.

7. Prohibition of Discrimination, title VI, Civil Rights Act of 1964, Public Law 88–352 (78 Stat. 241)—requires that no person in the United States shall, on the grounds of race, color, or national origin, be subject to discrimination under any program or activity receiving Federal financial assistance. Any program or activity supported by grants from the Vocational Rehabilitation Administration, like every program or activity receiving financial assistance from the Department of Health, Education, and Welfare, must be operated in compliance with this law.

8. Public Law 97 of 1965—provides for the payment of costs of rehabilitation services for qualified individuals from certain trust funds administered under the Social Security Act.

The Vocational Rehabilitation Administration has also been delegated the Secretary's functions under section 9 of the Federal Employees' Compensation Act, as amended (5 U.S.C. 759).

List II: All Federal legislation relating to Federal-State program, 1920–65.—The basic enabling legislation is to be found in four legislative enactments:

1. The first Vocational Rehabilitation Act of 1920 which provided grants to States for limited services in vocational training, counseling, and placement. (The authority for the program was renewed several times until it was made "permanent" as title V, part 4 of the Social Security Act of 1935.)

2. Public Law 113 of 1943, which broadened the concept of rehabilitation to include the provision of physical restoration services to remove or reduce disabilities and to include services to the mentally handicapped. Under this law, for the first time, the separate State agencies serving the blind came into the Federal-State program.

3. Public Law 565 of 1954, which gave great impetus to the cooperative Federal-State program. These amendments were designed to help provide for specialized rehabilitation facilities, for more comprehensive services to individuals, and for other administrative improvements to increase the program's overall effectiveness.

4. Public Law 89–333 which provides for an improved and expanded program of services for handicapped individuals under liberalized Federal financing. It also provides for increased and expanded Federal financial participation in research and training and project development. Attention is also given to special problems, such as architectural barriers and correctional rehabilitation.

Complete list of Federal laws relating to the Federal-State vocational rehabilitation programs, 1920–65

Act of June 2, 1920, Public Law 236, 66th Congress: Provision for an appropriation of $750,000 for the fiscal year 1921 and $1 million a year for fiscal years 1922 to 1924, for payments to States cooperating in vocational rehabilitation of persons disabled in industry. Federal funds were to be matched by the States, and funds were not to be used for institutions for handicapped persons except for special training of individuals entitled to benefits of the act, as determined by the Federal Board of Vocational Education.

Supplemental acts:

Act of March 10, 1924, Public Law 35, 68th Congress: Extended provisions of several grant-in-aid programs, including vocational rehabilitation to Hawaii.

Act of June 5, 1924, Public Law 200, 68th Congress: Authorized appropriations of $1 million a year for fiscal years 1925 to 1930, for payments to States under similar conditions.

Act of February 23, 1929, Public Law 801, 70th Congress: Provided for a program of vocational rehabilitation in the District of Columbia to be administered by the agency which administered the Federal grants to the States, rather than a District agency.

Act of June 9, 1930, Public Law 317, 71st Congress, and act of June 30, 1932, Public Law 222, 72d Congress: Authorized appropriations of $1 million a year for fiscal years 1931 to 1937 for payments to States under similar conditions, except that funds were for persons disabled in industry or otherwise. (Executive Order 6166 of June 10, 1933, transferred the functions of the Federal Board for Vocational Rehabilitation Education to the Department of the Interior, where the functions were administered by the Office of Education.)

Act of March 3, 1931, Public Law 791, 71st Congress: Extended provisions of Vocational Rehabilitation Act to Puerto Rico.

Other changes occurred after the 1931 amendment that affected the law as materially as an amendment of the act. The Social Security Act provided for increased aid to vocational rehabilitation in recognition of the importance of such work in a permanent program for economic security. The Social Security Act did not amend the Vocational Rehabilitation Act. Rather it authorized certain appropriations to be made in order to extend and strengthen the cooperative programs of vocational rehabilitation and "to continue to carry out the provisions and purposes" of the National Vocational Rehabilitation Act of 1920, as amended. The Social Security Act included a permanent authorization, increased grants, and increased support of Federal administration.

Social Security Act, Public Law 271, 74th Congress: The Social Security Act authorized additional appropriations of $841,000 for fiscal years 1936 and 1937 and an additional appropriation of $1,938,000 thereafter.

Social Security Amendments of 1939, Public Law 379, 76th Congress: The social security amendments increased the authorized annual appropriations of $3,500,000 for grants to the States, set the minimum allotment for any State at $20,000, and authorized $150,000 a year to be appropriated for Federal administration. Also, provided that Puerto Rico should share in the grants for vocational rehabilitation on the same basis as a State.

(NOTE.—The basic rehabilitation legislation remained the Vocational Rehabilitation Act of 1920, as amended in 1924, 1930, and 1932, although the authorization for grants under such basic legislation expired in 1937).

Vocational Rehabilitation Act Amendments of 1943, Public Law 113, 78th Congress, amended and superseded the act of 1920, as amended: Payments to States with approved plans for vocational rehabilitation were authorized for (1) the entire expense for vocational rehabilitation of the war disabled; (2) half the expense of vocational rehabilitation of other disabled persons, the remainder to be

State financed; and (3) the entire expense of administration including guidance and placement services. This law placed the 48 States, Alaska, Hawaii, and Puerto Rico on the same footing with respect to Federal grants. The law also significantly broadened the concept of rehabilitation, to define "vocational rehabilitation services" as "any services necessary to render a disabled individual fit to engage in a remunerative occupation."

The effect was to authorize the provision of physical restoration services to remove or reduce disabilities and to make the mentally handicapped eligible for vocational rehabilitation services. In addition, separate State agencies serving the blind came into the Federal-State program for the first time.

Vocational Rehabilitation Amendments of 1954: Vocational Rehabilitation Act (29 U.S.C. ch. 4), as amended by section 2 of Public Law 565, 83d Congress:

Section 2—Grants to States for the basic support of vocational rehabilitation services.

Section 3—Grants to States for the extension and improvement of vocational rehabilitation services.

Section 4—Grants for research, demonstration, and training.

Amendments to the Vocational Rehabilitation Act since 1954:

Act of August 1, 1956, section 16, Public Law 896, 84th Congress, extension of provisions of Vocational Rehabilitation Act to Guam.

Public Law 937, 84th Congress (now expired—extended expansion grants program through fiscal year 1957).

Public Law 85–198, amendments to exempt physicians enrolled in residency training program in physical medicine and rehabilitation from the 2-year limitation on receipt of Vocational Rehabilitation Administration traineeship and permit them to receive a traineeship for as long as 3 years.

Public Law 85–213 (now expired—an extension relating to expansion grant projects).

Public Law 86–70, Alaska Omnibus Act—in connection with Alaska's statehood, amendments of financing provisions for Alaska's basic support program under section 2 of the Vocational Rehabilitation Act.

Public Law 86–624, Hawaii Omnibus Act—in connection with Hawaii's statehood, amendments of financing provisions for Hawaii's basic support program under section 2 of the Vocational Rehabilitation Act.

Public Law 88–605, Appropriations Act, amendment to authorize as State funds for matching purposes, contributions of funds made by private organizations or individuals to a State to assist in meeting the costs of establishment of a public or other nonprofit workshop or rehabilitation facility, where the contributor imposes a condition limiting the use of such funds to establishment of such workshop or facility.

Public Law 89–333 which provides for an improved and expanded program of services for handicapped individuals under liberalized Federal financing. It also provides for increased and expanded Federal financial participation in research and training and project development. Attention is also given to special problems such as architectural barriers and correctional rehabilitation.

Randolph-Sheppard Vending Stand Act, as amended (20, U.S.C. ch.

6a)—This act provides that qualified blind persons licensed by a designated State agency shall be given preference to operate vending stands on Federal and other property. Heads of Federal departments and agencies in control of Federal property are required to prescribe regulations designed to assure that such preference is given. The Secretary of this Department designates the State Commission for the Blind in each State (or, where there is no such commission, some other State agency) as the agency for licensing blind persons to operate vending stands on Federal and other property in such State. In any State having an approved plan under the Vocational Rehabilitation Act, the licensing agency to be designated shall be that which administers vocational rehabilitation of the blind.

Rehabilitation facilities construction provisions of title VI of the Public Health Service Act as amended by section 3A of Public Law 88–413, Hospital and Medical Facilities Amendments of 1964 (42 U.S.C. ch. A, subchapter IV)—in connection with construction and modernization of hospital and other medical facilities, authorizes appropriations for construction of public or other nonprofit rehabilitation facilities.

Disability benefits provisions of the Social Security Act, as amended (42 U.S.C. 421, 422)—in connection with the disability determination provisions of the Social Security Act, authorizes agreements whereby responsibility is assigned to State vocational rehabilitation agencies for evaluating the disability and rehabilitation potential of each person who applies for disability benefits under OASDI and also requires Federal referral of such persons to the State agency for necessary vocational rehabilitation services.

International Health Research Act of 1960 (22 U.S.C. ch. 30) Public Law 86–610 and section 104(k), Agricultural Trade Development and Assistance Act of 1954 as amended (7 U.S.C. 1704) foreign currency program—legislation in connection with administration of an international research program for the purpose of enhancing rehabilitation research within the United States and over the world.

Public Welfare Amendments of 1962 (42 U.S.C. 303, 603, 1203, 1353, 1383)—use of State vocational rehabilitation services to assistance recipients or applicants.

Civil Rights Act of 1964 Public Law 88–352—title VI requires that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

The Vocational Rehabilitation Administration has also been delegated the Secretary's function under section 9 of the Federal Employees' Compensation Act, as amended (5 U.S.C. 759).

The regulations, carrying out the foregoing acts are in Title 45 of the Code of Federal Regulations, chapter 4, as follows:

Part 401—The State vocational rehabilitation programs.

Part 402—Project grants and assistance for workshops and rehabilitation facilities.

Part 403—Research and training.

Part 404—Vending stand program for the blind on Federal and other property.

Part 405—Correctional rehabilitation study.

Part 406—The National Commission on Architectural Barriers to Rehabilitation of the Handicapped.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic aim of the State-Federal vocational rehabilitation program is to enable disabled persons to participate in the Nation's economic activity to the greatest possible degree. Although the effect on the economy as a whole due to vocational rehabilitation may not be great because of the relatively small number of persons involved, the economic gains to rehabilitated persons are nevertheless considerable. Some of these economic gains realized by the rehabilitation of 138,583 [1] persons in the regular State-Federal program and through research and demonstration projects during fiscal 1965 are as follows:

The annual rate of earnings of these 138,583 rehabilitated persons at the time they were accepted for vocational rehabilitation was $50 million. By the time of rehabilitation closure the earnings rose to $300 million—a sixfold gain.

These successful clients were contributing at acceptance 40 million man-hours of work to the economy on an annual basis and 190 million man-hours at closure—nearly a fivefold increase.

More than 100,000 of these persons were not working at the time of acceptance. This group constituted nearly three-quarters of all rehabilitated persons in fiscal 1965.

The State agencies created State-managed business enterprises for about 500 persons while another 100 persons who needed rehabilitation were already in such enterprises at acceptance.

The number of those who were self-employed rose from 3,100 at acceptance to 8,400 at closure.

There were about 24,000 persons who, at acceptance, were either on public assistance or were residing in tax-supported public institutions. About 6,700 of these persons were residing in tax-supported public institutions. The cost of their support is estimated to be about $16 million. The remaining 17,300 persons were drawing public assistance payments at an annual rate of $20 million. At closure, 7,200 persons were on public assistance, drawing $7 million. Thus, a net savings of about $13 million was effected.

The persons rehabilitated in fiscal 1965 are expected to pay in taxes a little over half a billion dollars to the Federal Government during the course of their working lives. Since the Federal Government spent nearly $100 million on the entire program in fiscal 1965, the eventual return in taxes by last year's rehabilitated persons is thus about $5 for every $1 expended. In addition, the return in income taxes to State and local governments by these persons over their working lives is estimated to be about $35 million.

[1] Of these 138,583 persons, 134,859 were rehabilitated under the State-Federal vocational rehabilitation program and the remainder through research and demonstration projects.

10. Economic classification of program expenditures. (See table 2.)

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

Program: Vocational rehabilitation.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Vocational Rehabilitation Administration.

[In thousands of dollars]

Program	*Expenditures*
1. Grants for rehabilitation services, basic support program, sec. 2:	
Federal Government: Grants to State and local governments	93,385
2. Innovation of vocational rehabilitation services, sec. 3:	
Federal Government: Grants to State and local governments	2,276
3. Expansion of rehabilitation services	(1)
4. Statewide planning grants for development of comprehensive vocational rehabilitation programs	(1)
5. Construction grant program	(1)
6. Workshop improvement	(1)
7. Training service projects for workshops and rehabilitation facilities	(1)
8. Research and demonstration:	
Federal Government:	
Transfer payments to individuals and nonprofit organizations	12,742
Grants to State and local governments	4,025
Total, Federal expenditures	16,767
9. Training activities under secs. 4 and 7:	
Federal Government:	
Transfer payments to individuals and nonprofit organizations	16,719
Grants to State and local governments	342
Total, Federal expenditures	17,061
10. Research and training centers:	
Federal Government: Transfer payments to individuals and nonprofit organizations	3,167
11. Special foreign currency program:	
Federal Government: Grant payments to nonresidents in foreign countries	1,519
12. Correctional Rehabilitation Study Act	(1)
13. Salaries and expenses	
Federal Government:	
Purchase of goods and services:	
Wages and salaries	2,746
Other	402
Total, Federal expenditures	3,148
14. Rehabilitation of disability beneficiaries, paid from social security trust funds	(1)
Total, Federal expenditures for all vocational rehabilitation programs listed above	137,323

[1] New program; not in operation in fiscal 1965.

Public Health Service [1]

CONTENTS

BUREAU OF STATE SERVICES—COMMUNITY HEALTH

[1] Public Health Service responses were prepared before Reorganization Plan No. 3 of 1966 became effective. Consequently they do not reflect organizational changes which were in progress during late 1966.

BUREAU OF STATE SERVICES—COMMUNITY HEALTH

INTRODUCTION

"The Health of the people is really the foundation upon which all their happiness and all their prowess as a State depend." That statement, almost a hundred years old, is as true today as it was when it was written. The reverse is also true: the ultimate price of inadequate health protection is the destruction of national, as well as individual strength and vitality.

The concern of the American people over matters affecting their health and their access to health services is already great and is increasing. So, too, is their financial investment in activities related to health.

Federal health programs represent only a modest portion of total health expenditures; those which are the peculiar responsibility of the Bureau of State Services—Community Health, an even smaller part. Nonetheless, the public investment in health is already sizeable, and it continues to grow because there are more people in need of protection, because our understanding of what adequate health protection entails has deepened, and because our ability to undertake effective action has grown.

The entire system of personal health services in this country is based on the treatment of the patient by the individual physician and dentist, and will continue to be. But we know today how complex and varied are the activities which must first be undertaken to prepare for that meeting between doctor and patient and to make it as productive and effective as possible.

We must have further knowledge of the process of disease and of its prevention and control. This requires a massive effort both in the basic research which provides such knowledge and particularly in the applied research which will make it possible to put such knowledge to work for the benefit of the people.

We must educate a great many more physicians and dentists and the other professional people who assist them—the nurses, the laboratory technicians, the dental hygienists—than ever before. This obviously demands extensive systems of undergraduate and graduate schools. But it also demands far greater attention than we have yet given to the development of systems of effective continuing education to keep professionals abreast of the latest advances. Ways must be found to overcome current problems of maldistribution—to attract doctors to work in under-manned sections of the country. Where we cannot achieve adequate distribution, we must find other ways to bring care to people. Further, we must attract and train more doctors for those medical fields which do not now enlist enough to meet growing needs for treatment—mental illness and chronic illness, to name but two.

We must work to remove other artificial barriers separating the people from necessary health care. This means helping people themselves to understand the values of health services—not only personal health services but those more broadly based, such as wide-scale preventive measures. We must emphasize the critical importance of coordinating the planning of health services and treatment facilities, not just for a single community but for a complex of communities, even for several counties or for an entire region.

Ways must be developed for reducing the cost barrier to care and methods devised to take adequate treatment and rehabilitation services to groups such as the homebound, who cannot be treated in routinely available facilities.

A great many of the things which must be undertaken today to protect a nation's health would not have been considered standard activities for a health agency even a generation ago. But the statistical tools which have made it possible for us to gauge the future needs more accurately, and the medical advances which have made so much

possible in the way of prevention and treatment, have made the broadening of the base of action not only desirable but necessary. The programs of the Bureau of State Services—Community Health reflect this diversity and variation. Because the mission of the Bureau is to facilitate the delivery of high quality health services to the people who need them, its programs emphasize the practical application of knowledge, and their setting is the community in which people live. The Bureau's programs range from the construction of schools, hospitals and long-term treatment facilities, to demonstrations in treatment and diagnostic techniques for the practitioner, to education programs for the public, to experiments in the design of comprehensive community programs for the chronically ill and aged, to wide-scale preventive activities, such as the vaccination programs.

A summary showing the amounts expended by the Bureau of State Services—Community Health on all intramural and extramural activities appears in table 1. Major examples of the type of programs which result from these expenditures are given in the narrative supplied by each of the Divisions within the Bureau. Many of our programs are carried on in cooperation with the Social Security Administration, the Office of Education, and other components of the Department. Other programs are complemented by the activities of different government agencies, such as the Office of Economic Opportunity and the Department of Labor. The majority are centered in State and local health agencies and other organizations at the community level, with the Bureau supplying financial support and expert consultation. Indeed, health matters are so closely interwoven with the total economic and cultural fabric of American life that any agency concerned with social improvement will undoubtedly have programs which supplement or strengthen Bureau efforts to achieve better health.

It is difficult to measure, in economic terms, the benefits the American people derive from their investment in health protection.

We cannot precisely estimate the cost of disease itself. However, with regard to cancer and cardiovascular diseases, for example, the President's Commission on Heart Disease, Cancer, and Stroke estimates that in 1962, the direct costs of prevention, treatment, rehabilitation, facilities, etc., amounted to $4.3 billion and the costs of estimated losses in the gross national product traceable to death and disability caused by these diseases was $38.8 billion. These estimates do not cover hidden costs—special diets, special housing facilities, additional household help, etc.—much less the pain and grief diseases and death cause.

Because we cannot precisely measure the cost of disease, we cannot state the exact monetary value of prevention, control or cure. We can say that, in humanitarian terms, it is beyond price.

Another example can be found in a program like that conducted under the Nurse Training Act. The goal of the program is to produce more nurses in a time of shortage and, therefore, to assure higher standards of nursing care. These goals will be accomplished. But there are additional benefits. It opens the door to a health profession for girls who otherwise might never have had such an opportunity. It gives them a chance to exercise their skills at the highest possible level. It can mean a higher economic status, not only for the individual, but for her family as well.

Whatever the difficulties of precise economic evaluation, the return the American people have received on their investment is impressive. Our progress against some of the major communicable diseases suggests how impressive:

Malaria and smallpox, still two of the world's most serious disease problems, are eradicated in the United States.

Polio is all but eliminated—122 cases in 1964 as against 38,476 cases in 1954.

The toll of tuberculosis is drastically reduced.

We now have a measles vaccine—a new tool against the communicable disease with currently the highest number of reported cases.

Add to these examples the less dramatic but important fact that we are steadily improving our training capacity and increasing our general and long-term treatment facilities, that we are beginning to make headway in such fields as continuing education and the more effective use of auxiliaries, that individual demands for health services are rising, that in spite of the shortages of basic resources and the resulting difficulties in providing adequate care of the general population, we are nonetheless finding ways to reach special problem groups, such as migrant workers and the mentally retarded or physically disabled.

The Nation is closer than it has ever been to the goal of adequate health protection for all its citizens and to realizing the benefits, economic and humanitarian, which will inevitably accrue. The Bureau of State Services—Community Health has a crucial role to play in reaching this goal.

TABLE 1.—*Amounts expended by Bureau of State Services—Community Health on all intramural and extramural activities, fiscal years 1964–67*

[In thousands of dollars]

Community health programs	Obligations			
	Fiscal year 1964 actual	Fiscal year 1965 actual	Fiscal year 1966 estimated	Fiscal year 1967 estimated
Total	[1] $369,326	[1] $486,573	[1] $677,791	[1] $802,042
A. Grants	[1] 320,682	[1] 426,509	[1] 593,788	[1] 709,622
1. Research grants	13,590	13,082	25,937	24,272
A. Regular	10,113	10,636	14,187	17,672
B. Hospital and medical facilities	3,477	2,446	11,750	6,600
1. Experimental construction	(1,500)	----------	(6,900)	----------
2. Extramural research	(1,977)	(2,446)	(4,850)	(6,600)
2. Fellowships	309	362	562	762
3. Student loans	----------	13,289	24,500	21,225
4. Formula grants	38,886	34,572	48,300	46,000
5. Training grants	17,851	22,839	43,411	74,759
A. Research training	284	564	1,330	1,730
B. Public health traineeships	4,188	4,415	7,000	8,000
C. Grants to schools of public health	1,900	2,436	3,500	3,500
D. Project grants for graduate public health training	1,994	2,498	4,000	5,000
E. Auxiliary utilization (dental)	2,160	2,269	2,399	2,399
F. Continuing education (dental)	----------	----------	----------	100
G. Nurse traineeships	7,325	7,879	9,000	10,000
H. Payment to diploma schools of nursing	----------	788	2,500	6,000
I. Improvement of nurse training	----------	1,990	3,000	4,000
J. Scholarships	----------	----------	200	4,030
K. Educational improvement grants	----------	----------	10,482	30,000

See footnote at end of table, p. 594.

TABLE 1.—*Amounts expended by Bureau of States Services—Community Health on all intramural and extramural activities, fiscal years 1964–67*—Continued

[In thousands of dollars]

Community health programs	Obligations			
	Fiscal year 1964 actual	Fiscal year 1965 actual	Fiscal year 1966 estimated	Fiscal year 1967 estimated
A. Grants.—Continued				
6. Project grants	[1] $34, 195	[1] $45, 956	[1] $61, 750	[1] $72, 229
A. Cancer	4, 489	5, 268	13, 933	15, 000
B. Neurological and sensory	2, 432	2, 744	2, 750	3, 500
C. Other chronically ill and aged	6, 957	6, 985	10, 000	10, 000
D. Mental retardation project grants	503	699	4, 500	4, 500
E. Mental retardation planning and implementation	1, 140	[1] 1, 060	2, 750	2, 750
F. Community immunization	[1] 9, 712	[1] 15, 679	[1] 8, 888	[1] 9, 100
G. Migrant health services	1, 500	2, 336	3, 000	7, 200
H. Control of tuberculosis	1, 575	4, 991	9, 700	13, 950
I. Control of venereal disease	5, 887	6, 194	6, 229	6, 229
. Construction grants	[1] 215, 851	[1] 296, 409	[1] 389, 328	[1] 470, 375
A. Areawide planning	----------	1, 879	3, 000	5, 000
B. Public Health Service Act	[1] 213, 351	[1] 204, 099	[1] 247, 759	[1] 262, 000
C. Mental retardation facilities	----------	----------	[1] 13, 500	[1] 14, 000
D. Mental retardation, university affiliated facilities	----------	[1] 7, 223	[1] 15, 277	[1] 10, 000
E. Demonstration and health facilities (Appalachian)	----------	----------	[1] 1, 500	[1] 19, 375
F. Teaching facilities for physicians, dentists, etc	----------	[1] 83, 208	[1] 91, 792	135, 000
G. Teaching facilities for nurses	----------	----------	15, 000	25, 000
H. Construction of multiservice facilities	----------	----------	1, 500	0
I. George Washington University Hospital construction	2, 500	----------	----------	----------
B. Direct operations	48, 644	60, 064	84, 003	92, 420
1. All divisions	48, 632	60, 048	83, 985	92, 398
2. BSS–CH management fund	(1, 198)	(1, 998)	(2, 288)	(2, 829)
2. Gift funds	12	16	18	22

[1] Includes funds carried over from previous year.

NOTE.—Total Federal obligations for community health programs (excluding hospital construction activities of the Hill-Burton program) are $282,473,000 in fiscal year 1965. Actual Federal expenditures for these same programs in fiscal 1965 are $167,058,000. Information is not readily available to permit a precise economic classificaton of the expenditure data by program as requested in question 10. A breakdown is shown for obligations. It is assumed that expenditures and obligations are very close for purchases of goods and services and that most of the lag is in the categories of grants to State and local governments and transfer payments to nonprofit institutions.

RESEARCH GRANT PROGRAMS

PART I. DESCRIPTION OF THE PROGRAM

Following is the information requested by the Joint Economic Committee of Congress concerning the Research Grant Programs of seven of the Divisions making up the Bureau of State Services—Community Health. The newly-established Division of Medical Care Administration is not represented because a research program has not yet been established within that division.

1. Objectives

The research and research training programs of this Bureau are relatively new, being in their third and second fiscal years, respectively. They are designed to improve the effectiveness and availability of medical care and other health services. The technical health goals which the research program seeks to achieve include: Improve-

ment of community medical care and other health services for those with chronic diseases, and the reduction of the occurrence of chronic and communicable diseases through more effective control measures; improvement of the dental health of the whole population; the reduction of accidental injuries which result in disability or death; improvement of techniques for the academic training and continuing education of doctors, dentists, nurses, and other professionals in the health field; development of the higher professional role of the trained nurse in the increasingly scientific pattern of medical care; development of professional guidelines and medical criteria for use in administration of the Medicare and other national health programs; the creation of more efficient hospitals and other health facilities; the better understanding of the economics of the health industry; and the development of knowledge which can be used for more effective organization and coordination of total health services in communities.

2. Operation

Five divisions of the Bureau of State Services-Community Health make grants to colleges and universities to support research training. These grants enable colleges and universities to start, or give more emphasis to, programs for training graduate students in the scientific knowledge necessary to conduct the type of research described above. Research training grants provide funds for support of faculty and stipends and tuition for a limited number of graduate students selected by the recipient schools. Research training grants therefore have the dual effect of supporting existing teaching faculty, and supporting graduate students who are training for future careers of research and for university teaching in fields related to the Bureau mission.

The factor of broad geographic spread of institutions and agencies conducting research and research training has a definite scientific pertinence in certain types of health services research. For example, research concerned with organizational, economic, geographic, social, and cultural factors affecting health and health services often must be conducted in localities where samples of these variables are found, including the less-developed areas of the United States.

3. History

The research and research training programs of the Bureau of State Services-Community Health are directed toward problems which arise in what may be called the "health industry"—the sum total of health services rendered by doctors, dentists, nurses, and others working in hospitals, private offices, clinics, official and voluntary health agencies, and other health facilities. Besides being the means through which we all obtain medical care, the health industry is also a major part of the national economy.

The health services industry in 1960 employed about 2.6 million persons.

The health industry of the United States must increase rapidly in size as the national population increases. Any program of research which helps the industry to grow in a more orderly way and to utilize medical manpower, money, and other scarce resources in a more efficient manner will thereby contribute much to the economy of the country, as well as to its health. An informed opinion in the health professions is to the effect that improved health of a nation is reflected in the increased level and quality of its economic output.

4. Level of operations. (See table 1.)

Program: Research grant programs (including hospital and medical facilities demonstration grants), all divisions, Bureau of State Services—Community Health.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure (see committee inquiry for definitions) and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimates)	Fiscal year 1967 estimates [1]
(a) Magnitude of the program, number of grant projects	306	314	392	470
(b) Applicants or participants:				
State government agencies	23	17	34	38
Local communities or governments	8	12	14	18
Individual or families		2	1	1
Other [2]	275	283	343	413
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred, thousand dollars	$13,590	$13,082	$25,937	$24,272
Allotments or commitments made (no date available re additional expenditures by grantees)				
(d) Matching or additional expenditures				
(e) Number of Federal employees, man-years	37	39	41	41
(f) Non-Federal personnel, persons	[3] 1,535	[3] 1,610	2,015	2,345
(g) Other measures of performance				

[1] President's budget.
[2] Universities, hospitals, and other nonprofit institutions.
[3] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

See answers for specific divisions.

8. Laws and regulations

See answers for specific divisions.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

See answers for specific divisions.

10. Economic classification of program expenditures. (See table 2.)

Program: Total research grant program, all divisions, Bureau of State Services—Community Health.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[Thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	1,126
Transfer payments to individuals and nonprofit organizations	11,956
Total Federal expenditures	13,082

[1] Expenditures here refer to obligations.

NOTE.—No data available on additional expenditures by grantees.

Division of Accident Prevention Research Grants Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

Research grants are made by the Division of Accident Prevention for the purpose of:

a. Studying basic causes and conditions associated with or leading to accidental injuries or fatalities in man.

b. Developing, improving, and evaluating protective measures and means of preventing accidents.

c. Minimizing the consequences of accidental impacts, poisonings, burns, or other injurious encounters.

Scientific information is sought on all types of accidental injuries occurring on the highway, in the home, at work, at play, or elsewhere.

2. Operation

Within the research grants framework, support is provided for research that is *not directed* by the Federal government. A research proposal is initiated and generated by an independent investigator and submitted to the Public Health Service by his institution (occasionally the investigator submits it as an individual). The system for reviewing applications, making awards, and administering the grant projects is the same as that used by the institutes in the National Institutes of Health and by the other Divisions in the Bureau of State Services.

3. History

In 1951 the Public Health Service first supported research in accident prevention through the research grants program of its National Institutes of Health. During the period fiscal year 1951 through 1961, 44 projects were supported at a cost of over $4 million; of this number, 30 projects were concerned with motor vehicle traffic accidents.

Increasing interest in accidents as a public health problem led to the establishment in 1961 of the Division of Accident Prevention in the Bureau of State Services. An integral part of this Division is the Research Grants Branch with budget and administrative responsibility for research grants in the broad areas of accident prevention research. During the period fiscal year 1962 through fiscal year 1965, 68 additional projects were supported at a cost of over 7 million dollars.

The large proportion of projects in the area of traffic accidents is not the result of any deliberate decision of the Public Health Service nor of the reviewers but simply reflects the interest of those who have applied for grants.

4. Level of operations. (See table 1.)

Program: Division of Accident Prevention, Research grants program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit [1]	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate [2]
(a) Magnitude of the program (grant projects)	42	44	44	53
(b) Applicants or participants:				
State government agencies (grant projects)	2	2	2	3
Local communities or governments (grant projects)		[3] 1		
Individuals or families				
Other (grant projects)	[4] 40	[5] 41	42	50
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred (thousands)	$1,860	$1,691	$1,785	$2,014
Allotments or commitments made				
(d) Matching or additional expenditures [6]				
(e) Number of Federal employees (man-years)	6	6	6	6
(f) Non-Federal personnel (persons)	[7] 220	[7] 220	[7] 220	[7] 240
(g) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Public school.
[4] 29 colleges and universities, 7 research institutions, 2 foundations, 1 laboratory, 1 museum.
[5] 30 colleges and universities, 8 research institutions, 1 foundation, 1 laboratory, 1 museum.
[6] No data available regarding additional expenditures by grantees.
[7] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Research in the motor vehicle accident area is related to other Division of Accident Prevention areas; emergency medical services, childhood accidental injury, injury of the aging population, and recreational accidents. The Division is in continual contact with the following agencies and organizations, with which the Division shares information and co-sponsors conferences and action programs:

Bureau of Public Roads, Department of Commerce
American Association of Motor Vehicle Administrators
Automotive Safety Foundation
Department of Labor
National Safety Council
Institute for Highway Safety

8. Laws and regulations

Authority to make research grants is contained in Section 301(d) of the Public Health Service Act as amended (42 U.S.C. 241).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See discussion included under "Direct Operation," below.)

10. Economic classification of program expenditures. (See table 2 above for "Research Grant Programs.")

Division of Chronic Diseases Research Grants Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The objective of the Research Grant Program of the Division of Chronic Diseases is to develop the research necessary to provide the information, knowledge, and techniques to expedite the translation of medical knowledge into health services for the chronically ill and aged in the communities of the Nation. This type of research is generally of a highly practical or applied nature and may involve field or survey research, operations research, and systems development. The Research Training Program has as its objective, to develop investigators who have the competency to carry out the needed research.

The ultimate objective is to develop community health services which are oriented to prevention of chronic diseases; provision of the best therapy; and for advanced cases of chronic disease the latest methods of rehabilitation or restoration to a functional state of health.

In terms of an "investment in people," the entire program can be considered this type of investment. The program seeks to insure through the use of the latest medical knowledge that individuals live a healthy life free from the disability associated with chronic diseases.

2. Operation

The program operates as a grant-in-aid program to non-profit institutions which are capable of performing research in chronic disease problems. The proposal for a project is the idea of an independent investigator. He describes his idea in an application which is reviewed for scientific merit by his peers who are scientists acting as consultants to the Public Health Service. The projects with the highest priorities are paid as the funds allow.

3. History

The Study Group on Mission and Organization of the Public Health Service recommended in 1960 that the Bureau of State Services—Community Health should provide a focus for research on the application of fundamental observation in the biological and medical sciences, and on the organization, financing, and delivery of comprehensive health services.[1]

In order to implement this recommendation it was suggested that the authority to support research grants should be extended to the Divisions of the Bureau.

In fiscal year 1963, a group of 36 separate research projects which had been previously supported at the National Institutes of Health were transferred to the Division of Chronic Diseases. These grants had been identified as applied chronic disease research rather than basic medical research. The total funds to support those grants in the fiscal year 1963 was $1,158,633.

Since the transfer of the original group of grants, the program has sought to develop needed areas of research and has supported 9 new grants in fiscal year 1964 and 18 new grants in fiscal year 1965.

[1] Final Report of Study Group on Mission and Organization of the Public Health Service, 1960, p. 31.

4. Level of operations. (See table 1.)

Program: Division of Chronic Diseases research grants program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure [1] and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate [2]
(a) Magnitude of the program (grant projects)	31	46	84	108
(b) Applicants or participants:				
State government agencies (grant projects)	1		4	6
Local communities or governments (grant projects)		1	3	4
Individuals or families (grant projects)				
Other [3] (grant projects)	30	45	77	98
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred (thousands)	$1,218	$1,790	$3,551	$4,839
Allotments or commitments made				
(d) Matching or additional expenditures [4]				
(e) Number of Federal employees (man-years)	5	5	6	6
(f) Non-Federal personnel [5] (persons)	165	235	380	540
(g) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Universities, colleges, research foundations, hospitals professional organizations, other agencies.
[4] No data available regarding additional expenditures by grantees.
[5] This is not an actual count but an estimate.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(a) Bureau, Division or Office:

The Research Grant Program is carefully coordinated with the other funded programs of the Division of Chronic Diseases. These consist of formula grants, demonstration grants and contract activities. The program also is integrated into the total activities of each of the Branches through the designation of a Research Officer in each Branch. The research which is supported is complementary to the overall program service efforts of the Division.

There is an interchange of information and meetings with other Divisions of the Bureau to insure broad application of research findings and to develop common approaches to support of necessary research. There is a monthly meeting of research grant personnel sponsored by the Bureau of State Services—CH for this purpose.

(b) Other Units of Department or Agency:

The division personnel of the program are in continuing contact with the individual Institutes of the National Institutes of Health and the Division of Research Grants which is the central administrative unit for research grants in the Public Health Service. The objective is to allow a smooth transition from basic research findings to application in a community and the development of clear functional guidelines to program activities. The program is also in close liaison with the Vocational Rehabilitation Administration, the Children's

Bureau in the Welfare Administration and the Social Security Administration.

(c) Other Federal Government:

The Division has had occasion to work with other Federal agencies in several instances. The interests of the Veterans Administration and the Department of Defense in medical research quite often offer opportunities to compare research efforts. The interests of the Public Housing Administration in housing for the aged and the provision of health services has been the subject of interagency meetings attended by representatives of each agency.

The Science Information Exchange which is part of Smithsonian Institution provides information upon request about research in specific areas supported by other agencies. The Division uses this mechanism rather frequently to learn of other research and to seek cooperation in mutually beneficial areas.

Cooperation with other types of institutions in the U.S. and throughout the world is an essential part of the operation of the research grant program. State health departments, local health departpartments, community agencies, professional associations, academic institutions and in some cases under sub-contracts, profit-making organizations, are the types of institutions which must plan, perform and carry out community research. The staff of the Research Grant Program seeks to expand relationships with these types of institutions and to provide the leadership to point out needed areas of research.

8. Laws and regulations

The Research Grant Program of the Division of Chronic Diseases is carried out under the Public Health Service Act, Section 301(d), as amended. The Regulations—Grants for Research Projects, Code of Federal Regulations, Title 42—Public Health, Chapter 1—Public Health Service, Department of Health, Education, and Welfare, Subchapter D, Part 52 also pertains to the program.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from the Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 2, above summary of "Research Grant Programs" for all divisions.)

Communicable Disease Center Research Grants Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The Communicable Disease Center research grants program is intended to support extramural research of a generally practical or applied nature in areas leading to communicable disease control. As such, it does not fund so-called basic research, but instead makes possible the conversion of existing basic knowledge into useful health practices, techniques, or technology, through research.

2. Operation

Investigators supported represent medical schools, universities, hospitals, and health departments, and apply for support through regular Public Health Service channels. Technical and policy reviews of applications are made by study sections and advisory committees. The staff of the Communicable Disease Center is responsible for programming support areas and selective grants to be supported from among those recommended for approval. This staff also negotiates actual costs of projects with investigators and works closely with the latter in the management of grants.

3. History

The program was initiated by a "comparative transfer" of funds in fiscal year 1964 from the National Institutes of Health, at an initial level of $1,712,000. Since that time, projects transferred from the National Institutes of Health have been supported by appropriations to the Communicable Disease Center until they expire, and are replaced by more recently submitted proposals. Current level (fiscal year 1966) of funding is $1,921,000.

4. Level of operations. (See table 1.)

Program: Communicable Disease Center Research Grants Program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure [1] and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate [2]
(a) Magnitude of the program (grant projects)	68	56	57	60
(b) Applicants or participants:				
State government agencies (grant projects)	9	7	10	11
Local communities or governments [3] (grant projects)	2	2	3	4
Individuals or families				
Educational institutions (grant projects)	57	47	44	45
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred (thousands)	$1,711	$1,739	$1,921	$2,188
Allotments or commitments made				
(d) Matching or additional expenditures [4]				
(e) Number of Federal employees (man-years)	4	4	4	4
(f) Non-Federal personnel (persons)	[5] 300	[5] 325	[5] 350	[5] 365
(g) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Local health departments.
[4] No data available regarding additional expenditures by grantees.
[5] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Not answered.

8. Laws and regulations

The Research Grant Program of the Communicable Disease Center is carried out under the Public Health Service Act, Section 301(d)

as amended. The Regulations—Grants for Research Projects, Code of Federal Regulations, Title 42—Public Health, Chapter 1—Public Health Service, Department of Health, Education, and Welfare, Subchapter D, part 52 also pertain to the program.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from the Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 2, above, summary of research grant programs for all divisions.)

Division of Community Health Services Research Grants

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

Research grants supported by the Division of Community Health Services provide funds to qualified researchers to seek answers to a wide variety of questions relating to all aspects of health in the community. These grants support studies seeking knowledge regarding better methods of planning, organizing, delivering, financing and evaluating personal health services on a community wide basis. They also support studies into the characteristics, attitudes, values, and other socio-economic and political factors in the community having significance for the delivery and acceptance of health service.

There is an increasing amount of new medical information available. The problems of applying the knowledge are immense. Research is needed to provide additional knowledge in diverse areas, such as—

standards of quality for personal health services and quality factors in medical care programs and practices

consolidation of fragmented health services, through such methods as regionalization and metropolitan organization

areas of health insurance leading to the development of new benefits and methods of payment most conducive to effective utilization and quality of care

roles and relationships of resources within the community and their coordination and utilization through a variety of mechanisms

integration of special programs dealing with particular community groups, such as the agricultural migrants or school children, or with particular disease conditions, such as alcoholism, with existing community programs

health education of the public to enhance the individual's understanding of the available opportunities for care and of his own responsibility for the protection of his health and the management of disease

redefinition of the role of law in the strengthening of health services and for urban and suburban planning as it applies to health services

productivity of health personnel and organizations, including experimentation with new professional and paramedical categories

data recording, transmission, storage, retrieval, and analysis techniques serving professional and administrative needs of personnel health services programs

recruitment, training, and continuing education of health services personnel

socio-economic, cultural, political, and behavioral factors in relation to health status and the provision and acceptance of health services

types of community settings, such as rural, metropolitan, depressed and transitional areas, and the attendant health needs of the population

relation of health and health services to the national economy and to productivity in general

2. Operation

The Research Grant Program operates by the submission of applications by qualified researchers, review by two non-Federal scientific advisory groups, and funding of those applications approved by the dual review process.

3. History

Although research grants for these purposes had been approved and funded for some time by the National Institutes of Health review process, it was not until 1964 that a specific appropriation for research in community health areas was established. Since then the number and quality of applications in these areas have continued to increase.

4. Level of operations. (See table 1.)

Program: Division of Community Health Services research grants program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure [1] and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate [2]
(*a*) Magnitude of the program (grant projects)	47	51	68	95
(*b*) Applicants or participants:				
State government agencies (grant projects)	2	2	4	5
Local communities or governments (grant projects)	1	2	3	4
Individuals or families (grant projects)	0	0	1	1
Universities and other nonprofit (grant projects)	44	45	60	85
(*c*) Federal finances:				
Unobligated appropriations available				
Obligations incurred (thousands)	$2,686	$2,680	$3,816	$5,194
Allotments or commitments made				
(*d*) Matching or additional expenditures [3]				
(*e*) Number of Federal employees (man-years)	8	8	8	8
(*f*) Non-Federal personnel (persons)	[4] 220	[4] 220	315	390
(*g*) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.
[3] No data available regarding additional expenditures by grantees.
[4] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

The problems in these areas of community health are known: the increasing population, the continued urbanization and surbanization, the increasingly fragmented delivery of health services, the difficulties of transmitting new knowledge to those currently practicing, the lack of trained manpower, the problems of health education of the population, etc. As the population continues to expand, each of these problems will become more pressing.

7. Coordination and cooperation

There are a wide variety of sources of funds for health research, many within the Government and many outside. Most of these granting organizations have their own areas of interest in research, their own forms and regulations. There is informal contact between these groups by such mechanisms as having representatives of the major organizations with parallel interests sitting on the review committees of the Public Health Service.

In specific answer to the question of coordination within the Public Health Service and its component parts, there is good coordination. All of the research parts are governed by one grants policy manual. Coordination with other health related granting programs in the Department and in other Federal agencies is less well defined. This subject is currently under restudy by the Public Health Service. All of the other agencies mentioned [in the inquiry] are potential grantees and the question is not applicable to them.

8. Laws and regulations

This program is authorized under section 301 of the Public Health Service Act (42 USC 241) and the fiscal year 1966 Department of Health, Education, and Welfare Appropriation Bill. It is governed by regulations published in 42 CFR 52.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from the Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 2, above, summary of research grant programs for all divisions.)

Division of Dental Health Research Grants Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The purpose of this program is to support, by means of grants to investigators employed by universities and other private and public non-profit institutions, research which will aid in the accomplishment of the Division's mission. This mission is, essentially, to develop and improve methods for the application of basic dental health knowledge to the public through organized community effort.

The Division's research program is directed toward four major health areas: (1) preventive dentistry, (2) continuing education for practicing dentists, (3) the development of paradental auxiliary pro-

fessions, and (4) developing dental educators. In programming research grants, including the stimulation of interest among psychologists, sociologists, economists, engineers, mathematicians, and other nondentists as well as dentists of various specialties, the staff of the Research Grants Program has found it useful to adopt the following classification for our past, ongoing, and future grants: (1) The evaluation of existing and development of new techniques, equipment, methods, and programs for rendering therapeutic and preventive dental services to the public, including application of disease control procedures and related epidemiologic studies, (2) The recruitment and education of dentists and auxiliary personnel, (3) The attitudes, behavior patterns and other characteristics of individuals and groups related to public health dental problems, (4) The supply, distribution and organization of dental manpower, and (5) Methods of financing dental services. This provides a focus for discussions with investigators in planning for research in the areas identified by the Division.

2. Operation

The research grants program is administered by the Research Grants Unit, a component of the Office of the Division Chief. Programming of grant proposals is conducted by the professional staff of the unit, consisting of one dentist and one research psychologist, by the Regional dental representatives and by personnel of the Division's seven program Branches.

This program is one of the two dozen research grants programs of the Public Health Service. As such, receipt, referral, and initial review of applications is the responsibility of the Division of Research Grants, attached to the National Institutes of Health. The National Advisory Community Health Committee makes the final review and recommendations for the Surgeon General, Public Health Service.

3. History

The program began official operation in fiscal year 1964 with the transfer of 22 active grants from NIH, specifically, in this case, from the National Institute of Dental Research. During the first year, five new applications were approved and one additional grant transferred in, to make a total of 28 active projects in fiscal year 1964. In fiscal year 1965, 10 new grants were approved and funded. An additional 8 applications were approved, for which there were not sufficient funds in the 1965 appropriation to pay. These have been carried over into fiscal year 1966.

The staff of the program has remained at approximately its original level during this time. This consists of two professionals, one grants assistant, and one secretary, augmented periodically by clerk-typists employed on a part-time basis.

4. Level of operations. (See table 1.)

Program: Division of Dental Health research grants program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure [1] and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate [2]
(a) Magnitude of the program (grant projects)	19	25	31	36
(b) Applicants or participants:				
State government agencies (grant projects)	5	5	7	5
Local communities or governments (grant projects)				
Individuals or families (grant projects)				
Other [3] (grant projects)	14	20	24	31
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred (thousands)	$659	$784	$944	$1,207
Allotments or commitments made				
(d) Matching or additional expenditures [4]				
(e) Number of Federal employees (man-years)	3	3	4	4
(f) Non-Federal personnel (persons)	[5] 140	[5] 150	210	270
(g) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Universities, voluntary-nonprofit institutions.
[4] No data available regarding additional expenditures by grantees.
[5] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Formal liaison is maintained with the National Institute of Dental Research and other pertinent groups of the National Institutes of Health. Informal contacts are also maintained with personnel managing extramural research programs of the Environmental Health Divisions. Both formal and informal contacts are maintained with the extramural research programs of the other Community Health Divisions. In addition, various elements of the staff have liaison with staff of the Children's Bureau dental program in order to facilitate to the maximum possible extent community dental programs planned in conjunction with other health and welfare activities. The Division maintains one or more representatives in each HEW Regional Office in order to provide consultation to local officials interested in providing dental services in conjunction with planned activities related to urban renewal, housing for the aged, and other emerging programs dealing with special population groups.

8. Laws and regulations

Section 301 of the Public Health Service Act.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from the Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 2, above, summary of research grant programs for all divisions.)

DIVISION OF NURSING RESEARCH GRANT PROGRAM

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The purposes of research grants in nursing are to encourage and support research, and investigations in medical and allied health

research related to nursing, with emphasis upon research important to the improvement of patient care.

Research grants also support studies of the development and utilization of nursing services, facilities, and resources.

Research grants in nursing are intended to expand research activities throughout the country, and to encourage nurse and non-nurse investigators to undertake research in health fields important to nursing.

2. Operation

Through extensive programing efforts, the professional nursing staff of the branch provides consultation to potential investigators throughout the United States and in selected international areas prior to the submission of research grant applications. New research areas are identified and stimulated to encourage research needed immediately and in the next five to ten years.

Under the authority of the Public Health Service Act, research grants are made in support of research related to nursing in universities, colleges, medical and nursing schools, schools of public health, hospitals, laboratories, State and local health departments, and other nonprofit institutions, such as regional and national nursing organizations.

3. History

The Division of Nursing's research project grants program was started in 1955 under the Division of General Medical Sciences (now the National Institute of General Medical Sciences). Both Divisions shared the administrative responsibility for the program

In 1963, the total program was transferred to the Division of Nursing, Bureau of State Services (Community Health).

4. Level of operations. (See table 1.)

Program: Division of Nursing research grant program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollars in thousands—estimates]

Measure [1]	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967 [2]
(*a*) Magnitude of the program (number of grant projects)	64	55	63	63
(*b*) Applicants or participants:				
State government agencies	1			
Local communities or governments [3]	2	1	1	1
Individuals or families				
Other [4]	59	51	62	62
(*c*) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$1,980	$1,952	$2,170	$2,230
Allotments or commitments made				
(*d*) Matching or additional expenditures	[5]	[5]	[5]	[5]
(*e*) Number of Federal employees (man-years)	3	3	3	3
(*f*) Non-Federal personnel	[6] 315	[6] 275	315	[6] 315
(*g*) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Visiting nurses associations, city research organizations.
[4] Colleges, universities, research institutions, hospitals, schools of nursing, National and regional nursing organizations.
[5] No data available regarding additional expenditures by grantees.
[6] Estimates.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The staff of the Division of Nursing grants research program works very closely with all of the Institutes of the National Institutes of Health, the Office of Education, Vocational Rehabilitation Administration, Children's Bureau, Veterans' Administration, Army, Navy, other military units, research foundations such as the American Nurses' Association, and with other regional bodies such as Western Interstate Commission for Higher Education.

8. Laws and regulations

Section 301 of the Public Health Service Act. Code of Federal Regulations, title 42, part 52.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Grants are made to universities and colleges; medical, dental, and nursing schools; schools of public health; laboratories; hospitals; State and local health departments; other public or private nonprofit institutions; and individuals. Federal institutions which may be awarded grants are hospitals of the Public Health Service, St. Elizabeths Hospital in Washington, D.C., and the Bureau of Prisons of the Department of Justice.

10. Economic classification of program expenditures. (See table 2, above, summary of research grant programs for all divisions.)

Division of Hospital and Medical Facilities Research and Demonstration Grants Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objective

The objective of this program is the development of scientific information through research, experiment, and demonstration relating to the effective development, utilization, and coordination of hospital services, facilities, and resources.

2. Operation

(*a*) Administers extramural research project and demonstration grant programs related to the social, administrative, clinical organizational and physical structural aspects of hospitals and other patient care facilities.

(*b*) Fosters the application of the findings of extramural grant-supported and intramural research and studies.

(*c*) Provides consultation to grant applicants and scientific design and related services to Division staff engaged in research and associated studies.

3. History

The authorizing legislation for the research and demonstration grant program was enacted in 1949. Appropriations were first made available in 1956. From 1956 to 1961 the appropriation authorization was $1.2 million annually.

In 1961, the Community Health Services and Facilities Act increased the appropriation authorization to $10 million annually and provided authority to make grants for experimental construction grants. Since 1956 this Division has supported 172 projects at a total expenditure of $24,631,852. Of these, 105 projects have been completed, and 67 projects are currently active.

4. Level of operation. (See table 1.)

Program: Division of Hospital and Medical Facilities research and demonstration grants program.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure (see committee inquiry for definitions)	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967 [1]
(*a*) Magnitude of the program	Number of grants; projects	35	37	45	55
(*b*) Applicants or participants:					
State government agencies	do	3	1	7	8
Local communities or governments	do	1	2	4	5
Individuals or families	do				
Other [2]	do	31	34	34	42
(*c*) Federal finances:					
Unobligated appropriations available.					
Obligations incurred	Thousands of dollars	3,477	2,446	11,750	6,600
Allotments or commitments made					
(*d*) Matching or additional expenditures	[3]	[3]	[3]	[3]	[3]
(*e*) Number of Federal employees	Man-years	8	10	10	10
(*f*) Non-Federal personnel	Persons	[4] 175	[4] 185	225	225
(*g*) Other measures of performance					

[1] President's budget.
[2] Universities, hospitals, and other private and nonprofit institutions.
[3] No data available regarding additional expenditures by grantees.
[4] Estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

This program coordinates closely with the National Institutes of Health, particularly the Division of Research Grants and the National Institute of Mental Health, with other programs of the Bureau of State Services and, particularly in the area of mutual problems relative to medicare legislation, with the Social Security Administration.

8. Laws and regulations

This program's legislative and appropriation authorizations are (*a*) Public Law 81–380, to conduct research, experiments, and demonstrations relating to the effective development and utilization of hospital facilities, services, and resources and makes grants-in-aid

to governmental and nonprofit groups for these same purposes; and (b) Public Law 87-395, to make grants for experimental or demonstration construction or equipment projects.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 2, above, summary of research grant programs for all divisions.)

FELLOWSHIP PROGRAM

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

Three divisions of the Bureau of State Services award fellowships to individual students who are preparing for careers in research and/or university teaching in fields related to the Bureau mission. Fellowships are granted directly to the individual student and provide a stipend and tuition. Fellows may be supported for predoctoral, postdoctoral, or special training. Predoctoral fellows are enrolled in appropriate university graduate programs; postdoctoral and special fellows may take training in academic or other appropriate institutions.

2. Operation

See "Objectives," above.

3. History

Not answered.

4. Level of performance. (See table 1.)

Program: Fellowship program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964-67*

Measure (see committee inquiry for definitions)	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967 [1]
(a) Magnitude of the program	Number of fellows	60	65	102	129
(b) Applicants or participants:					
State government agencies					
Local communities or governments	do	60	65	102	129
Individuals or families					
Other					
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred	Thousands of dollars	$309	$362	$462	$762
Allotments or commitments made					
(d) Matching or additional expenditures					
(e) Number of Federal employees					
(f) Non-Federal personnel					
(g) Other measures of performance					

[1] President's budget.

5. Estimated magnitude of program in 1970
Not answered.

6. Prospective changes in program orientation
Not answered.

7. Coordination and cooperation
Not answered.

8. Laws and regulations
Not answered.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects
Not answered.

10. Economic classification of program expenditures. (See table 2.)

Program: Fellowship program.
Department or agency and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[Thousands of dollars]

Federal Government: [1]	
Transfer payments to individuals	362
Total Federal expenditures	362

Expenditures here refer to obligations.

HEALTH PROFESSIONS STUDENT LOAN PROGRAM

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To increase the opportunities for the training of physicians, dentists, and optometrists, through the establishment of loan funds in professional schools from which low-interest loans may be made to students in need thereof to pursue their courses of study.

2. Operation

Appropriated moneys are allocated to eligible schools of medicine, dentistry, and optometry for the establishment of loan funds. Each participating school must contribute a matching amount equal to one-ninth of the Federal moneys allocated. The schools have the responsibility of selecting recipients, making and collecting the loans within conditions prescribed by the act and regulations. No loans are made directly by the Federal Government.

3. History

The Health Professions Educational Assistance Act of 1963 was enacted September 24, 1963 and amended by Public Law 88-654 October 13, 1964, to include schools and students of optometry. The program was established in fiscal year 1965 when the first appropriations were made available. Allocation of funds was made to 147 schools which were eligible and wished to participate. A total of $10,200,000 was allocated for the establishment of loan funds. Approx-

imately 11,450 students borrowed a total of $10,276,000 at an average of about $900 each.

In fiscal year 1966 the appropriation was $15,600,000. The final allocation of funds was made in September 1965 to 147 participating schools which requested approximately $20,900,000 in Federal funds to meet the needs of an estimated 18,500 borrowers.

It is planned that invitation to participate during fiscal year 1967 will be extended to 152 eligible schools.

4. Level of operations. (See table 1.)

Program: Health Professions Student Loan Program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 estimates [1]
(a) Magnitude of the program	Borrower [2]		11,431	18,500	21,000
(b) Applicants or participants:					
State government agencies					
Local communities or governments					
Individuals or families					
Other public and private nonprofit schools	Schools [3]		147	147	225
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred			$10,200	$15,600	$12,725
Allotments or commitments made					
(d) Matching or additional expenditures			$1,123	$1,680	$1,160
(e) Number of Federal employees	Man-years		8	8	10
(f) Non-Federal personnel	Individuals [4]		441	441	675
(g) Other measures of performance					

[1] President's budget.
[2] Indirect recipients who receive loans from the established loan funds.
[3] Direct recipients of Federal moneys to establish loan funds.
[4] Estimated number of persons required in the schools to assume responsibilities in the loan program. These persons consider applicants, make loans, maintain records of notes and the funds, and are responsible for collection of the loans when they become due and payable—activities which require an estimated minimum of 13 years of continuing responsibility for each participating school.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The delegation of authority from the Office of the Secretary indicated the need for close coordination and cooperation between the health professions student loan program and the national defense student loan program. Since the same schools are involved in many instances it was necessary to develop the programs as similarly as possible. These efforts have been maintained between the Division of Community Health Services, Division of Nursing, Office of Education, Office of General Counsel, and the participating schools.

8. Laws and regulations

Title VII Public Health Service Act as amended (42 U.S.C., ch. 6A).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Students in schools of medicine, dentistry, osteopathy, and optometry have borrowed from established funds to enhance personal resources. The additional financial assistance has enabled students to pursue or continue to pursue their chosen courses of study, which would increase the manpower available for the health professions.

10. Economic classification of program expenditures. (See table 2.)

Program: Health Professions Student Loan program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[Thousands of dollars]

Federal Government [1] [2]	
Grants to State and local governments	10,108
Transfer payments to nonprofit institutions	92
Total Federal expenditures	10,200
Non-Federal expenditures financed by individuals and nonprofit organizations	1,123
Total expenditures for the program	11,323

[1] Grants are made to public and nonprofit schools which in turn make loans to students within the guidelines set forth in the act.
[2] Expenditures here refer to obligations.

NURSING STUDENT LOAN PROGRAM

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The purpose of this program is to increase the opportunities for the training of nurses through stimulating and assisting in the establisment of loan funds in accredited professional schools of nursing from which low-interest loans may be made to students in need thereof to pursue their courses of study.

2. Operation

Annually, eligible schools desiring to participate in the program are required to submit a request for Federal funds for the establishment of a nursing student loan fund and a signed agreement to operate the fund in accordance with the Nurse Training Act of 1964 and the regulations issued pursuant thereto. As prescribed in the act, Federal funds are allocated to the participating schools for nine-tenths of the working capital of their nursing student loan fund; the school is required to contribute the remaining one-tenth. Schools that are unable to raise their share of the fund may borrow from the Federal Government. The schools are responsible for the administration of the funds, including making and collecting loans, and for reporting to the Public Health Service on the operation of the fund. Upon request, technical assistance is provided to the schools from the Division of Community Health Service.

3. History

The Nurse Training Act of 1964 was enacted on September 4, 1965. Federal funds in the amount of $3.1 million were allocated to 402 eligible institutions that applied for participation in the program and the individual schools were notified of the amount of their award on December 26, 1965. In fiscal year 1965, the schools loaned $1.6 million to approximately 3,650 nursing students. For fiscal year 1966 $8.9 million was appropriated for the establishment of nursing student loan funds, and in October this amount was allocated among 559 eligible applicants. These schools requested $9.7 million of Federal funds to meet the needs of 16,900 borrowers. Invitations to participate in the program during fiscal year 1967 will be mailed to approximately 1,100 schools of nursing in February 1966.

4. Level of operations. (See table 1.)

Program: Nursing Student Loan Program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967 [1]
(a) Magnitude of the program	Borrower [2]		3,650	16,900	23,000
(b) Applicants or participants:					
State government agencies					
Local communities or governments					
Individuals or families					
Other—Public and non-profit private schools	Schools [3]		402	559	700
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred			3,089	8,900	8,500
Allotments or commitments made					
(d) Matching or additional expenditures			340	990	935
(e) Number of Federal employees	Man-years		13	13	15
(f) Non-Federal personnel	Individuals [4]		1,206	1,777	2,100
(g) Other measures of performance					

[1] President's Budget.
[2] Indirect recipients who receive loans from the established loan funds.
[3] Direct recipients of Federal moneys to establish loan funds.
[4] Number of persons required in the schools to assume responsibilities in the loan program. These persons consider and select applicants, make loans, maintain records and are responsible for the collection of the loans when they become due and payable—activities which require an estimated minimum of 11 years of continuing responsibility for each participating school.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The delegation of authority from the Office of the Secretary indicated the need for close coordination and cooperation between the nursing student loan program and the National Defense Education Act program. Since the same schools are involved in many instances it is necessary to develop the programs as similar as possible. These efforts have been maintained between the Division of Community

Health Services, Division of Nursing, Office of Education, Office of General Counsel, and the participating schools.

8. Laws and regulations

Title VIII, Public Health Service Act as amended (title 42, United States Code, ch. 6A).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The benefits of the program are twofold: Students who, for financial reasons find it difficult or impossible to continue their education are enabled to do so and the Nation will be provided with a much needed increase in the number of professional nurses.

10. Economic classification of program expenditures. (See table 2.)

Program: Nursing student loan program.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	1,018
Transfer payments to nonprofit organizations	2,061
Loans	10
Total Federal expenditures	3,089
Non-Federal expenditures financed by individuals and nonprofit organizations	340
Total expenditures for program	3,429

[1] Expenditures here refer to obligations.

FORMULA GRANT PROGRAMS

Assistance to State and local governments is an important part of many programs of the Public Health Service, particularly in the broad fields of community health. Frequently the Federal assistance takes the form of cash grants, but various other types of aid also are extensively used, such as technical assistance, consultations, investigations of special problems, field demonstration, and personnel training.

In the formula grants, the aid usually is given to State departments of public health and partly transmitted by them to local public health agencies. Annual Federal allotments establish the amounts available for each State for particular purposes. Application for Federal payments of formula grants must be supported by formal State plans. Federal approval of the State plan and State or local government compliance with other requirements of Federal law and regulations are prerequisites to Federal payment of alloted amounts. Each formula grant is subject to matching from State or local government sources. The matching requirements of each program are outlined for the following programs:

Cancer control.
Chronic illness and aged.
Dental health.

General health.
Heart disease control.
Home health services.
Tuberculosis control.

The individual programs are discussed separately with the exception of question 7, relating to coordination and cooperation, and question 4 (e) and (f), relating to staffing. These questions are answered for all the programs at the end of the section.

Program: Formula grants, Bureau of State Services—Community Health (summary).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67: Summary*

[Dollar amounts in thousands (estimates)]

Measure (see committee inquiry for definitions)	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967 [1]
(a) Magnitude of the program	[2] 54	$355,327	$367,499	$404,010	$417,940
(b) Applicants or participants:					
State government agencies					
Local communities or governments					
Individuals or families					
Other					
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred		38,886	34,572	48,300	46,000
Allotments or commitments made					
(d) Matching or additional expenditures [3]		316,441	332,927	355,710	371,940
(e) Number of Federal employees					
(f) Non-Federal personnel					
(g) Other measures of performance					

[1] President's budget.
[2] Includes 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands.
[3] Matching and other State and local expenditures.

Program: Formula grants, Bureau of State Services—Community Health (summary).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965: Summary*

[In thousands of dollars]

Federal Government: [1] Grants to State and local governments	34,572
Total Federal expenditures	34,572
Non-Federal expenditures financed by State and local governments	332,927
Total expenditures for program	367,499

[1] Expenditures here refer to obligations.

CANCER CONTROL PROGRAM

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives.

To assist States in initiating and furthering programs to reduce morbidity and mortality from cancer.

2. Operation

The program operates with formula grant-in-aid funds which are allocated by the Public Health Service through its regional offices to the health departments of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

3. History

Formula grants for the prevention, control, and eradication of cancer were initially appropriated in fiscal year 1948 in the amount of $2,500,000. Because of the existing opportunities for prevention and control, major attention is directed at strengthening services relating to cervical and lung cancers. Studies have recently been initiated to seek ways in which coordination of voluntary and governmental programs at the State level might be improved.

4. Level of operations. (See table 1.) See additional information at the end of this section.

Program: Cancer control program—formula grants.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[In thousands of dollars]

Measure [1]	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimate)	Fiscal year 1967 [2] (estimate)
(a) Magnitude of the program	[3] 54	$22,216	$23,265	$24,000	$25,600
(b) Applicants or participants:					
State government agencies	54				
Local communities or governments					
Individuals or families					
Other					
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred		3,431	3,447	3,500	3,500
Allotments or commitments made					
(d) Matching or additional expenditures [4]		18,785	19,818	20,900	22,100
(e) Number of Federal employees					
(f) Non-Federal personnel					
(g) Other measures of performance					

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Includes 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands.
[4] Matching and other State and local expenditures for the cancer control program.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation. (See general statement at end of this section.)

8. Laws and regulations

Formula grants for the control of cancer are authorized in the annual appropriation act for fiscal year 1966, Public Law 89–156. General authority for cooperation with State health agencies is contained in section 402(f) of the Public Health Service Act, as amended (42 U.S.C. 282(f)). No allotment formula or procedure is prescribed

by law. Sections 51.1(c), 51.1(i), and 51.2(e) of the Public Health Service regulations (42 CFR) define the basic factors used in the formula. Section 51.3(f) prescribes the range of percentage distribution for each factor. Section 51.9(c) prescribes that matching ratio.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Data available on formula grants do not readily provide information for specific response to this type of question. However, the level of support for the program by the expenditure of State and local funds clearly indicates increases in the employment of personnel and services to people. Federal appropriations have risen from $2.5 million in 1948 to only $3.5 million in fiscal 1966. During this period the State and local funds used to match the Federal funds increased from slightly less than $2 million to almost $20 million. In fiscal year 1964 when the combined Federal, State and local funds totaled slightly over $22 million for preventive and outpatient services, over $9.5 million was utilized for diagnostic clinics and casefinding, and over $5 million for local health services. Not included in these totals is an additional reported expenditure of State and local funds amounting to more than $9.5 million for hospitalization of cancer patients.

10. Economic classification of program expenditures. (See table 2.)

Program: Cancer control program—formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1] Grants to State or local governments	3,447
Total Federal expenditures	3,447
Non-Federal expenditures financed by: State or local governments	19,818
Total expenditures for program	23,265

[1] Expenditures here refer to obligations.

CHRONIC ILLNESS AND AGED

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist States to increase the availability and improve the quality of health services for the chronically ill and aged.

2. Operation

The program operates with formula grant-in-aid funds which are allocated by the Public Health Service through its regional offices to the health departments of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

3. History

Formula grants for this program were authorized for fiscal year 1962 under new authority granted by the Community Health Services

and Facilities Act of 1961. During the two previous fiscal years, 1960 and 1961, the Congress in appropriating increased general health grant funds emphasized the need for improvement of the scope and quality of nursing home services. Consequently, $2 million of the general health grant was devoted to this objective. This initial assistance to improve services for the chronically ill and aged became, in fiscal year 1962, a part of the new categorical grant. Emphasis in the use of the new grant is placed on the development and improvement of nursing care of the sick at home, homemaker services, coordinated home care, information and referral services, health appraisal, and nursing home care. Major developments to date include:

(*a*) A marked increase in the number of States where the collection of fees for services by local official agencies was established or authorized, thereby increasing the total resources available to provide health services to the chronically ill and aged.

(*b*) A marked increase in the number of States programing within the State on a project basis, thereby involving local communities and agencies, and increasing their interest, services, and financial contribution.

(*c*) A noticeable increase in the types of ancillary health personnel effectively utilized in community programs for the chronically ill and aged.

4. *Level of operations.* (See table 1.) See additional information at the end of this section.

Program: Chronic illness and aged formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[In thousands of dollars]

Measure (see committee inquiry for definitions)	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (Estimates)	Fiscal year 1967 [1] (Estimates)
(*a*) Magnitude of the program	[2] 54	$30,098	$31,614	$35,500	$38,700
(*b*) Applicants or participants:					
State government agencies	54				
Local communities or governments					
Individuals or families					
Other					
(*c*) Federal finances:					
Unobligated appropriations available		12,246	11,293	12,300	12,300
Obligations incurred					
Allotments or commitments made					
(*d*) Matching or additional expenditures [3]		17,852	20,321	23,200	23,100
(*e*) Number of Federal employees					
(*f*) Non-Federal personnel					
(*g*) Other measures of performance					

[1] President's budget.
[2] Includes 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands.
[3] Matching and other State and local expenditures for the chronic illness and aged program.

5. *Estimated magnitude of program in 1970*

Not answered.

6. *Prospective changes in program orientation*

Not answered.

7. Coordination and cooperation. (See general statement at end of this section.)

8. Laws and regulations

Formula grants to States are authorized in section 314(c) of the Public Health Service Act, as amended (42 U.S.C. 146(c)). Public Law 87-395 requires separate matching of any earmarked section 314(c) funds. The 1966 Appropriation Act (Public Law 89-156) earmarked funds for these grants.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Data available on formula grants do not readily provide information for specific response to this type of question even though this program received its own initial grant as recently as fiscal year 1962. The level of support by State and local funds and the developments described under the brief history are indications of its impact. In fiscal year 1964 the Federal appropriation of $13 million was matched by nearly $18 million in State and local funds for a total program expenditure of almost $31 million. Of this total, over $14 million supported local health services, $3.1 million was used for nursing and home care services, and nearly $2 million for alcoholism. Not included in these totals is an additional reported expenditure of State and local funds in the amount of $11,246,714 for hospitalization.

10. Economic classification of program expenditures

Program: Chronic illness and aged formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:[1] Grants to State and local governments	11, 293
Total Federal expenditures	11, 293
Non-Federal expenditures financed by State or local governments	20, 321
Total expenditures for program	31, 614

[1] Expenditures here refer to obligations.

DENTAL HEALTH

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To stimulate the development of adequate State and local resources to combat the increasing dental health problem of the Nation.

2. Operation

The program operates with formula grant-in-aid funds which are allocated by the Public Health Service through its regional offices to the health departments of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

3. History

Although this program was not initiated until midway through fiscal year 1965, 49 States submitted approvable plans and budgets and launched dental health programs in the last half of the year. The appropriation for this program was increased by the Congress from $520,000 to $1 million for fiscal year 1966.

4. Level of operations. (See table 1.) (See additional information at the end of this section.)

Program: Dental health formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[In thousands of dollars]

Measure (see committee inquiry for definitions)	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimated)	Fiscal year 1967 [1] (estimated)
(a) Magnitude of the program	[2] 54	[3]	$1,580	$3,200	$3,500
(b) Applicants or participants:					
State government agencies	54	[3]			
Local communities or governments		[3]			
Individuals or families		[3]			
Other		[3]			
(c) Federal finances:					
Unobligated appropriations available		[3]			
Obligations incurred	54	[3]	448	1,000	1,000
Allotments or commitments made		[3]			
(d) Matching or additional expenditures [4]		[3]	[5] 1,132	[6] 2,200	[6] 2,500
(e) Number of Federal employees		[3]			
(f) Non-Federal personnel		[3]			
(g) Other measures of performance		[3]			

[1] President's budget.
[2] Includes 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands.
[3] Program not initiated until mid fiscal year 1965.
[4] Matching and other State and local expenditures for the dental health program.
[5] Budget estimate provided by State agencies.
[6] Rough estimate arrived at by projecting the fiscal year 1965 budget estimate.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation. (See general statement at end of this section.)

8. Laws and regulations

Formula grants for dental health are authorized in the annual appropriation act for fiscal year 1966 (Public Law 89–156). Authority is included in section 314(c) of the Public Health Service Act as amended (42 U.S.C. 246). Section 314(d) of the Public Health Service Act, as amended, cites the basic allotment factors of population, financial need, and extent of the problem. Sections 51.1(c), 51.1(i), and 51.2(h) of the Public Health Service Regulations define these factors and section 51.3(i) describes the allocation. Section 51.9(a) prescribes the matching ratio.

9. Economic effects

Although the program was begun too recently to provide any detailed response to this item, there is no question but that it will provide employment to additional personnel and increase the availability of dental care and supportive services, including the provision of preventive and restorative services for both children and adults, and the establishment of demonstrations of more effective methods of providing treatment services. Such groups as the indigent, handicapped, geographically isolated, chronically ill and aged, and homebound will receive priority.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

10. Economic classification of program expenditures. (See table 2.)

Program: Dental Health Formula Grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[Thousands of dollars]

Federal Government:[1] Grants to State and local governments	448
Total Federal expenditures	448
Non-Federal expenditures financed by: State and local governments	1,132
Total expenditures for program	1,580

[1] Expenditures here refer to obligations.

GENERAL HEALTH

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The general health grant was started in 1936 as title VI of the Social Security Act to provide financial assistance and stimulation to the nationwide development and improvement of State and local public health services for the prevention and control of disease, disability, and premature death. It was conceived that the mass protection of the population through these services would prolong the productive life of individuals, reduce the costs of medical and hospital care, lower welfare costs resulting from dependency due to loss of personal income, protect against the interstate spread of disease, and generally promote the health and welfare of the people. Authority for the general health grant was included with relatively little change in the Public Health Service Act of 1944.

2. Operation

The program operates with formula grant-in-aid funds which are allocated by the Public Health Service through its regional offices to the health departments of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

3. History

While the basic purposes of the grant have remained unchanged since its inception, two factors have influenced the major emphasis of

programs which it helps to support. The first of these has been the initiation at later dates of grant programs for various categories of diseases (e.g., tuberculosis, heart disease, poliomyelitis) that have provided funds for the specialized costs of programs and services for certain disease control programs. The second factor has been the remarkable advancements in scientific knowledge that have made possible the initiation through the general health grant of new programs and services for the control on a community public health basis of diseases and conditions for which there were formerly no preventive or control measures. Underlying these developments, however, the basic purpose of the grant has continued to be the strengthening and improvement of a nationwide network of basic local public health organizations, staff, and services through which the more specialized disease control programs can operate effectively.

4. Level of operations. (See table 1.) See additional information at the end of this section.

Program: General health formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[In thousands of dollars]

Measure (see committee inquiry for definitions)	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 [4]	Fiscal year 1967 [1 4]
(a) Magnitude of the program	[2] 54	$239,101	$253,897	$266,410	$280,270
(b) Applicants or participants:					
State government agencies	54				
Local communities or governments					
Individuals or families					
Other					
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred		13,999	9,997	10,000	10,000
Allotments or commitments made					
(d) Matching or additional expenditures [3]		225,102	243,900	256,410	270,270
(e) Number of Federal employees					
(f) Non-Federal personnel					
(g) Other measures of performance					

[1] President's budget.
[2] Includes 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands.
[3] Matching and other State and local expenditures for the general health program.
[4] Estimates.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation. (See general statement at end of this section.)

8. Laws and regulations

Formula grants for general health are authorized in the annual appropriation act for fiscal year 1966 (Public Law 89–156). Authority is included in section 314(c) of the Public Health Service Act as amended (42 U.S.C. 246). Section 314(d) cites the basic factors of population, financial need and extent of the problem. Sections

51.1(c), 51.1(i), and 51.2(c) of the Public Health Service Regulations (42 C.F.R.) define these factors and section 51.3(c) prescribes the range of percentage distribution for each factor. Section 51.9(a) prescribes the matching ratio.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Data available on formula grants do not readily provide information for specific response to this type of question. However, a review of the purpose and history of the general health grant program (above) and the vast sustained increase in State and local fund expenditures, despite the decrease in Federal funds, are a clear indication of this program's impact in terms of additional people employed and additional people receiving health services. In the initial year (1936), the Federal appropriation totaled $3,330,000 and slightly over $15 million of State funds were expended. During the next 25 years the Federal appropriation increased to $17 million while State expenditures increased to over $200 million. In fiscal years 1962 and 1963 the Federal grant was reduced to $15 million and in fiscal 1965 to $10 million. These Federal reductions notwithstanding, it is estimated the final reports will reveal that States expended about $250 million in State and local funds in fiscal 1965.

10. Economic classification of program expenditures. (See table 2.)

Program: General health formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:[1]	
Grants to State and local governments	9,997
Total Federal expenditures	9,997
Non-Federal expenditures financed by State and local governments	243,900
Total expenditures for program	253,897

[1] Expenditures here refer to obligations.

HEART DISEASE CONTROL

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist the States in establishing and maintaining organized community programs for heart disease control.

2. Operation

The program operates with formula grant-in-aid funds which are allocated by the Public Health Service through its regional offices to the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The legislation for this grant provided for submission of a plan by a political subdivision of a State or any public or nonprofit agency if the State health authority has not submitted a plan prior to August 1 of any fiscal year, but the plan must be submitted through the State health authority and have its approval.

To date, only one such agency has participated in the program; at present all formula grant heart disease control programs are administered by the State health authorities.

3. History

The grant for community programs for heart disease control was authorized by the National Heart Act, approved June 16, 1948, by amendment to section 314 of the Public Health Service Act. In 1949, the initial year of the grant, only $130,000 was made available for grants to States. Because this small amount did not permit a formula allocation to all States, grants were made to seven States for demonstration projects. The first year of operation under an allocation for all States was 1950.

State and local funds expended for heart disease control continue to increase annually; the overall expenditures for preventive and outpatient services increased almost 18 percent between fiscal years 1962 and 1963, and for the latter year States reported approximately 43 percent of the total funds as supporting local heart disease control activities.

The supplemental fiscal year 1966 appropriation authorized an increase of $2.5 million in the heart disease control formula grant to States for the purposes of carrying out the recommendations of the President's Commission on Heart, Cancer, and Stroke for establishing and maintaining coordinated statewide laboratory facilities. The establishment or expansion of laboratory services primarily for cardiovascular diseases through this program should help in forming a coordinated Statewide program of chronic disease control.

4. Level of operations. (See table 1.) See additional information at the end of this section.

Program: Heart disease control formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[In thousands of dollars]

Measure [1]	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 [2]	Fiscal year 1967 [2 3]
(*a*) Magnitude of the program	[4] 54	$18,350	$19,422	$23,500	$24,500
(*b*) Applicants or participants:					
State government agencies	54				
Local communities or governments					
Individuals or families					
Other					
(*c*) Federal finances:					
Unobligated appropriations available					
Obligations incurred	54	6,312	6,467	9,500	9,500
Allotments or commitments made					
(*d*) Matching or additional expenditures [5]		12,038	12,955	14,000	15,000
(*e*) Number of Federal employees					
(*f*) Non-Federal personnel					
(*g*) Other measures of performance					

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Estimates.
[4] Includes 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands.
[5] Matching and other State and local expenditures for the heart disease control program.

5. Estimated magnitude of program in 1970.

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation. (See general statement at end of this section.)

8. Laws and regulations

Formula grants for heart disease control are authorized in the annual appropriation act for fiscal year 1966 (Public Law 89–156). Authority is included in section 314(e) of the Public Health Service Act as amended (42 U.S.C. 246(e)). Section 314(e) cites the basic factors of population and financial need for the allocation of funds. Sections 51.1(c) and 51.1(i) of the Public Health Service Regulations (42 CFR) define these factors. Section 51.3(e)(1) is in the process of amendment. Section 51.9(a) prescribes the matching ratio.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Data available on formula grants do not readily provide information for specific response to this type of question. Federal appropriations for this program have increased steadily from $2 million in 1950 to $9.5 million for fiscal 1966. The support level for the program continues to rise commensurately with $2 of State and local funds being expended for each $1 of Federal money. In fiscal 1964 slightly over 40 percent of the total expenditures were for local health services and almost 23 percent were used for diagnostic clinics and casefinding for preventive and outpatient services.

10. Economic classification of program expenditures. (See table 2.)

Program: Heart disease control formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	6,467
Total Federal expenditures	6,467
Non-Federal expenditures financed by State and local governments	12,955
Total expenditures for program	19,422

[1] Expenditures here refer to obligations.

HOME HEALTH SERVICES

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist States and communities to develop, improve, or expand the capacity of new or existing public or private agencies which meet the qualifying conditions for participation in the health insurance program to provide home health services throughout each State.

2. Operation

The program will operate with formula grant-in-aid funds which are allocated by the Public Health Service through its regional offices to

the health departments of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

3. History

This is a new program for which the President has submitted to the Congress a supplemental budget request for fiscal year 1966 of $9 million. At this writing, action is pending in Congress.

4. Level of operations. (See table 1.) See additional information at the end of this section.

Program: Home health services formula grants.
Department or agency, and office or bureau: Department of Health, Education and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[In thousands of dollars]

Measure [1]	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimates)	Fiscal year 1967 [2] (estimates)
(a) Magnitude of the program	[3] 54	None	None	$9,900	$7,370
(b) Applicants or participants:					
State government agencies	54				
Local communities or governments					
Individuals or families					
Other					
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred	54	None	None	9,000	6,700
Allotments or commitments made					
(d) Matching or additional expenditures [4]				[5] 900	[5] 670
(e) Number of Federal employees					
(f) Non-Federal personnel					
(g) Other measures of performance					

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Includes 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands.
[4] Matching and other State and local expenditures for the home health services program.
[5] Based on requirement of 1 local and/or State dollar for each 10 Federal dollars.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation (See general statement at end of this section.)

8. Laws and regulations

The House completed action on a supplemental appropriation bill under section 314(c) of the Public Health Service Act to provide funds for a new home health services formula grant for fiscal year 1966. Public Health Service regulations, in the process of amendment for this program, will be published in the Federal Register.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Under this program persons aged 65 years and older will be entitled to receive home health services from certified home health agencies which must offer, as a minimum, skilled nursing services and one other therapeutic service. Currently there are not sufficient agencies on a nationwide basis to assure services to the potential 19 million beneficiaries of the health insurance benefits program. This grant program is aimed at insuring that there will be an adequate number of such home health agencies.

10. Economic classification of program expenditures

Program not in operation in 1965.

Tuberculosis Control

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist States in establishing and maintaining adequate measures for the prevention, treatment, and control of tuberculosis and to provide basic tuberculosis control services such as laboratory services, and record and statistical services, and to insure the continuation of direction, coordination and planning.

2. Operation

The program operates with formula grant-in-aid funds which are allocated by the Public Health Service through its regional offices to the health departments of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

3. History

The tuberculosis control grant was approved in 1944. This grant program was the outgrowth of Public Health Service case-finding programs during fiscal years 1943 and 1944 that were designed to prevent an increase in tuberculosis as a result of war conditions. The case-finding programs had been carried out chiefly in war industries, through the operation and loan to State and local governments of mobile X-ray units. The development during this period of a portable 35-millimeter X-ray unit and of a 4- by 5-inch photofluorographic X-ray unit made possible chest X-ray examinations of large groups of people at a nominal expenditure of materials and personnel. Thus a national program for tuberculosis control was feasible.

In order to focus attention on the need for case-finding, Congress in the 1955 Appropriation Act restricted the use of the Federal grant and State and local matching funds for direct expenses of prevention and case-finding activities. The use of grant funds was further restricted in fiscal year 1965 in keeping with the recommendations of the Surgeon General's Task Force on Tuberculosis Control.

4. Level of operations. (See table 1.) See additional information at the end of this section.

Program: Tuberculosis control formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[In thousands of dollars]

Measure [1]	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimate)	Fiscal year 1967 [2] (estimate)
(a) Magnitude of the program	[3] 54	$45,562	$37,721	$41,100	$38,000
(b) Applicants or participants:					
State government agencies	54				
Local communities or governments					
Individuals or families					
Other					
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred		2,898	2,920	3,000	3,000
Allotments or commitments made					
(d) Matching or additional expenditures [4]		42,664	34,801	38,100	35,000
(e) Number of Federal employees					
(f) Non-Federal personnel					
(g) Other measures of performance					

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Includes 50 States, District of Columbia, Guam, Puerto Rico, and the Virgin Islands.
[4] Matching and other State and local expenditures for the tuberculosis control program.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation. (See general statement at end of this section.)

8. Laws and regulations

Formula grants for the control of tuberculosis are authorized in the annual Appropriation Act for fiscal year 1966 (Public Law 89–156). Authority is included in section 341 (b) of the Public Health Service Act as amended (42 U.S.C. 246). Section 314(b) cites the basic factors of population, financial need, and extent of the tuberculosis problem to be considered in allotting funds. Sections 51.1(c), 51.1(i), and 51.2(b) of the Public Health Service Regulations (42 CFR) define these factors, and section 51.3(b) prescribes the range of percentage distribution for each factor. Section 51.9(b) prescribes the matching ratio for the formula grant.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Data available on formula grants do not readily provide information for specific response to this type of question. For this program, however, the level of support through expenditure of State and local funds clearly indicates increases in the employment of personnel and services to people. Federal appropriations, beginning with $1,370,000 in 1945, rose to $6,790,000 in 1948–50 and then decreased gradually to $3 million in fiscal years 1965 and 1966. Meanwhile, the State and local funds used to match the Federal funds increased from $902,000 in 1945 to $42,199,506 in fiscal year 1964. The combined Federal, State, and local expenditures for 1964 totaled $45,132,913 for preventive and outpatient services; of this total 60.1 percent was spent for local health services. Not included in this total is an additional reported expenditure of State and local funds amounting to $77,255,485 for hospitalization of tuberculosis patients.

10. Economic classification of program expenditures. (See table 2.)

Program: Tuberculosis control formula grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures*

[In thousands of dollars]

Federal Government: [1] Grants to State and local governments	2,920
Total Federal expenditures	2,920
Non-Federal expenditures financed by: State, local governments	34,801
Total expenditures for program	37,721

[1] Expenditures here refer to obligations.

GENERAL STATEMENTS ON FORMULA GRANT PROGRAMS

4(e) Number of Federal Government employees administering, operating or supervising activities

Because of the organizational structure of the Bureau of State Services (CH) it is almost impossible to report how many personnel are working in the various programs supported by Federal formula grants. For example, the immediate Bureau staff provides administrative guidance to all activities in which the Bureau is engaged, the Office of Grants Management provides services related to fund control and disbursement, including the development of policies and procedures, and as an example within an example, the Division of Chronic Diseases in the Bureau is responsible for three formula grant programs, four project demonstration programs and is also engaged in contracts for services and training grants. This latter example is also true for the other divisions within the Bureau. Because of this multiplicity of program responsibility it would be impossible to

identify what each employee does for each program unless we maintained a rather elaborate system of time keeping records which we are not doing at the present. Of course we could single out certain program specialists, but to do this would to no measurable degree, provide an indicator of how many individual employees are engaged in the various programs and activities administered by the community health portion of the Bureau of State Services. To further complicate the situation, the Public Health Service, as is true for all of DHEW, is decentralized into nine regional offices. Here again personnel are responsible for multiple activities and are not assigned to a single program area from the standpoint of the several formula grants. We have found this method of personnel administration to be more economical than to have categorical specialists assigned to individual programs.

4(f) Non-Federal personnel employed in the programs.

The Federal formula grant funds described in this section of the report, are allocated to the 50 states, the District of Columbia, the Virgin Islands, Guam, Puerto Rico and two separate State cancer agencies. Because the funds are split into so many segments, we have never requested State or local health departments to report to us how many personnel are engaged in each of the various programs supported by these funds nor from required State and/or local matching expenditures. Our main objective, from the standpoint of improving the level of health in the Nation and its territories is, and continues to be, the numbers and kinds of services provided to people. We feel this, so long as the quality is good, and the quantity meets the needs of the majority of the population, to be more important than a listing of numbers of people separately engaged in each of the programs conducted at the State and local level. We do however receive on an annual basis from States, and biennially from local health departments, a listing of the number of employees engaged in the health industry. While these reports segment the number of physicians, nurses, sanitarians, clerks and other classifications, it is our opinion that the best indicator of progress is not the increase in the number in each classification or program, but the total overall increase from one period to another. In this connection our records reveal there were 17,674 personnel working in State health departments in 1952. By 1964 this total had climbed to 19,909. This to us is both significant and gratifying. During the same period local health personnel rose from 35,997 in 1952 to 51,632 in 1964.

To supplement these personnel statistics, please see the following tables. Here again we feel this increase represents progress in furthering our objectives of bringing more and better public health service to all of our citizens. We feel confident this trend will continue.

Comparison of total number of full-time public health workers of different classifications reported by State and local health departments for designated years [1]

Class of personnel	1964	1962	1960	1958	1956	1955	1954	Difference, 1964–54
All types	70,641	65,744	62,575	59,742	55,392	54,810	54,255	16,386
Physicians	2,277	2,166	2,082	2,088	2,095	2,065	2,085	192
Public health nurses	16,927	15,894	15,471	15,223	14,273	14,052	13,802	3,125
Clinic nurses	902	922	735	743	663	665	654	248
Dentists	566	493	464	423	393	378	358	208
Dental hygienists	554	483	451	450	417	422	411	143
Engineers	1,294	1,263	1,185	1,028	1,037	1,032	1,030	264
Professional sanitarians and other sanitation personnel	10,734	10,304	9,075	8,973	8,139	8,211	8,037	2,697
Veterinarians	260	290	299	343	347	342	363	−103
Laboratory	3,704	3,393	3,385	3,149	2,931	2,895	2,968	736
Health educators	594	544	527	496	490	490	494	100
Nutritionists	323	300	281	260	245	234	233	90
Medical and psychiatric social workers	918	699	607	523	395	385	340	578
Psychologists	225	205	157	137	91	87	74	151
Analysts and statisticians	637	543	483	443	426	375	364	273
Public health investigators	880	727	712	622	607	574	688	192
X-ray technicians	602	584	623	665	641	626	633	−31
Physical therapists	331	234	219	224	186	168	162	169
Administrative management personnel	1,923	1,546	1,330	1,217	1,116	1,045	1,063	860
Clerks	19,367	18,099	17,147	16,403	15,173	15,035	14,843	4,524
Maintenance, custodial, and service	4,820	4,157	4,252	3,639	3,803	3,719	3,636	1,184
Others	2,803	2,898	2,460	2,693	1,924	2,010	2,017	786

[1] Includes the 50 States, District of Columbia, and the territories.

Source: State health department personnel, joint form 5. Local health department personnel—Report of public health personnel.

State and local public health workers, by professional categories and by States, Jan. 1, 1964

State	Total			Physicians		Public health nurses		Clinic nurses		Dentists		Dental hygienists		Engineers		Sanitarians	
	State and Local	State [1]	Local [2]	State	Local	State	Local	State	Local	State	Local	State	Local	State	Local	State	Local
Total	70,61[illegible]	10,009	51,632	609	1,668	869	16,058	61	841	164	402	58	496	830	464	688	7,508
Alabama	1,09[illegible]	344	747	7	25	10	233	3	------	2	1	------	6	15	4	11	114
Alaska	24[illegible]	87	158	4	3	3	47	------	1	------	------	------	------	2	2	1	16
Arizona	57[illegible]	158	412	4	15	12	95	------	21	2	1	1	1	5	2	3	77
Arkansas	561	246	315	10	6	7	132	------	2	1	------	------	------	12	------	15	61
California	6,862	1,377	5,485	54	254	19	1,503	------	248	4	17	------	11	90	21	114	876
Colorado	728	210	518	13	12	14	216	------	10	3	------	1	2	11	2	11	106
Connecticut	949	477	472	22	20	22	209	7	3	3	1	5	30	15	3	3	62
Delaware	258	111	147	5	4	4	53	------	------	2	2	1	3	3	------	4	29
District of Columbia	881	------	881	------	44	------	94	------	34	------	16	------	23	------	6	------	4
Florida	2,749	758	2,001	24	81	50	706	------	21	3	18	1	6	33	16	11	375
Georgia	2,165	637	1,528	19	38	25	552	------	43	4	8	1	8	18	24	15	188
Hawaii	617	157	460	14	6	7	90	------	2	1	2	1	26	4	4	4	85
Idaho	246	121	125	4	2	6	55	------	------	1	------	1	------	3	3	8	17
Illinois	2,373	641	1,732	12	46	32	449	2	3	5	57	------	1	39	28	18	99
Indiana	1,166	395	771	10	10	6	275	------	6	2	------	1	------	33	10	25	245
Iowa	355	137	218	2	3	14	103	------	------	1	------	------	------	11	10	3	38
Kansas	535	213	322	5	7	7	107	------	4	2	2	------	------	9	14	10	76
Kentucky	1,429	556	873	11	38	11	306	1	1	6	2	2	2	16	2	13	176
Louisiana	1,354	457	897	9	20	18	251	------	8	1	------	------	------	13	------	31	198
Maine	313	164	149	3	6	------	87	------	1	------	------	3	2	4	2	4	15
Maryland	1,877	449	1,428	9	38	11	563	------	16	1	6	------	3	23	12	13	186
Massachusetts	2,092	641	1,451	20	30	27	565	------	21	2	36	5	72	39	14	39	217
Michigan	2,427	693	1,834	20	47	20	526	------	30	4	36	2	13	46	22	6	229
Minnesota	763	277	486	8	17	20	200	2	6	2	6	3	7	11	6	5	72
Mississippi	937	278	659	12	31	11	256	------	------	1	------	4	------	4	------	18	106
Missouri	1,372	244	1,128	8	22	16	249	1	6	5	9	------	3	10	26	10	148
Montana	252	102	50	3	3	14	30	------	1	1	1	------	------	8	------	3	8
Nebraska	269	119	150	2	2	4	43	------	1	1	1	------	------	4	3	3	38
Nevada	168	107	61	5	2	15	16	1	4	4	------	1	------	4	------	6	15
New Hampshire	155	111	44	4	1	14	20	------	------	------	------	1	------	6	------	------	3
New Jersey	2,115	526	1,589	16	12	21	575	------	39	4	7	------	4	24	4	24	243
New Mexico	346	143	203	3	8	10	81	------	1	5	------	------	------	6	------	4	33
New York	8,349	1,208	7,141	53	201	23	1,841	3	51	4	41	2	212	55	97	5	565
North Carolina	1,108	407	1,501	14	62	11	584	------	22	25	31	------	------	22	5	19	251
North Dakota	188	104	84	3	------	6	44	------	------	1	------	2	------	7	1	1	14
Ohio	2,755	392	2,363	6	80	14	853	1	27	------	4	------	20	17	3	8	526
Oklahoma	686	232	454	7	9	17	169	------	4	4	5	------	1	10	1	18	118
Oregon	662	222	440	12	22	13	165	------	13	2	------	------	------	11	1	11	67
Pennsylvania	3,178	769	2,409	30	41	20	694	11	64	2	26	1	10	30	68	11	331
Rhode Island	321	216	105	12	2	17	49	------	2	2	------	------	2	7	------	29	20
South Carolina	934	323	611	9	22	37	224	14	16	3	1	3	2	9	2	10	122
South Dakota	106	79	27	1	------	8	7	------	------	------	------	------	------	6	2	7	6

Tennessee	1,492	492	1,000	12	38	20	346		12	9	4	2	1	20	5	11	200
Texas	2,746	731	2,015	15	45	24	476	2	27	3	5	2	7	37	18	47	417
Utah	356	160	196	8	3	9	90	3	2	1				5	5	8	43
Vermont	161	161	(3)	7	(3)	44	(3)		(3)	1	(3)	2	(3)	3	(3)	7	*
Virginia	1,896	478	1,418	19	52	19	494		12	23	29		1	23	1	14	298
Washington	1,144	245	899	10	31	17	315		49	1		1	1	11	1	15	154
West Virginia	509	188	321	7	6	18	124		3	2		1		2		7	80
Wisconsin	1,301	230	1,071	6	39	8	446		3	1	4		13	22	14	7	111
Wyoming	65	57	8	3		7	3		1	1				4		4	1
Guam	74	74	(4)	2	(4)	29	(4)	2	(4)	1	(4)	5	(4)		(4)	6	(4)
Puerto Rico	3,401	1,126	2,275	27	162	36	447	6		1	23	1	3	7		8	29
Virgin Islands	179	179	(4)	4	(4)	22	(4)	2	(4)	4	(4)	2	(4)	1	(4)		(4)

State	Other sanitation personnel		Laboratory personnel (professional and technical)		Health educators		Nutritionists		Medical and psychiatric social workers		Psychologists		Analysts and statisticians	
	State	Local	State	Local	State	Local	State	Local	State	Local	State	Local	State	Local
Total	350	2,188	2,158	1,546	233	361	146	177	230	688	69	156	387	250
Alabama	7	81	61	8	2	3	2	1	3	6	3	3	5	2
Alaska		8		12						6	1	2	2	1
Arizona	3	6	26	6	1	2	1	3	8	9	1	1	2	2
Arkansas	3		23	2	6	1	3	3			2			
California	67	121	97	232	15	70	8	19	11	131	1	30	115	78
Colorado		9	22	10	2	2	3		10	6		3	2	1
Connecticut	10	17	72	17	6	3	4		12	1	1		10	2
Delaware	2	4	9	3	1		1		3	5	1	4	1	1
District of Columbia		41		37		5		2		84		16		14
Florida	7	62	152	17	7	9	6	4	10	61	4	23	9	2
Georgia	2	33	63	17	12	3	5	5	9	14	2	8	9	2
Hawaii		3	3	26	4		2	2	4	26	2	6	3	4
Idaho		2	15	6	1				8	7	2	2	2	
Illinois	6	158	96	87	3	19	1	14	1	24		6	12	11
Indiana	10		45	12	12	6	4	5					3	3
Iowa		14		11	4	1	3			1			5	2
Kansas		6	37	5	3	2	1			2		2	2	
Kentucky	36	20	34	10	9	13	8	11		1			12	2
Louisiana		8	73	3	7	4	8	1	10		3		2	
Maine		3	17	1	3	2	1	1	1	1			4	
Maryland	7	8	66	41	4	4	2	3	4	22	1	10	13	7
Massachusetts		50	144	36	14	10	4	10	6	10			26	2
Michigan		135	94	40	3	10	5	4	4	4			6	5
Minnesota	13	13	38	8	4	2	1	1		2	1	2	6	1
Mississippi			24	1		1	2		7		4		3	
Missouri		137	15	42	5	10	1	2		34		7	2	2
Montana			9		5		1		1	1	1		1	
Nebraska	7	1	9	9	5	3	2		1					
Nevada	1	1	10		1				7		7		2	

See footnotes at end of table, p. 637.

State and local public health workers, by professional categories and by States, Jan. 1, 1964—Continued

State	Other sanitation personnel		Laboratory personnel (professional and technical)		Health educators		Nutritionists		Medical and psychiatric social workers		Psychologists		Analysts and statisticians	
	State	Local	State	Local	State	Local	State	Local	State	Local	State	Local	State	Local
New Hampshire	8	7	19	3					5				1	1
New Jersey	8	85	67	48	4	7	2	3	2	6	1		4	16
New Mexico		1	17		1		1		3	2	3		2	
New York	15	265	171	334	9	44	10	32	3	73		4	18	52
North Carolina	3	20	56	30	7	14	4	2	1	10		6	5	1
North Dakota		5	17	3	1		1		1		3			
Ohio	9	112	41	48	4	20	2	2	1	6	1	1	5	5
Oklahoma		10	28	15	1	1	1		4	3	6	4	3	
Oregon	2	12	26	6	4	3	1		1	21		6	9	1
Pennsylvania		101	37	69	6	21	4	12	3	18		2	5	13
Rhode Island	4	6	25	2	4		1		2		1		2	
South Carolina	10	16	33	10	2	6	4		5	1				1
South Dakota		1	8	3									2	
Tennessee		18	84	3	3	5	5	1		4		1	12	
Texas	36	164	61	106	23	9	4	6	3	15		2	11	6
Utah	1	3	22	4	3	1	1		2	7	1	2	4	
Vermont		(3)	16	(3)	1	(3)	2	(3)	2	(3)	3	(3)	1	(3)
Virginia	34	59	42	51	4	3	3	1	6	6	1	2	6	4
Washington	3	39	26	37	3	3	2	1	6	15			8	2
West Virginia	3	2	22	8			4		4	6	1			
Wisconsin	5	74	19	44	5	9	2	8	1	3	2	1	4	4
Wyoming			3		1		1				1		1	
Guam		(4)	4	(4)		(4)		(4)	3	(4)		(4)		(4)
Puerto Rico	19	247	56	23	6	30	10	18	50	34	6		19	
Virgin Islands	9	(4)	4	(4)	2	(4)	2	(4)	2	(4)	2	(4)	6	(4)

State	Veterinarians		Public health investigators		X-ray technicians		Physical therapists		Administrative management personnel		Clerical		Maintenance, custodial, and service		Other personnel	
	State	Local	State	Local	State	Local	State	Local	State	Local	State	Local	State	Local	State	Local
Total	51	209	337	543	222	380	82	249	1,128	795	7,733	11,634	1,677	3,143	927	1,876
Alabama		4	10	5	11	1			14	4	128	189	38	44	12	13
Alaska					1	2			9		62	57		1	2	
Arizona	1	2	4	8	2	6	1	1	6	5	69	98	1	50	5	1
Arkansas	2	1	2	5	4				14	1	103	88	17	13	22	
California	4	12		94		43	4	88	49	88	518	1,314	122	133	85	102
Colorado	1	4	2	2	2	1	1		8	9	70	92	15	13	19	18
Connecticut		1	11	1	1	4	6	1	35	3	172	86	35	4	24	4

Delaware			1	1	4		5	3		2	42	26	12	1	10	
District of Columbia		10		10		5		20		22		246		111		37
Florida	1	2	27	32	9	16			43	22	231	419	106	68	24	41
Georgia	1	6	44	42	7	15	3	1	48	10	235	359	68	135	47	17
Hawaii			1	1	1	4	3	4	12	1	83	84		68	8	16
Idaho			4	1					20		38	27	6	2	2	1
Illinois	1	5	5	49	10	2		1	16	24	302	411	45	143	35	95
Indiana	1	2	6	6	9	1			20	1	147	148	34	17	27	24
Iowa	1		9	1	4				14	2	66	27		5		
Kansas	2	1	5	3	2	2			7	5	103	68	9	13	9	3
Kentucky	2	1	9	1	6	4	3		53	30	254	218	30	28	40	7
Louisiana	1	2	15	14	9	13			19	3	192	262	36	109	10	1
Maine					3	2			17	2	90	22	5		9	2
Maryland	1	7	11	9	3	7	1	8	32	20	164	345	75	38	8	75
Massachusetts	1	2	25	2	6	10		12	28	35	212	246	35	49	8	22
Michigan	3	20	7	11	8	18	3	3	26	80	193	423	216	45	27	133
Minnesota		1		2			1		9	3	121	114	16	12	16	11
Mississippi				28	1		1		22		121	168	23	67	20	1
Missouri	2	8		4		7	1		18	52	122	263	16	69	12	28
Montana							1		3		42	6	2		7	
Nebraska			1	1	3				7	2	60	30	3	6	7	10
Nevada			1	1	1	1	1		2	2	20	17	3		6	2
New Hampshire		1			3		1		10	2	36	6			3	
New Jersey	3	7	32	33	2	6			30	85	212	297	28	80	42	32
New Mexico	1		1	5		2			12		53	59	17	4	4	7
New York	6	15	20	13	18	77	2	66	45	123	493	1,793	209	590	44	652
North Carolina	1	4		25	10	9	7	5	14	3	163	301	18	109	27	7
North Dakota			4						5	4	44	13	5		3	
Ohio	1	44	1	8	4	7		5	60	28	160	484	34	51	23	29
Oklahoma		2	3	3	3	1	1		15	2	81	95	19	6	11	5
Oregon	1	3				3	1		11	5	89	92	5	12	23	8
Pennsylvania	1	14	2	30	9	23	1	7	41	59	475	587	27	123	53	96
Rhode Island	2		4		3		2		14	1	72	19	13	2		
South Carolina		4	4	2	5	5	1		16	3	127	152	12	21	19	1
South Dakota			2		1				6	2	31	6	6		1	
Tennessee	1	2	6	6	20	15	1		14	7	186	248	52	38	34	46
Texas	5	15	45	34	2	11	2	7	53	10	284	357	64	296	8	72
Utah		1	1		1	1	3		5		62	31	13	2	7	1
Vermont		*		*	2	*	3	*	5	*	53	*	6	*	3	*
Virginia	1	1	2	18	21	13	3	4	17	9	215	303	10	39	15	18
Washington		4	1	5		12	2	1	20	6	98	193	5	19	16	11
West Virginia			5	1	3	1			10	3	80	78	13	9	6	
Wisconsin		1		2	3	4	1	8	25	7	110	227	6	22	3	27
Wyoming									2		29	2		1		
Guam		(4)		(4)		(4)		(4)	2	(4)	13	(4)	7	(4)		(4)
Puerto Rico	1		3	24	5	26	15	4	109	8	555	438	125	565	61	194
Virgin Islands	2	(4)	1	(4)		(4)	1	(4)	36	(4)	42	(4)	15	(4)	20	(4)

[1] The personnel serving in State Health Districts are excluded from State Health Department figures and included with local Health Unit figures.

[2] In addition, 536 workers were reported in areas not organized for local public health services.

[3] Vermont has no local health units recognized by the State health department.

[4] Data for local health units in Guam and the Virgin Islands are not available.

Source: Joint form 5, report of State health department personnel by organizational unit, and report of public health personnel, submitted by local health department.

7. Coordination and cooperation

After allocating all of the categorical formula grants to official State agencies, the only authorized recipient under the law, we work closely with States to coordinate and cooperate in the administration of the Federal funds. This includes such items as budget and plan development, proper expenditures of the formula grant, and the required State and local matching, and the periodic reporting to the Public Health Service of program and expenditure experiences. There are close working relationships between the various community health divisions within the Bureau of State Services, as it relates to fund administration, program execution, adequate reporting of accomplishments by State health agencies and as needed, policy and procedure changes directed toward improving effectiveness and efficiency in utilizing the Federal formula grant funds at the State and local level. We coordinate our programs with other units in the Department as well as other Federal Government agencies which also allocate funds to States to support health programs or kindred activities. As examples, we work very closely with the Bureau of State Service's environmental health section in radiological health, water pollution, and air pollution. Currently we are providing the grants management requirements necessary to administer their formula grants. We also work closely with the community mental health program of National Institute for Mental Health. Here again we provide the grants management function in order to better coordinate the administration of all Public Health Service formula grant funds appropriated by Congress to support health and health-like activities. We have coordinated our efforts so closely with the Children's Bureau in welfare administration that for the past several years we have been using a health grants administrative manual which was jointly and cooperatively developed by Children's Bureau and Public Health Service personnel. This manual continues to be used and is updated and revised as legislative changes become effective. We also coordinate and cooperate with the poverty program, the Office of Economic Opportunity, the Appalachian Regional Commission, the Social Security Administration, the Department of Labor, and the Office of Education. Because our formula grant funds can only be allocated to official State health agencies, we do not cooperate to any significant extent with foreign governments, international organizations, nonprofit organizations and institutions, and business enterprises except to occasionally exchange information. Even though the formula grants are allocated only to States, we do attempt to cooperate with local city and county health departments. The regulations in our health grants manual have purposely been designed to permit the reallocation of a portion of the individual State's share of the formula grant funds to local health units. The technique has resulted in a closer working relationship between State and local health officials and as a consequence there has been a gradual increase, over the last 15 years, of both the level of program activity and the amount of funds available for expenditures to support health programs. On occasion, and as the need exists, we have also assigned specially trained public health personnel to States for use at either the State or local level. Such assignments are made on the basis of need, inability to recruit, and

availability of qualified personnel. The assignment cannot exceed 2 years. The salary and related costs are paid, in lieu of cash, from one of the categorical grants associated with the type of work to be performed. This type of cooperation has been very helpful to the State, the local health unit and the Public Health Service.

Training Grants

RESEARCH TRAINING

For narrative description of the research training grants, see section on research grant programs.

4. Level of operations. (See table 1.)

Program: Research training grants: Bureau of State Services—Community Health (summary).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67: Summary*

[Dollars amounts in thousands]

Measure (see committee inquiry for definitions)	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 [2]	Fiscal year 1967 [1 2]
(a) Magnitude of the program	Grants	5	10	20	27
(b) Applicants or participants:					
State government agencies	Trainees	30	91	176	242
Local communities or governments					
Individuals or families					
Other—Universities	Grants	5	10	20	27
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred		$284	$564	$1,330	$1,730
Allotments or commitments made					
(d) Matching or additional expenditures		[3]	[3]	[3]	[3]
(e) Number of Federal employees					
(f) Non-Federal personnel					
(g) Other measures of performance					

[1] President's budget.
[2] Estimates.
[3] Not available.

10. Economic classification of program expenditures.—(See table 2.)

Program: Research training grants: Bureau of State Services—Community Health (summary).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	125
Transfer payments to nonprofit organizations	439
Total Federal expenditures	564

[1] Expenditures here refer to obligations.

Public Health Traineeship Program (Section 306, Public Health Service Act)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The objectives of the program are to increase the number of trained public health personnel and to bring new professional health workers into the field through the opportunities for graduate or specialized formal public health training that are provided. The program also seeks to increase the competence of professional health personnel and to decrease the lag between the discovery of new knowledge and its effective application in public health practice through short-term continuing education public health training.

2. Operation

The program supports graduate or specialized training in public health by providing traineeship support to individuals who plan to pursue careers in this field. Traineeships provide a monthly or daily stipend to the trainees, tuition and fees, and an allowance for travel to the training institution. Traineeships are awarded by several methods:

A. General purpose traineeship grants to schools of public health accredited by the American Public Health Association to award the master of public health degree.

B. Special purpose traineeship grants to support trainees in high-priority training program areas designated by the Public Health Service.

C. Grants to schools of nursing accredited by the National League for Nursing to prepare registered nurses for first-level positions in public health nursing.

D. Environmental health traineeship grants to schools providing graduate public health training in the environmental health sciences.

E. Traineeship grants to accredited residency programs in preventive medicine and dentistry.

F. Traineeships awarded directly by the Public Health Service to individuals pursuing public health training in programs or institutions not receiving support under the above mechanisms.

G. Apprenticeship traineeship grants to public or nonprofit private institutions for the support of medical, dental, and osteopathic students engaged in preceptor-guided public health training.

H. Short-term traineeship grants to public or nonprofit private institutions providing continuing education in public health for professional health personnel.

3. History

Title I of the Health Amendments Act of 1956 authorized public health traineeships which support "professional health personnel" in "graduate or specialized training in public health." In 1959 and again in 1964 the Congress extended the program for an additional 5 years.

Traineeships in schools of nursing have been awarded since the beginning of the program. In addition, traineeships to support

students in the 12 schools of public health originally were awarded directly to individuals and in a few instances through institutional grants. Beginning in fiscal 1963 all such traineeships are awarded through these institutions under general-purpose traineeship grants. The Public Health Service also initiated at that time the special-purpose traineeship grants mechanism, the environmental health and short-term traineeship grants listed above. In fiscal year 1965 the apprenticeship traineeship grants were established under the program and residency traineeship grants were first awarded in fiscal year 1966. A total of 6,311 trainees received traineeship support for long-term public health training and 10,575 received traineeship awards for short-term public health training from fiscal year 1957 through fiscal year 1965. Appropriations for the program increased from $1 to $4.5 million during this period as shown below.

Fiscal year:	*Appropriation*	Fiscal year—Continued	*Appropriation*
1957	$1,000,000	1963	$4,000,000
1959	2,000,000	1964	4,195,000
1961	2,000,000	1965	4,500,000
1962	2,000,000		

4. Level of operations. (See table 1.)

Program: Public health traineeship program (sec. 306, PHS Act).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollars in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimate)	Fiscal year 1967 [1] (estimate)
a) Magnitude of the program (trainees)	4,527	[2] 6,540	9,460	12,430
(b) Applicants or participants:				
State government agencies [3]	11	24	48	70
Local communities or governments [3]	9	10	20	30
Individuals or families (trainees)	4,527	[2] 6,540	9,460	12,430
Other academic institutions (schools)	137	175	208	240
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$4,418	$4,415	$7,000	$8,000
Allotments or commitments made				
(d) Matching or additional expenditures	[4] None			
(e) Number of Federal employees (man-years)	14.0	16.5	18.5	18.5
(f) Non-Federal personnel [5] (national)	([6])	([6])	([6])	([6])
(g) Other measures of performance				

[1] President's budget.
[2] Estimated upon the basis of fiscal year 1965 grants which are still active.
[3] Agencies receiving short-term apprenticeship, and residency traineeship grants under which individual trainees were supported. Such agencies do not receive funds under these grants, except for tuition for short courses, but provide the training.
[4] Many State, local, and voluntary health agencies support individuals pursuing public health training but no supplemental support of trainees under the public health traineeship program is currently allowed.
[5] Considerable faculty and preceptor time is required to train the recipients supported under this program but estimates in this regard have not been made. 24 non-Federal members of advisory groups devote considerable time to these activities.
[6] Part-time, unknown.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) The operation of the public health traineeship program is closely coordinated with other training grant programs of the Bureau of State Services (community health) and Bureau of State Services (environmental health), particularly those of the Division of Chronic Diseases, Division of Nursing, and Division of Water Supply and Pollution Control, which are closely related and meshed through day-to-day contact of the staff administering these programs. In addition, there is regular contact and referral of applications with the Public Health Service research fellowship and training grant programs (primarily administered through the Division of Research Grants, National Institutes of Health) and the Public Health Service mental health training grant programs. The recently adopted Public Health Service Training Grants Manual has facilitated this process.

(*b*) Relevant applications under this program are occasionally referred to the Children's Bureau and there is direct contact concerning such matters between Children's Bureau staff and the staff administering the public health traineeship program. On occasion, similar contact and discussion is held with the Office of Education and the Vocational Rehabilitation Administration staff.

(*c*) The only instances in which training activities to date under the public health traineeship program have been related to programs in other departments have involved the National Science Foundation, the Agency for International Development, and the Atomic Energy Commission. No formal arrangements for coordination at the division level have seemed indicated, but a few informal conversations concerning the possible eligibility of individual applications have been held.

(*d*) Program staff are in regular contact with training officers of State health departments and the directors of residencies, apprenticeship programs, and continuation education in these and comparable agencies. Such agencies routinely receive program materials and some officials of these agencies serve as consultants on the statutory National Advisory Committee on Public Health Training and the Preventive Medicine and Dentistry Review Panel.

(*e*) Information is routinely distributed to local health departments and community health agencies through regional office staff and State agencies. Some of these agencies receive traineeship grants.

(*f*) No Division of Community Health Service contacts exist with foreign governments but program staff occasionally clarify program policies and other matters informally with staff of the Pan American Health Organization.

(*g*) Representatives of organizations such as the American Public Health Association and the National League for Nursing have served on the National Advisory Committee on Public Health Training. Since public or nonprofit institutions and agencies are eligible to participate under section 306 of the Public Health Service Act, some short-term traineeship grants have been awarded to hospitals, voluntary health organizations, and professional organizations. Of course, the bulk of the program's activities deal with academic institutions and there are regular contacts with the representatives of such schools (for example, Public Health Service staff attend public meetings of the Association of Schools of Public Health).

8. Laws and regulations

Section 306 of the Public Health Service Act (42 U.S.C. 242d) as amended by Public Law 88–497.

Prior to fiscal year 1965 there was no limitation on the amount authorized for this program. Appropriations are now authorized and ceilings established for each fiscal year through June 30, 1969 (legislative authorization will expire at that time).

Fiscal year:	*Authorization*
1957 to 1964	(1)
1965	$4, 500, 000
1966	7, 000, 000
1967	8, 000, 000
1968	10, 000, 000
1969	10, 000, 000

[1] No limitation

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Studies have been done on the efficacy of stipend support in enabling individuals to pursue graduate study, but no comprehensive study on the public health traineeship program has been conducted. A survey for a national conference in 1963 did suggest that over one-half of these recipients did not believe they would have completed the training without these awards. Nonetheless, over 60 percent of the respondents sustained a loss of income, over 30 percent consumed a significant amount of savings at the effective stipend level ($200 baccalaureate, $250 post-bachelors, $300 post-masters, and $400 post-doctoral, plus $30 per dependent).

Graduate public health training is often required in merit system criteria for positions in public health and completion of such training enables recipients to advance. Nonetheless, salaries in public health employment for many categories are substantially below those paid to the same professional groups in the private sector of the economy (that is physicians, engineers, etc.).

A sizable portion of the student bodies of schools of public health, and some other professional schools, are supported under this program and curtailment would inevitably cause a major reduction in the size and employment of those institutions.

The delivery of effective health services throughout the Nation, including home care services to the aged, preventive health programs of official agencies, programs for the abatement of environmental pollution, and the U.S. commitment to provide technical assistance in the area of public health to other countries are directly dependent upon the number of public health personnel being trained. This program supports a significant portion of that training.

Current analyses of the distribution of trainees by State and the distribution of short-term training courses by State are in process. A report on long-term trainees by State of residence for the first 7 years of program operations is included in the report of the Second National Conference on Public Health Training. (Table 17, p. 56.)

10. Economic classification of program expenditures

Federal obligations for the public health traineeship program in fiscal 1965 were $4,415,000. The program provides stipends to trainees, and these would be classified as a transfer payment to individuals. The stipends are administered by private nonprofit colleges and universities and also by State and local universities.

Support under this program is limited to individual stipends, tuition fees, and a travel allowance. No indirect costs (overhead) are paid. The institutions benefit only to the extent that they are compensated through tuition.

Although many State, local, and voluntary health agencies support public health training, supplementation of trainees is not currently allowed. Faculty of schools, preceptors in State and voluntary agencies, and members of non-Federal advisory groups and panels make a sizable contribution to the operation of this program, but no attempt has been made to estimate the cost of these contributions.

Public Health Training—Schools of Public Health

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The Surgeon General is authorized to make grants for the provision of comprehensive professional training, specialized consultative services, and technical assistance in the fields of public health to public or nonprofit schools of public health accredited by a body recognized by the Surgeon General. The educational institutions which meet the legal qualifications at the present time are the 12 schools of public health accredited by the American Public Health Association for the granting of the degree of master of public health. These schools are the University of Minnesota, University of North Carolina, University of Michigan, University of California (Berkeley), University of California (Los Angeles), University of Puerto Rico, Yale University, Johns Hopkins University, Harvard University, Columbia University, Tulane University, and the University of Pittsburgh. These schools, together with other schools specializing in such fields as nursing and engineering, perform an essential role in the training of professional public health personnel for Federal, State, and local government and voluntary organizations.

These grants are intended to support the provision of public health training in schools of public health by offsetting a portion of the deficit which occurs as a result of the disparity between income from tuition and the cost of instruction of federally sponsored students. The effect of the grants is to expand and improve the public health training offered by these schools and to enable them to accept increased enrollments.

2. Operation

Public Law 85–544 authorized utilization of $1 million of the annual appropriation to carry out the purposes of section 314(c) of the Public Health Service Act. Enactment of Public Law 87–395 increased the authorization to $2,500,000 for fiscal years 1962 through 1968. The following table shows the amounts authorized, appropriated, and expended for this program.

Fiscal year	Authorization	Appropriation	Federal expenditures [1]
1959	$1,000,000	$450,000	$442,300
1960	1,000,000	1,000,000	952,498
1961	1,000,000	1,000,000	951,210
1962	2,500,000	[2] 1,173,000	1,094,608
1963	2,500,000	1,900,000	1,863,573
1964	2,500,000	1,900,000	1,900,000
1965	2,500,000	2,500,000	

[1] Obligations.
[2] Amount available.

Method of distribution.—One-third of the funds are allotted equally among eligible schools and the remaining two-thirds on a 3-year average of the number of federally sponsored students. Funds are available after approval of an application from eligible schools showing the purposes for which the funds will be used.

Data are collected annually from each school of public health concerning the number of federally sponsored students enrolled.

The listing of institutions accredited for granting the degree of master of public health is used to determine eligibility under this program.

Matching requirements.—None.

Who may receive Federal aid.—Grant funds are made available to schools of public health.

3. History

Not answered.

4. Level of operations. (See table 1.)

Program: Public health training (grants to school of public health).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimate)	Fiscal year 1967 [1] (estimate)
(a) Magnitude of the program				
(b) Applicants or participants:				
State government agencies				
Local communities or governments				
Individuals or families				
Other—Public and nonprofit private schools (number of schools)	13	13	13	13
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$1,900	$2,436	$3,500	$3,500
Allotments or commitments made				
(d) Matching or additional expenditures				
(e) Number of Federal employees (man-years)	0.5	0.5	0.5	0.5
(f) Non-Federal personnel				
(g) Other measures of performance				

[1] President's budget.

5. Estimated magnitude of program in 1970.

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Not answered.

8. Laws and regulations

Section 314(e) of the Public Health Service Act, as amended (42 U.S.C. 246a).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 2.)

Program: Public health training grants to schools of public health.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[Thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	1,335
Transfer payments to individuals and nonprofit organizations	1,101
Total Federal expenditures	2,436

[1] Expenditures here refer to obligations.

GRADUATE PUBLIC HEALTH TRAINING GRANTS

(Sec. 309, PHS Act)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

Graduate public health training grants are available for strengthening or expanding graduate public health training in eligible schools of public health, nursing, and engineering and the teaching of preventive medicine and dentistry in schools of medicine, osteopathy, and dentistry. For purposes of this program graduate public health training is defined as the specialized training in public health offered at the post-baccalaureate or post-professional registration level.

2. Operation

The program supports graduate or specialized training by awarding grants to eligible schools of public health, nursing, engineering, medicine, dentistry, and osteopathy. Grant funds may be expanded for salaries of professional and supportive personnel, consultant fees, equipment, supplies, travel, rental of space, and minor renovations.

Projects are supported for periods of up to 7 years, and at that time grants are renewable.

3. History

Public Law 86–720, enacted in 1960, authorized project grants for graduate training in public health to be awarded to schools of public health, engineering, and nursing. The Graduate Public Health Amendments of 1964 extended the authorization through June 30, 1969, and extended the eligibility for grants to all public and private

nonprofit institutions providing graduate or specialized training in public health. For administrative purposes the Public Health Service administratively limited the extension of eligibility to schools of medicine, dentistry, and osteopathy, but it is anticipated that eligibility will be extended after June 30, 1966.

Grants have been awarded to schools of public health, engineering, and nursing since 1960; the first grants to schools of medicine, dentistry, and osteopathy were awarded in 1965. Appropriations for the program have been as follows:

Fiscal year:	*Appropriation*	Fiscal year—Continued	*Appropriation*
1961	$1,435,000	1964	2,000,000
1962	2,000,000	1965	2,500,000
1963	2,000,000	1966	4,000,000

4. Level of operations. (See table 1.)

Program: Graduate public health training grants (sec. 309, PHS Act).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(*a*) Magnitude of the program (funded projects)	80	91	135	165
(*b*) Applicants or participants:				
State government agencies				
Local communities or governments				
Individuals or families				
Other (schools)	53	67	95	110
(*c*) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$1,994	$2,498	$4,000	$5,000
Allotments or commitments made				
(*d*) Matching or additional expenditures	(2)	(2)	(2)	(2)
(*e*) Number of Federal employees (man-years)	2.0	2.5	4.0	4.0
(*f*) Non-Federal personnel (National Advisory Committee)				
(*g*) Other measures of performance (Project directors)				

[1] President's Budget.
[2] No matching funds are required; many of the projects also receive support from other sources. There are not sufficient data available on which to base an estimate of the amount of such support.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The operation of the graduate public health training program is coordinated with other training programs in the Branch, Division, and Bureau, including the public health fellowship program (especially special purpose traineeships, residency in preventive medicine, short-term traineeships, and appropriate training) and the training grant programs of the Division of Nursing and the Office of Resource Development, Bureau of State Services (Environmental Health). The traineeship mechanism provides support to students enrolled in programs of study supported by training

grant, and it is often helpful to refer to materials received from such grantees by the public health traineeship program. Our areas of interest often are closely related to those of the Office of Resource Development and the Division of Nursing, and we often refer applications we receive to these offices for review and consideration.

(*b*) We occasionally refer applications to one of the various grant programs of the National Institutes of Health for consideration if this is indicated.

(*c*) through (*i*): None.

8. Laws and regulations

Section 309 of the Public Health Service Act as amended by Public Law 88-497.

Appropriations have been authorized as follows:

Fiscal year:	*Authorization*	Fiscal year—Continued	*Authorization*
1961	$2,000,000	1966	$4,000,000
1962	2,000,000	1967	5,000,000
1963	2,000,000	1968	7,000,000
1964	2,000,000	1969	9,000,000
1965	2,500,000		

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effe

Salaries of a ber of professional and clerical personnel are paid from grant fundut it is difficult to say whether these persons have higher incomes use of these grants.

Graduate puhealth training is often required in merit system criteria for positin public health, and completion of such training enables people blic health occupations to advance.

The deliveryffective health services throughout the Nation, including homeservices to the aged, preventive health programs of official agenprograms for the abatement of environmental pollution, and S. commitment to provide technical assistance in the area of publth to other countries are directly dependent upon the number of rained public health personnel. This program supports a signportion of this training.

As would beed, the States receiving the largest amounts of funds are Puerand the 10 States which have schools of public health. In fisc1965 over half of the grant funds were awarded to schools of tes. In order, they were California, Massachusetts, Northina, Michigan, Pennsylvania, and Maryland. Puerto Rico wah. Fewest grants were awarded to institutions in the South, thwest, and the Rocky Mountain area.

10. Economic cion of program expenditures. (See table 2.)

Program: Graduhealth training grants (sec. 309, PHS Act).

Department or a office or bureau: Department of Health, Education, and Welfare; lth Service—Bureau of State Services (Community Health)

TABLE 2.—*Ecotification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Governm	
Grants to Stal governments	1,464
Transfer paydividuals and nonprofit organizations	1,034
Total Fedtures	2,498

1 Expendi tures here ins.

Dental Auxiliary Utilization Grants Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The ratio of dentists to population has been falling for a generation. Efforts are directed to increasing dental professional manpower and to improving the productivity of the dentists.

2. Operation

The Division provides grants to 46 dental schools in the United States so that they can include instruction in the use of dental assistants in their curriculum.

3. History

The program was begun as a small pilot project in the 1950's to demonstrate the use of dental chairside assistants. In 1961, the present grant program was authorized under the appropriation of the National Institute of Dental Research. This program was transferred to the Bureau of State Services in 1964.

It has become a major factor in extending the arm of the dentist and enabling him to care for more patients in better fashion in a given period of time.

4. Level of operation. (See table 1.)

Program: Dental auxiliary utilization grants program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

Table 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (dental students)	5,200	5,200	5,200	5,700
(b) Applicants or participants:				
State government agencies				
Local communities or governments				
Individuals or families				
Other—Dental schools	46	46	46	46
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$2,160	$2,269	$2,399	$2,399
Allotments or commitments made				
(d) Matching or additional expenditures				
(e) Number of Federal employees (man-years)	2	2	2	2
(f) Non-Federal personnel	(2)	(2)	(2)	(2)
(g) Other measures of performance				

[1] President's budget.
[2] Unknown.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The Division maintains and promotes close working relationships with other dental activities of the Service, particularly with the National Institute of Dental Research.

The Division also actively seeks and promotes its dental health activities in cooperation with professional dental organizations and societies, dental programs of State and local health departments, educational institutions, professional organizations related to health, dental practitioners and dental scientists.

8. Laws and regulations

This program is authorized in accordance with section 422(f) of the PHS Act, as amended, Public Law 410, 78th Congress, (58 Stat. 682).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from the Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 2.)

Program: Dental auxiliary utilization grants program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	1,203
Transfer payments to individuals and nonprofit organizations	1,066
Total Federal expenditures	2,269

[1] Expenditures here refer to obligations.

TRAINEESHIPS FOR ADVANCED TRAINING OF PROFESSIONAL NURSES

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The purpose of the professional nurse traineeship program is to increase the number of nurses qualified as nurse specialists, as teachers in schools of nursing of all types, and in schools of public health, and as administrators and supervisors of nursing service in institutions and community health agencies. The program offers professional nurses traineeships for full time academic study and short-term intensive training.

Long-term traineeships which provide stipends, costs of transportation to the school, tuition and fees, and dependency allowances accelerate the increase in the number of nurses for leadership positions by enabling them to secure the necessary academic preparation more quickly.

Short-term traineeships providing stipends and cost of tuition enable nurses in leadership positions to update their knowledge, skills, and understanding of new developments in patient care and community health practices.

2. Operation

The program is administered by the Public Health Service. Traineeships are awarded to public and to nonprofit private institutions and agencies providing the training. Trainees are selected by the institutions or agencies.

Academic institutions eligible for long-term grants are approved in conformity with policies of the Public Health Service.

A non-Federal professional committee, appointed by the Surgeon General, reviews requests for grants for short-term training and recommends approval or disapproval.

3. History

The professional nurse traineeship program was originally authorized for 3 years under the Health Amendments Act of 1956 for the purpose of increasing the number of professional nurses prepared as administrators, supervisors, and teachers in all fields of nursing. It was extended in 1959 for 5 years. The Nurse Training Act of 1964, Public Law 88–581, continued the program through June 30, 1969, and expanded it to include professional nursing specialties.

4. Level of operations. (See table 1.)

Program: Traineeships for Advanced Training of Professional Nurses
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (awards)	160	168	161	165
(b) Applicants or participants (trainees)	[2] 6,261	[2] 7,230	[2] 6,300	[2] 6,400
State government agencies [3] (units)	82	100	101	103
Local communities or governments [4] (units)	3	2	2	2
Individuals or families	75	66	58	60
Other [5] (units)				
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$7,325	$7,879	$9,000	$10,000
Allotments or commitments made				
(d) Matching or additional expenditures				
(e) Number of Federal employees (man-years)	7	7	7	7
(f) Non-Federal personnel (man-years)	0.2	0.2	0.4	0.4
(g) Other measures of performance				

[1] President's budget.
[2] Breakdown not available.
[3] State government agencies, State-supported schools of nursing.
[4] Local communities or governments-community owned school of nursing.
[5] Other—Private, nonprofit schools of nursing.

5. Estimated magnitude of the program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Policies and procedures for the administration of the traineeship grants were established with the advice of an Advisory Committee appointed by the Surgeon General.

The policies governing professional nurse traineeships are coordinated with other training grant policies of the Public Health Service to maintain consistency and prevent overlapping and duplication.

Cooperation with institutions and agencies who are applicants or potential applicants for traineeship grants is essential in order to expedite administrative procedures with the greatest degree of simplicity.

These agencies or institutions may be private or nonprofit public health agencies, colleges and universities, professional organizations and others.

8. Laws and regulations

Traineeships for professional nurses under this program are authorized under section 821 of the Nurse Training Act of 1964, Public Law 88–581. (Title VIII, Public Health Service Act, as amended, 42 U.S.C. 296–298.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

A. This program increases the number of graduate nurses with preparation in teaching, administration, supervision, or in a nursing specialty. Approximately 1,500 nurses annually are direct recipients of $2,400 to $3,600 in stipends. The additional training received under this program enables them to earn an estimated additional $2,500 to $3,500 per year.

Moreover, since this program involves leaders and teachers of others, it can conservatively be estimated that each of the 1,500 annual recipients of traineeships after graduating has a multiplier effect on the salary of about 30 students and subordinates by increasing their skill and earning capacity by about $2,000 for an effect of about $95 million each year.

Since the recipients of traineeships are distributed among the 50 States and their students are similarly distributed, this increase of income is felt in all States.

B. Not only is the productivity of the trainees and their students and subordinates increased, but this increased skill and commitment has probably contributed to the increased length of working life of all nurses from 15 years a few years ago, to 20 years today.

This contributes to an added 5 years of earnings for approximately 582,000 nurses.

C. There is no doubt that the production of nurse leaders from this program has improved the quality of nursing education by providing prepared faculty, has improved patient care by providing competent administrators and supervisors for institutions and community health agencies and has assisted the development of the nurse specialist for critical clinical areas.

D. The graduate education provided under this program has enabled nurse leaders to become academically equivalent members of the university community and this has had the effect of pushing up salary levels for deans of schools of nursing and professors of nursing. Since there is a tendency for higher educated personnel to stay longer in the labor force, this program has tended to help stabilize the nurse work force and smooth the peaks and valleys of labor force participation of this occupation.

E. The entire Nation benefits from this program for nursing leaders, since these leaders return to the field of education, to the hospital field, to public health nursing, and other fields of nursing thereby making their impact felt wherever the public has a requirement for nursing services.

F. During 1964 fiscal year, 1,956 long-term traineeships were used by the 96 participating programs in 38 States and territories.

G. Assuming that each one of the estimated 1,500 annual trainees have an increase of $3,000 per year and each assist 30 other students or subordinates to increase their salary an average of $2,000, this would have an impact of $94,500,000 on the gross national product.

10. Economic classification of program expenditures. (See table 2.)

Program: Traineeships for Advanced Training of Professional Nurses
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	3,930
Transfer payments to individuals and nonprofit organizations	3,949
Total Federal expenditures	7,879

[1] Expenditures here refer to obligations.

PARTIAL REIMBURSEMENT TO DIPLOMA SCHOOLS FOR COSTS ATTRIBUTABLE TO NURSE TRAINING ACT

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The Nurse Training Act of 1964 authorizes the payment of grants to eligible public and nonprofit private diploma schools of nursing to help defray a portion of the cost of training students whose enrollment in such schools can be reasonably attributed to the provisions of this act.

The purpose of such grants is to prevent further attrition of these schools and to promote their development.

2. Operation

This is a federally administered program of direct entitlement for payments to eligible schools. Grants are paid to eligible public and to nonprofit private diploma schools of nursing on a formula basis. Each fiscal year each qualifying school is entitled to an amount equal to the product of $250 and the sum of (1) the number of students enrolled in the school on a full-time basis, who during that year received a loan of $100 or more under this legislation, and (2) the number by which the full time enrollment in the school exceeds the average of the enrollment totals during the 3 fiscal years of 1962, 1963, and 1964. The date for counting the federally sponsored students and for determining the school enrollment for each year is February 15. In no case may a school, for any year, receive more than the product of $100 and the total full time enrollment in the school for that year.

3. History

Payments to diploma schools of nursing were included in the Nurse Training Act, Public Law 88–581, as a result of testimony from members of the American Hospital Association and from individual administrators of hospitals that conduct diploma programs in nursing.

The purpose of these moneys is to help relieve the hospital of some of the costs that accrue as a result of the training of students whose enrollment in such schools can be reasonably attributed to the pro-

visions of the Nurse Training Act. The first funds under this legislation were paid in June 1965.

4. Level of operations. (See table 1.)

Program: Partial reimbursement to diploma schools for costs attributable to Nurse Training Act.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar anounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (number of schools)		190	303	360
(b) Applicants or participants:				
State government agencies				
Local communities or governments				
Individuals or families				
Other—Diploma schools of nursing		190	303	360
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred		$788	$2,500	$6,000
Allotments or commitments made				
(d) Matching or additional expenditures				
(e) Number of Federal employees				
(f) Non-Federal personnel				
(g) Other measures of performance				

[1] President's budget.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program in 1970

Not answered.

7. Coordination and cooperation

The authorization for the distribution of annual sums appropriated for partial reimbursement to diploma schools requires the applicant institutions to provide selected information regarding the increase in enrollment and the number of students on federally sponsored loans. These data provide the basis for the distribution of funds and do not require coordination with other organizational units within the department, service, or bureau, or other governmental agencies.

The information provided in the application has been independently determined as of February 15 of each fiscal year and is not subject to review by organizational elements not specifically charged with the administration of the act.

Coordination is essential within the controlling institution of diploma programs and with professional nursing and hospital elements necessary to the administration of this legislation.

8. Laws and regulations

Payments to diploma schools of nursing are authorized under section 806 of the Nurse Training Act of 1964, Public Law 88–581. (Title VIII, Public Health Service Act, as amended, 42 U.S.C. 296–298.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

This program reimburses diploma schools of nursing for a portion of the cost of training students whose enrollment can be reasonably attributed to the provisions of the Nurse Training Act of 1964.

Since the diploma schools are located in all of the States, the dollar impact will be felt throughout the United States.

Since the effect of this program will be to increase the supply of nurses and nursing service, the productivity of the general work force should be increased. The availability of increased nursing service should shorten the time employees will be absent from work due to injury or illness to themselves or family members for whom they would have to give care at home in the absence of an adequate nurse supply.

Since payments to the schools are in direct recognition of the administrative burden imposed by the increased enrollment, these payments should result in ability to hire additional staff or add equipment within hospitals.

Since employment in the field of nursing has been declining in the last few years from 4 percent of 17-year-old girls to about 3.6 percent, this program with its incentive to the diploma schools to increase enrollment should restore and hold the nurse supply at approximately 4 percent of 17-year-old girls.

Since enrollments should increase in all diploma schools throughout the United States, the monetary benefit to the schools and the stability effect on the economy due to increased employment should be felt in every State.

One hundred and ninety programs in 42 States including Puerto Rico received payment to diploma schools during fiscal year 1965.

10. Economic classification of program expenditures. (See table 2.)

Program: Partial reimbursement to diploma schools for costs attributable to Nurse Training Act.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965.*

[In thousands of dollars]

Federal Government: [1] [2]	
Grants to State and local governments	682
Transfer payments to nonprofit organizations	106
Total Federal expenditures	788

[1] Expenditures here refer to obligations.

[2] Grants are made to diploma schools to help them defray some of the additional costs resulting from additional enrollment of students attending with student loans and to promote further development of those schools.

IMPROVEMENT OF NURSE TRAINING

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The Nurse Training Act of 1964 (Public Law 88–581) authorizes a program of project grants to enable public and nonprofit private diploma, collegiate, and associate degree schools of nursing which are

accredited or have reasonable assurance of accreditation to strengthen, improve, and expand programs to teach and train nurses.

These grants are intended to promote the preparation of a larger number of nurses, to improve educational programs in nursing, and to demonstrate new or more effective methods of instruction.

2. Operation

This is a federally administered direct grant program with no matching requirements. Applications are submitted to the Division of Nursing. All eligible applications are given a technical review. Applications are submitted to the National Advisory Council on Nurse Training (established under sec. 841, Public Law 88–581) which makes recommendations to the Surgeon General. The act provides that consideration be given—

> to the extent to which such projects will contribute to general improvement in the teaching and training of nurses of the kind involved, the extent to which they will aid in attaining a wider geographical distribution throughout the United States of high quality schools of the type involved, and the relative need in the area in which the school is situated and surrounding areas for nurses of the type trained in such school.

The members of the National Advisory Council on Nurse Training are appointed without regard to civil service laws.

3. History

This program is a legislative implementation of the recommendations of the consultant group on nursing appointed by the Surgeon General of the Public Health Service in the spring of 1961 to advise him on nursing needs and to identify the appropriate role of the Federal Government in assuring adequate nursing services for the Nation. The consultant group specifically recommended that:

> Federal funds should be made available, by means of project grants, to nursing education programs in universities, colleges, schools, and in public and nonprofit hospitals, institutions, and agencies—for the improvement, expansion, and extension of their educational programs and services. This would include experimentation and demonstration of new and effective methods of teaching, the development and use of teaching aids and equipment, and, where indicated, the establishment of new programs.[1]

4. Level of operation. (See table 1.)

Program: Improvement of nurse training.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

[1] "Toward Quality in Nursing—Report of Surgeon General's Consultant Group on Nursing," USPHS publication, No. 992, p. 37, 1963.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1]
(a) Magnitude of the program [2]		39	50	60
(b) Applicants or participants:				
State government agencies [3]		10	12	15
Local communities or governments [4]		1	1	2
Individuals or families				
Other—Private nonprofit		28	37	43
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred		$1,990	$3,000	$4,000
Allotments or commitments made				
(d) Matching or additional expenditures [5]		$218	$310	$420
(e) Number of Federal employees (man-years)		3.6	8.4	9.8
(f) Non-Federal personnel (man-years)		3.2	.2	5
(g) Other measures of performance				

[1] President's budget.
[2] Applications approved and funded.
[3] State supported (public) schools of nursing.
[4] Local (public) schools of nursing, e.g. community hospital.
[5] Applicant's voluntary share of project costs.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Project grants for the improvement of nurse training operate under policies and procedures developed for this program. They are derived from the policies outlined in "Health Services Project Grant Manual" (GPO 884772). Grants may be made to eligible programs of nursing education in public and in nonprofit private institutions. These may be located in or with public or nonprofit private hospitals, colleges, universities, and community junior colleges.

8. Laws and regulations

Grants for projects to improve nurse training are authorized under section 805 of the Nurse Training Act of 1964, Public Law 88–581. (Title VIII, Public Health Service Act, as amended, 42 U.S.C. 296–298.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

This program provides schools of nursing with funds to meet the additional costs of projects designed to improve, strengthen, or expand programs to teach nurses. Since all (accredited or with reasonable assurance of accreditation) public or nonprofit private schools of nursing (diploma, collegiate—undergraduate, or graduate—or associate degree institutions) are eligible to apply and these funds can be used for salaries and other costs, and operating expenses (such as executive and administrative costs, accounting, building maintenance), very wide impact will be felt in the various occupations due to the many fields of endeavor affected by this program.

The teaching methods and techniques developed by these grants, that is, TV teaching, programmed learning, et cetera, will greatly increase productivity by extending the ability of outstanding teachers to reach much larger numbers of students, thereby improving the skills of a very considerable number of nurses and nursing students.

The requirements for projects are that the applications set forth the need and background, methodology to be used, staff and facilities available, participation of other agencies, plans for evaluation, budget, and experience of staff conducting the projects. Complying with these requirements should do much to upgrade the organization and management of the educational and service type organizations applying for grants under this program.

Since this program is directed toward stimulating new ways of improving, strengthening, and expanding programs to teach nurses, a very considerable amount of new economic activity is generated by promoting faculty development, demonstrating new or more effective methods of instruction, exploring curriculum revision, establishing new courses, and discovering ways to increase enrollment.

The results of these projects will, in many cases, be applicable to teaching in other professional disciplines and should have this multiple productivity effect in the related disciplines of medicine and dentistry as well as in general education.

Up to the present 51 contracts have been awarded in this area.

10. Economic classification of program expenditures. (See table 2.)

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Program: Improvement of Nurse Training.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

Federal Government:[1]	
Grants to State and local governments	793
Transfer payments to nonprofit organizations[2]	1,197
Total Federal expenditures	1,990
Non-Federal expenditures financed by:	
Nonprofit organizations[2]	218
Total expenditures for program	2,208

[1] Expenditures here refer to obligations.
[2] Schools of nursing.

PROJECT GRANTS

Answers to questions 4 and 10 are summarized here for all project grants of the Bureau of State Services—Community Health.

4. Level of Operations. (See table 1.)

Program: Project grants, Bureau of State Services—Community Health (summary).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (projects)	820	898	1,133	1,299
(b) Applicants or participants:				
State government agencies				
Local communities or governments				
Individuals or families				
Other				
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$34,195	$45,956	$61,750	$72,229
Allotments or commitments made				
(d) Matching or additional expenditures [2]	$33,501	$37,290	$46,175	$48,087
(e) Number of Federal employees [3] (man-years)	518	924	947	1,009
(f) Non-Federal personnel (man-years)	3,923	4,714	6,016	7,670
(g) Other measures of performance (number of trainees)	181	186	224	250

[1] President's budget.
[2] Omits tuberculosis control projects. The total of non-Federal matching or additional expenditures for tuberculosis control projects was reported as $43 million for the fiscal year 1965 but was not reported for any other year.
[3] Includes personnel furnished in lieu of cash.

10. Economic classification of program expenditures. (See table 2.)

Program: Project grants, Bureau of State Services—Community Health (summary).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Purchases of goods and services:	
Wages and salaries	3,301
Other	1,200
Grants to State and local governments	28,494
Transfer payments to nonprofit institutions	12,960
Total Federal expenditures	45,955
Non-Federal expenditures financed by:	
State and local governments	64,828
Individuals or nonprofit organizations	15,462
Total expenditures for program	126,245

[1] Expenditures here refer to obligations.

CANCER CONTROL AND DEMONSTRATION PROJECT GRANTS

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The purpose of these grants is to extend and improve the application, throughout the Nation, of measures that can improve control of cancer. They do this by training physicians and ancillary medical personnel, and by evaluating and demonstrating cancer control procedures and their administration.

2. Operation

Project proposals are solicited and grants-in-aid are awarded to those deemed by the Public Health Service after review by an advisory committee to be likely of success and significant to control of cancer.

The Cancer Control Branch directs the program; most liaison with applicants and grantees is conducted by regional office staffs; while accounting and audit services are provided by centralized Public Health Service units.

Training grant programs planned with professional society cooperation (a) give basic and special training and continuing education to cytotechnologists, medical technologists, and radiation technologists; (b) provide postresident training and continuing education to physicians and dentists, graduate training to other specialized professional personnel, and continuing education to physicians; and (c) provide short-term training in the mammography procedure for radiologists and their technicians.

Demonstration and evaluation projects are programed in (a) detection of cancer of the uterine cervix; (b) detection of oral cancer; (c) evaluation of cancer detection and diagnostic procedures and aids; and (d) field studies of such questions as identification of population groups having high risk of cancer and problems of public education.

3. History

The cancer control program became an entity separate from the research program in 1957, when it was decided that the National Cancer Institute should concentrate on research, and that efforts to improve grassroots application of available cancer control knowledge should be concentrated in the Bureau of State Services. Project grant appropriations for cancer control in the Bureau have been:

1960	$1,500,000	1964	$4,850,000
1961	1,500,000	1965	5,273,000
1962	3,050,000	1966	13,933,000
1963	4,750,000		

4. Level of operation. (See table 1.)

Program: Cancer control and demonstration project grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (projects)	234	251	395	440
(b) Applicants or participants:				
State government agencies	$230	$436	$615	$660
Local communities or governments	$318	$375	$700	$740
Individuals or families	$997	$907	$1,000	$1,100
Other	$2,944	$3,549	$11,618	$12,500
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$4,489	$5,268	$13,933	$15,000
Allotments or commitments made				
(d) Matching or additional expenditures [2]	$2,178	$2,370	$5,000	$6,000
(e) Number of Federal employees [3]	7	9	14	15
(f) Non-Federal personnel [4]	1,225	1,426	2,000	3,000
(g) Other measures of performance (number of individual traineeships)	108	89	100	110

[1] President's budget.
[2] Not required and not auditable; therefore, incomplete estimate.
[3] Programing personnel excluded.
[4] Man-years funded by grant and contributed by grantees (excluding trainees).

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) Within the Division: The nature of the categorical disease programs of the Division has been such that there has been little need or opportunity for joint action during these formative years. Wherever profitable to immediate program needs, cooperation has developed, as in the smoking and health program. In the next few years it is probable that more extensive interbranch or divisionwide cooperation will be developed, particularly in such activities as continuing education for physicians and ancillary medical personnel. Such training often is most attractive and effective when it is geared to the needs of specific fields of practice, and presents training related to several disease categories in ways in which the trainees encounter them in actual practice.

(*b*) and (*c*) Within the Department and with other Federal agencies: The Cancer Control Branch maintains a continuing liaison with the National Cancer Institute of the Public Health Service. Through this liaison the Cancer Control Branch obtains leads to control program planning for the future as they are suggested by developments in the research programs of the Institute. Through this liaison the two organizations also determine which picks up project proposals that fall in the "gray areas" between research and application, and each is enabled to maintain contact with the thinking of the other's extramural advisers.

Cooperation with other Federal agencies occurs on an ad hoc basis, as occasions arise and does not require continuing negotiation or liaison.

(*d*) With State governments: Cooperation with State health agencies is required in assisting the latter to develop cancer control programs that are financed in part by a Federal formula grant-in-aid. State public health agencies are asked for comments and suggestions on project grant applications that originate in their States, but do not participate in administration of project grants programs. State agencies are eligible to apply for project grants to aid their own cancer control activities that cannot be supported by their own or formula grant funds.

(*e*) With local governments: Local public agencies may and occasionally do apply for and receive project grants. Their programs also may share in formula grants within the approved cancer control programs of their States. Local governments do not share in the administration of project grants to other grantees.

(*f*) With foreign governments and international organizations: Staff members of the Cancer Control Branch participate in meetings, share information and provide consultation as necessary. The Branch does not finance or administer international programs.

(*g*), (*h*), and (*i*). With nonprofit organizations; businesses; others: Most project grants are awarded to nonprofit hospitals, schools, professional societies, and voluntary agencies. A continuing exchange of program plans and information is maintained with the American

Cancer Society. None of these organizations participates in management of any project grant program, beyond the operation of their individual projects to which grants have been awarded. Business houses occasionally bid on and receive contracts for specified survey or developmental tasks, but are not eligible for project grants.

8. Laws and regulations

The Public Health Service Act and the annual appropriation acts.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 2.)

Program: Cancer control and demonstration projects grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[Thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	811
Transfer payments to non-profit organizations	4,456
Total Federal expenditures	5,267
Non-Federal expenditures financed by: Individuals and non-profit organizations	2,370
Total expenditures for program	7,637

[1] Expenditures here refer to obligations.

NEUROLOGICAL AND SENSORY DISEASE PROJECT GRANTS

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The purpose of these grants-in-aid is to stimulate the development, expansion, or improvement of community service activities which identify and deal with problems of neurological, visual, or communicative disorders, including but not limited to such areas as epilepsy, mental retardation (reported separately), glaucoma, hearing disability and so forth. Activities may involve the preventive, diagnostic, treatment, and rehabilitative aspects of these disorders.

This program also supports the training of physicians and allied medical personnel for community services in the detection, diagnosis, treatment, and management of persons with neurological disorders. Grants are made for program expansion or improvement or curriculum enrichment; for short-term institutes, seminars, and so forth; to individuals for specialized experience; and for demonstrations of better methods of manpower utilization and new teaching techniques.

2. Operation

Assistance is in the form of a financial grant to approved applicants. Any State or local public agency, or nonprofit private agency, organization, or institution in the United States (including Guam, Puerto Rico, and the Virgin Islands) is eligible to apply for the above grants.

To be considered for a training program, an institution must have an accredited or acceptable program. Individual traineeships are available to allied medical personnel for specialized training, and to physicians who have completed residencies for training in the neurological and sensory diseases.

3. History

This grant assistance was first made available in fiscal year 1962, when $1 million was appropriated for this purpose; $2,600,000 was appropriated for this program in fiscal year 1963; $2,950,000 in fiscal year 1964 (including $503,000 for mental retardation); $3,450,000 in fiscal year 1965 (including $700,000 for mental retardation); and $2,750,000 in fiscal year 1966 (excluding funds for mental retardation).

4. Level of operation. (See table 1.)

Program: Neurological and sensory disease project grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (projects)	163	178	161	229
(b) Applicants or participants:				
State government agencies	$422	$488	$489	$623
Local communities or governments	$72	$134	$136	$173
Individuals or families	$314	$367	$368	$469
Other—Universities, nonprofit	$1,624	$1,755	$1,757	$2,235
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$2,432	$2,744	$2,750	$3,500
Allotments or commitments made				
(d) Matching or additional expenditures [2]	$1,337	$1,520	$1,700	$2,000
(e) Number of Federal employees [3]	5	6	6	6
(f) Non-Federal personnel (man-years) [4]	243	272	286	350
(g) Other measures of performance (number of traineeships)	71	89	89	105

[1] President's budget.
[2] Not required and not auditable; therefore, incomplete estimate.
[3] Programing personnel excluded.
[4] Man-years funded by grant and contributed by grantees (excluding trainees).

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(a) Within the Division: The Neurological and Sensory Disease Service Branch, which administers this program, has special interest in stroke and mental retardation activities, which are the responsibility of the Heart Disease Control and Mental Retardation Branches, respectively, of the Division of Chronic Diseases. The Neurological and Sensory Disease Service Branch lends advisory committee and specialized consultant support to the heart program for shaping programs, especially in the preventive aspects in the stroke activities of the latter branch. With respect to mental retardation, Neurological

and Sensory Disease Service cooperates with the Mental Retardation Branch on the neurological aspects of this problem by lending its staff consultant in speech and hearing, vision, and neurology to the furthering of the goals of the mental retardation activity. Projects are freely exchanged between these branches and staff are continually in close contact on the various problems which can be met collectively.

Within the Public Health Service: Neurological and Sensory Disease Service maintain close liaison with the National Institute of Neurological Diseases and Blindness, and to a lesser extent with the Institute on Child Health and Human Development. This liaison consists of periodic contacts with the Director of the NINDB and his immediate staff in subject areas in which the two units have mutual interests. Staff of each of the programs reciprocate attendance at study counsel, review panel, and advisory committee meetings and, where indicated, there is an exchange of staff comment on project applications coming before these review bodies. Exchange of staff ideas has assisted in opening the door to joint funding of projects in selected States and localities—projects in which the interest was necessarily much broader than either a service or research effort.

(*b*) Within the Department: The Neurological and Sensory Disease Service Branch maintains continuing liaison with the Office of Education, the Vocational Rehabilitation Administration, and the Children's Bureau of the Welfare Administration. Liaison with these agencies includes an exchange of grant applications coming before the review bodies of the respective offices, with invitations to staff to participate in the review process. In some cases applications have been restructured to prevent overlap and duplication. This continuing liaison has contributed significantly to developing mechanisms for meeting the overall needs of afflicted persons.

(*c*) With other Federal Government departments: No formal arrangements or outstanding examples of coordination or cooperation.

(*d*) With State governments: An evaluation by the State health authority is usually sought for grant applications for community service projects which have implications for State-supported activities in the same area.

(*e*) With local governments: One of the criteria upon which a community service grant application is judged is the extent of cooperation and coordination with interested or involved local agencies, which would tend to assure a successful and productive project.

(*f*) With foreign governments and international organizations: None.

(*g*) With nonprofit organizations and institutions: See (*i*) below.

(*h*) With business enterprises: None.

(*i*) With others: Program cooperates with such voluntary organizations as the National Society for the Prevention of Blindness and its local units, and appropriate epilepsy volunteer agencies; and with such professional organizations as the American Academy of Otolaryngology and Ophthalmology, the American Academy of Neurology, the Association of Audiology and Speech Pathology, to further the mutual goals of such agencies and the Neurological and Sensory Disease Service program.

8. Laws and regulations

Annual DHEW Appropriation Act.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from the Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 2.)

Program: Neurological-and-sensory-disease-project grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	622
Transfer payments to nonprofit organizations	2,122
Total Federal expenditures	2,744
Non-Federal expenditures financed by individuals and nonprofit organizations	1,520
Total expenditures for program	4,264

[1] Expenditures here refer to obligations.

COMMUNITY HEALTH PROJECT GRANT PROGRAM

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The community health project grant program provides project grants for studies, experiments, and demonstrations looking toward development of new or improved methods of providing health services outside the hospital, with particular emphasis on the needs of chronically ill or aged persons.

2. Operation

The program operates as a project grant program administered by the Bureau of State Services (Community Health). Grant requests may be submitted by any State or local public agency or any nonprofit agency, institution, or organization. Projects are approved by the Surgeon General or his designee after considering the recommendations of an expert review committee.

3. History

The program began in fiscal year 1962. Forty-four projects were approved and funded during that year in which the appropriation was $2,319,000. Sixty-eight projects were approved and funded in fiscal year 1963, 50 in 1964, and 48 in 1965. Appropriations for the program totaled $6 million in fiscal year 1963 and $7 million for each year in 1964 and 1965. The appropriation for fiscal year 1966 totals $10 million, which is the amount authorized under the enabling legislation. In fiscal year 1965, it was impossible, for the first time, to fund all projects which were recommended for approval because insufficient funds were available.

4. Level of operations. (See table 1.)

Program: Community health project grant program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (projects)	135	129	139	144
(b) Applicants or participants:				
State government agencies (projects)	24	23	23	24
Local communities or governments (projects)	24	23	23	24
Individuals or families				
Other (projects)	87	93	93	96
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$6,957	$6,985	$10,000	$10,000
Allotments or commitments made				
(d) Matching or additional expenditures	$2,892	$3,305	$5,000	$5,000
(e) Number of Federal employees				
(f) Non-Federal personnel				
(g) Other measures of performance				

[1] President's budget.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) The community health project grant program is a Bureau of State Services (CH) administered program which involves projects in the program areas of all eight community health divisions of the Bureau. Applications which are approved are assigned to one of the divisions which then has responsibility for surveillance over the project. The Project Grants Branch in the Bureau coordinates the administration of the program. Assignment of projects is based upon division responsibilities in relation to the purposes and objectives of the individual projects.

(*b*) From time to time applications are received for consideration under this program which more appropriately should be considered under one of the other grant programs of the Public Health Service, the Children's Bureau, or another unit of Government. In each instance, the application is referred to the grant program which should consider the application based upon its program content.

(*c*) Consideration is given to transfer of applications to other departments of the Federal Government if it appears that such a department has a grant program under which the application more appropriately should be considered.

(*d*) The community health project grant program achieves coordination with State governments in that the State health department is asked to review and comment on each application received from that State. In so commenting, the health department points out

how the proposed project fits into the health program of the State as envisioned by the State health department.

(*e*) In reviewing projects designed to provide local services, particular attention is directed to the cooperation of agencies at the community level and the degree to which the project as proposed recognizes the responsibility of the local government for the activities to be carried out. Attention is also given to the manner in which the proposed program will become a part of the total community health program.

(*f*) This program has no relationship to foreign governments or international organizations.

(*g*) Nonprofit organizations and institutions constitute a major group of applicants under this particular grant program. Any nonprofit agency is eligible to submit an application if the proposed activity falls within the purposes of the program. It is expected that a nonprofit agency will work in close harmony with official agencies in carrying out any program which it proposes to undertake.

(*h*) The community health project grant program has little relationship to business enterprises since profitmaking organizations may not apply for grants. Most projects approved under the program are designed to provide health services to segments of the population which need them. Expenditures are directed primarily to the hiring of health professionals and subprofessionals to provide such services and to the purchase of supplies and travel needed to augment such services. Only minimal amounts are expended on equipment or supplies procured from profitmaking organizations.

8. Laws and regulations

The community health project grant program is authorized in section 316 of the Public Health Service Act, as amended (42 U.S.C. 247a). Appropriations to carry out the program are included in the annual appropriation act of the Department of Health, Education, and Welfare.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from Office of the Surgeon General.)

The greatest impact upon the economy of the Nation lies in the new and improved methods of providing health services which may develop as a result of projects which are approved. These, over a long period of time, may result in additional productivity from the aged and the prolonging of life for the chronically ill. To the degree that this happens, one may consider that the grants are contributing to the general economic improvement of the country.

10. Economic classification of program expenditures. (See table 2.)

Program: Community health project grant program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	1, 381
Transfer payments to nonprofit organizations	5, 604
Total Federal expenditures	6, 985
Non-Federal expenditures financed by:	
Individuals and nonprofit organizations	3, 305
Total expenditures for program	10, 290

[1] Expenditures here refer to obligations.

MENTAL RETARDATION PROJECT GRANTS

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The purpose of these grants is to stimulate the development, expansion, or improvement of community service activities which identify and deal with problems in mental retardation, including the preventive, diagnostic, care, and rehabilitative aspects of this condition.

This program also supports the training of physicians and allied personnel for community services in the detection, diagnosis, care, and management of persons with this condition. Grants are made for curriculum enrichment; for short-term institutes and seminars; for demonstrations of better methods of manpower utilization and new teaching techniques; and to individuals for specialized training.

2. Operation

Assistance in the form of a financial grant is awarded to approved applicants. Any State or local public agency, or nonprofit private agency, organization, or institution in the United States (including Guam, Puerto Rico, and the Virgin Islands) is eligible to apply for the above grants. Individual traineeships are available to paramedical personnel for specialized training, and to physicians who have completed residencies for special training in the area of mental retardation.

3. History

During fiscal years 1963 and 1964, a few projects directed to the special problems of the mentally retarded were funded under the Neurological and Sensory Disease Service project grant program. Following the stimulation of activity in this field which resulted from the passage of Public Law 88–156 (Maternal and Child Health and Mental Retardation Planning Amendments of 1963 which included title XVII: Grants for Planning Comprehensive Action To Combat Mental Retardation), in fiscal year 1965, $700,000 of neurological and sensory project grant funds was earmarked for community service and training grants in mental retardation; and in fiscal year 1966, $4,500,000 is available.

4. Level of operations. (See tables 1 and 2.)

Program: Mental retardation project grants.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (projects)	11	49	73	100
(b) Applicants or participants:				
State government agencies	$104	$113	$1,000	$1,000
Local communities or governments			$875	$875
Individuals or families	$18	$59	$325	$325
Other—Universities, nonprofit agencies	$381	$527	$2,300	$2,300
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$503	$699	$4,500	$4,500
Allotments or commitments made				
(d) Matching or additional expenditures [2]	$168	$170	$1,125	$1,125
(e) Number of Federal employees [3]		2	4	5
(f) Non-Federal personnel [4]				
(g) Other measures of performance (number of traineeships)	2	8	35	35

[1] President's budget.
[2] Not required and not auditable; therefore, incomplete estimate.
[3] Programing personnel excluded.
[4] Man-years funded by grant and contributed by grantees (excluding trainee).

Program: Mental Retardation Planning and Implementation Grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (projects)	36	18	53	53
(b) Applicants or participants (55) [2]				
State government agencies				
Local communities or governments				
Individuals or families				
Other				
(c) Federal finances:				
Unobligated appropriations available	[3] $2,200	[3] $1,060	[4] $2,750	[4] $2,750
Obligations incurred	$1,140	$1,060	$2,750	$2,750
Allotments or commitments made				
(d) Matching or additional expenditures			$1,000	$1,000
(e) Number of Federal employees				
(f) Non-Federal personnel				
(g) Other measures of performance				

[1] President's budget.
[2] 50 States, District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands.
[3] Planning grants to assist States in planning for comprehensive action to combat mental retardation.
[4] Implementation grants to assist in implementing the planning and other steps against mental retardation.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(a) Within the Division and Bureau: A Bureau committee on mental retardation exists to facilitate coordination and cooperation on this activity within the Bureau. Staff of the Mental Retardation Branch are in daily contact with staff of other Branches of the Division

about possible coordination of activities and cooperation in joint endeavors.

(*b*) Within the Department: The Secretary's Committee on Mental Retardation includes representation from every mental retardation program in the Department—Vocational Rehabilitation Administration; Office of Education; Public Health Service (NIH-NINDD, NIMI, DGMS; Bureau of Medical Services; Bureau of State Services—Division of Chronic Diseases); Welfare Administration (Bureau of Family Services and Children's Bureau).

(*c*) With other Federal Government agencies: This Branch administers the program of grants for planning comprehensive State action to combat mental retardation (Public Law 88–156). Applications are reviewed by representatives of programs with mental retardation interests in the Departments of Health, Education, and Welfare; Labor, and Interior. This kind of cooperation is reflected in the project grants activity, although not formalized.

(*d*) With State governments: In addition to grants, support for training and service activities is provided through contract and cooperative agreements. All of these support mechanisms involve participation by the recipient agency, which frequently calls for continuing liaison with the State Mental Retardation Planning group.

(*e*) With local agencies: See (*d*) above.

(*f*) With foreign governments and international organizations: Support for applied research activities is carried out under the provisions of Public Law 480 (using counterpart funds).

(*g*) With nonprofit institutions: See (*d*) above.

(*h*) With business enterprises: None.

(*i*) With others: Works with professional organizations, such as the American Association on Mental Deficiency, to promote improved standards for mental retardation services and training. Consultation to and participation in national and regional meetings of other organizations.

8. Laws and regulations

This grant activity is authorized in the annual DHEW Appropriation Act. Programs authorized by Public Law 88–156, which included authority for grants to States for the planning of comprehensive mental retardation activities, and the Mental Retardation Facilities Construction Acts, Public Law 88–164, have a direct effect and bearing on the activities funded under this grant program.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from the Office of the Surgeon General.)

10. Economic classification of program expenditures. (See table 3.)

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Community Health).

TABLE 3.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Program: Mental retardation project grants.	
Federal Government: [1]	
Grants to State and local governments	$113
Transfer payments to nonprofit organizations	586
Total Federal expenditures	699
Non-Federal expenditures financed by individuals and nonprofit organizations	170
Total expenditures for program	869
Program: Mental retardation planning and implementation grants.	
Federal Government: [1]	
Grants to State and local governments	1,060
Non-Federal expenditures not available.	

[1] Expenditures here refer to obligations.

IMMUNIZATION PROJECT GRANTS

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

(*a*) The immunization of practically all susceptible persons in all communities throughout the United States, Puerto Rico, and the Virgin Islands, particularly preschool children, against the five diseases covered by the legislation (measles, poliomyelitis, diphtheria, whooping cough, and tetanus).

(*b*) The establishment of effective ongoing immunization maintenance programs.

2. Operation

Direct Federal operation providing project grants to State health departments and, with the approval of the State health authority, to local health departments. A headquarters staff administers and supervises the program, with specialized services provided in consultative, training, informational and promotional areas by Communicable Disease Center branches, staff services, and regional offices. Field assignments are made to States and localities to coordinate these activities.

3. History

Existing vaccination programs conducted in communities throughout the country were not effective in reaching all groups of the population, particularly preschool children, and low-income neighborhoods. A bill was proposed requesting funds to support programs in States and localities directed toward eradicating four of the communicable diseases causing so much loss of life, disability, suffering, and resulting cost of care. After months of close scrutiny by Congress of the proposed bill, the Vaccination Assistance Act of 1962 was passed, authorizing the Surgeon General to make project grants within a 3-year period to State and local health departments for the support of intensive vaccination programs designed to raise and maintain high levels of immunization against the four diseases, poliomyelitis, diphtheria, whooping cough, and tetanus. The Communicable Disease Center was charged with the responsibility of administering and carrying out the provisions of this act. Funds were made available in May

1963, and an organizational unit designated as immunization activities was established in the office of the center chief in June 1963.

On August 5, 1965, the President signed Public Law 89–109 which amended and extended the Vaccination Assistance Act of 1962 for 3 years. The new act enables the Surgeon General to make project grants to assist States and communities in the conduct of immunization programs against measles, as well as the other four diseases, and provides for the purchase of vaccines for preschool children.

4. Level of operations. (See table 1.)

Program: Immunization project grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(*a*) Magnitude of the program (number of State and local health departments)	75	75	100	100
(*b*) Applicants or participants:				
State government agencies	35	35	40	40
Local communities or governments	40	40	60	60
Individuals or families				
Other (percentage of population covered) [2]	70.1	70.1	80	80
(*c*) Federal finances:				
Unobligated appropriations available	$18,661	$16,641	$8,888	$9,100
Obligations incurred	$9,712	$15,679	$8,888	$9,100
Allotments or commitments made				
(*d*) Matching or additional expenditures	$8,340	$9,850	$11,850	$12,000
(*e*) Number of Federal employees [3]	9	10	15	15
(*f*) Non-Federal personnel [4]	30	50	75	80
(*g*) Other measures of performance [5 6]	1,500	1,500	1,700	1,700

[1] President's budget.
[2] 127,465,599, 1960 census population.
[3] Headquarters personnel in administrative and supervisory activities.
[4] Personnel in lieu of cash grant.
[5] (*g*) Other measures of level or magnitude of performance:
In comparing the findings of the 1962 and 1964 national immunization surveys conducted by the Bureau of the Census, significant gains in immunization levels are noted. It is felt that the 75 Vaccination Assistance Act projects covering over 70 percent of the population in the United States, Puerto Rico, and the Virgin Islands contributed significantly to the progress shown in this 2-year interval.
In the 1- through 4-year age group, the percent of children who had received a basic series of DTP inoculations increased from 68 to 76 percent, reflecting protection for 1½ million more preschool children than 2 years earlier.
For children under 15 years, 7,000,000 more have received 4 or more DTP inoculations than was the case in 1962—an increase from 42 to 54 percent.
Although information collected in the national immunization surveys does not furnish adult protection levels against diphtheria and tetanus, data collected show a ½ increase in the net distribution of doses of adult DT vaccine in the past year—some 1,250,000 doses more.
Perhaps the most dramatic gain in immunization protection since 1962 occurred with oral poliomyelitis vaccine. National survey figures indicate that between September 1962 and September 1964, the percentage of 1- to 4-year-old children receiving all 3 types rose from 6 to 74 percent—close to 7,000,000 more preschoolers.
Similar gains were registered in other age groups resulting in the protection of nearly 60,000,000 people under age 50 in a 2-year period of time.
[6] Personnel paid from State and local health funds.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) Within the bureau, division, or office: Currently working on satisfactory cooperative basis with branches, staff services, and regional

offices in promoting and administering the immunization program. These offices provide consultative, training, informational, and promotional services.

(*b*) With other units of the department or agency: Continuation of cooperative working relationships affecting administrative aspects and grants policies and procedures.

Possible cooperative working relationships with Children's Bureau [and National Institute of] Mental Health [and National Institute of] Child Health [and Human Development].

(*c*) With other Federal Government departments or agencies: Cooperative working agreement with Veterans' Administration—mailing of immunization flyers.

(*d*) With State governments or their instrumentalities.

(*e*) With local governments or communities: Continuation of satisfactory working relationships with State and local health agencies in initiating, conducting, and maintaining intensive vaccination programs. These activities are directed toward providing:

(1) Central leadership and coordination of the State and local efforts to improve immunization levels.

(2) Evaluation and development of new or improved techniques of immunology, community organization, and surveillance.

(3) Rapid application of both accepted practices and new or improved methods of operation in the States and communities.

(*f*) With foreign governments or international organizations: World Health Organization.

(*g*) With nonprofit organizations or institutions: PTA, civic, and community groups.

(*h*) With business enterprises: National Advisory Council.

(*i*) With others.

8. Laws and regulations

Public Law 87–868, and Public Law 89–109.
Section 317, Public Health Service Act.
Communicable disease activities.
Community immunization grants.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from Office of the Surgeon General.)

With revision and extension of the act, primary emphasis is being placed on implementation of a nationwide program against measles. While the total economic costs of measles and the relatively large numbers of measles-related complications cannot be calculated, estimates can be made of a portion of the financial losses to individuals and communities. Based on an incidence of about 4 million cases of measles per year, it is estimated that each year:

Approximately $12 million is spent for physician visits and medical expenses.

About $23.8 million in hospitalization costs is incurred.

The loss to school systems in average daily attendance funds amounts to approximately $18.3 million.

It is hoped these costs can be eliminated by the programs directed toward eradication of the diseases.

10. Economic classification or program expenditures. (See table 2.)

Program: Immunization project grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:[1] Grants to State and local governments[2] (total Federal expenditures)	$15,679
Non-Federal expenditures financed by State and local governments	9,850
Total expenditures for program	25,529

[1] Expenditures here refer to obligations.
[2] Includes $304,000 for personnel costs in lieu of cash.

MIGRANT HEALTH

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The migrant health grant program permits funds to be made available for project grants to assist in improving health conditions and in planning, developing, expanding, and improving health services for domestic agricultural workers and their families. More specifically, funds are to be available to pay part of the cost of the following: (1) Setting up and operating family health service clinics; and (2) developing other types of special projects, including inpatient hospital care, to improve health services and conditions

2. Operation

Assistance is in the form of a financial grant to State and local public agencies and nonprofit private organizations. These include such groups as health departments, health and welfare councils, medical societies, growers' associations, educational institutions, and other community groups interested in planning and conducting a project to improve health services for domestic migratory farmworkers and their families.

Funds are available upon approval of a grant application by the Surgeon General or his designee, after review and recommendation by a national review committee. There is no fixed matching ratio. Grantee pays "a part" of the cost which varies from project to project depending upon the relationship between the magnitude of the problem and other available resources.

3. History

Studies and recommendations of various commissions and conferences have been concerned with the improvement of the living and working conditions of migrant labor for the past 25 years. Some of these were the Tolan committee report in 1941 which recognized the need for States of heavy immigration to adopt laws establishing minimum conditions of health, sanitation, and housing on farms employing migratory labor; the War Food Administration which provided an opportunity to help migrants, but this was stopped at end of World War II; the report of the Truman Commission on Migratory Labor in 1951; and others.

National recognition was again given to the migrant problem in the early 1960's, when the U.S. Senate established a Subcommittee on Migratory Labor under Senator Harrison Williams of New Jersey, which held hearings and brought the situation to national attention. The passage of the Migrant Health Act in September 1962 (Public Law 87–692), introduced by Senator Harrison Williams, represented a major legislative breakthrough.

4. Level of operations. (See table 1.)

Program: Migrant Health.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (projects)	49	62	70	90
(b) Applicants or participants:				
State government agencies	16	24	25	30
Local communities or governments	24	26	32	55
Individuals or families				
Other—Universities and voluntary nonprofit organizations	9	12	13	5
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$1,500	$2,336	$3,000	$7,200
Allotments or commitments made				
(d) Matching or additional expenditures	$1,248	$2,075	$2,500	$2,962
(e) Number of Federal employees (man-years)	12	12	13	18
(f) Non-Federal personnel (man-years)	200	334	400	500
(g) Other measures of performance				

[1] President's budget.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

U.S. Department of Agriculture: A cooperative agreement is currently in effect for the development of plans for the construction of improved low-cost healthful housing designed for short-term occupancy by migrant workers.

Office of Economic Opportunity: Arrangements have been made for the use of regional migrant health representatives to assist, on a reimbursable basis, in the development of migrant projects under the Economic Opportunity Act.

Department of Labor: 1. Arrangements are currently in process for the use of the crew-leader registration program as a means of providing information on migrant health programs to the crewleaders.

2. Plans are being developed on a cooperative basis to obtain information on (*a*) numbers of agricultural migrants and (*b*) their work locations on a county basis to assist health agencies in planning health services for these migrant families.

8. Laws and regulations

Public Law 87–692 became effective on September 25, 1962. It authorized to be appropriated for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed $3 million for any year, as may be necessary to enable the Surgeon General (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 to provide services in the establishing and operating of such clinics, and (ii) special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons 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.

Public Law 89–109 was enacted on August 5, 1965, to extend section 310 of the Public Health Service Act through June 30, 1968, and to amend this section by authorizing necessary hospital care for agricultural migratory workers and their families. This law authorized appropriations not to exceed $7 million for the fiscal year ending June 30, 1966, $8 million for the fiscal year ending June 30, 1967, and $9 million for the fiscal year ending June 30, 1968 (42 U.S.C. 242h).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from Office of Surgeon General.)

The improved health status of the migrant worker, resulting from the migrant health program, should have a favorable effect on his productivity as well as on his earnings.

10. Economic classification of program expenditures. (See table 2.)

Program: Migrant health.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health)

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965.*

[In thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	2,144
Transfer payments to nonprofit organizations	192
Total Federal expenditures	2,336
Non-Federal expenditures financed by:	
State and local governments	1,978
Individuals and nonprofit organizations	97
Total expenditures for program	4,411

[1] Expenditures here refer to obligations.

Tuberculosis Control Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The program objective is to control and ultimately eradicate tuberculosis from the United States.

2. Operation

The program provides technical assistance and grants-in-aid for tuberculosis control activities that are carried out by means of formula and special project grants and contracts to State and local health agencies and selected private institutions.

3. History

The Public Health Service Act of 1944 authorized the establishment of a tuberculosis control program within the Service. It placed upon the Public Health Service the responsibility of administering grants-in-aid to State health departments, and of conducting demonstrations and research in tuberculosis. In accordance with this act the Surgeon General established a Tuberculosis Control Division in the Bureau of State Services of the Public Health Service and it was subsequently approved by the Federal Security Administrator. In the fall of 1960, the tuberculosis program became a part of the Communicable Disease Center and in 1962 it moved to Atlanta, Ga., as the Tuberculosis Branch. In 1963, following a suggestion of the Congress, a Special Task Force on Tuberculosis Control was appointed by the Surgeon General to consider ways and means that the Public Health Service might improve the Nation's tuberculosis control program. The task force prepared a report for a 10-year program which contained a number of recommendations, including increased grants to the States for selected activities, improvement of skills of present and prospective tuberculosis workers to meet existing and future needs, and continued and expanded research in tuberculosis. In fiscal year 1966 funds were made available by the Congress to commence the task force program at the recommended first-year level.

4. Level of operations. (See table 1.)

Program: Tuberculosis control program project grants.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (projects)	41	65	80	85
(b) Applicants or participants:				
State government agencies [2]	37	37	52	52
Local communities or governments				
Individuals or families				
Other				
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$1,575	$4,991	$9,700	$13,950
Allotments or commitments made				
(d) Matching or additional expenditures	[3]	43,000	[3]	[3]
(e) Number of Federal employees [4]	23	220	100	150
(f) Non-Federal personnel [5]	510	937	1,360	1,850
(g) Other measures of performance				

[1] President's budget.
[2] States including District of Columbia and Puerto Rico.
[3] Not reported.
[4] Personnel in lieu of cash.
[5] Personnel paid from cash funds, project grants to State and local health departments.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

As to purposes, policies, operations and financing, the program will continue to function in coordination and with the cooperation of the Bureau of State Services and the Communicable Disease Center. On special problems, committees are set up to coordinate activities with the Division of Indian Health, Pan American Sanitary Bureau (PASB), and other special groups. As the program expands into the recommended activities, coordination and cooperation with such agencies as Children's Bureau, the Bureau of Disability and Health Insurance, and the Division of Medical Care Administration will be required and promoted for effective implementation.

The entire program now functions with the cooperation and coordination of State, county, and local health agencies. It is imperative, if the program is to succeed, that this continue in the future.

In carrying out the recommended research activities, a number of foreign countries are cooperating in therapy and prophylaxis trials. These are long-range studies, and continued cooperation and coordination are essential.

The program cooperates and will continue to work with the National Tuberculosis Association and its affiliates in joint staff meetings, national meetings, planning sessions, and work group committees.

To evaluate the effectiveness of new antituberculosis drugs, the program plans, directs, and coordinates a number of extensive therapeutic and prophylaxis drug studies that are carried out with the cooperation and assistance of national drug firms and a large group of tuberculosis hospitals across the Nation.

8. Laws and regulations

Section 314(b) and 314(d) of the Public Health Service Act as amended (42 U.S.C. 246). 1965 Appropriation Act, Public Law 88–605.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from the Office of the Surgeon General.)

Improved ambulatory care for tuberculosis patients outside of the hospital reduces the period of hospitalization that is required and enables the patients to return to productive work much sooner. This affects an estimated 35,000 persons during the year and should result in an estimated savings in hospital costs of $100 million each year of the 10-year program. The contribution that this may make to the gross national product cannot be identified specifically. Most of the persons affected by the program are in the lower socioeconomic groups and the majority reside in economically deprived metropolitan areas. The program will have a significant, although unmeasured, impact, on the Nation's health and income by improving and returning to productive activity a large number of those persons who are temporarily disabled or affected by tuberculosis.

10. Economic classification of program expenditures. (See table 2.)

Program: Tuberculosis control program project grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Purchases of goods and services:	
Wages and salaries	791
Other	1,200
Grants to State and local governments	3,000
Total Federal expenditures	4,991
Non-Federal expenditures financed by:	
State and local governments	[2] 35,000
Individuals and nonprofit organizations	[2] 8,000
Total expenditures for program	47,991

[1] Expenditures here refer to obligations.
[2] Budgeted for tuberculosis control.

VENEREAL DISEASE

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The venereal disease program has two objectives: (1) to eradicate syphilis as a public health problem, and (2) to develop methods and control techniques which will permit the undertaking of a gonorrhea control program.

2. Operation

The venereal disease program operates through the provision of grants of funds, detail of personnel, and program consultation to State and local health agencies in which the responsibilities for venereal disease control is vested. The venereal disease program also conducts research for the purpose of (1) improving diagnostic and therapeutic techniques for syphilis and gonorrhea, and (2) to develop methods of artificially producing immunity in man to venereal infection.

3. History

Venereal disease activities in the Federal Government date from the Chamberlin-Kahn Act of 1918 which provided for grants to States for venereal disease control and a small headquarters operation to provide analysis of morbidity and program data. No funds for grants were available from 1920 until the passage of the LaFollette-Bulwinkle Act in 1939 from which time the modern venereal disease control program should be dated. The Public Health Service Act of July 1, 1944, codified authority for venereal disease control with current program operations being carried out under the authorities of section 301 and section 314(a) of the act.

The advent of penicillin as a cure for syphilis and gonorrhea in the 1940's permitted the program emphasis to be concentrated on case-finding rather than treatment. The current syphilis eradication effort is predicated on the concept that epidemiologic activity can operate to locate source and spread cases from known infections faster than the disease can spread. The elements of this program are contained in the report of the Surgeon General's task force "The Eradication of Syphilis" (December 1961).

4. Level of operations. (See table 1)

Program: Venereal disease project grants.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (number of projects)	70	71	69	69
(b) Applicants or participants:				
State government agencies				
Local communities or governments				
Individuals or families				
Other				
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$5,887	$6,194	$6,229	$6,229
Allotments or commitments made				
(d) Matching or additional expenditures [2]	$17,338	$18,000	$18,000	$18,000
(e) Number of Federal employees [3]	432	615	720	720
(f) Non-Federal personnel [4]	245	245	270	270
(g) Other measures of performance				

[1] President's budget.
[2] Funds budgeted for venereal disease control (State and local governments).
[3] Personnel in lieu of cash.
[4] Personnel paid from cash funds, project grants to State and local health departments.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The primary point of Public Health Service venereal discharge program coordination with other agencies is with State and local health departments. Additionally the venereal disease program cooperates with the Armed Forces in providing services in and around military installations and with the American Social Health Association in conducting surveys of the venereal disease control problem posed by prostitution. The American Social Health Association, the Association of State and Territorial Health Officers, and the American Venereal Disease Association conduct an annual survey of health departments needs and assists in providing a basis for Federal budget requests.

8. Laws and regulations

In addition to the authorities cited in question 3, the annual appropriation act item, "Control of Venereal Disease," provides authority for the venereal disease program to make grants to State and local health departments upon such terms and conditions as the Surgeon General may determine.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic impact of venereal disease program activities lies primarily in two areas: (1) The direct benefits made possible through reductions in venereal disease morbidity and mortality so as to reduce the necessity of expenditures of public funds for hospitalization of those individuals suffering from the late manifestations of syphilis. The direct economic cost of hospitalization is in 1965 estimated at approximately $50 million a year. (2) The indirect benefits are made possible through worker productivity that would otherwise be lost. The total estimated benefits of syphilis eradication is estimated to be in the magnitude of $3 billion a year. (See Herbert E. Klarman "Syphilis Control Programs" in "Measuring Benefits of Government Investments," Brookings Institution studies of American finance 1965.) [1]

10. Economic classification of program expenditures. (See table 2.).

Program: Venereal disease project grants.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

[1] [Editor's note: Klarman's estimate is not $3 billion a year but a discounted present value of $3 billion. His statement is as follows: "The present value of the benefits accruing from total eradication would be $117.5 million realized in perpetuity, or $2.95 billion (at a discount rate of 4 percent) * * *. An added benefit is the control and surveillance mechanism, which could presumably be abandoned * * * In sum, the present value of eradicating syphilis, on the above assumptions, would be $3.1 billion." Op. cit., p. 405.]

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Purchases of goods and services: Wages and salaries	2, 510
Grants to State and local governments	[2] 3, 684
Total Federal expenditures	6, 194
Non-Federal expenditures financed by State and local governments	[3] 18, 000
Total expenditures for program	24, 194

[1] Expenditures here refer to obligations.
[2] Cash grants ($2,510 thousand for salaries of Federal personnel assigned in lieu of cash grants is included in wages and salaries, above).
[3] Funds budgeted for venereal disease control.

CONSTRUCTION GRANTS

Answers to questions 4 and 10 are summarized here for all construction grant programs of the Bureau of State Services—Community Health.

4. Level of operations. (See table 1.)

Program: Construction grants, Bureau of State Services—Community Health (summary).

Department or agency, and office or bureau: Department of Health, Education and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67: Summary*

[Dollar amounts in thousands]

Measure (see committee inquiry for definitions)	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [1] estimates
(a) Magnitude of the program (projects)	562	560	694	720
(b) Applicants or participants:				
State government agencies	36	61	77	85
Local communities or governments	216	173	231	235
Individuals or families				
Other—Voluntary nonprofit	310	326	386	400
(c) Federal finances:				
Unobligated appropriations available	$379, 666	$524, 517	$600, 203	$670, 375
Obligations incurred [2]	$215, 851	$296, 409	$389, 328	$470, 375
Allotments or commitments made				
(d) Matching or additional expenditures	$448, 827	$541, 690	$641, 800	$748, 800
(e) Number of Federal employees (man-years)	226. 5	295	376	404
(f) Non-Federal personnel [3]				
(g) Other measures of performance (1st year student placement)		1, 630	1, 000	1, 200

[1] President's budget.
[2] Includes funds from previous years.
[3] Not available.

10. Economic classification of program expenditures. (See table 2.)

Program: Construction grants, Bureau of State Services—Community Health (summary).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965: Summary*

[In thousands of dollars]

Federal Government: [1]	
Purchases of goods and services:	
Wages and salaries	2,096
Other	409
Grants to State and local governments [2]	75,748
Transfer payments to nonprofit organizations	209,276
Loans to nonprofit organizations	414
Total Federal expenditures	287,943
Non-Federal expenditures financed by: Individuals and nonprofit organizations [3]	94,435
Total expenditures for program	382,378

[1] Federal Government expenditures refer to obligations except for Hill-Burton hospital construction
[2] Includes planning grants.
[3] Includes institutions of higher learning.

HOSPITAL AND MEDICAL FACILITIES CONSTRUCTION

(HILL-BURTON PROGRAM)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist the States in providing adequate hospital and medical facilities through a program of construction or modernization grants or loans; to improve the utilization of health facilities and their services through programs of research and areawide planning.

2. Operation

At the Federal level, the program is administered by the Division of Hospital and Medical Facilities in the Bureau of State Services (Community Health), Public Health Service. To maintain direct contact with State authorities, the Division maintains a staff in each of the nine regional offices of the Department of Health, Education, and Welfare. These regional staffs work with the responsible State authorities in developing and maintaining plans, programs, and budgets for the Hill-Burton grant-in-aid program for health facility construction. To participate in the program, each State is required by the Hill-Burton Act to designate a single State agency for the administration of the program.

The construction of health facilities provided for under the Hill-Burton Act involves a planning phase as well as the actual construction phase. States conduct surveys to determine their needs for health facilities and develop statewide construction plans. Individual projects are entitled to Federal financial assistance provided they conform with the State plan and have the approval of the State agency administering the program and of the Public Health Service. Federal participation ranges from one-third to two-thirds of the total costs of construction and equipping health facilities.

Effective methods of utilizing and coordinating health facility service and resources are developed through an areawide planning program, through a program of research conducted by universities, hospitals, and States and their political subdivisions, and through a program of intramural research.

3. History

During the depression years and for the duration of World War II, few hospitals were constructed in the United States. For this reason, many hospitals became obsolete and there were manifest shortages in the number of hospital beds and other related health facilities and services. To identify and meet these needs, Congress enacted into law on August 13, 1946, the Hospital Survey and Construction (Hill-Burton) Act (Public Law 725, 79th Cong.). The purpose of the act was to survey needs and to assist the local sponsors in the several States in the construction of public and other nonprofit hospitals. As a result, the United States undertook, for the first time, an orderly appraisal of its existing hospital and public health center resources and developed comprehensive State plans for furnishing "adequate hospital, clinic, and similar services to all their people." Annual revisions of these plans by each State became mandatory by regulation.

Since the original Hill-Burton legislation was passed several major amendments have been enacted. In 1954, the act was amended to assist the several States in the construction of diagnostic or treatment centers, hospitals for the chronically ill, rehabilitation facilities, and nursing homes. In 1958, Congress gave an eligible sponsor the option to take a loan in lieu of a grant. The Community Health Services and Facilities Act of 1961 increase the annual appropriation authorization for nursing homes from $10 million to $20 million and liberalized the definition of rehabilitation facilities.

On August 18, 1964, the President signed into law the Hospital and Medical Facilities Amendments of 1964 (Public Law 88–443), extending and revising the Hill-Burton program to keep pace with changing concepts of health facility construction and operation.

The most far-reaching change in the program is the establishment of a new grant program, beginning with fiscal year 1966, for modernization or replacement of public and nonprofit hospital and other health facilities.

In addition to the modernization program, the Hill-Harris amendments also provide:

1. A single category of long-term care facilities, which combines the previously separate grant programs for chronic disease hospitals and nursing homes, and lifts the annual ceiling from $40 million to $70 million.

2. The use by the States of 2 percent of their allotments (up to $50,000 a year) to assist in the efficient and proper administration of the State plan.

4. Level of operations. (See table 1.)

Program: Hospital and medical facilities construction (Hill-Burton program).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure and unit [1]	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [2] estimates
(*a*) Magnitude of the program (projects initially approved)	562	478	570	550
(*b*) Applicants or participants:				
State government agencies (projects initially approved)	36	32	40	40
Local communities or governments (projects initially approved)	216	173	220	210
Individuals or families				
Other, voluntary nonprofit (projects initially approved)	310	273	310	300
(*c*) Federal finances:				
Unobligated appropriations available [3]	$374,666	$378,642	$429,759	$452,000
Obligations incurred (final approval)	$213,351	$204,099	$247,759	$262,000
Allotments or commitments made (appropriation)	$220,000	$220,000	$258,500	$270,000
(*d*) Matching or additional expenditures (matching)	$448,827	$447,255	$525,000	$570,000
(*e*) Number of Federal employees (man-years)	221	245	289	400
(*f*) Non-Federal personnel	[4]	[4]	[4]	[4]
(*g*) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.
[3] In each of the fiscal years 1963 through 1965, the Hill-Burton appropriation totaled $220,000,000. In fiscal year 1966, the appropriation was increased to $258,500,000. Under the Hill-Burton program, each year's appropriation remains available for 2 fiscal years. In other words, funds appropriated in fiscal year 1963 which remain uncommitted at the close of that fiscal year, are available for commitment during fiscal year 1964. In the above column for fiscal year 1964, the $374,666,000 in funds shown as unobligated appropriations represent funds remaining from the 1963 appropriation plus the appropriation for fiscal year 1964.
[4] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The Division of Hospital and Medical Facilities has extensive working relationships with other programs throughout the Public Health Service and with other units of the Department which have responsibilities in the health or health facility construction field. The following are illustrative of the cooperative arrangements which exist:

(*a*) Within the Bureau of State Services (Community Health) continuous and close relationships are maintained with the Office of the Bureau Chief, the Office of Grants Management and other offices and Divisions with regard to program operating plans, procedures, and problems.

(*b*) With other units of the Public Health Service and Department. The Division makes a deliberate effort to bring about a consistency of policies and procedures among the several organizational units within the Public Health Service which have official responsibilities in the area of health facility construction. For example, continuous contacts are made with the Research Facilities and Resources Division of the National Institutes of Health regarding mutual problems and policies in health research facility construction. Cooperative working relationships are maintained with the National Institute of Mental Health with regard to policy determination and procedures for construction of community mental health facilities. A continuous relationship also exists between the Division and the Office of General

Counsel, Office of the Secretary, regarding legal problems that arise in the operation of the programs.

(*c*) With other Federal departments. Extensive working relationships are maintained with other Federal departments or agencies, such as:

(1) Federal Housing Administration, Housing and Home Finance Agency, with which the Division develops joint policies regarding approval of applications for mortgage insurance for construction of privately owned nursing homes, the development of standards of design and construction, and for resolving mutual problems which may arise in the conduct of both the HHFA and Hill-Burton programs for assisting nursing home construction.

(2) U.S. Department of Agriculture, Rural Electrification Administration, with which the Division has occasional contacts regarding the availability of REA funds to pay for certain electrical equipment in rural hospitals.

(3) U.S. Department of Commerce, Area Redevelopment Administration, with which the Division works cooperatively in the development of policies and procedures governing the approval of hospital and other health facilities projects under the economic development program.

(4) Appalachian Regional Commission, with which the Division works cooperatively in the development of mutually acceptable policies and procedures governing the approval of health facility and mental retardation facility projects under sections 202 and 214 of Public Law 89–4, which authorizes aid for the construction and operation of certain health facilities in the Appalachian region.

(5) Veterans' Administration, with which the Division cooperates to achieve mutually agreeable design criteria for constructing hospitals and other medical facilities.

(*d*) With State governments. The Division, through its regional and central office staff, provides continuous guidance and guideline to the 54 State agencies which administer the Hill-Burton program. Division staff participates actively in all regional and national meetings of the agencies. Upon inauguration of new regulations or procedures, orientation sessions are held with State agency personnel.

(*f*) With foreign governments. Relationships with representatives of foreign governments are of two types. First, frequent visits are made to the Division by representatives of other governments for the purpose of obtaining firsthand information as to how the program operates and the criteria, standards, and working relationships which have been established with States, communities, and sponsors of hospital projects. Second, the minimum standards of design and construction and guide material issued pertaining to these facets of the program are frequently requested by foreign governments. Indeed, foreign governments have translated one publication, Design and Construction of General Hospitals, into approximately 20 different languages.

(*g*) With nonprofit organizations. Close relationships exist between the Division and a wide variety of professional associations which are concerned with the design, construction, equipping, and operation of health facilities, as well as with the planning for such facilities. Division activities with these associations include the cosponsoring of

nationwide institutes, collaboration on reports, manuals, and other documents; serving as committee members; preparation of exhibits; and serving as consultants on a variety of projects, and as representatives at numerous meetings and conferences. An illustrative listing of professional associations with which continuous contacts are maintained is as follows:

American Hospital Association.
Association of American Medical Colleges.
American Medical Association.
American Institute of Architects.
American Physical Therapy Association.
Illuminating Engineering Society.
National Fire Protection Association.
American Dietetic Association.
American Nursing Home Association.

8. Laws and regulations

Authority for hospital and medical facilities construction and modernization grants is included in title VI of the Public Health Service Act, as amended (42 USC 291–291o).

The following table shows Hill-Burton authorizations for fiscal years 1964–66.

	Construction	Areawide planning
1964	$220,000,000	
1965	250,000,000	$2,500,000
1966	260,000,000	5,000,000

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

In its 19 years of operation, the Hill-Burton program has made substantial contributions to the national economy and to economic growth. Some have been readily adaptable to quantitative measurement. Others, although of equal importance, are not so clearly measurable; for example, the effect upon individual and community health productivity. The following are examples of measurable benefits of the program since its inception:

a. Construction of needed hospitals and other health facilities has been stimulated throughout the Nation, bringing to many communities the basic resources for saving life, preventing sickness, and rehabilitating the disabled. At the start of the program, 10 million people were living in areas without any acceptable general hospital beds. Today, fewer than 2 million live in areas without acceptable facilities. Altogether, $7.5 billion in health facility construction funds has been expended in local communities since 1947, a dollar volume three times the Federal aid involved.

b. During the period of construction of Hill-Burton projects approved to date, opportunities have been created for an estimated 2,500,000 man-months of employment for workers in the building and equipment trades.

c. Permanent, year-round employment opportunities have also been created for an estimated 325,000 persons in the various health

facilities aided under the program—from maintenance personnel to persons in professional service. Annual payroll costs involved reach about $1.3 billion. This amount, coupled with direct operating costs such as for equipment, power, laundry and supplies (roughly one-third of payroll costs) bring a total annual contribution to local economy—solely for the operation of approved Hill-Burton projects—to $1.73 billion.

10. Economic classification of program expenditures. (See table 2.)

Program: Hospital and medical facilities construction (Hill-Burton program).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures, for fiscal year 1965*

[In thousands of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	2,096
Other	409
Grants to State and local governments	75,748
Transfer payments to nonprofit organizations	116,966
Loans to nonprofit organizations	414
Total Federal expenditures	195,633

CONSTRUCTION OF TEACHING FACILITIES, HEALTH PROFESSIONS AND NURSES

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To increase the opportunities for training of physicians, dentists, and other professional health personnel through a grant program to assist in the construction of teaching facilities.

2. Operation

The "Health Professions Educational Assistance Act of 1963" (Public Law 88–129) established a National Advisory Council on Education for Health Professions. The Council consists of the Surgeon General of the Public Health Service, Chairman ex-officio, the Commissioner of Education, ex-officio, and 16 appointed members. The "Nurse Training Act" was approved September 4, 1964, and erected an Advisory Council on Nursing.

Funds are granted upon approval of a grant application by the Surgeon General, and after review and evaluation by review committees composed of outside consultants in the various disciplines and recommendation by the National Advisory Council on Education for Health Professions.

Criteria used in considering applications for construction grants are:

(*a*) In the case of a project for a new school or expansion of an existing school, the relative effectiveness of the project in expanding capacity for the training of professional public health personnel or first-year students of medicine, dentistry, pharmacy, optometry, podiatry, osteopathy, and nursing. In cases of a 2-year school expanding to a 4-year school, the criterion is the expansion of capacity for 4-year training of students in the field. Consideration is also given to the promotion of equitable geographic distribution of opportunities for such training.

(*b*) In the case of a project for replacement or renovation of existing training facilities, the relative need to prevent curtailment of the school's enrollment or deterioration of the quality of the relative size of any such curtailment and its effect on the geographic distribution of opportunity for training.

(*c*) The relationship of the application, in a State which has in existence a State planning agency, or which participates in a regional or other interstate planning agency, to the construction or training program which is being developed by such agency with respect to such State.

(*d*) Grants may be made only for that portion of any health facility which the Surgeon General determines to be attributable to the need of a new school for teaching purposes, or of an existing school for the construction of facilities to expand its training capacity, or for the modernization of facilities to prevent curtailment of enrollment or deterioration of the quality of training.

(*e*) An applicant for a construction grant under this program must be either a public or nonprofit school of medicine, dentistry, osteopathy, pharmacy, optometry, podiatry, public health, or nursing (collegiate and through June 30, 1965, collegiate, associate and diploma beginning in fiscal year 1966) accredited by a recognized body approved by the Commissioner of Education. A new school may be deemed accredited if the Commissioner finds, after consultation with the appropriate accreditation body, that there is reasonable assurance that the school will meet accreditation standards upon completion of the facility. A public or other nonprofit agency may file an application on behalf of an affiliated hospital, if the application is approved by the school of medicine or osteopathy with which the hospital is affiliated.

(*f*) Grants for new schools, or for new facilities for an existing school providing a major expansion of training capacity may not exceed 66⅔ percent of the necessary cost of construction. Other grants may not exceed 50 percent of such cost, except that grants to schools of public health may cover up to 75 percent of such costs. Any other Federal grants, and the non-Federal matching funds for them, made with respect to the construction is excluded from the cost of construction in determining the amount of the grant under this program.

3. History

The approval on September 24, 1963, of the "Health Professions Educational Assistance Act of 1963," authorized a program of grants for the construction of teaching facilities for the training of physicians, osteopaths, dentists, professional public health personnel, pharmacists, optometrists, podiatrists, and nurses (collegiate—through June 30, 1965 and to include associate and diploma beginning with fiscal year 1966 as expanded by Public Law 88–581).

For some years now, the country has been faced with critical shortages of physicians. This situation has been studied thoroughly over the years and well documented. The number of graduates of the health profession schools of the United States simply has not kept pace with the growing population and the ever-increasing demands for health care. It was recognized that existing schools could not reverse the tide or even maintain existing ratios and that additional facilities for training were needed. There was also an evident need

to modernize and replace some existing schools that were obsolete, overcrowded, or deficient in teaching facilities.

Beginning with the first grant awarded about 1 year ago, a total of 64 grants have been awarded to date amounting to $127,300,000. When construction is completed on these projects, 2,307 new 1st-year student places will have been provided.

4. Level of operations. (See table 1.)

Program: Construction of teaching facilities, health professions and nurses.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure and unit [1]	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 [2] estimates
(a) Magnitude of the program (applications approved and funded)		45	30	30
(b) Applicants or participants:				
State government agencies (applications approved and funded)		26	18	18
Local communities or governments				
Individuals or families				
Other, voluntary nonprofit (applications approved and funded)		19	12	12
(c) Federal finances:				
Unobligated appropriations available		$100,000	$106,792	$160,000
Obligations incurred [3]		$83,208	$106,792	$160,000
Allotments or commitments made (appropriation)		$100,000	$90,000	$160,000
(d) Matching or additional expenditures [4] (matching funds)		$90,000	$95,000	$150,000
(e) Number of Federal employees (man-years)		18	40	52
(f) Non-Federal personnel				
(g) Other measures of performance (1st-year student places created)		1,630	1,000	1,200

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Obligations incurred on grant awards during the year.
[4] Entry is estimated teaching costs to be borne by applicants. The data for fiscal year 1965 are based on information contained in those applications that were funded. The fiscal year 1966 entry is based on the assumption that the same ratio will obtain between Federal funds awarded and non-Federal funds supplied by grantees.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Full opportunity is afforded for coordination and exchange in all aspects of the professional school construction programs. All interested agencies, both public and private, are encouraged to participate fully. List follows:

Educational Facilities Branch: Contacts with other organizations.
Public Health Service:
Division of Community Health Services.
Division of Dental Health.
Division of Nursing.
National Institutes of Health:
Division of Research Facilities and Resources.
Division of Research Grant.

National Library of Medicine.
Bureau of Medical Services, Division of Hospitals.
Departmental—Office of Education: Bureau of Higher Education Facilities.
Other governmental agencies:
National Science Foundation.
Veterans' Administration.
Bureau of Labor Statistics.
Nongovernmental agencies:
Association of American Medical Colleges.
American Medical Association.
American Association of Colleges of Pharmacy.
American Pharmaceutical Association.
American Podiatry Association.
American Optometric Association.
American Public Health Association.
Western Interstate Commission for Higher Education.
New England Board of Higher Education.
Southern Regional Education Board.
Health profession facilities (schools).

8. Laws and regulations

(*a*) Public Law 88–605, September 24, 1964.
(*b*) Public Law 89–156, August 31, 1965.
(*c*) Public Law 88–129, September 24, 1963.
(*d*) Public Law 88–581, September 4, 1964.
(*e*) Title 42, public health (regulations, December 1, 1964).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from the Office of the Surgeon General.)

The Nation continues to be faced with critical shortages of health manpower. Moreover, regardless of what action is taken, the shortages can be expected to continue for several years. A measure of relief can be hoped for through such legislation as Public Law 88–129 and its continuance, but the Nation's late start in accelerating construction and renovation of medical professional schools leaves an indication of worsening of the condition before real improvement can be realized. We face this situation at the dawn of the Nation's concerned effort to bring better medical attention to the aged and others in need.

The Public Law 88–129 and Public Law 581 programs are "problem solution" oriented—that is, they were conceived and have been aimed at overcoming the health manpower shortages in the health professions. While, to date, little or no attention has been directed toward measurement of quantitative effect of these programs on the national economy, it is certain that a significant impact will be realized; studies designed to evaluate such effects will be pressed forward as expeditiously as possible.

The economic impact of the increased construction (procurement of materials, labor, equipment, real estate, and other services) is noteworthy. Graduates from these professional schools can be expected to

offset their costly education in a few years by increased personal incomes which will continue throughout their professional careers.

Further, these additional professionals will make it possible to expand the utilization of a multiplicity of medical care facilities, thereby helping to generate additional increases in goods and services associated with these facilities. The expansion will, of necessity, provide for further augmenting the labor ranks of the paramedical occupations.

Those persons in need of medical care can look to the future and expect improvement as one of the products of the programs under consideration; these improvements can certainly, in time, be measured by increases in life span and concomitant additions to the GNP.

10. Economic classification of program expenditures. (See table 2.)

Program: Construction of teaching facilities, health professions and nurses.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:[1]	
Grants to State and local governments	49,925
Transfer payments to individuals and nonprofit organizations	33,283
Total Federal expenditures	83,208
Non-Federal expenditures financed by:	
Nonprofit institutions of higher learning	90,000
Total expenditures for program	173,208

[1] Expenditures here refer to obligations.

UNIVERSITY-AFFILIATED FACILITIES FOR THE MENTALLY RETARDED

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The program objectives are to provide Federal support in the construction of clinical facilities that provide a full range of inpatient and outpatient services for the mentally retarded which will either aid in demonstrating provisions of specialized services for the diagnosis and treatment, education, training or care of the mentally retarded or in the clinical training of physicians and other specialized personnel needed for research, diagnosis and treatment, education, training or care of the mentally retarded. This grant program assists applicants in the construction of facilities which are associated with a college or university. The main goal of the construction grant program is: (1) to provide additional numbers of trained personnel in all disciplines needed to staff and provide services to the mentally retarded in community facilities; and (2) to produce an adequate number of professionals who will become teachers and trainers in the various disciplines to staff training facilities located at universities and training centers associated with colleges or universities.

2. Operation

The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164) authorizes

grants to accomplish the foregoing objectives which may not exceed 75 percent of the necessary cost of construction. Applicants must provide assurance that financial support will be available for construction of the project to cover the non-Federal share of cost and for its maintenance and operation when the project is completed. The Surgeon General has appointed a Subcommittee on Construction of University-Affiliated Facilities for the Mentally Retarded. The subcommittee submits recommendations to the Surgeon General for action to be taken on applications submitted in accordance with the regulations issued pursuant to the provisions of the act, title 42, chapter I, subchapter D, part 54, subpart A. The six members of the subcommittee are outstanding experts in disciplines interested in the field of mental retardation.

Applications for assistance under the act are submitted to the Division prior to scheduled subcommittee meetings. Staff, assigned to the program, review applications, consult with the subcommittee and offer suggestions for improvement, and review proposed plans and specifications.

Funds are allocated to those projects in which applicants propose exemplary interdisciplinary training programs of professionals who will either provide direct services to the mentally retarded or provide training of teachers in the disciplines needed for care and treatment of the mentally retarded.

The criteria followed and the provision of staff assistance are concerned with whether the proposed clinical facility will provide a full range of inpatient and outpatient services, as nearly as practicable, and whether the proposed training programs will serve as interdisciplinary models of excellence and provide appropriate settings for professional training. The emphasis is upon quality, both in service and in professional training, which promotes the recruitment of professional personnel for work in mental retardation. Grants may be made only for that portion of a university-affiliated facility which the Surgeon General determines to be attributable to the needs for demonstration and training purposes. The construction phase of the program is administered through regional offices, with Washington office supervision and technical assistance given when the need is indicated.

3. History

Part B, title I, Public Law 88–164, which was approved on October 31, 1963, authorized programs to assist colleges and universities in the construction of clinical facilities providing, as nearly as practicable, a full range of inpatient and outpatient services for the mentally retarded which would either demonstrate provisions of specialized service for the diagnosis and treatment, education, training or care of the mentally retarded or would help in the clinical training of physicians and other specialized personnel needed for research, diagnosis and treatment, education, training or care of the mentally retarded.

The act authorizes appropriations in the total amount of $32½ million over a 4-year period beginning with fiscal year 1964. Congress has appropriated $5 million for fiscal year 1964, $7½ million for fiscal year 1965, and $10 million for fiscal year 1966. Six applications have been approved which total $8,455,560. A portion of the balance, $14,044,440, may be obligated in November 1965 after the subcom-

mittee has made recommendations to the Surgeon General on six projects which total $12,857,749. At the present time, applications have been received and are being reviewed by the staff which request Federal assistance in the approximate amount of $5 million. Information has been received that 20 additional applicants will submit applications for Federal assistance in the amount of $60 million. These applications are in various stages of development, and applicants are receiving staff assistance in the development of training programs and plans and specifications.

4. Level of operations. (See table 1.)

Program: University-affiliated facilities for the mentally retarded.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure and unit [1]	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 [2] estimate
(a) Magnitude of the program (projects funded)		5	7	5
(b) Applicants or participants:				
State government agencies (projects funded)		2	3	2
Local communities or governments				
Individuals or families				
Other, voluntary nonprofit (projects funded)		3	4	3
(c) Federal finances:				
Unobligated appropriations available	$5,000	$12,500	$15,277	$10,000
Obligations incurred		$7,223	$15,277	$10,000
Allotments or commitments made (appropriation)	$5,000	$7,500	$10,000	$10,000
(d) Matching or additional expenditures (matching)		$2,556	$4,800	$3,000
(e) Number of Federal employees (man-years)	3	5	7	8
(f) Non-Federal personnel				
(g) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.

5. Estimated magnitude of the program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The Division of Hospital and Medical Facilities in the Public Health Service has administrative responsibility for the program. Coordination is maintained and full cooperation is given to Federal agencies responsible for programs involving mental retardation. These agencies are:

Office of Education;
Office of Vocational Rehabilitation;
Welfare Administration, Children's Bureau;
National Institute of Child Health and Human Development;
Division of Chronic Diseases.

8. Laws and regulations

Public Law 88–164 approved October 31, 1964 (enabling legislation).
Public Law 88–268 approved February 10, 1964 ($5 million appropriated for fiscal year 1964).

Public Law 88–605 approved September 9, 1964 ($7½ million appropriated for fiscal year 1965).

Public Law 89–156 approved August 31, 1965 ($10 million appropriated for fiscal year 1966).

Title 42, public health, chapter 1, subchapter D, part 54, subpart A (regulations published September 5, 1964).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

An estimated 3 percent of the population is retarded. By 1970 we will have at least 1 million more retarded persons. Deaths at birth have been reduced by 75 percent in the last 20 years as a result of advances in medical science, but the prevalence of mental retardation has steadily increased. Over 700,000 draftees were rejected as unfit for military duty during World War II because they were mentally deficient. The number of retarded who could not participate in the war effort was even greater.

The Nation cannot afford the impact on the economy of this waste of human resources. Although the contribution that the retarded can make to the growth of the GNP has not been measured, it can be stated that the Nation is being denied the benefit of the work product of these individuals. To reverse this trend, more trained professional personnel are needed to determine the causes of mental retardation, prevent and reduce the incapacity, where possible, and prepare the retardate for a useful role in society and industry.

10. Economic classification of program expenditures. (See table 2.)

Program: University-affiliated facilities for the mentally retarded.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government: [1]	
Grants to State and local governments	3,363
Transfer payments to nonprofit organizations	3,860
Total, Federal expenditures	7,223

[1] Expenditures here refer to obligations.

COMMUNITY FACILITIES FOR THE MENTALLY RETARDED

(Title I, Part C, Public Law 88–164)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist States and communities in providing adequate community facilities and services for the mentally retarded, through a construction program for diagnostic and evaluation clinics, day facilities, and residential facilities providing the following services: diagnosis, treatment, education, training, custodial care, sheltered workshop.

2. Operation

The program is a formula grants program administered at the Federal level by the Division of Hospital and Medical Facilities, Public Health Service, and at the State level through an officially designated State agency. A State advisory council is required to advise and consult with the State agency for carrying out the provisions of title I, part C, of Public Law 88–164.

Funds allocated to the States become available for distribution upon the submission and approval of the State plan. The State plan presents a program for the construction of facilities for the mentally retarded which is based on a statewide inventory of existing facilities and survey of need. The State plan sets forth the priority of projects on the basis of the relative need for facilities in the area to be served by the project, taking into consideration existing facilities and services.

Individual projects are entitled to Federal financial assistance provided they conform with the State plan and have the approval of the State agency administering the program and of the Public Health Service. Applications may be for new construction or replacement, expansion, remodeling, or alteration of existing buildings. The Federal share ranges from one-third to two-thirds of the eligible costs of construction and equipment. Payments of the Federal share are made on the basis of work completed as determined by inspections of the project by the State agency.

3. History

The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88–164) was enacted in response to the report of the panel of outstanding consultants appointed by President Kennedy in 1961 to develop a national plan to combat mental retardation.

Title I, part C, of this legislation provides grants to States for assistance in the construction of specially designed public and nonprofit facilities for the diagnosis, treatment, education, training, or custodial care of the mentally retarded, including sheltered workshops which are a part of facilities providing comprehensive services for the mentally retarded.

The act authorizes the appropriation of a total of $67½ million over a 4-year period beginning with fiscal year 1965. Appropriated funds have been allocated to States on a formula basis for fiscal years 1965 and 1966. State plans, a legal requirement for the utilization of allocated funds by States, have been received by the Public Health Service from 25 States. Assistance is provided State agencies on the techniques and procedures involved in the development of State plans through central office guidelines and consultation with State agencies by central office and regional office staff.

Ten State plans have been approved, and 15 others are in various stages of review. It is anticipated that approximately 7 of the 15 presently being reviewed will be approved by the first of November.

No applications for the construction of community facilities for the mentally retarded have been approved as of this date [November, 1965]. Partial returns of a recent inquiry show that at least 175 potential applicants exist at this time, as indicated by actions ranging from responsible inquiries received by State agencies to submission of applications.

4. Level of operations. (See table 1.)

Program: Community facilities for the mentally retarded (title I, part C, Public Law 88–164).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure and unit [1]	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 [2] estimate
(a) Magnitude of the program (projects approved)			50	50
(b) Applicants or participants:				
State government agencies (projects approved)			15	15
Local communities or governments (projects approved)			10	10
Individuals or families				
Other, voluntary nonprofit (projects approved)			25	25
(c) Federal finances:				
Unobligated appropriations available		$10,000	$22,500	$24,000
Obligations incurred			$13,500	$14,000
Allotments or commitments made (appropriation)		$10,000	$12,500	$15,000
(d) Matching or additional expenditures (matching)			$13,500	$14,000
(e) Number of Federal employees (man-years)	2.5	26	30	34
(f) Non-Federal personnel	[3]	[3]	[3]	[3]
(g) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The Division of Hospital and Medical Facilities in the Public Health Service has administrative responsibility for the program. Coordination is maintained through participation in the review of State plans by the following agencies at the central office and regional office levels:

Office of Education, Division of Handicapped Children and Youth.
Vocational Rehabilitation Administration, Division of Rehabilitation Facilities.
Welfare Administration, Children's Bureau.
Public Health Service:
Division of Chronic Diseases.
National Institute of Mental Health, Community Mental Health Facilities Branch.

8. Laws and regulations

Public Law 88–164.

[In millions]

	Fiscal year 1965	Fiscal year 1966	Fiscal year 1967	Fiscal year 1968
Authorized appropriation	$10	$12.5	$15	$30
Appropriated	10	12.5		

NOTE.—Total authorized appropriations, $67,500,000.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See overall statement from Office of the Surgeon General.)

As noted above, about 3 percent of the population of the United States are mentally retarded. About one-third of this 3 percent, or 1 percent of the total population, are in need of the services which may be housed in facilities for which Federal assistance is available for construction under this program. Approximately 25 percent (500,000) of this number are already receiving some form of care and treatment with considerable drain on family and community resources. Additional facilities are needed to house services for 1.5 million retarded persons. Since these persons would need services the year around, this number compares with 1.43 million average daily census in 1964 in hospitals of all types in the United States as reported in the Guide Issue of Hospitals on August 1, 1965.

In addition to the vast sums expended for the care and treatment of the mentally retarded, the Nation is denied a large amount of economic output because of the underachievement, underproduction, or complete incapability of the mentally retarded. The impact on the national economy becomes more significant when it is considered that an estimated 126,000 babies born each year will be regarded as mentally retarded at some time in their lives.

10. Economic classification of program expenditures

Not operating in fiscal 1965.

Hospital and Medical Facilities Construction

(Appalachian Program)

(Secs. 204 and 214)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To assist the Appalachian States in providing adequate hospitals and medical facilities through comprehensive and coordinated plans, programs, and priorities, giving due consideration to other Federal, State, and local health facility planning in the Appalachian region.

2. Operation

The President's Appalachian Regional Commission was established on April 9, 1963. In establishing the Commission, the President realized the intense economic distress of the region, and called for a new joint commitment of efforts by Federal, State, and local governments and private agencies to deal more effectively with this problem.

The Commission is to prepare a comprehensive program for the economic development of the Appalachian region, consult with the appropriate Federal agencies and with the Governors of the affected States, and implement a plan for comprehensive remedial action.

This program provides that, in order to demonstrate the value of adequate health and welfare facilities to the economic development

of the regions, the Secretary of Health, Education, and Welfare is authorized to make grants for the construction, equipment, and operation of multicounty demonstration health facilities. Grants for such construction shall be made in accordance with the applicable provisions of title VI of the Public Health Service Act and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, without regard to any provisions therein relating to appropriation authorization ceiling or to allotments among the States. No grant for construction shall exceed 80 percent of the cost of the project. Grants for operation may be made up to 100 percent of the costs thereof for a 2-year period. For the next 3 years of operations such grants shall not exceed 50 percent. No grants may be made after 5 years following the commencement of operations.

Supplements to Federal grant-in-aid programs are provided for in section 214 of the act and in order to enable States and local communities to take maximum advantage of Federal grant-in-aid programs for which they are eligible but for which, because of their economic situation, they cannot supply the required matching share. The Secretary of Commerce is authorized, pursuant to specific recommendations of the Commission, to allocate funds to the heads of departments of the Federal Government responsible for the administration of such Federal grant-in-aid programs. Funds so allocated shall be used for the sole purpose of increasing the Federal contribution to projects under such programs above the fixed maximum portion of the cost of such projects otherwise authorized by the applicable law. Funds shall be so allocated for Federal grant-in-aid programs for which funds are available under the act authorizing such programs. Further, the Federal portion shall not be increased to exceed 80 percent of project costs.

3. History

The Appalachian region of the United States, while abundant in natural resources and rich in potential, lags behind the rest of the Nation in its economic growth and its people have not shared properly in the Nation's prosperity. The region's uneven past development, with its historical reliance on a few basic industries and a marginal agriculture, has failed to provide the economic base that is a vital prerequisite for vigorous, self-sustaining growth. The State and local governors and people of the region understand their problems and have been working and will continue to work purposefully toward their solution. The Congress recognized the comprehensive report of the President's Appalachian Regional Commission, documenting these findings, and concluded that regionwide development is feasible, desirable, and urgently needed.

The purposes of this program are, therefore, to assist the region in meeting its special problems, to promote its economic development, and to establish a framework for joint Federal and State efforts toward providing the basic facilities essential to its growth and attacking its common problems and meeting its common needs on a coordinated and concerted regional basis. As the region obtains the needed physical and transportation facilities and develops its human resources, it is anticipated that the region will generate a diversified industry, and that it will be able to support itself through the workings of a strengthened free enterprise economy.

4. Level of operations. (See table 1.)

Program: Hospital and medical facilities constructions (Appalachian program).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure and unit [1]	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 [2] estimate
(a) Magnitude of the program (projects approved)			2	50
(b) Applicants or participants:				
State government agencies (projects approved)			1	10
Local communities or governments (projects approved)			1	15
Individuals or families				
Other, voluntary nonprofit (projects approved)				25
(c) Federal finances:				
Unobligated appropriations available		$20,875	$20,875	$19,375
Obligations incurred		0	$1,500	$19,375
Allotments or commitments made (appropriation)		$20,875		$2,500
(d) Matching or additional expenditures (matching)			$500	$6,800
(e) Number of Federal employees (man-years)		1	10	10
(f) Non-Federal personnel		[3]	[3]	[3]
(g) Other measures of performance				

[1] See committee inquiry for definitions.
[2] President's budget.
[3] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The Division of Hospital and Medical Facilities has extensive working relationships with other programs throughout the Public Health Service and other units of the Department which have responsibility in the health facility construction field. For example, frequent cooperative efforts are made with the Appalachian Regional Commissions, Hill-Burton authorities, in both the central and regional offices, and the National Institute of Mental Health.

8. Laws and regulations

For the period July 1, 1965, through June 30, 1967, Congress appropriated $41 million for construction and $28 million for operation of comprehensive health facilities.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The Appalachian Regional Development Act should have a tremendous impact upon the local community by: (1) providing jobs with the construction of health facilities, (2) increasing sales and manufacture of hospital and health facility equipment, (3) adding supporting jobs in the local communities, (4) attracting professional and technical staff personnel, and (5) improving health of local citizens

to provide additional needed labor force. Collectively the above would financially boost the local economy.

10. Economic classification of program expenditures

No expenditures were made in fiscal 1965.

DIRECT OPERATIONS

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The mission of the programs in the community health area is to foster the availability of the best health services for the people when they need them and where they need them.

The objectives of many community health programs have been described in one fashion or another under programs supported by grants. However, there are three programs which will be described more fully in this section.

Accident prevention.—Accidental injury and death constitute a major problem of public health with far-reaching social, economic, and medical implications. Injuries resulting from accidents are the leading cause of death among children and young adults in the United States, and they rank fourth as a cause of mortality in the total population. Accidents kill 95,000 Americans a year, and injure 45 million. Motor vehicle accidents alone accounted for 48,000 fatal injuries in this country last year.

The injury control program administered by the Public Health Service is aimed at minimizing this loss of life and the injuries caused by accidents, and alleviating insofar as possible the effects of injury-producing accidents as these occur. Basically, accidents are caused by specific things that people do or fail to do, or by errors and momentary behavioral lapses. Successful applications of effective control measures have demonstrated over and over again that accidental injuries are preventable. The injury control program is designed to prevent accidents by developing and applying adequate preventive measures. This involves research aimed primarily at the human aspects of accident causation and the application of proven control measures through public health channels. The program is designed to minimize the effects of accidental injuries by assuring adequate emergency medical services for the accident victim between the time of his injury and the initiation of medical treatment.

Dental diseases.—The Division of Dental Health seeks to protect and improve the dental health of the American people by stimulating the widespread application of health knowledge. The objective of the Division is to conquer dental disease in the same way that certain communicable diseases have now been conquered. At the present time, dental disease is so prevalent that less than 5 percent of our population has achieved optimum dental helath.

The efforts of the Division are concentrated in four areas: control of dental disease; economics of dental care; improvement in the quantity and quality of dental care; research and development in dental health, materials and technology.

Medical Care Administration.—This Division was established on August 11, 1965. Its creation was precipitated by the passage of Public Law 89-97, the Social Security Amendments of 1965. The

Division is the focal point for liaison between the Public Health Service, the Social Security Administration, and the Bureau of Family Services, Welfare Administration, in the establishment and maintenance of standards for the professional health aspects of the health insurance for the aged program (title XVIII) and the medical assistance program (title XIX).

Health Insurance for the Aged.—The Secretary of Health, Education, and Welfare will enter into agreements with State agencies, under which these agencies will determine and certify that hospitals, extended care facilities, home health agencies and independent laboratories meet and continue to meet conditions for participation in the program. In addition to certification, the State agency, which is usually the health department, will give consultation to assist providers who have difficulty in meeting and maintaining the standards. The State agency will also perform certain coordinating functions to insure that the health insurance program is closely integrated with ongoing or new health and medical care activities within the States.

Standards for the four kinds of providers of service mentioned above are being drafted by joint work groups of the Public Health Service and the Social Security Administration. These work groups are chaired by staff of this Division. After review by appropriate advisory groups and the Health Insurance Benefits Advisory Council, these standards will be revised and subsequently included in regulations promulgated by the Secretary. Another joint staff working group responsible for principles and methods applicable to reimbursement for the health benefits is also chaired by the Public Health Service.

The hospital and home health services benefits of this program will be available on July 1, 1966. The extended care facilities benefit becomes available January 1, 1967. The number of potential beneficiaries in 1966 is 19 million.

Medical Assistance.—Title XIX of Public Law 89–97 makes sweeping changes in the Federal-State medical assistance programs with complementary relationships to the title XVIII program. This Division will give consultation and technical assistance to the Welfare Administration in such matters as:

1. The formulation of standard, and conditions of participation for providers of health services, including the extent to which conditions of participation for title XVIII will be applied in title XIX. Because the latter has a potentially broader benefit structure and involves both State and Federal financing, the standards will not be identical.
2. The development of requirements relating to patient care planning, including transfer agreements, utilization reviews and other mechanisms for assuring use of the most appropriate resource for a patient at a given time.
3. The development of optimal relationships between State health and welfare agencies.

Statistical data on the number of public assistance beneficiaries are not presented. This program, unlike title XVIII, gives States several options and provides for progressive phasing-in features which make such forecasts of doubtful value, especially by an agency whose relationship to the program is largely consultative.

Home Health Services Development.—Under the health insurance program, the aged are entitled to home health services as part of their benefits. At present, however, sufficient resources are not available to meet the needs of this age group, much less the needs of the entire population.

The Public Health Service, for several years, has made funds and technical assistance available to State and local agencies which provide home health services: health departments, visiting nurse associations, hospitals, and other types of agencies. This effort is now being enlarged to help existing agencies expand their programs and to help new ones organize in advance of July 1, 1966, when the benefit becomes available.

The network of existing agencies within which home health services can be expanded and developed include 1,700 State and local official health agencies, 700 visiting nurse associations, 50 combination agencies, and 100 multiservice agencies including 70 programs administered by hospitals. Many more are needed. At present, only about 16 percent of the aged who need this type of care are able to secure the service.

The basic service included in the health insurance home health services benefit is skilled nursing care. Agencies must also provide one or more therapeutic services to be certified as providers. Only a minimal number of the nursing organizations provide these other services: physical, speech, and occupational therapy; medical social service; and home health aid services. The accelerated development program will help agencies add these services to their armamentarium.

The characteristics of this home health program have special significance for investment in human resources as well as in economic benefits. This program in a sense is an antidote to the overproliferating hospitalization and institutional system. At the same time, the coordination by a single agency of a multiplicity of services for a patient at home should tend to give to home care some of the same qualities of excellence generally, if not always deservedly, attributed to hospital care. For the physician, his patient, or the patient's family, shopping throughout the community for the many services a patient at home is likely to need is so time consuming and difficult that it is likely to be self-defeating. Surveys of hospitals and extended care facilities repeatedly reveal patients who could be cared for in less costly surroundings.

Nursing Homes and Related Facilities.—The health insurance for the aged program will meet a small portion of the needs of older persons commonly referred to as nursing home care. The "extended care facility" benefit is designed to meet the immediate short-term post-hospital needs of older persons who still require inpatient medical or nursing care or rehabilitation services. The period during which the benefit is payable is limited.

Standards prescribed by law include 24-hour nursing service. Only a small percentage of institutions which the general public considers nursing homes will meet this standard. Thus, it is not the intent of the law to meet the long-term needs for institutional care of sick aged persons or the needs of well aged persons who may, because of infirmity, lack of relatives or other reasons, need domiciliary or custodial care. The Division will have a twofold purpose concerning nursing home care: (1) to assist with activities related to the health insurance

program; and (2) to continue efforts to upgrade the 23,000 nursing home establishments of all kinds which now provide care to about 500,000 persons. Both purposes will require activities related to augmenting and improving staffing patterns and performance in the several kinds of institutions.

Fortunately, the health insurance program will meet the reasonable cost of care. Nursing homes in the United States developed, for the most part, after passage of the Social Security Act in 1935. They are a fairly direct result of a prohibition in that law against assistance payments to inmates of public institutions and of a maximum on payments in which the Federal Government could share. Thus, the almshouse established in colonial days was in the midtwenties displaced in large part as a result of Federal law. Now titles XVIII and XIX of Public Law 89–97 will set in motion standards and moneys which again will play a part in the future facilities to be developed.

Improving Medical Care Administration.—The broad purposes of the Division are an outgrowth of 5 years effort in the specific areas of medical care administration and health economics. Through research, studies, demonstrations, and technical assistance, staff recently transferred to form this Division have developed and promoted concepts and methods related to organization, interrelationships, delivery, quality and evaluation of public and private personal health services. Concurrently, through the same mechanisms, systems of financing costs of services and methods of payment for personal and public medical care programs have been analyzed. Research studies and demonstrations have also been carried on concerning the effects of social and economic factors on the volume, services, and economic productivity of such programs.

2. Operation

In carrying out its mission, the Community Health program utilizes a wide variety of techniques.

These may be broadly classified under grants or financial assistance, and direct operations or technical assistance. The grant programs are described in the preceding portion of this report. The direct operations are described in this portion of the report. For budgetary analysis, the direct operations are broken out into several areas: research, training, technical assistance, review and appraisal of grants, and program direction.

There are more than 4,000 persons in the Bureau located in eight divisions:

Division	*Number*[1]
Total	4, 510
Accident Prevention	153
Chronic Diseases	850
Communicable Disease Center	2, 225
Community Health Services	276
Dental Health	219
Hospital and Medical Facilities	336
Medical Care Administration	97
Nursing	153
BSS–CH Management Fund	199
Gift Funds	2

[1] Budget positions, fiscal year 1965.

In each of the nine regional offices operated by the Department of Health, Education, and Welfare in Boston, New York, Charlottesville, Atlanta, Chicago, Kansas City, Dallas, Denver and San Francisco there is an Associate Regional Health Director for Community Health Services. He is supported by various program specialists from each of the Community Health Divisions who furnish technical assistance and leadership to the community health programs in the States in the region.

How most of the programs of the BSS(CH) operate is described in other sections of the report. However, it seems desirable to present more information about the injury prevention program.

The injury control program of the Division of Accident Prevention provides technical leadership to health departments in the design, establishment, and operation of services aimed primarily at prevention. Guidance is provided in the development and testing of new preventive measures, in the application of these measures to the accident problem, and in the use of a wide range of public health resources for the prevention of accidental injuries. Twenty-seven State and territorial health departments now conduct full-time programs for the control of accidental injuries, and all State health departments provide some services in this field. Limited financial support is provided by the Division of Accident Prevention for demonstration and other types of projects in this field, for education and training of professional personnel in accident prevention, and for assignment of accident prevention specialists to health department staffs.

A major element of the program is the conduct and support of research relating to the causes and means of prevention of accidents. Research in this field is carried out directly by the Division, largely through contracts with universities and other scientific organizations, and by means of grants-in-aid. Intramural and extramural research in which the Division has participated has resulted in the wide acceptance of automobile seat belts, improved safety, improved standards for glass doors and the use of glass paneling in building, and greater acceptance of safety devices used in outdoor recreation.

The National Clearinghouse for Poison Control Centers, operated by the Division's Poison Control Branch, serves 550 of these centers throughout the country by providing prompt information on ingredients, toxicity, symptoms and findings, and treatment for the accidental ingestion of medicines and household products. A nationwide educational program aimed at preventing accidental poisonings is an element of the injury control program.

Description of Community Health Divisions

Office of Deputy Bureau Chief.—Administers Federal-State programs concerned with (1) the development of techniques for the application of scientific observations in the fields of biology and medicine; (2) the social and behavioral aspects of major health problems; (3) the organization and delivery of comprehensive community health services; (4) the development and effective utilization of professional, technical, and supplementary manpower; and (5) the planning, construction, coordination, and operation of hospitals and related medical facilities including teaching facilities for certain medical personnel to stimulate the widespread application of health knowledge; and (6)

assisting and supplementing State and local activities by direct operations or through grants-in-aid in the community health area. This office works with a variety of official agencies and professional and voluntary groups to define and develop effective ways of dealing with public health problems appropriate to the needs of communities.

Division of Accident Prevention.—Conducts technical assistance, education and intramural research programs to assist and encourage health departments and other public and private agencies to develop and operate community services aimed at preventing accidental deaths and injuries and at providing adequate emergency medical services for the sick and injured; investigates poisonings having public health implications and carries out measures to prevent accidental poisonings; operates the National Clearinghouse for Poison Control Centers; administers extramural research project and research training grant programs and communicates and fosters the application of research findings; cooperates with other PHS components in the development and/or operation of related programs.

Division of Chronic Diseases.—Conducts technical assistance, education, formula, and project grant and intramural research programs to prevent the occurrence and progression of chronic long-term illness (cancer, diabetes, heart disease, arthritis, kidney disease, neurological and sensory diseases, etc.) including mental retardation and the problems of the aged; provides consultation in specific coordinated chronic disease prevention and care services (home nursing, homemaking, dental and nutritional services, coordinated home care), referral services, multiple screening, periodic health appraisals, and restorative services (and promotes the elevation of standards of care in nursing homes); operates the National Clearinghouse on Smoking and Health; administers an extramural research grant program and communicates and fosters the application of research findings; cooperates with other PHS components in the development and/or operation of related programs.

Division of Community Health Services.—Conducts technical assistance, education, formula, project and training grant and intramural research programs to determine effective means of providing community health services through public and private channels, to promote improved organization, financing, and practices in public health and medical care administration, including services related to rural, migrant, metropolitan and school health; conducts program of counseling and referral of selective service medical rejectees; administers student loan programs for physicians, dentists, osteopaths, optometrists, and nurses; promotes programs for the continuing education of physicians and other health professionals; provides leadership in the development and conduct of public health education activities; assesses and projects medical and paramedical manpower needs and resources; administers extramural research project and research training grant programs and communicates and fosters the application of research findings; cooperates with other PHS components in the development and/or operation of related programs.

Communicable Disease Center.—Conducts technical assistance, education, training, project grant and intramural research programs to diagnose, prevent and control communicable and certain other preventable diseases and to train public health workers in methods and techniques of communicable disease prevention and control; adminis-

ters a program to eradicate the yellow fever (*aedes aegypti*) mosquito; operates an immunization program to provide vaccination against poliomyelitis, diptheria, whooping cough, and tetanus; maintains surveillance over communicable and certain preventable diseases and provides epidemic aid and epidemiological services; enforces the medical aspects of interstate quarantine regulations; produces, disseminates, and exchanges medical audiovisual materials; administers an extramural research grant program and communicates and fosters the application of research findings; cooperates with other PHS components in the development and/or operation of related programs.

Division of Dental Health.—Conducts technical assistance, education, formula grant, training and intramural research programs to prevent, control and treat dental diseases and disorders and to develop and improve the utilization of dental resources; assesses dental manpower supply, distribution, utilization and productivity and projects future manpower requirements; stimulates the development of modern organized dental health programs; administers extramural research project and research training grant programs and communicates and fosters the application of research findings; provides consultation on facilities planning and financing, the design of teaching and treatment facilities and on student loan programs and cooperates with other PHS components in the development and/or operation of these and other related programs.

Division of Hospital and Medical Facilities.—Conducts technical assistance, education, formula and project grant and intramural research programs to assist communities and nonprofit organizations in the planning, design, construction, modernization, equipping and operation of hospitals and related health facilities, university affiliated facilities for the mentally retarded, other facilities for the mentally retarded, community mental health centers (in conjunction with NIMH) and teaching facilities for the training of physicians, pharmacists, optometrists, podiatrists, dentists, and professional public health personnel; assesses health facility needs and resources and develops measures of adequacy for a comprehensive health facility system; assists communities in the areawide planning of health facilities to provide medical, diagnostic, preventive, treatment or rehabilitative services; administers an extramural research grant program and communicates and fosters the application of research findings; cooperates with other PHS components in the development and/or operation of related programs.

Division of Medical Care Administration.—Provides the focus in the Public Health Service for medical care administration activities in general, and for the administration of the professional health aspects of the health insurance for the aged program in particular. Administers operational and grant programs for the development, expansion, and improvement of medical care systems, services, and resources. Administers the professional health aspects of the health insurance for the aged program in such areas as standards, State and local agency activities, training, evaluation, studies, utilization review, and relationships with the National Medical Review Committee. Develops and implements an integrated approach to the planning, organization, administration, financing, and evaluation of medical care services and resources. Conducts and supports studies related to the health insurance program and to advance knowledge

and understanding in the field of medical care administration generally. Provides consultation and technical assistance to other related programs of the Department and to official, voluntary, and professional agencies and organizations in such areas of medical care administration as health insurance program administration, reimbursement, quality and standards of personal health services, patient care planning and management, administrative processes and methods in medical care settings, community and regional planning and coordination of medical care services and resources, health personnel and the economics of health, and education in medical care administration. Evaluates the impact of new and existing medical care systems, financial mechanisms, and services on the health services and resources of the country.

Division of Nursing.—Conducts technical assistance, education, training, formula and project grant, and intramural research programs to improve and augment public health and institutional nursing education and services, the utilization of public health nursing skills and public health nursing administration; administers the professional nurse traineeship program of financial aid to graduate nurse students in administration, supervision, and teaching; maintains a continuing review of national nursing needs and resources and projects future nursing requirements and supply; administers an extramural research grant program and communicates and fosters the application of research findings; provides consultation in developing program requirements and plans for the construction or remodeling of nursing education facilities and for student loan programs; and cooperates with other PHS components in the development and/or operation of these and related programs.

3. History

The concept of comprehensive health care gradually has come into clearer focus. The principal challenge was the development of health services which provide for the American people a level of health care commensurate with the Nation's scientific capabilities.

During the past two decades the Congress has authorized programs which have brought about great progress in this area.

The Community Health Services and Facilities Act of 1961 authorized the Service to support community studies and demonstrations to develop new and improved out-of-hospital services, particularly for the chronically ill and aged.

The Vaccination Assistance Act of 1962 authorized the Service to help States and communities carry out communitywide immunization programs against poliomyelitis, tetanus, diphtheria, and whooping cough. Measles has been added by later legislation.

Under the Health Professions and Educational Assistance Act of 1963 and its 1965 amendments, the Service assists schools of medicine, dentistry, and other health professions with grants for construction, educational improvement, and student loan and scholarship funds. The Nurse Training Act of 1964 aids schools of nursing.

With the enactment of the health insurance program for the aged (medicare), the Service was assigned responsibility that encompasses such matters as the vital question of standard setting, cooperative endeavors with the States and other agencies, and studies in the fields of health personnel and economics.

4. Level of operations. (See table 1.)

Program: Direct operations, Bureau of State Services—Community Health (summary).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure	1964	1965	1966 estimate	1967 estimate
(c) Federal finances:				
Obligations incurred:				
Direct research	$16,302	$17,396	$19,650	$22,314
Direct training	3,120	3,989	5,639	6,635
Technical assistance	25,281	33,893	52,917	56,669
Review and approval of grants	2,139	2,772	3,491	3,951
Program direction	1,790	1,998	2,288	2,829
Total, direct operations	48,632	60,048	83,985	92,398
(d) Matching or additional expenditures: Direct research [1] (total, direct operations)	12	16	18	22
(e) Number of Federal employees (budgeted positions):				
Direct research	1,354	1,479	1,490	1,546
Direct training	311	344	412	412
Technical assistance	2,178	2,241	2,646	2,864
Review and approval of grants	190	247	346	354
Program direction	199	199	214	229
Total, direct operations	4,233	4,510	5,108	5,405

[1] Gift funds, mostly from World Health Organization for special studies such as influenza, shigella, etc.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The Bureau of State Services, Community Health Divisions, as described earlier in this report, carry on their activities and programs in close cooperation with State and local health programs and with a variety of organizations and groups—public, professional, and voluntary. The following are examples of organizations with whom divisions work.

The Division of Accident Prevention has had a long and close association with the Bureau of Public Roads. The recent National Conference on Medical Aspects of Driver Safety and Driver Licensing was sponsored jointly by the American Medical Association, the American Association of Motor Vehicle Administrators, and the Public Health Service.

The Food and Drug Administration and the Bureau of State Services have developed procedures for the regular exchange of program information of mutual interest, including information from poison control records about outbreaks of selected communicable diseases.

The Division of Dental Health is cooperating with the Bureau of Standards and the National Institute of Dental Research to test, clinically, new dental materials and techniques.

The Division of Chronic Diseases maintains continuing working relations with many public, professional, and voluntary organizations: the American Medical Association, the National Society for Crippled Children and Adults, the American Hospital Association, and the American Nursing Home Association. The Division works closely with the National Interagency Council on Smoking and Health.

The Division of Hospital and Medical Facilities has established working relationships with more than 90 professional and voluntary business organizations; with more than 25 Federal departments and agencies; and with all of the State and local health departments, Hill-Burton agencies, mental retardation agencies, and mental health agencies.

The Division of Medical Care Administration maintains close liaison with the Social Security Administration. The development of standards for the hospitals, extended care facilities, home health agencies, and health laboratories which provide services to the aged has been an effort of many groups. The Public Health Service, which is responsible for the professional aspects of the program, and the Social Security Administration have sought and received the counsel of a great number of professional associations. Currently, the Public Health Service is carrying on discussions with the Welfare Administration with regard to the application of conditions for participation in title 18 (medicare) to the title 19 program, which greatly broadens coverage under the existing Federal-State program for medical assistance to the aged.

The Interagency Conference on Nursing Statistics is composed of representatives from the American Hospital Association, American Nurses' Association, Bureau of the Census, Bureau of Labor Statistics, the National League for Nursing, and the Public Health Service.

8. Laws and regulations

Division of Accident Prevention—PHS Act, as amended, particularly secs. 301, 314 (42 U.S.C. 241, 246).

Division of Chronic Diseases—PHS Act, as amended, particularly secs. 301, 311, 314, 316, 402, 403 and title XVIII of the Social Security Act (42 U.S.C. 241, 243, 246, 247, 282, 1391–1394).

Communicable Disease Center—PHS Act, as amended, particularly secs. 301, 311, 314, 317, 361, 363 (42 U.S.C. 241, 243, 246, 247b, 264, 266).

Division of Community Health Services—PHS Act, as amended, particularly secs. 301, 306, 309, 310, 311, 314, 316, title VIII (42 U.S.C. 241, 242, 242g, 242h, 243, 246, 247a, 294–294e, 296–298b, and Executive Order 11074).

Division of Dental Health—PHS Act, as amended, particularly secs. 301, 311, 314, 422 (42 U.S.C. 241, 243, 246, 288a).

Division of Medical Care Administration PHS Act, as amended, particularly secs. 301, 311, 314 and title XVIII of the Social Security Act (42 U.S.C. 241, 243, 246, 1395–1395 *ll*).

Division of Hospital and Medical Facilities:

A. Hill-Burton program, title VI of the PHS Act, as amended, and sec. 202 of the Appalachian Regional Development Act of 1965 (42 U.S.C. 247c, 40 U.S.C. app. 202).

B. Mental retardation construction program, Mental Retardation Facilities Construction Act. Part B and part C (42 U.S.C. 2661–65, 2671–2677, 2691–96.)

C. Health professions construction program, title VII, part B of the PHS Act (42 U.S.C. 293–293h).

D. Community Mental Health Centers, construction program—Title II of the Community Mental Health Centers Construction Act; section 202 of the Appalachian Regional Development Act of 1965. (42 U.S.C. 2681–2687; 40 U.S.C. app. 202).

E. Nursing schools construction program, title VIII, part A of the PHS Act (42 U.S.C. 296–296e).

Division of Nursing, PHS Act, as amended, particularly secs. 301, 311, and title VIII (42 U.S.C. 241, 243, 296–298f).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The following are illustrations of the economic effects of these programs:

The economic impact of accidents in the United States is virtually incalculable. Accidental nonfatal injuries require nearly 40 million people a year to seek medical care, and annually result in 107 million days of work lost and 13 million days lost from school. Accidental injuries impose enormous burdens on the Nation's medical treatment facilities. The number of visits to hospital emergency rooms necessitated by injury amounts to 10 million a year. The treatment of accident cases requires the use of 50,000 hospital beds and absorbs more than 18 million hospital bed days. The loss to the economy resulting from accidental deaths and disabling injuries, particularly within the work force, are of staggering proportions. Injury control programs in the Division of Accident Prevention have resulted in the reduction of injuries and deaths in selective areas where tested preventive measures have been applied. However, estimates concerning the economic value of such services are not yet available.

Receipt of dental care is very closely linked with income level. As a result of this, only 40 percent of the American public sees a dentist even once a year. To lower the cost barrier, plans of dental prepayment or insurance are being developed. The Division of Dental Health analyzes prepayment plans of various types in different parts of the country, serves as a clearinghouse of information on such programs, and offers consultative service to groups planning and developing dental insurance programs. Approximately 1½ million Americans are now covered by plans of this kind.

It is estimated that dental diseases account for a loss from work of 85 to 100 million man-hours a year. Prevention of dental decay and control of periodontal disease, which are now quite feasible, would reduce this toll by one-half to two-thirds.

The national bill for professional dental services is about 2.5 billion dollars a year. In cities with fluoridated water, the bill for children's dental care is half or less than half the amount in nonfluoridated cities.

It has been demonstrated that children in fluoridated cities require 30 percent less orthodontia than in nonfluoridated cities.

Some groups of patients—the aged, the chronically ill, the disabled, the handicapped, the mentally retarded and mentally ill—cannot as a rule seek dental care. The dental health programs are providing support to States and communities and dental schools so that such

care may be available and methods of caring for such groups can be developed. How many such people can be made more productive members of society cannot be readily calculated.

Expansion of job opportunities in the field of dental assisting has been a definite result of the programs in dental schools and junior colleges.

The primary benefit from the training branch program is the increase in the effectiveness of those professional health workers who attend training branch courses in their efforts to reduce the disability and mortality of infectious diseases.

The cost in human misery and death, as well as the cost to the Nation in man-days of labor, productivity, and wealth, is difficult to measure. However, some figures are available:

> The National Health Survey data indicated that, during the period 1963–64, there were over 30 million incidences of infective and parasitic diseases (excluding upper respiratory infections, such as the common cold and influenza, and the common childhood diseases). Among employed persons, these diseases alone extracted a total of 20,735,000 days lost from work.

However, there are some indications that an impact is being made. For example: (1) As a direct result of an educational seminar on viral hepatitis held in Indiana, five physicians changed their procedures for sterilizing instruments from boiling to autoclaving. This one change will considerably reduce the possibility of an outbreak of serum hepatitis among the more than 5,000 patients cared for by these physicians. (2) Another example can be found in the analysis of the cost benefit (medical, wage, burial) of U.S. tularemia control, 1950–1964. Training branch, CDC, in addition to training in the control of some 100 other vector-borne diseases, has done training in the control of tularemia since 1950. Since 1948, the incidence of this disease has decreased but still remains a serious problem. Reduction in incidence can be attributed to widespread control efforts at the State and local level to which training branch, CDC, furnishes support. As a conservative minimum, it is estimated that 1,000 cases per year (average considering that tularemia is highly cyclical) would have occurred had the control program not been effective. Cost benefits, 1950–64, from medical expenses, wage loss, and related costs alone total $7,803,000 which rises to $10,920,000 when population increase is taken into account. The total benefit in terms of the gross national product is probably much greater than this, especially if effects on tourism are calculated. The impact of the training branch activities in the field of vector-borne disease control becomes even more impressive when it is considered that the total budget for training in all vector-borne disease over the last 25 years has only been $3½ million.

Quality of hospital and medical care furnished to aged patients.—The program will enhance the quality of care furnished to aged patients because it will:

(*a*) Remove economic barriers to needed care and eliminate financial considerations from decisions concerning the need for hospitalization;

(*b*) Facilitate continuous medical supervision by the patient's own physician by guaranteeing free choice of institution;

(*c*) Provide for the establishment of national standards in consultation with appropriate professional and other organiza-

tions. These standards for health and safety will be a significant addition to the efforts of State licensing agencies to improve quality;

(*d*) Pay for the cost of quality care beyond minimum standards. The program offers a financial incentive for high quality care by operating under the principle of reasonable cost reimbursement for service provided;

(*e*) Pay for certification, consultation, and coordination services: certification to assure that standards are met, consultation to assist providers in meeting the standards, and coordination to integrate the health insurance program with ongoing or new health and medical care activities in each State.

Utilization of hospitals and related medical facilities.—An increase in days of hospital care for the aged resulting from the program has been estimated as 20 percent nationally, over and above the increases that would simultaneously occur through expansion of the population age 65 and over. Spread across all ages, the impact is expected to produce a national increase of 5 percent in bed occupancy.

The expansion in bed requirements will be uneven, community by community and hospital by hospital, affecting some more than others. There will be some shifting of geriatric patients, since the program will not finance care in nonaccredited hospitals. There may be shifts from public to voluntary hospitals resulting from the new resource for financing care privately. A variety of factors may be expected to alter the current patterns of care and increase the effective demand of the aged for hospital and nursing home care, including the requirement that there be effective utilization review committees functioning for each hospital and extended care facility.

When examining the impact of the program on utilization, there is a tendency to overlook the fact that a large proportion of the aged have had some kind or amount of voluntary hospital insurance and another segment has been eligible for care at public expense. While not all of those with voluntary insurance were adequately protected for the costs of care, it is probably true that the inadequacy of their coverage was not brought home to them until they had received hospital care. Effective demand could be said to have existed, then, for most of them. The same might be said of those whose care was publicly financed. Of the remainder some would have received all the care they required, in some cases at a sacrifice. Others would have had unmet needs.

Summing up, utilization of hospital care by geriatric patients is expected to rise, but is unlikely to expand markedly unless there is sudden expansion in the number of hospital beds. Dislocation in beds will undoubtedly occur, but the requirements for beds for acutely ill, younger patients will remain as a strong deterrent to unsound hospitalization of the elderly. Expansion of beds should not be undertaken without areawide planning to see if dislocations can be corrected through upgrading existing facilities, etc.

Extended care facilities.—Beginning in January 1967, there will be an increased demand for nursing home beds, since a means of financing will be available to many aged for the first time.

The shortage of nursing home beds will be a major problem, and the supply varies greatly from one part of the country to another.

The five States with the most beds average 42 beds per 1,000 persons over age 65. The five States with the fewest beds average 7 per 1,000. If all States were at the present higher level of beds, it would require an estimated 500,000 new beds.

There is currently a boom in nursing home construction. The new medical care program may be expected to stimulate the boom further so that the bed shortage may be somewhat alleviated in the future. When hospitals can convert closed wings into extended care facilities, some of the need will be filled without new construction.

Factors offsetting these pressures are the utilization review committee requirement and the provision of rehabilitative services which should shorten the nursing home patient's stay. The deductible of $5 a day for the 21st through 100th days of covered care may also have a deterrent effect.

Financing.—The program will alter the sources for financing hospital care by transferring from the private sector to the public sector most of the payments for hospital care of the elderly. It will result in increased use of hospitals by the aged; and, hence, increased hospital revenue from public funds. It also provides for payment of reasonable costs of care by State welfare programs, after July 1, 1967, a provision which will ultimately correct the inadequacies of welfare payments for hospitalization in most jurisdictions.

The program is also expected to change existing reimbursement arrangements among nongovernmental third-party agencies purchasing hospital care. The 77 Blue Cross plans may well adopt the Federal reimbursement formula when paying for care of persons under age 65. To the extent that insurance plans provide coverage to supplement the benefits provided by Public Law 89–97, this portion of care of the aged may also reflect the Federal approach to reimbursing hospitals.

The law also provides that reimbursement paid to hospitals will be on the basis of current costs. This language means that any inflation in hospital costs will be covered: heretofore the rate of reimbursement reflected a hospital's cost in a prior period and was seldom adjusted upwards to reflect the cost of care in the period during which the care was provided

Certain costs incurred by hospitals have not been recognized in many existing reimbursement formulas. Public Law 89–97 recognizes such costs, including nursing education, intern and residency training costs, and depreciation.

In summary, hospitals will be in an improved financial position for the following reasons:

1. They will be fully reimbursed for the actual cost of care (as defined);
2. Their occupancy rate will rise;
3. They will be paid at the current level of costs;
4. The costs of several hospital activities and some part of capital will henceforth be recoverable;
5. Some portion of their present bad debts will henceforth be paid in full.

Some hospitals will be adversely affected by the new law:

1. Overcrowding may occur.
2. Their costs may increase because of the upgrading of standards required to qualify under the law, and they may not be able

to modify reimbursement from third-party agencies other than Health Insurance Benefits to cover these added costs and to adjust charges to reflect their higher costs

3. If they cannot be accredited, their geriatric patient load will drop.

Home health services.—Public Law 89-97 introduces a new source of financial support to the field of services brought to the patient in his home. In so doing it will alter and expand the patient load that existing agencies have been serving as well as promoting the development of new home health agencies.

Health manpower.—Recent advances in medicine have resulted in marked changes in the structure of medical practice. Techniques and equipment for accurate diagnosis of illness and effective treatment have become increasingly numerous and complex. The technological achievements in medicine and the subsequent complex developments in the application of new knowledge have tended to increase specialization and fragmentation of medical practice. This, in turn, has led to an interdependence of a variety of personnel, including a multiplicity of paramedical professions. Diagnostic procedures now call for the services of medical laboratory and X-ray technicians as well as the physician and nurse. Effective disease prevention requires the services of the biostatistician, epidemiologist, sanitary engineer, and radiological health specialist, in addition to the physician, nurse, social worker, and public health worker. The country's expanding and aging population and the associated chronic illnesses require the combined services of the physician, professional and practical nurse, pharmacist, physical, speech and occupational therapist, home health aide, and social worker.

There are now about 3 to 4 million persons in the United States working in some aspect of health services in hospitals, clinics, health organizations, private offices, laboratories, and remaining places where medical and other health services are provided. Physicians, dentists, and professional nurses comprised two-fifths of the total in health occupations in 1960. Other professional health occupations with sizable employment are dietitians, pharmacists, hospital and dental laboratory technicians. Large numbers are also employed as practical nurses, aides, orderlies, and attendants.

The shortages in the supply of physicians, dentists, and nurses have been well documented. The supply of manpower in these areas can barely keep pace with the population growth, and the enactment of the health insurance program for the aged will impose additional demands.

It is generally recognized that increased and more effective use of auxiliary medical personnel will assist in the alleviation of current and projected shortages in the supply of key professional medical personnel.

10. Economic classification of program expenditures. (See table 2.)

Program: Direct operations, Bureau of State Services—Community Health (summary).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of State Services (Community Health).

TABLE 2.—*Economic classification of program expenditures for fiscal 1965*

[In thousands of dollars]

Program: Direct Research:	
Federal Government:	
Purchases of goods and services:	
Wages and salaries	$11,893
Other	5,519
Total Federal expenditures [1]	17,412
Program: Direct Training:	
Federal Government:	
Purchases of goods and services:	
Wages and salaries	2,766
Other	1,223
Total Federal expenditures	3,989
Program: Technical Assistance:	
Federal Government:	
Purchases of goods and services:	
Wages and salaries	17,908
Other	15,985
Total Federal expenditures	33,893
Program: Review and approval of grants:	
Federal Government:	
Purchases of goods and services:	
Wages and salaries	1,978
Other	794
Total Federal expenditures	2,772
Program: Program Direction:	
Federal Government:	
Purchases of goods and services:	
Wages and salaries	1,729
Other	269
Total Federal expenditures	1,998
Program: Total Direct Operations (sum of above):	
Federal Government:	
Purchases of goods and services:	
Wages and salaries	36,274
Other	23,790
Total Federal expenditures [1]	60,064

[1] Includes $16,000 of matching gift funds, mainly from World Health Organization.

SUPPLEMENTARY REPLY FROM OFFICE OF THE SURGEON GENERAL

ECONOMIC EFFECTS OF THE PROGRAMS OF THE BUREAU OF STATE SERVICES (COMMUNITY HEALTH)

This statement is supplied to the Joint Economic Committee of the Congress in response to question 9 (economic effects of the program). The Bureau of State Services (Community Health) has prepared a very extensive report for the Joint Economic Committee, responding comprehensively and in considerable detail to the committee's inquiry. However, the wide range of diversity in the programs of the Bureau of State Services precluded a sharply specific answer to question 9. This supplement to the Bureau's report is supplied as a response in broad terms, based in part, on Public Health Service publication No. 1178, "Economic Benefits From Public Health Services—Objectives, Methods, and Examples of Measurement." In part, the statement is

designed to indicate Bureau of State Service (Community Health) programs that have important economic effects that are not susceptible to measurement.

One approach to anticipating or appraising the economic effects of a health program is represented by Public Health Service publication No. 1178 (hereinafter identified as publication No. 1178). The two leading ideas in it are far from novel, but the document tries to show ways of utilizing them. The ideas are (1) that health services can pay off in terms of the productivity of workers whose early death is averted or whose sickness is avoided, shortened, or made less severe; and (2) that some types of preventive health service are much cheaper than the treatment which is needed if the preventive approach is not used.

A completely different economic approach considers, in a direct way, the contribution of health programs to the gross national product. The shortcoming of this idea is that the GNP is simply the total of what is paid for goods and services; and a statement that another $1 million worth of health services has been added to the GNP gives no clue as to whether this was relatively desirable or undesirable apart from the increase in GNP. For example, a million-dollar consignment of thalidomide would provide precisely the same direct increment to GNP as a million-dollar consignment of a clinically more trustworthy drug. Health services need to be appraised, if that be possible, in the light of the good that they do to people who receive them, whether the recipients are workers, prospective workers, retired persons, the hopelessly ill, or anyone else. From the standpoint of an overall appraisal of the economy and consideration of what the national effort is being used for, there is good reason for considering the health services component of GNP. This approach, however, does not provide an appropriate appraisal of the usefulness of health services to humanity.

In the fiscal year 1965, public and private expenditures for health services in the United States were $38,441 million, which amounted to almost 6 percent of the gross national product of about $650 billion. That expenditure for health services—which includes medical research, medical care, protection of the environment, etc.—breaks down as follows:[1]

Health expenditures	Amount (millions)	Percent
Total health expenditures	$38,441	100
Private expenditures (i.e., expenditures other than by governments)	28,492	74
Governmental expenditures	9,949	26
Federal Government expenditures	5,092	13
State and local government expenditures	4,857	13

While the importance of this expenditure to the GNP is certainly worthy of note, it is not the accent in this supplementary response to question 9.

The eight divisions here mentioned are the sections of the Bureau of State Services (Community Health) report.

[1] Data derived from figures in the following: (*a*) U.S. Social Security Administration, Social Security Bulletin, October 1965, pp. 5, 10 and 11; (*b*) U.S. Council of Economic Advisers, Economic Indicators, October 1965, p. 2. Omitted from the above data are the sums spent for income maintenance of the sick and their dependents, such as disability benefits for the long-term disabled under the social security insurance system, and public assistance (on a means-test basis) to the blind and the permanently and totally disabled.

1. RESEARCH GRANTS

Chronic diseases.—In terms of the effect on actual and potential patients, the economic impact of this research grant program is important both (*a*) from the standpoint of enabling people to remain productive for a longer period of years, and (*b*) from the standpoint of enabling them to be more productive, per day on the job, than they would be if they were employable but in poorer health. Measurement of the latter type of benefit from health services (greater productivity per hour or day) is a task recognized as desirable but not thus far achieved. (See publication No. 1178, pp. 7 and 14, where the problems of economic losses from mortality and morbidity are discussed.)

Communicable Disease Center.—The economic and other significance of CDC's research grant program cannot be assessed independently of other aspects of the control of communicable diseases. The United States has, by this time, brought various communicable diseases under a high degree of control through the efforts of the various levels of government, and through the efforts of private individuals, foundations, etc. In consequence, we tend to take for granted the freedom from heavy economic and other losses of, for example, a smallpox epidemic. However, there is an occasional opportunity to make meaningful estimates of the economic benefit when a breakthrough occurs in the control of a communicable disease, as happened recently with regard to vaccination against poliomyelitis. (See publication No. 1178, p. 7.) Somewhat less spectacular are the benefits from vaccination, sanitation, etc., where the means of control have been in use for a long time. With regard to vaccination, there are very marked external benefits—the economists' way of saying that, if vaccination is widespread but not universal, even the unvaccinated get substantial protection. (See publication No. 1178, p. 6.)

Community health services.—In this research grant program, the measurement of the comparative cost-effectiveness of two or more alternative ways of delivering the same sort of service is probably feasible but remains to be done. Likewise, it is probably feasible to measure the relative effectiveness of two or more ways of delivering the same sort of service in terms of a performance measure—that is, given that two approaches require expenditure of identical sums of money, which reaches the greater number of beneficiaries? (See publication No. 1178, p. 16, last two paragraphs.) Such studies remain to be done.

Dental health.—The economic impact of this research grant program is considered along with the economic impact of the formula grant program in dental health; topic 4, below.

Nursing.—This research grant program makes itself felt ultimately through improved patient care; and it thus needs to be considered along with other BSS(CH) programs related to nursing, especially the following: the nursing student loan program, the formula grant program for home health services, and the several training grant programs for nurses.

In publication No. 1178, page 11, the staffing pattern of nursing homes is used to illustrate the fact that, to an important extent, health services can be expanded without even a short-run reduction in the other services and goods produced by the economy. The report mentions that the unemployed—

do not include any conspicuous numbers of physicians or professional nurses; but consider for a moment the staffing pattern in nursing homes, with their heavy reliance on nurses' aids, orderlies, and attendants. If added funds were made available, to pay for nursing home care, vastly increasing the number of patients in nursing homes, the nursing homes would—even if they substantially increased their ratio of professional nurses and licensed practical nurses to the less skilled personnel—be able to acquire prospective aids, orderlies, and attendants by suitable selection from among the unemployed and brief training of them. There would thus be an increase in nursing home care without a proportionate decline in the other services and goods produced by the economy.

Hospital and medical facilities.—The ideas and practices emerging from this research grant program are best viewed as having their effect—economic and other—through nonresearch programs focused on the construction of hospital and medical facilities. The economic effect of the latter sort of programs is discussed in the Bureau of State Services—Community Health report, under, "Construction Grants."

2. FELLOWSHIPS

If these fellowships were viewed primarily as an education program rather than as a health program, the consideration of economic impact might be very different from what it needs to be in view of the fact that the fellowships are granted for furtherance of health. As a health measure, the fellowships have whatever economic impact is achieved through the health services ultimately rendered by the health professionals thus trained. This is a diverse and complex matter, not susceptible of estimation of such results as the prospective savings in the man-years of labor by prospective patients who are kept alive or made healthy. But the economic impact is both large and important.

For this program, publication No. 1178 as a whole is relevant, for the reason that the training of health professionals is essential to all types of health programs and makes itself felt through them. In addition, there are specific references in that report (such as that on p. 20), to the need for more personnel in the health professions, for greater effectiveness of health programs.

3. STUDENT LOANS

The economic impact is discussed in the BSS(CH) report.

The comment made above, regarding fellowships, is equally relevant here.

4. FORMULA GRANTS

The economic impact is discussed in the BSS(CH) report. The following additional comments are offered:

Cancer control program.—Substantial work has been done in estimating the economic burden of cancer. See the remarks in publication No. 1178, pages 4 and 7, and the estimates in volume II of the Report of the President's Commission on Heart Disease, Cancer, and Stroke. However, what needs to be done—as a first installment in estimating economic benefits from cancer control—is to study both the economic burden of the disease and the cost of its prevention, so far as they concern some category (such as cervical cancer) that is relatively specific as to site and is susceptible of early detection by mass methods and susceptible of effective treatment.

Dental health.—The economic importance of this formula grant program and of the dental health research grant program is documented by "The False Economy of Dental Neglect," which is chapter III of publication No. 1178 (pp. 18–23).

* * * the evidence available is convincing; our dental problem places a heavy financial burden on the economy, and much of this is due to dental neglect (Pub. No. 1178, page 19).

In the cited source, the problem stemming from dental neglect is discussed in terms of some of the major components and some of the major preventive measures.

5. TRAINING GRANTS

The economic impact is discussed in the BSS(CH) report. In addition, it should be noted that the most important economic impact of these programs is like that of the fellowship program (topic 2, above).

6. PROJECT GRANTS

The economic impact is discussed in the BSS(CH) report. Also, in broad terms, publication No. 1178 is relevant here, as it is in other health programs. In addition, the following comments are offered:

Cancer control program.—The comments made above, regarding the formula grant program for cancer control, are equally relevant here.

Immunization.—Insofar as the above comment regarding the Communicable Disease Center research grant program (in the BSS(CH) report) relates to vaccination, that comment is relevant here.

7. CONSTRUCTION GRANTS

As noted above, the economic impact is discussed in the BSS(CH) report. Also, in broad terms, publication No. 1178 is relevant here, as it is in other health programs.

8. DIRECT OPERATIONS

Illustrations are given of the economic effects of these programs in the BSS(CH) report.

Bureau of State Services—Environmental Health: Research and Training in Environmental Health

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

In fiscal year 1964, the Bureau of State Services (Environmental Health) through the Office of Resource Development initiated a program to provide extramural grants to stimulate and support research and training programs in environmental health at universities and other nonprofit institutions.

2. Operation

This is a program of grants to universities for the conduct of research and training in the field of environmental health.

3. History. (See item 1, above.)

4. Level of operations. (See tables 1 and 2.)

Program: Extramural program to support research and training in environmental health.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services—Environmental Health; Office of Resource Development.

TABLE 1.—*Level of operations or performance, fiscal years 1964–66*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate
RESEARCH			
4(a) (grants awarded)	23	50	80
4(b) other (universities)	20	40	50
4(c) obligations incurred	$1,608,000	$3,078,000	$4,719,000
4(d) (not applicable)			
4(e) (man-years)	6	10	16
4(f) (National Advisory Environmental Health Committee, 12 members)			
4(g) (not applicable)			
TRAINING			
4(a) (grants awarded)	36	46	55
4(b) other (universities)	24	31	40
4(c) obligations incurred	$1,519,000	$2,262,000	$3,578,000
4(d) (not applicable)			
4(e) (man-years)	6	10	12
4(f) (National Advisory Environmental Health Committee and Environmental Sciences Training Committee, 24 persons)			
4(g) (not applicable)			

TABLE 2.—*Level of operations or performance, for fiscal year 1967*

Measure	*Fiscal year 1967 estimate*[1]
(*a*) Magnitude of program (projects)	172
(*b*) Applicants or participants: Other (academic institutions)	90
(*c*) Federal finances:	
Obligations incurred	$11,372,000
Allotments or commitments	$11,372,000
(*d*) Matching or additional expenditures for the program (none, except cost sharing, per appropriations act)	
(*e*) Number of Federal Government employees administering, operating, or supervising the activity (man-years)	32
(*f*) Non-Federal personnel employed in the program (National Advisory Environmental Health Committee and Environmental Sciences Training Committee, 24 persons)	
(*g*) Other measures or magnitude of performance (not applicable)	

[1] Unlike the data for fiscal years 1964–66, those for 1967 are for research and training combined.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*)(i) Opportunity for coordination and cooperation arises in respect to: joint funding of extramural grant projects with the Divisions of the Bureau of State Services—Environmental Health (BSS–EH); cross-divisional utilization of research grant specialists on site visits; development of an advanced automatic data processing system to include all intramural and extramural research programs of BSS–EH Divisions; conduct of manpower need studies for BSS–EH Divisions; development of uniform BSS–EH-wide policy in respect to extramural

grant operations; stimulation of divisional programs supported by Public Law 480 funds.

(ii) The Office of Resource Development does the following: coordinates the BSS–EH activities supported by the foreign currency program (Public Law 480) through review of technical and budgeting aspects of proposed international agreement; provides policy guidance on extramural grant operations to other Divisions of BSS–EH through its Program Coordination Branch; maintains an automatic data processing program on extramural grant programs of BSS–EH through its Program Analysis Branch.

(*b*)(i) Opportunities for coordination and cooperation arise in respect to: Office of Resource Development participation in program of Division of Research Facilities and Resources, National Institutes of Health, by reviewing applications from universities conducting research supported by BSS–EH funds, and by advising the Division concerning universities which may submit applications for facilities grants as a result of BSS–EH supported projects: Office of Resource Development utilization of full supporting services provided by the Division of Research Grants, Public Health Service; development of a Department-wide automatic data processing system; Office of Resource Development utilization of resources of Office of Education on manpower studies.

(ii) Coordination and cooperation are promoted by informal meetings, frequent exchanges of information, and invitations to attend and participate in meetings of advisory committees where appropriate.

(*c*)(i) Opportunities for coordination and cooperation arise in respect to Office of Resource Development utilization of National Academy of Science-National Research Council.

(ii) Coordination and cooperation are promoted by joint organization of seminars and by means of Office of Resource Development extramural grants to National Academy of Science-National Research Council.

(*d*) Not applicable.

(*e*) Not applicable.

(*f*) Not applicable.

(*g*)(i) Opportunities for coordination and cooperation arise in respect to expanded participation of universities and other nonprofit agencies in environmental health research and training operations.

(ii) These activities are supported by financial grants. The Public Health Service manuals on administrative policies and procedures for extramural grant programs are used for this activity.

(*h*) Not applicable.

(*i*) Not applicable.

8. Laws and regulations

The legal basis for Office of Resource Development activities is section 301, Public Health Service Act as amended (42 USC 241) and CFR title 42, chapter 1.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The Office of Resource Development program utilizes extramural grants to universities and other nonprofit institutions for research and training in environmental health. While the program may have no direct bearing on the economy, it seeks to obtain knowledge that is essential to the development and maintenance of a healthful environment. On a long-term basis, therefore, the program may affect the economy through its beneficial influence on the health and well-being of man.

10. Economic classification of program expenditures. (See table 3.)

Program: Extramural program to support research and training in environmental health.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Bureau of State Services—Environmental Health; Office of Resource Development.

TABLE 3.—*Economic classification of program expenditures for fiscal year 1965*

Federal Government:	
Grants to State and local governments	$1,869
Transfer payments to individuals and nonprofit organizations	1,080
Total Federal expenditures	2,949

OFFICE OF PESTICIDES

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The Office of Pesticides plans, institutes, and directs the national program of the Public Health Service in the detection, assessment, control and reduction of potentially harmful and/or unnecessary exposure of man to pesticides.

2. Operation

The program encompasses (1) a field laboratory, (2) negotiated contracts (with State health departments, universities, research institutes) for pesticide research and support, (3) a direct operations staff (located in Washington), and (4) a headquarters staff (also located in Washington).

3. History

The program was established officially on November 27, 1964, by order of the Surgeon General, PHS. Prior to that date, the program had operated as a part of the Program Office of the Bureau of State Services—Environmental Health, since the spring of 1963, when one professional employee was assigned responsibility for the public health aspects of pesticides in the Bureau of State Services. The total staff had grown to about 15 employees by the date of establishment. The staff presently numbers 65. The first direct appropriation for the program came in fiscal year 1965.

4. Level of operations. (See table 1.)

Program: Office of Pesticides.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services—Environmental Health.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Contracts (number)	0	13	18	24
Field laboratories (number)	0	1	1	1
(b) State government agency participants (number)	0	10	12	17
Local government agency participants (number)	0	0	1	1
Private universities and research institutes (number)	0	3	5	5
(c) Appropriation	0	$2,394,000	$3,992,000	$7,319,000
Obligations	0	$2,394,000	$3,990,000	$7,319,000
Allotments	0	$2,394,000	$3,990,000	$7,319,000
(d) Matching or additional expenditures	0	0	0	0
(e) Federal employees (man-years)	0	24	66	115
(f) Non-Federal personnel (number)	0	72	90	120
(g) Other measures (pesticide registration applications)	0	13,250	15,000	15,000

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

A. Within the Bureau of State Services-EH, the program has been assigned responsibility for all matters relating to pesticides. The Divisions of BSS–EH regularly and routinely refer to the program for all such matters, and the program, in turn, cooperates fully with the Divisions. This working relationship has been most fruitful for all concerned.

B. Under a memorandum of agreement dated April 8, 1964, certain Government agencies, including PHS and the Food and Drug Administration, cooperate closely in matters relating to pesticides. Under this agreement, the program and FDA keep each other fully informed on pesticidal problems. The program also works closely with the Poison Control Center, PHS, in an evaluation of hazards posed by accidental ingestion of pesticides by people, particularly children. The program is increasingly cooperating with the National Institutes of Health, PHS, in an estimation of the potential hazard of pesticides to humans, particularly with reference to cancer, heart disease, and mental disease.

C. Under the memorandum of agreement referred to above, the program cooperates closely with the U.S. Department of Agriculture and the Department of the Interior in activities relating to pesticides. Further, the program furnishes the secretariat staff for the Federal Committee on Pest Control. This committee, composed of high officials from the Government agencies that are the principal users of pesticides, concerns itself with all federally sponsored pesticidal programs.

D. As shown in table 1, above, the program had contracts with 10 State government agencies in fiscal year 1965. This number will increase to 12 in fiscal year 1966.

E. As shown in table 1, above, the program anticipates establishing a contract with a local government agency (viz., city of Chicago Board of Health) during fiscal year 1966.

F. The program has no formal association with foreign governments or international organizations.

G. The program has contracts with one private university (viz., Tulane University) and one nonprofit institution (viz., Southwest Research Institute).

H. The program is enjoying increasing cooperation from the chemical industry, which is furnishing valuable data from its files to the pesticide registration staff. In turn the program advises the chemical industry on hazards to public health posed by individual pesticides.

I. The program handles an ever-increasing number of public inquiries relating to pesticides.

8. Laws and regulations

The program functions under Public Law 78–410, as amended, and receives its current appropriation from the Departments of Labor and Health, Education, and Welfare Appropriation Act, 1966, Public Law 89–156.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Although the pesticide program is new, having had funds for only 1 year, assumptions can be made about economic impact in general. Since pesticides contaminate all segments of the environment, it is estimated in the light of past medical findings that one-half of 1 percent of chronic diseases are the result of long-term, low-level exposure effects.

PHS community studies show that in certain areas, individuals under high exposure are improving safety and health practices to protect themselves and their environment. This will reduce lost time and acute illness episodes. It is too early to determine industrial and salary savings, but they should be in the millions of dollars as the program progresses.

10. Economic classification of program expenditures. (See table 2.)

Program: Office of Pesticides.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services—Environmental Health.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	1,110
Other	490
Total Federal expenditures	1,600

DIVISION OF AIR POLLUTION

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The objectives of the Division of Air Pollution program are to protect the Nation's air resources so as to promote the public health and welfare and the productive capacity of its population; to initiate and accelerate a national research and development program to achieve

the prevention and control of air pollution; to provide technical and financial assistance to State and local governments in connection with the development and execution of their air pollution prevention and control programs; and to encourage and assist the development and operation of regional air pollution control programs.

2. Operation

The Division of Air Pollution carries out its program research through direct Federal operation conducted in the field, primarily at Cincinnati, with headquarters supervision; by providing funds to support projects carried out by other Federal agencies; and by contracting with nongovernmental organizations and institutions and providing grants to individuals and nonprofit organizations. It also provides grants and technical assistance to State, regional, and municipal agencies to initiate and develop better air pollution control programs. An extensive short-term intramural training program for technical personnel is provided as well as training grants to institutions and individuals for academic training at specified universities.

3. History

The Federal air pollution program is a relatively recent one. The first statutory authorization for an organized, coordinated Federal program was the Air Pollution Research and Technical Assistance Act of 1955 (Public Law 84–159). The initial full-year appropriation made in 1956 to carry out this act was relatively small, $1,722,000. The principal research and technical assistance staff were located at the Robert A. Taft Sanitary Engineering Center, Cincinnati, Ohio, as a means of providing maximum support to this group in the form of necessary supporting services for laboratory work.

Since the enactment of Public Law 84–159, the legislative authorizations for the Federal air pollution program have increased substantially, and the program level has increased from $1,722,000 in 1956 to $26,622,000 appropriated in 1966, an increase of 1446 percent. The level of staffing has grown from 94 positions in 1956 to 609 positions authorized in 1966. Public Law 84–159, as amended, was replaced in 1963 by the Clean Air Act (Public Law 88–206), and this has recently been amended by Public Law 89–272 of October 20, 1965.

4. Level of operations. (See table 1.)

Program: Division of Air Pollution.
Department or agency, and office or bureau: Department of Health, Education and Welfare; Public Health Service; Bureau of State Services—Environmental Health.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollar amounts in thousands]

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(*a*) Magnitude of progress, excluding research grants (projects)	140	154	175	200
(*b*) Not applicable				
(*c*) Federal finances (obligations incurred):				
Research:				
Intramural	$4,432	$4,953	$5,334	$5,855
Contracts	2,405	2,907	3,595	5,465
Grants	3,851	4,600	5,339	6,958
Control grants		4,180	5,000	7,000
Survey and demonstration grants		765	1,850	2,000
Abatement activities		599	1,748	2,497
Technical services	873	1,235	1,441	2,639
Training:				
Direct	355	427	614	695
Grants	955	1,250	1,687	2,468
Total	12,911	20,916	26,608	35,577
(*d*) Matching funds		1,916	2,249	3,150
(*e*) Number of Federal employees (people)	414	525	609	775

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation.

The Division of Air Pollution—

(*a*) Coordinates in studies concerning community planning, urban renewal, pesticides, atmospheric analysis, and exchange of technical information with other divisions of the Bureau of State Services;

(*b*) Has an agreement with the National Center for Health Statistics, PHS to receive mortality data for use in air pollution epidemiology studies;

(*c*) Supports air pollution research by the Tennessee Valley Authority, the National Bureau of Standards, and the Bureau of Mines. Through funds provided by the Division, the Weather Bureau and the Department of Agriculture assign staffs to programs of the Division. The Library of Congress screens literature to obtain air pollution technical information. Arrangements are underway for a joint study with the Army of the disease syndrome "Tokyo Yokohama asthma". The General Services Administration is assisting in an automotive vehicular emission testing program sponsored by the Division. The Division also provides technical representatives and staff work for DHEW on the Interdepartmental Committee for Atmospheric Sciences (ICAS) and the Interdepartmental Committee for Applied Meteorological Research (ICAMR) which include membership by other Federal agencies. In connection with the responsibilities for preventing and controlling air pollution from Federal facilities, close cooperation has been received from all agencies;

(*d*) and (*e*) Provides technical assistance and program grants to air pollution control agencies at the State, local, and regional levels;

(*f*) Participates in international activities in the field of air pollution, including a wide range of participation of air pollution experts in international organizations, such as the World Health Organization (WHO), Organization for Economic Cooperation and Development (OECD), Economic Commission for Europe (ECE), Council of Europe (COE), World Meteorological Organization (WMO), European Coal and Steel Community (ECSC), and Eurotox, the loan of temporary advisers; presentation of technical papers at international meetings; exchange visits of key personnel; orientation and training of foreign nationals; the translation of foreign technical publications; and the international dissemination of U.S. reports on air pollution. The Division provides representation on the International Joint Commission—United States and Canada, which has been authorized to make investigations and recommend preventive or remedial measures for air pollution in the vicinity of the cities of Detroit and Windsor, Canada.

(*g*) Provides contracts and grants to universities and to nonprofit research institutes and public assistance organizations to ascertain the effects of air pollution on the population and to cooperatively provide abstracts of current literature on air pollution to about 4,000 technical personnel in the field;

(*h*) Enters into contracts for research concerning air pollution with business activities of all types which have competence in specialized areas of interest to the Division programs.

8. Laws and regulations

Public Law 88–206 (the Clean Air Act) and Public Law 89–272—the current laws providing appropriation authorizations, and title 42, part 56, Code of Federal Regulations (pertaining to grants for air pollution control programs).

Specifically, appropriation authority for current operation is provided under section 13 of Public Law 88–206 of December 17, 1963 and section 101, title I, Public Law 89–272 of October 20, 1965 (section 209, title II, Clean Air Act, as amended) (42 U.S.C. 1857–1857g).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Present efforts to desulfurize fossil fuels, revise chemical engineering technologies, devise new control devices, et cetera, to reduce or eliminate air pollution will have varying influences on the economy. For example, it is probable, that when automobile manufacturers add control devices to the 1968 model automobiles, this will increase the price to the consumer, as did the addition of safety devices to certain 1966 year models. On the other hand, it is quite possible that in revising a chemical manufacturing process to reduce pollution the new process could become more efficient or generate a salable by-product and thus become more economical.

10. Economic classification of program expenditures. (See table 2.)

Program: Division of Air Pollution.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services—Environmental Health.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	4, 172
Other	4, 259
Grants to State and local governments	5, 196
Transfer payments to individuals and nonprofit organizations	2, 685
Total Federal expenditures	16, 312

DIVISION OF ENVIRONMENTAL ENGINEERING AND FOOD PROTECTION

INTRODUCTION AND SUMMARY OF DIVISION ACTIVITIES

Total program.—The Division of Environmental Engineering and Food Protection has evolved from a series of reorganizations of sanitary engineering activities. The Division of Sanitary Engineering Services, the parent division for environmental health programs, was created in April 1954. As certain of the categorical engineering activities, notably water pollution, air pollution, and radiological health, gained sufficient stature, they were established as separate divisions in 1958, 1959, and 1960.

The Division carries out its mission to improve and protect public health and general welfare by: (1) conducting research, investigations, demonstrations, and training; (2) administering a grants-in-aid program; (3) providing consultation and technical services to other Federal, interstate, State, and local agencies to private industries, and organizations; and (4) developing program guides, model codes, ordinances, and standards. Program activities are administered by the Division Chief through six branches, from field research centers, and staffs assigned to the nine HEW regional offices. For a list of selected publications, see "Bibliography of Selected Publications on Environmental Engineering and Food Protection," published periodically by the Department of Health, Education, and Welfare—Public Health Service.

Legal basis.—Public Law 78–410, as amended, Public Health Service Act, particularly sections 301, 311, 314, 361 (42 U.S.C. 241, 243, 246, 264) and title II, the Solid Waste Disposal Act, Public Law 89–272. In this document, "Public Law 410" means Public Law 410 of the 78th Congress.

Source of funds. (See table 1.)

TABLE 1.—*Environmental engineering and sanitation—Appropriations available*

	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 [1]
Direct operations	$4, 350, 000	$4, 263, 000	$5, 930, 000
Grants	4, 720, 000	4, 907, 000	7, 899, 000
Total	9, 070, 000	9, 170, 000	13, 829, 000

[1] Estimate.

4. Level of operations. (See table 2.)

Program: Division of Environmental Engineering and Food Protection (summary).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services—Environmental Health.

TABLE 2.—*Level of operations or performance, fiscal years 1964–67*

Program activity	Fiscal year 1964		Fiscal year 1965		Fiscal year 1966 (estimated)		Fiscal year 1967 (estimated)	
	Unobligated appropriations available	Obligations incurred	Unobligated appropriations available	Obligations incurred	Unobligated appropriations available	Obligations incurred	Unobligated appropriations available	Obligations incurred
Grants (research, training, demonstration, and planning)	$4,720,000	$4,715,112	$4,907,000	$4,897,327	$7,899,000	$7,870,000	$12,595,000	$12,586,000
Review and approval of grants	161,000	159,888	162,000	160,976	135,000	135,000	135,000	135,000
Milk and food	1,440,000	1,437,354	1,357,000	1,343,000	1,538,000	1,524,000	1,553,000	1,550,000
Shellfish sanitation	1,589,000	1,575,700	1,545,000	1,539,000	1,732,000	1,712,000	1,742,000	1,740,000
Interstate carriers	816,000	803,000	839,000	824,000	1,079,000	1,069,000	1,109,000	1,100,000
Special engineering services	98,000	97,500	98,000	96,000	82,000	82,000	82,000	82,000
Solid wastes	70,000	67,800	71,000	66,250	994,000	990,000	4,250,000	4,220,000
Urban environmental health	176,000	174,000	191,000	189,500	370,000	368,000	505,000	500,000
Total	9,070,000	9,030,354	9,170,000	9,116,053	13,829,000	13,750,000	21,971,000	21,913,000

10. Economic classification of program expenditures. (See table 3.)

Program: Division of Environmental Engineering and Food Protection (summary).
Department or agency, and office or bureau: Health, Education, and Welfare; Public Health Service; Bureau of State Services—Environmental Health; Division of Environmental Engineering and Food Protection.

TABLE 3.—*Economic classification of program expenditures for fiscal 1965*

[In thousands of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	3,013
Other	1,134
Grants to State and local governments	2,896
Transfer payments to individuals and nonprofit organizations	1,210
Total Federal expenditures	8,253

RESEARCH GRANTS

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The primary objective of the program is the development of new scientific information which will aid in the resolution of problems on such environmental factors as food, shelter, water supply, solid wastes disposal, and community planning. A secondary product is development of trained manpower for study of problems in these areas.

2. Operation

The program operates through the grant-in-aid mechanism. Proposals for research on program-related problems are accepted from investigators located in nonprofit institutions such as universities, State and local agencies, research foundations, etc. Each proposal so submitted is reviewed by a consultant panel of scientists knowledgeable in the scientific area, and by the National Advisory Environmental Health Committee. Only proposals favorably recommended by the Committee are eligible for funding.

3. History

Although research grants have been made by the Public Health Service in support of health-related research since 1948, it was not until 1962 that any grants were awarded by this Division. At that time an appropriation was approved by the Congress in the amount of $2,548,000. Since that time the program has gradually increased to its present level, resulting in the attraction of more non-Government scientists to the study of problems within the Division's area of responsibility.

4. Level of operations. (See table 1.)

Program: Research grants.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Environmental Health); Division of Environmental Engineering and Food Protection.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of program (projects)	252	248	268	293
(b) Applicants or participants:				
State government agencies [1] (projects)	188	182	194	
Local communities or governments (none)				
Individuals or families [2] (individuals)	0	0	12	12
Other [3] (projects)	64	66	74	74
(c) Federal finances. (See tab for total program of the Division.)				
(d) Matching or additional expenditures for the program (none)				
(e) Number of Federal Government employees administering, operating, or supervising the activity [4]	9	9	15	15
(f) Non-Federal personnel employed in the program [5]	1,000	1,000	1,200	1,200
(g) Other measures of level or magnitude of performance (none)				

[1] Includes State universities.
[2] Estimate of number of individual grants for training to be awarded under Solid Wastes Disposal Act, Public Law 89–272.
[3] Includes non-State supported universities and research foundations.
[4] Staff consists of scientific, management, administrative, and supporting personnel responsible for programing activity and processing of grant applications and other pertinent documents.
[5] This is an estimate of the number of individuals at grantee institutions.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The research grants program is coordinated with the appropriate operating programs of the Division through frequent contacts and distribution of information as to the nature of research being conducted and publications resulting therefrom. Servicewide coordination exists with respect to the review of applications and procedures followed in the award and funding of grants. The Food and Drug Administration is kept informed of the nature of all grants awarded, and coordination with other agencies of the Government is achieved on a case-by-case basis as the need arises.

8. Laws and regulations

The research grants program is carried out under authority of section 301 of the Public Health Service Act (42 U.S.C. 241) with regulations (pt. 52, title 42 of CFR; ch. 1, subpt. d). Grants in solid wastes will be carried out under authority of Public Law 89–272.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

A substantial part of the research grants appropriation is devoted to support of personnel working on grant-supported projects. Of the personnel supported, there are on the average two graduate students per grant during the advanced portion of their doctorate training, which enhances their capability and employability.

10. Economic classification of program expenditures. (See table above showing total program of the Division.)

Food Protection Activities

The food protection activities of the Division of Environmental Engineering and Food Protection provide a basic focal point for the Public Health Service foodborne illness control functions. These activities, while concentrating on certain foods and particular groups of food merchandisers, have effectively reduced the amount of milk-borne illness; have provided safeguards for food service on interstate carriers; have pioneered a system of State-Federal-industry cooperative effort to improve the safety and quality of shellfish; and have provided guidance to State and local health and other food protection agencies in the development of State laws, local ordinances, and programs of food hazards control.

The programs described in the following pages form a closely related and coordinated effort to develop and apply knowledge of foodborne disease control through research, training, technical assistance and consultation, and direct regulatory functions.

Milk and Food Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The basic objective of the milk and food program is the prevention and control of foodborne illness.

2. Operation

Since protection of the public health is primarily the function of State and local governments, unless specific problems of an interstate nature are involved, the milk and food program is designed to assist such jurisdictions in the development and maintenance of effective food protection programs. Such assistance is implemented through the conduct of the following coordinated and related activities:

(*a*) Development of model ordinances, codes, and standards recommended for State and local adoption and utilization, such as those governing milk sanitation, food service establishments, food and beverage vending machines, and poultry processing.

(*b*) Conduct of research and investigations of food protection problems associated with foodborne illness.

(*c*) Participation with States, and with industry in the conduct of voluntary programs for certification of fluid milk and milk products involved in interstate commerce.

(*d*) Conduct of formalized and inservice type food protection training courses for State, local, and industry personnel.

(*e*) Cooperation with national groups in the development of uniform standards for the sanitary design and construction of food equipment.

(*f*) Provision of technical services to the States and industry in the development and maintenance of effective food sanitation programs.

These activities are carried out through nine regional offices, under the general direction and supervision of the branch headquarters located in Washington, D.C.

3. History

The food protection program of the Public Health Service is one of its oldest and most respected activities. The Service's direct interest dates back to 1896, when the President requested the Public Health Service to undertake a study of the relationship between milk and the epidemic incidence of typhoid fever in the District of Columbia.

During the period 1900–22, the Public Health Service studied the thermal death points of organisms associated with foodborne illness, the processes in commercial use designed to effect control of pathogenic micro-organisms, and the efficacy of such processes.

At the request of the State of Alabama, in 1922 the PHS initiated the development of a statewide milk sanitation program. The PHS-recommended model milk ordinance was an outgrowth of the program. This model ordinance, recommended by the PHS for voluntary adoption by States and communities, has been revised 13 times since 1924 to recognize technological development and to translate new knowledge into public health practice.

During the 1930's a recommended model sanitation ordinance and code was developed for food service operations and procedures were developed for evaluation of State and local milk and food programs. In response to the needs of State and local health agencies, and in the exercise of national leadership, the PHS recommended model ordinances and other program guides for frozen desserts, poultry and poultry products, vending machines, dry milk products, and ice. Currently, similar recommendations are being developed for smoked fish, commercial baby formulas, eggs and egg products, and convenience foods.

All these program guides are periodically evaluated and updated in recognition of technological developments and emerging public health hazards. Solution to problems is sought through field studies, investigation, and research. Use of the resultant model ordinances by States is implemented through technical assistance and training programs for official agencies and industry.

4. Level of operations. (See table 1.)

Program: Food protection activities—Milk and food program.
Department or agency, and office, or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services—Environmental Health; Division of Environmental Engineering and Food Protection.

TABLE 1.—*Level of operations or performance, fiscal year 1964–67*

Measure	Unit	Fiscal year			
		1964	1965	1966 estimate	1967 estimate
(a) Magnitude of program	U.S. population	(1)	(1)	(1)	(1)
(b) Applicants or participants:					
States	States	48	48	48	48
Local	Local jurisdictions	3,000	3,000	3,100	3,200
(c) Federal finances (see table for total program of the Division).					
(d) Additional expenditures for program of States and communities (estimated).	Thousands of dollars.	30,000	30,000	30,000	30,000
(e) Number of Federal Government employees administering, operating, and supervising program.	Consulters	33	33	33	33
	Researchers	25	27	30	30
	Trainers	4	4	4	4
	Clerical	40	42	46	46
(f) Non-Federal personnel employed in program.	State and local official agency and industry.	6,500	6,500	6,500	6,500

[1] More than 97 percent.

(a) Population coverage by 1 or more of the PHS recommended model ordinances implemented by State and local health agencies, with technical advice and counsel by milk and food program. Progress will be in terms of State and local use of an increasing number of PHS model ordinances.

(b) Number of States using one or more of the PHS model regulations.

(d) Several years ago it was estimated that State and local agencies spent more than $29,000,000 for milk, meat, poultry, and other food protection programs. There has been only small increase in expenditures by State and local governments in these areas during the past few years because of the demands of some of the newer, more glamorous programs with public health problems of a speculative nature.

(e) The roles of the milk and food program personnel are broken down into 3 professional and 1 subprofessional categories in order to specify broadly the roles of these employees.

(f) The number of State and local official agency and industry personnel engaged in milk and food program activities is estimated.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Coordination and cooperation with other programs and agencies as to purposes, policies, operations and financing:

(*a*) *Within Bureau, Division, or Office.*—The Interstate Carrier Branch participates in the development of Milk and Food Branch model ordinances, standards, and other program guides which have applicability in the regulatory function of that Branch. Such guides are used in the technical interpretation and enforcement of the Interstate Quarantine Regulations. In addition, regional Milk and Food Branch personnel evaluate the acceptability of milk and other food sources used by interstate carriers.

(*b*) *With other units of Department or Agency.*—The Milk and Food Branch is dependent upon the Communicable Disease Center, Atlanta, Ga., for epidemiological investigations of foodborne disease outbreaks. When these occur on interstate carriers, both groups usually assist the Interstate Carrier Branch with studies necessary to enforce the Interstate Quarantine Regulations. Research and surveillance related to radionuclides in food are coordinated closely with the Division of Radiological Health, which, in fact, provides fiscal support for some Milk and Food Branch activities in this field.

In 1959, a document entitled Shellfish, Milk and Food Service Sanitation Activities of the Public Health Service and the Food and

Drug Administration was developed jointly by the two agencies and the Office of the Secretary, Department of Health, Education, and Welfare. This document, which is currently under revision, identifies and compares the activities of these agencies, and summarizes the cooperative agreements, understandings, and working relationships between PHS and FDA in the area of milk, food service, and shellfish sanitation. A similar document on PHS–FDA activities concerned with pesticide hazards indicates that the enforcement efforts of FDA against adulteration and misbranding of foods in interstate commerce are strengthened by the collateral efforts of PHS to support intrastate and local food protection programs. The differences in responsibilities of the two agencies are effective deterrents to duplication, even in research, when both may work on different facets of the same problem to the mutual advantage to all concerned. Continued cooperation and coordination are needed (1) in other areas of food protection; (2) to keep pace with the rapid developments in food science and technology; and (3) to keep abreast of the needs, requirements and desires of the American people.

(*c*) *With other Federal Government departments or agencies.*—PHS and the Fish and Wildlife Service of the Department of the Interior have a memorandum of agreement relative to the certification of interstate shellfish shippers. This relationship provides the basis for informal liaison and collaboration in research efforts and development of sanitation guides of mutual concern, such as those for public health protection in fish-smoking processes and operations.

Working relationships with the U.S. Department of Agriculture are primarily related to dairy, meat, and poultry products. The Public Health Service, the Atomic Energy Commission, and USDA have undertaken cooperatively the development of a feasible process for the removal of radioactive contamination from milk. The method of treatment of milk with ion-exchange resins to remove radionuclides was derived by Milk and Food Branch research staff of the PHS and pilot plant studies of the process were undertaken at the Beltsville Laboratory of the USDA.

A variety of relationships is maintained with the Department of Defense, ranging from individual consultation to formal agreements. The various departments within the Department of Defense use the technical food sanitation recommendations of the Milk and Food Branch, PHS, and rely on PHS for assistance in the resolution of specific food safety problems. PHS and DOD, together with FDA and the Food Research Institute of the University of Chicago, collaborate on problems, such as the study of staphylococcal enterotoxin, which is a commonly reported cause of food poisoning in the United States. Cooperative relationships also exist with other components of the Department of Defense, including the Armed Forces Food and Container Institute, and the Army Biological Laboratories.

(*d*) *With State governments or their instrumentalities.*—The basic mission of the Milk and Food Branch of the PHS is to assist State and local agencies in establishment and maintenance of effective food protection programs. Cooperation and coordination between the PHS and these governmental levels are both well established and close. The States traditionally look to the Public Health Service for leadership in the food protection area and closely follow PHS recommendations

(*e*) *With local governments or communities.*—Cooperation with State and local governments and communities exists through the responsible State agencies.

(*f*) *With foreign governments or international organizations.*—Many professional milk and food program counterparts in foreign countries have sought guidance of PHS in the form of recommended model ordinances, standards, and other program guides for their domestic programs. The PHS, through the Milk and Food Branch, is represented on World Health Organization Expert Committees in the milk and food area and on the Codex Alimentarious development efforts.

(*g*) *With nonprofit organizations or institutions.*—Many of the professional organizations, such as the American Public Health Association, International Association of Milk, Food and Environmental Sanitarians, the National Association of Sanitarians, Conference of State Sanitary Engineers, the Association of State and Territorial Health Officers, and many others, undertake studies and program promotional efforts in the milk and food sanitation areas. To the extent permitted by resources and governmental propriety, the Milk and Food Branch of the PHS cooperates fully and consults with these organizations in milk and food protection efforts.

(*h*) *With business enterprises.*—Many segments of the food industry recognize the desirability of public health protection of products offered to the American consumer. The competitive nature of private enterprise is a barrier to acceptance by industry of full responsibility for food protection, but it willingly cooperates with health agencies to protect the consumer from foreseeable hazards.

The Milk and Food Branch participates with other health agencies and industry in the development of standards for the sanitary design and construction of milk and food equipment. Notable among these cooperative standards development efforts are the 3–A Sanitary Standards for dairy equipment; National Sanitation Foundation standards for food service equipment; Baking Industry Sanitation Standards Committee for bakery and related equipment; and the Automatic Merchandising Health-Industry Council standards for milk and food vending equipment.

The PHS and industry cooperate in the identity and evaluation of food protection problems requiring research for solution. The food industry frequently supports projects in universities and privately owned laboratories on problems relating to health, such as sanitary requirements, foodborne diseases, nutrition, microbiological content, chemical composition, toxicology of additives, and a wide variety of related problems. Findings are generally published in technical periodicals of professional and trade associations, thus assisting in the resolution of public health problems.

(*i*) *With others.*—The Milk and Food Branch, in response to inquiries and by publication of recommendations, acquaints the private citizen with food protection problems and provides recommendations for their resolution.

8. Laws and regulations

The Public Health Service Act of 1944, as amended, particularly sections 301, 311, 314, and 361 of Public Law 410 (42 U.S.C. 241, 243, 246, 264). This broad authorization provides for the Public Health Service to assist the States and communities and to carry out interstate

quarantine activities, primarily directed at the control of communicable diseases. Under its mandate, the PHS is engaged in activities designed to assist State and local authorities in the development, operation, and maintenance of programs for the prevention and control of food-borne illness.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Since the basic objective is the prevention of disease caused by or transmitted by food, economic gain is of secondary consideration but inherently associated with freedom from debilitating illness. There can be no effective measure of numbers of cases of illness prevented, but estimates of current foodborne illness give a basis for judgment of the current problem.

Conservative estimates indicate that more than 1 million persons are made acutely ill each year by some type of foodborne health hazard. The average illness may result in a loss of 2 to 4 days of productive effort. The total cost, therefore, of 1 million cases of foodborne disease each year at a conservative personal income of $20 a day is in excess of $60 million in lost productive time.

While death is infrequently caused directly by foodborne disease, such disease does produce an extreme burden on infants and children suffering from other illness and is too often the "final straw" which terminates a young life. While this loss to society is rarely measured in terms of loss to the national economy, such economic loss is a reality.

It is impossible to estimate with any accuracy, the number of persons who would be made ill or the number who would die if we did not have governmental food protection systems. While the present level of such illness is unnecessarily high, there could well be a tenfold or even hundredfold increase if present services did not exist.

Medical care costs have produced hardships on individuals which are at least equivalent to the cost of productive time lost.

A distinctly different but important aspect of the economics of the PHS food protection system is the resultant saving to the food industries. By providing nationwide guidance in public health food protection standards, a basis has been established for uniformity of food equipment and acceptance of high-quality food products, particularly milk, in intrastate and interstate commerce. For example, there are in the United States, many hundreds of local milk ordinances. Each prescribes certain criteria regarding the sanitation of equipment in milk processing plants. Without the leadership of the Public Health Service in making recommendations in the form of a model milk ordinance, these local ordinances would have unlimited variables of requirements for milk processing equipment, causing excessive expense to manufacturers, processors, and ultimately the consumer of milk products.

10. Economic classification of program expenditures. (See table above showing total program of the Division.)

National Shellfish Sanitation Program

(Cooperative State-PHS-Industry Program for the Certification of Interstate Shellfish Shippers)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To prevent the transmission of disease by oysters, clams, and mussels and thereby to permit the continued use of a valuable, renewable, widely distributed natural resource.

2. Operation

The program is based on cooperative agreements between the Public Health Service, other interested Federal agencies, the States, and the shellfish industry. International agreements have been negotiated with Canada and Japan to assure the quality of shellfish imports from these two countries.

Public Health Service is responsible for the development of uniform standards, the training of State and industry personnel in new techniques, research necessary for the development and maintenance of effective standards, continuing technical audit of State programs, and publication of a semimonthly listing of State-certified shellfish shippers.

States are responsible for the adoption of laws or regulations based on recommended uniform standards; for the sanitary evaluation of growing areas; for the prevention of illegal harvesting of polluted or toxic shellfish from unacceptable areas; and the sanitary inspections of all elements of the growing, harvesting, processing, and the distribution of shellfish. (Program standards are outlined in National Shellfish Sanitation Program Manual of Operations, published by PHS.)

3. History

The program was established in 1925 by joint action of the States, Public Health Service, other interested Federal agencies, and the shellfish industry. This action followed a major typhoid epidemic attributed to oysters, and it was one which had a disastrous economic impact on the shellfish industry. Administrative and technical elements are subject to continuing technical review and revision through the mechanism of regional meetings and national shellfish sanitation workshops. The most recent workshop was held in 1965. (Copies of the proceedings of the workshop are published.)

4. Level of operations. (See table 1.)

Program: Food protective activities—National shellfish sanitation program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Environmental Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measures	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude: Program coverage [1]				
(b) Applicants or participants (State agencies):				
Shellfish producing (number)	21	21	21	21
Shellfish receiving (number)	29	29	29	29
State-certified interstate shippers (number)	1,524	1,443	[2] 1,500	1,500
(c) Federal finances. (See table for total program of the Division.)				
(d) Estimated expenditures of States (millions)	$2.707	$2.791	$2.996	$3.100
(e) Number of Federal employees administering program, including research	112	112	118	118
(f) Estimated number of State employees	408	417	435	450
(g) Other measures of workload:				
Total shellfish production resources (millions of acres)	8.09	9.00	11.89	12.00
Areas	777	811	845	860
Approved areas (millions of acres)	6.81	8.47	10.12	10.60
Areas	335	346	358	370
Conditionally approved areas (millions of acres)	0.30	0.17	0.05	0.30
Areas	51	43	34	25
Closed areas (millions of acres)	0.98	1.35	1.73	1.80
Areas	391	422	453	470
Individuals employed in industry (direct or indirect) (thousands)	[3]	50	60	60

[1] Public health benefits accrue to all persons in the United States who consume oysters, clams, and mussels. Economic gains accrue to the coastal counties in which shellfish are produced and processed. Secondary financial gains accrue to distribution, trades, and restaurant operators in all States which handle the product. International relations gains accrue through better understanding with Canada and Japan.
[2] Estimate.
[3] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Probable changes in program orientation

Not answered.

7. Coordination and cooperation

The program was established in cooperation with other interested Federal agencies. Formal agreements now exist with the Department of the Interior and Food and Drug Administration. All interested Federal agencies and the shellfish industry participate in the development of uniform standards. International agreements exist with Canada and Japan and representatives of these countries also participate in technical meetings for the development and maintenance of program standards.

The primary areas of weakness are in the coordination of program activities with those of the water pollution control agencies (State, interstate commission, and Federal), and with foreign governments other than Canada and Japan. Substantial progress has been made within the past year in the coordination of water pollution control and shellfish sanitation goals. Further progress is anticipated. Less satisfactory progress has been made in the development of sanitation agreements with foreign nations interested in shipping their products into the United States. Informal meetings have been held with representatives of many countries including France, Mexico, Venezuela, Korea, Australia, the Netherlands, and Denmark.

8. Laws and regulations

The Deficiency Appropriation Act, U.S. Statutes, volume 43, approved March 4, 1925, stated: "* * * for cooperation with State and municipal health agencies in the prevention of the spread of contagious and infectious disease in interstate traffic through oysters and other shellfish * * *." Public Law 410 also provides authority for cooperation with the States in preventing interstate spread of communicable disease.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Effect on personal income.—Continuing production and sale of shell fish products are dependent upon the maintenance of acceptable sanitary quality. The industry employs, directly or indirectly, approximately 50,000 persons. Thus the livelihood of 200,000 to 250,000 persons are, fully or in part, dependent upon the industry. Most of the jobs are concentrated in the coastal areas where the industry is, in many cases, an important element of the economic base. For example, a Public Health Service-sponsored study in Franklin County, Fla., discloses that 65 percent of the jobs and 55 percent of the income were generated by the oyster industry.[1] Any restrictions on marketing shellfish would be a great economic blow to many coastal regions and would result in a significant loss of income for coastal communities. Conversely, the effective administration of this program permits the continued utilization of this unusual natural resource.

Effects on earnings.—In many coastal areas shellfish resources are a significant source of income. Workers now employed in the industry could not be readily trained for other jobs nor could capital investments be readily utilized in other endeavors.

Effects on business.—Approximately 1,500 firms, mostly small businesses, are involved in the production and processing of shellfish. Their continuation in business is dependent upon protection of growing areas from pollution and other public health measures which will assure the sanitary quality of the product. The "protection" is provided by the national shellfish sanitation program.

Effects on wage levels.—Unknown.

Other benefits.—It is difficult to calculate the costs to the community of a major disease outbreak. For example, in 1961–62 approximately 1,100 cases of infectious hepatitis were attributed to raw clams or oysters which had apparently been harvested from polluted areas. The cost to the community in terms of hospitalization, loss of work, and welfare benefits must have been significant.

Geographic differentials.—The economic benefits of the program accrue most directly to the 21 States which have areas used for the production of shellfish. The distribution of these areas is shown in table 2.

[1] Marshall R. Colberg and Douglas M. Windham (both of Florida State University, Tallahassee), "The Oyster-Based Economy of Franklin County, Fla"; Public Health Service, U.S. Department of Health Education, and Welfare, Washington, D.C.; July 1965.

TABLE 2.—*National register of shellfish production areas* [1] [2]

State	I. Interstate areas													
	A. Active areas								B. Inactive areas					
	Total areas	Number	Areas fully approved	Number	Areas conditionally approved	Number	Closed areas	Number	Total areas	Number	Areas fully approved	Number	Closed areas	Number
REGION I														
Maine	14,295	6	0	0	0	0	14,295	6	0	0	0	0	0	0
New Hampshire	400	1	0	0	0	0	400	1	0	0	0	0	0	0
Massachusetts	5,625	6	548	1	3,043	2	2,034	3	0	0	0	0	0	0
Rhode Island	91,493	27	60,941	1	11,648	6	18,904	20	0	0	0	0	0	0
Connecticut	7,700	6	75	1	0	0	7,695	5	0	0	0	0	0	0
Total	119,513	46	61,564	3	14,691	8	43,328	35	0	0	0	0	0	0
REGION II														
New York	411,000	3	371,000	1	0	0	40,000	2	0	0	0	0	0	0
New Jersey	239,000	3	208,000	1	3,000	1	28,000	1	0	0	0	0	0	0
Delaware	196,000	1	196,000	1	0	0	0	0	2,300	2	0	0	2,300	2
Total	846,000	7	775,000	3	3,000	1	68,000	3	2,300	2	0	0	2,300	2
REGION III														
Maryland	877,820	14	864,710	6	4,680	2	8,430	6	1,147,300	4	1,120,804	2	26,496	2
Virginia	1,015,410	6	1,014,775	3	0	0	635	3	(4)	(4)	(4)	(4)	(4)	(4)
North Carolina	546,000	1	546,000	1	0	0	0	0	0	0	0	0	0	0
Total	2,439,230	21	2,425,485	10	4,680	2	9,065	9						
REGION IV														
South Carolina	31,500	3	0	0	0	0	31,500	3	0	0	0	0	0	0
Georgia	7,000	1	0	0	0	0	7,000	1	3,300	2	2,500	1	800	1
Florida	292,000	10	200,000	5	42,000	1	50,000	4	15,000	1	0	0	15,000	1
Alabama	289,500	6	132,000	2	155,000	1	2,500	3	0	0	0	0	0	0
Mississippi	0	0	0	0	0	0	0	0	1,000	1	1,000	1	0	0
Total	620,000	20	332,000	7	197,000	2	91,000	11	19,300	4	3,500	2	15,800	2

State	II. Intrastate areas														State totals	Number
	A. Active areas								B. Inactive areas							
	Total areas	Number	Areas fully approved	Number	Areas conditionally approved	Number	Closed areas	Number	Total areas	Number	Areas fully approved	Number	Closed areas	Number		
REGION VII																
Louisiana	38,200	1	38,200	1	0	0	0	0	2,500	1	0	0	2,500	1		
Texas	0	0	0	0	0	0	0	0	2,500	1	0	0	2,500	1		
Total	38,200	1	38,200	1	0	0	0	0	5,000	2	0	0	5,000	2		
REGION IX																
California	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Oregon	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Washington	500	2	0	0	300	1	200	1	600	1	0	0	600	1		
Total	500	2	0	0	300	1	200	1	600	1	0	0	600	1		
United States [5]	4,063,443	97	3,632,249	24	219,671	14	211,593	59	1,174,500	13	1,124,304	4	50,196	9		
REGION I																
Maine	350,000	164	291,567	68	0	0	58,433	96	9	0	0	0	0	0	364,295	170
New Hampshire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	400	1
Massachusetts	33,577	90	24,585	33	3,080	16	5,912	41	0	0	0	0	0	0	39,202	96
Rhode Island	4,934	9	3,921	4	192	1	821	4	0	0	0	0	0	0	96,427	36
Connecticut	54,340	23	47,000	16	0	0	7,340	7	20,000	(3)	20,000	(3)	0	0	82,040	29
Total	442,851	286	367,073	121	3,272	17	72,506	148	20,000	0	20,000	0	0	0	582,364	332
REGION II																
New York	566,400	86	385,000	56	0	0	181,400	30	0	0	0	0	0	0	977,400	89
New Jersey	100,530	92	76,000	33	1,100	1	23,430	58	19,500	12	13,500	2	6,000	10	359,030	107
Delaware	16,900	14	14,500	3	0	0	2,400	11	520	5	0	0	520	5	215,720	22
Total	683,830	192	475,500	92	1,100	1	207,230	99	20,020	17	13,500	2	6,520	15	1,552,150	218
REGION III																
Maryland	8,790	12	0	0	2,652	1	6,138	11	37,800	2	36,800	1	1,000	1	2,071,710	32
Virginia	53,126	15	0	0	3,246	7	49,880	8	(4)	(4)	(4)	(4)	(4)	(4)	(4)	(4)
North Carolina	26,710	16	0	0	0	0	26,710	16	756,472	12	712,929	6	43,543	6	1,329,182	29
Total	88,626	43	0	0	5,898	8	82,728	35								

See footnotes at end of table, p. 744.

TABLE 2.—*National register of shellfish production areas* [1] [2]—Continued

State	II. Intrastate areas														State totals	Number
	A. Active areas								B. Inactive areas							
	Total areas	Number	Areas fully approved	Number	Areas conditionally approved	Number	Closed areas	Number	Total areas	Number	Areas fully approved	Number	Closed areas	Number		
REGION IV																
South Carolina	165,750	19	149,250	13	4,000	1	12,500	5	0	0	0	0	0	0	197,250	22
Georgia	143,250	16	97,250	8	0	0	46,000	8	19,750	4	19,250	2	500	2	173,300	23
Florida	573,750	44	418,100	21	41,000	5	114,650	18	139,500	8	0	0	139,500	8	1,020,250	63
Alabama	0	0	0	0	0	0	0	0	0	0	0	0	0	0	289,500	6
Mississippi	107,150	7	10,550	3	9,400	2	87,200	2	0	0	0	0	0	0	108,150	8
Total	989,900	86	675,150	45	54,400	8	260,350	33	159,250	12	19,250	2	140,000	10	1,788,450	122
REGION VII																
Louisiana	1,033,000	8	1,010,000	7	0	0	23,000	1	300,000	1	300,000	1	0	0	1,373,700	11
Texas	733,200	11	602,000	5	10,000	1	121,200	5	100,000	2	95,000	1	5,000	1	835,700	14
Total	1,766,200	19	1,612,000	12	10,000	1	144,200	6	400,000	3	395,000	2	5,000	1	2,209,400	25
REGION IX																
California	5,041	4	2,734	3	0	0	2,307	1	1,237	5	610	3	627	2	6,278	9
Oregon	3,355	3	150	1	3,206	2	0	0	10,550	7	1,500	1	9,050	6	13,906	10
Washington	44,020	47	43,240	37	0	0	783	10	0	0	0	0	0	0	45,120	50
Total	52,417	54	46,124	41	3,206	2	3,090	11	11,787	12	2,110	4	9,677	8	65,304	69
United States [5]	4,023,814	680	3,175,847	311	77,876	37	770,104	332	1,405,329	58	1,199,589	17	205,740	41	----------	------

[1] All values in acres.
[2] Figures represent data compiled between October 1963 and April 1964.
[3] No breakdown as to specific areas.
[4] Data not available.
[5] Column totals in I–B, I–C, II–B, and II–C do not include Virginia.

Hawaii does not have commercial shellfish areas. Alaska has a large resource, but it cannot be used at the present time because of the presence of toxic materials. A recent meeting of State, Federal, and industry representatives in Alaska has concluded there is an urgent need for further studies to develop and apply public health control measures which would permit utilization of this resource in Alaska.

Effect on business or industrial organization.—Total contribution of the shellfish industry to the gross national product is estimated at $250 million.

Other data or comments.—There is a substantial economic relationship between utilization of shellfish resources and tourism in many areas. No attempt has been made to define the economic benefits of this element, but it is well known that areas such as Maine, Florida, Washington, and California stress seafoods and marine resources in promotion of tourism. There is also substantial recreational harvesting of shellfish in many parts of the country, although specific data are not available.

10. *Economic classification of program expenditures.* (See table above showing total program of the Division.)

Interstate Carrier Programs: A and B

A. Construction and Operation Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The Interstate Carrier Branch acts as the Surgeon General's agent in discharging his statutory responsibility for the health of the Nation's traveling public. This responsibility is defined in the provisions of the interstate quarantine regulations, and includes Public Health Service surveillance of interstate carrier food sources and service, water supply service, waste disposal, and insect and rodent control. Daily, over 2 million people travel on airlines, buses, railroads, and vessels. Annually, over 700 million days are spent by people on interstate conveyances. Surveillance of the sanitation problems is required in the servicing of over 5,800 conveyances and catering establishments serving them. The Branch reviews the construction and installation of equipment having public health significance on carriers and in carrier-connected establishments and areas, to determine that it complies with Public Health Service requirements. It evaluates and approves methods and procedures for the packaging and shipment of etiologic agents, and reviews the technical activities relating to the shipment of etiologic agents by the Department of Defense.

2. Operation

The interstate carrier program is a direct Federal operation conducted in regional and field offices with headquarters supervision. The program furnishes technical assistance and training to the interstate carrier industry (vessel companies, railroads, bus companies, and airlines), including their builders and suppliers of equipment, food, and water. Through routine inspections, the program furnishes surveillance of the health-related aspects in the construction and operation of interstate carriers. This includes review of construction plans, inspection, and consultation during construction, and routine inspec-

tions during the operation of conveyances related to water, food, waste handling and disposal, and insect and rodent control. Epidemiological investigations are conducted of reported foodborne outbreaks occurring on interstate conveyances to determine measures needed to prevent reoccurrence.

3. History

The first interstate quarantine regulations were promulgated on September 27, 1894, and were first amended in 1912. Many additional amendments have been made since that date. It was not until 1917, however, that interstate sanitary districts were established by the Service. Following this, sanitary standards were developed for interstate carriers and supervision of their operation became a regular function of the Public Health Service. In 1930, the Maritime Commission, now the Maritime Administration, established a policy that all ships constructed under its jurisdiction and subsidized by it must be constructed in accordance with Public Health Service sanitation standards. Virtually all American-flag ships today are built and operated in compliance with them. The greatest impetus to the vessel program occurred during 1940 to 1945, when all the Liberty and Victory ships were built. The later decline in ship construction was accompanied, however, by expansion of the airline industry. Similarly, although transportation by way of railroads has greatly declined, this has been accompanied by a huge expansion in bus travel.

4. Level of operations. (See table 1.)

Program: Interstate carrier program (construction and operation).
Department or agency, and office or bureau: Department of Health, Education and Welfare; Public Health Service; Bureau of State Services—Environmental Health; Division of Environmental Engineering and Food Protection.

TABLE 1.—*Level of operations or performance, fiscal year 1964–67*

Measure	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 estimates
(a) Magnitude of program:					
Construction	Conveyances [1] and establishments.	320	388	450	475
Operation	do [1]	7,937	7,912	7,950	7,975
(b) Applicants or participants:					
State government agencies	Health departments.	50	50	50	50
Local communities or governments.	do	140	150	160	170
Individuals or families	None				
Other	do				
(c) Federal finances (see table for total program of the Division).					
(d) Number of Federal Government employees administering, operating, or supervising the activity		58	49	49	40
(e) Non-Federal personnel employed in the program.	Estimated man-years.	3.5	3.75	4	4.25
(f) Other measures of level or magnitude of performance	Inspections	9,125	9,165	9,250	9,300

[1] Aircraft, railroad dining cars, vessels, buses, caterers, commissaries, watering points, servicing areas.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The program activities are carried out in cooperation with other branches of the Division and with the Federal Water Pollution Control Administration (Department of the Interior), the Departments of the Army, Navy, and Air Force, the Maritime Administration, the Federal Aviation Agency, and the Coast Guard. State health departments assist in providing inspectional services, particularly in regard to watering points and airline catering facilities. Some local health departments also provide this type of assistance. Foreign shipping companies partially or wholly owned by their governments have requested assistance and consultation in construction of foreign-flag passenger vessels in the Atlantic traffic. to the city of New York. This is provided, with the requesting company meeting the cost of travel. The nature of the program is such that full cooperation of the railroad, airline, vessel and bus industry is required. This applies to not only the operation of conveyances, but also in their construction.

8. Laws and regulations. (See Interstate Quarantine Regulations, of Public Health Service regulations.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The program to guard the health of the traveling public obviously has an effect on the personal incomes and productivity of all who utilize the various modes of travel. An outbreak of an intestinal disease or food poisoning usually incapacitates the victims for varying periods of time from at least 1 week to several months. The program benefits business and industry by assuring the traveler that he will arrive at his destination in good health and is an incentive to the individual to utilize this mode of travel. Although a specific measure of contributions to the growth of industry or the gross national product cannot be identified, such industries as airlines and buses certainly would relate their expansion to the patronage enjoyed from the healthy traveler.

10. Economic classification of program expenditures. (See table above showing total program of the Division.)

B. Water Supply Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

(*a*) To provide regulatory supervision and certification of interstate carrier water supply sources in accordance with the provisions of the interstate quarantine regulations; (*b*) to provide health hazard intelligence to other Federal units, State and local health departments, and public water supply groups; (*c*) to provide technical assistance to other Federal and State groups on water supply problems; (*d*) to assist the States in the development of water supply programs; (*e*) to provide assistance to organizations such as the Pan American Health Organization and the Agency for International Development, in the field of water supply; (*f*) to revise and update as needed the

PHS drinking water standards for application to water supplies throughout the Nation.

2. Operation

These activities are carried out under headquarters supervision by field representatives in nine regional offices, a research staff at the Robert A. Taft Sanitary Engineering Center, and overseas representatives in Brazil, Bolivia, and the Somalia Republic, as well as engineers assigned to cover Latin America generally through the Pan American Health Organization. The enforcement phase of the program is conducted with the assistance of sanitary engineers in the 50 State health departments. Emphasis is placed on promoting training of water supply operators, both at home and abroad, where—as in Brazil, for example—a team of engineers is engaged in a national effort to train water works operators.

3. History

The interstate quarantine regulatory responsibilities of the water supply program have been in existence since 1914 when the first Public Health Service drinking water standards were promulgated. Comprehensive water supply work had its beginning in 1960. Since that time the Water Supply Section has developed many projects, ranging from study of waterborne infectious hepatitis to investigations of water possibly related to cancer and heart disease jointly with the National Cancer and Heart Institutes. Since 1963, the impact of the work has been extended overseas.

4. Level of operations. (See table 1.)

Program. Interstate carrier program (water supply program).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services—Environmental Health, Division of Environmental Engineering and Food Protection.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimate)	Fiscal year 1967 (estimate)
(a) Magnitude of program:				
Interstate carrier water supplies	760	760	760	770
Overseas countries	0	2	4	16
Water supply special projects	4	4	5	3
(b) Applicants or participants:				
State and territorial health departments	52	52	52	52
Municipal water departments	1,000	1,000	1,000	1,100
Interstate travelers, daily	2,000,000	2,000,000	2,000,000	2,300,000
Residents using interstate carrier water supplies	77,000,000	77,000,000	77,000,000	80,000,000
(c) Federal finances (see table for total program of the Division).				
(e) Number of Federal Government employees administering, operating, or supervising the activity	12	17	56	56
(f) Non-Federal personnel employed in the program [1]	52	52	52	52

[1] Sanitary engineers in State health departments who contribute their time in making surveys of interstate carrier water supplies.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The Water Supply Section, Interstate Carrier Branch, cooperates with other divisions of the Public Health Service and with other Federal agencies such as the U.S. Forest Service, U.S. Navy, Agency for International Development, and the Food and Drug Administration. There is close liaison and cooperation with the 52 State and territorial health departments and with many municipal water supply agencies. On the international front, the section is working with the Governments of Brazil, Bolivia, and the Somalia Republic on cooperative water supply projects. The section has close ties with the American Water Works Association and the American Public Health Association.

8. Laws and regulations

Public Law 78–410, as amended.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The program has a beneficial effect upon the health of over 76 million American citizens for it is directed toward upgrading and improving the quality of the water they drink. A directly measurable effect of the program is its contribution to the gross national product (GNP). During the past 3 years the contribution to the GNP has been over $100 million by way of creating additional markets for goods and services required for improvement of water supplies. Nearly all these funds are from local sources.

10. Economic classification of program expenditures. (See table above showing total program of the Division.)

Special Engineering Services Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The special engineering services program seeks to improve and protect public health by providing technical assistance and advice to State and local health and other agencies, national associations, and organizations, and other Federal agencies on the environmental health and sanitation aspects of individual water supply and sewage disposal systems, institutions and schools, recreational areas, swimming pools and bathing places, plumbing, mobile home parks, travel trailer parking areas, and other problems requiring the application of sanitation principles.

2. Operation

Technical consultation on program activities is conducted primarily by regional office personnel of the Division of Environmental Engineering and Food Protection with appropriate supervision and assistance from headquarters. In addition, headquarters is responsible for the production or updating of technical manuals, guides, bulletins, standards, and criteria in the several areas covered by the program. Constant efforts are maintained to identify emerging problems and to watch and collect intelligence on industry and consumer trends in order to meet requests for pertinent information and advice. Data

and information derived from Federal, State, and local programs and new approaches to the administration and operation of control programs arising from investigations of university or professional organizations and from experience are evaluated and appropriately used to stimulate and improve practices at all levels of government and private endeavor in the several fields covered in the program.

3. History

The status of this program has changed during a series of reorganizations of sanitary engineering activities in the Public Health Service. This program encompasses a broad spectrum of activities which represent many of the basic environmental health problems existing in our urban and rural communities.

4. Level of operations. (See table 1.)

Program: Special engineering services program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services—Environmental Health; Division of Environmental Engineering and Food Protection.

TABLE 1.—*Level of operations or performance, fiscal year 1964–67*

Measure	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 (estimate)	Fiscal year 1967 (estimate)
(a) Magnitude of the program:					
Septic tank sewerage systems	Thousands	16,000	16,300	16,600	16,850
Population served	do	57,000	58,000	59,000	59,840
Individual water supply system	do	13,000	13,250	13,500	13,750
Population served	do	45,000	45,800	46,400	47,000
(b) Participants:					
State government agencies	(1)	50	50	50	50
Local communities or governments (percent)	(1)	100	100	100	100
Individuals or families	See (a) above				
(c) Federal finances (see table for total program of the Division).					
(e) Number of Federal Government employees administering, operating, and supervising activity	Man-years	7	7	7	
(f) Non-Federal personnel employed in program		(2)	(2)	(2)	(2)

[1] See "measure" column.
[2] Estimated 2 to 3 man-years at the local level and at least 4 man-years at the State level.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The broad spectrum of environmental health activities in this program requires active coordination and cooperation with many programs and agencies.

(a) The development of technical manuals, guides, bulletins, and criteria is done in cooperation with other branches of the Division, including the Interstate Carrier Branch, Shellfish Sanitation Branch, Milk and Food Branch, and the Office of Urban Environmental Health Planning. Program policies and operating procedures are appropriately coordinated within the Division.

(*b*) Technical standards, etc., are developed in cooperation with other departments or agencies as appropriate within the Department. "Environmental Engineering for the School," PHS Publication No. 856, was developed in cooperation with the Office of Education. The Division of Accident Prevention and the Division of Water Supply and Pollution Control assisted in the development of chapters included in "Environmental Health Practice in Recreational Areas," PHS Publication No. 1195.

(*c*) Branch activities on recreational sanitation are under the general coordination of the Bureau of Outdoor Recreation, Department of the Interior.

(*g*) Various standards are developed in cooperation with other organizations and agencies with the PHS providing representation to special committees such as:

(1) "Suggested Ordinance and Regulations Covering Public Swimming Pools," American Public Health Association Joint Committee on Swimming Pools and Bathing Places.

(2) "American Standards Installation of Plumbing, Heating, and Electrical Systems in Mobile Homes," American Standards Association (ASA) A119.1–1963 and "American Standards Installations of Plumbing, Heating, and Electrical Systems in Travel Trailers," ASA A119.2–1963.

(3) "Report of Public Health Service Technical Committee on Plumbing Standards," PHS Publication No. 1038.

(*h*) "Environmental Health Guide for Mobile Home Parks With a Recommended Ordinance" and "Environmental Health Guide for Travel Trailer Parking Areas With a Recommended Ordinance" were developed in cooperation with the Mobile Homes Manufacturers Association, Chicago, Ill.

8. Laws and regulations

Public Law 78–410, as amended.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

There is a direct and indirect economic effect on the growth of the Nation as a result of activities of the Branch in dealing with problems of environmental health. These activities are subject to some control and guidance through Federal and State leadership.

It is estimated that 250,000 to 300,000 individual house sewage disposal systems are installed annually. Based on research conducted by the Public Health Service, major advancements have been made in assuring better operation of these systems, extension of their life expectancy, and dollar savings in the construction of the facilities. For example, a revision in these criteria regarding the need for distribution boxes resulted in an estimated savings of $15 million per year. The plumbing standards should permit the installation of adequate plumbing at a saving of approximately $50 per residence. Based on an estimated 1 million residential units per year, this represents annual savings of $50 million.

Indirectly it is impossible to determine for other programs many of the detailed savings that have been effected from these activities.

Publications developed:

1. Manual of Septic Tank Practice, PHS Publication No. 526.
2. Manual of Individual Water Supply Systems, PHS Publication No. 24.
3. Environmental Health Practice in Recreational Areas, PHS Publication No. 1195.
4. Environmental Engineering for the School, PHS Publication No. 856.
5. Safe Drinking Water in Emergencies, PHS Publication No. 389 (pamphlet).
6. Home Sanitation, PHS Publication No. 231 (pamphlet).
7. Septic Tank Care, PHS Publication No. 73 (pamphlet).
8. Environmental Health Guide for Mobile Home Parks With a Recommended Ordinance.
9. Environmental Health Guide for Travel Trailer Parking Areas With a Recommended Ordinance.
10. Report of Public Health Service Technical Committee on Plumbing Standards, PHS Publication No. 1038.

10. Economic classification of program expenditures. (See table above showing total program of the Division.)

Solid Waste Disposal Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

Public Law 89–272, the Solid Waste Disposal Act, states the purposes of the solid wastes program as follows:

(1) To initiate and accelerate a national research and development program for new and improved methods of proper and economic solid waste disposal, including studies directed toward the conservation of natural resources by reducing the amount of waste and unsalvageable materials and by recovery and utilization of potential resources in solid wastes; and

(2) To provide technical and financial assistance to State and local governments and interstate agencies in the planning, development, and conduct of solid waste disposal programs.

2. Operation

The program will include several methods of operation: (1) direct Federal management and research; (2) technical assistance; (3) contracts and matching grants, and (4) training programs with public authorities, agencies, and institutions, and with private agencies, institutions, and individuals.

3. History [1]

The solid wastes engineering program has been a very small operation with an average of five professional people. Solid wastes legislation has been submitted by Congress several times over the past few years, but no action was taken until this year. In the past, only very limited funds were available for program activities. Technical assistance was provided as funds and personnel allowed. With the signing of Public Law 89–272, the program is expected to grow to approximately 200 people and $14 million for fiscal year 1967.

4. Level of operations. (See table on Federal finances for all programs of the Division of Environmental Engineering and Food Pro-

[1] After the response was submitted, responsibility for administration of the Solid Waste Disposal Act (title II of Public Law 89–272) was placed in a newly created Office of Solid Wastes. This is separate from the Division of Environmental Engineering and Food Protection but (like that Division) is in the Bureau of State Services (Environmental Health).

tection, and also research grants of the Division, question 4, footnote 2.)

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) Within Division: Appropriate branches through contacts and distribution of information.

(*b*) Within Department: Solid wastes disposal, when improperly performed, often involves air and water pollution. Therefore, close contact will be maintained with the Division of Air Pollution and the Water Pollution Control Administration to make a more complete solid waste program.

(*c*) With other Federal departments or agencies: The Tennessee Valley Authority and Public Health Service have a cooperative composting research project underway. An operating agreement could be made with the Department of Housing and Urban Development for the review by PHS of plans for solid waste handling facilities submitted to the Department with applications for construction loans.

Contact will be maintained by the PHS with the Department of the Interior, as stated in Public Law 89–272, for activities involving minerals or fossil fuels.

(*d*), (*e*) With State and local governments: Grants and/or contracts will be made for solid waste planning and demonstration projects.

(*f*) With international organizations: Information on solid wastes handling will continue to be exchanged with various international organizations.

(*g*) With nonprofit organizations or institutions: There has been close cooperation with universities and organizations such as the American Public Works Association. This is expected to increase.

(*h*), (*i*) With business enterprises and individuals: Contracts may may be made with business enterprises and individuals for planning and demonstration projects.

8. Laws and regulations

Public Law 89–272, the Solid Waste Disposal Act of 1965.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*c*) The solid wastes disposal program will probably lead to more construction of disposal plants which will in turn lead to increased business for the engineers and construction companies involved.

(*g*) Solid waste disposal operations cost close to $3 billion per year.

10. Economic classification of program expenditures. (See table above showing total program of the Division.)

URBAN ENVIRONMENTAL HEALTH PLANNING

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

Program consists of two elements: activity to encourage better short-and-long range planning for health-related environmental facilities in urban areas, and activity to improve the healthfulness of the residential environment primarily through systematic enforcement by neighborhoods of hygienic standards in minimum and healthful housing codes.

2. Operation

Program operates from regional offices with headquarters supervision. Technical assistance and training are provided (*a*) to State and local health agencies, (*b*) to corresponding public works and planning officials, and (*c*) to other related inspection-enforcement personnel at the State and local level.

3. History

Environmental health planning activity has been in progress 6 years. About 25 medium-sized urban areas have been assisted in locally conducted studies of their planning needs for water, sewerage, housing, solid wastes, air pollution control, etc. The program has resulted in better understanding of facility needs, environmental health planning and provision of public works and public services for future urban requirements of what are often multijurisdictional areas. The activity involves demonstrations in urban areas selected by State health departments, and in some instances training of personnel from outside the survey area so they may be prepared to do similar surveys in their home communities.

Residential environment hygiene activities are just beginning after a 10-year lapse. Emphasis will be on (*a*) research to fill gaps in knowledge of housing-health relationships focusing on health-related criteria for two levels of standards based on thresholds of tolerance of healthy persons and families and thresholds of those predisposed to some form of ill health, (*b*) development of model standards and manuals and technical assistance on their administration, and (*c*) training for local housing inspectors.

4. Level of operations. (See table 1.)

Program: Urban environmental health planning

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of Public State Services—Environmental Health; Division of Environmental Engineering and Food Protection.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(*a*) Technical assistance in field studies (communities)	6	10	14	18
Training courses (persons)	500	650	1,600	2,100
(*b*) Applicants or participants:				
Local communities	6	10	14	18
Individuals	500	650	1,600	2,100
(*c*) Federal finances (see table for total program of the Division).				
(*d*) Additional expenditures	[1]	[1]	[1]	[1]
(*e*) Number of Federal employees	9	9	18	24
(*f*) Non-Federal personnel (State and local agency employees)	375	550	[2] 900	[2] 900

[1] Not available.
[2] State and local personnel operating within the scope of this program.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) With all divisions of Bureau. (*b*) Improved coordination with programs which are involved in individual health care programs may be desirable in developing a total urban health planning operation. (*c*) Several preliminary coordination meetings have been held with components of the Department of Housing and Urban Development, and further meetings are planned on a continuing basis. (*d*) Community study projects have been conducted with State coordination, and increased State responsibility is being assumed. One goal is the establishment, perhaps with a Federal support program, of an urban public health planning operation within the State level of government. (*e*) The Division coordinates with State and local governments in selected areas in assisting in the development of environmental health plans and training of personnel. (*g*) Activity planning has been reviewed with institutions such as the American Institute of Planners, National Association of Housing and Redevelopment Officials, Urban Land Institute, American Public Health Association.

8. Laws and regulations.

Public Health Service Act, as amended.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*), (*b*) No direct effect on personal income. Indirect improvement may result from improved housing conditions allowing greater productivity.

(*c*), (*d*) Improved community facility planning and requirements projection are expected to provide greater incentive for business retention and attraction. Capital improvement programs should result in expanded opportunities for construction industries concerned with water and sewerage works, solid wastes disposal facilities, etc. Minimum housing code enforcement activity should greatly expand business opportunities for small building supply businesses and tradesmen, such as plumbing, electrical, appliances and construction material supply.

10. Economic classification of program expenditures. (See table above showing total program of the Division.)

Division of Occupational Health

PART I. DESCRIPTION OF THE PROGRAM

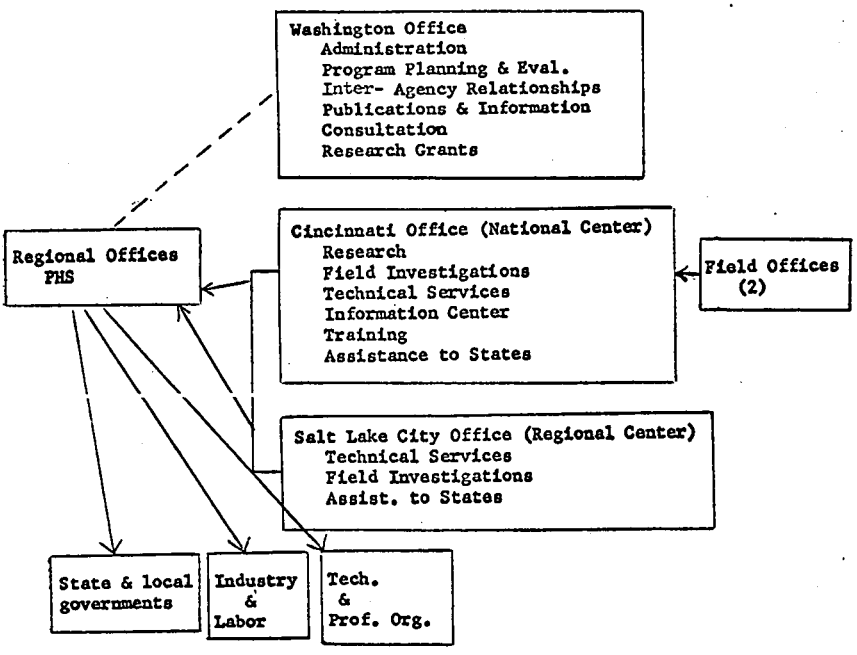
1. Objectives

The objective of the occupational health program is to protect and improve the health of the working population, through the prevention and control of occupational diseases and hazards to health, and through the promotion of preventive health service at the worksite.

The effects of occupation on health, and of health on productivity, are of great significance. Identification of occupationally related disease is often difficult and mechanisms for reporting their incidence and prevalence are inadequate. New chemicals are being introduced into American industry at a prodigious rate and the chemical industry is growing at a rate about three times that of industry generally. The increasing industrial use of chemicals and radioactive substances and the proliferation of new industrial processes are multiplying the number of workers exposed to situations dangerous to health and have increased the complexity of such exposures. Workers can be overwhelmed swiftly by lethal exposure to micro-organisms, chemicals, radiation, physical stress, trauma, and other factors associated with the work environment. On the other hand, many of the effects of such exposures are especially pernicious because they are not readily detected, revealing themselves usually only after long exposure and frequently simulating diseases of nonoccupational origin. Consequently, protection of workers' health from damage arising from their work requires extensive research, calling upon a broad range of scientific disciplines, close cooperation between government, industry and labor, and dissemination of technical information.

2. Operation

The program is wholly a Federal operation but has a working relationship with States and local governments which is carried out through the regional offices of the Public Health Service. The following is a schematic diagram of the program's operational procedures.



The essential elements of the program are:

Problem identification.—Problem areas are identified through various techniques such as morbidity and mortality studies, literature reports, occupational disease reports, problems referred by management and labor, conferences with international sources, and information supplied by State and local governments, universities and professional organizations. Such information is quantified and the necessary action is identified.

Field studies.—Some problems require field epidemiologic studies which involve medical evaluations of the workers at their worksite together with environmental evaluation of the workplace. This technique has been very effective in identifying the etiology of occupational diseases and the necessary medical and engineering procedures for their control.

Research.—Many health problems require a research effort. Therefore, most of the research is problem oriented and related to the toxicity of industrial chemicals, mechanisms of biologic action, diagnostic procedures, development of analytical procedures, engineering controls, and instrumentation.

Technical assistance.—Professional assistance is provided State and local governments and through these agencies to industry and labor for the solution of health problems, which for the most part requires the application of existing knowledge.

Standard setting.—Although the program has no legal responsibility for standard setting, the information gathered in its field investigations and research effort is supplied to official and nonofficial agencies which have a standard-setting role. The widely used threshold limit values have been an outgrowth of this activity.

Training.—The program operates a continuous training program for employees of State, local, and Federal Governments. Training relates to the basic principles of occupational health as well as specialized courses in new problem areas and refresher courses as new information becomes available. Although priority is given to government, a limited number of trainees are accepted from private industry and labor.

Administrative assistance.—Aid is provided to State and local governments in establishing and operating occupational health programs, the administration of programs, and the development of new program areas.

Information center.—To meet a very large demand for technical information on the part of the general public, technical and professional organizations, industry and labor, the program operates a technical information center. Information can be provided quickly on a broad spectrum of subjects including the health effects of almost any industrial chemical and process.

Preventive medical services.—The provision of occupational health services is best done at the worksite through medical and environmental surveillance. To promote the expansion of occupational health services in industry, the program offers a consultation service, makes studies of the most efficient methods of providing services, and maintains a current roster of industry and labor programs.

Implementing findings.—To implement its findings and recommendations the program publishes its scientific works, holds workshops and seminars, develops worker information, and disseminates infor-

mation to the scientific and technical communities through established channels.

Research grants.—Grants are made to universities, hospitals, research institutes, State and local health departments, private and public nonprofit institutions, and to individuals. These grants support basic and applied research in all facets of occupational health. Grants are administered through the Division of Research Grants, National Institutes of Health.

3. History

At the turn of the century, the Nation was plagued with many problems brought on by a rapidly expanding industry. Not the least of these was the severe health problem resulting from uncontrolled exposures to toxic materials. Tuberculosis, silicosis, lead poisoning, and many other occupational diseases were an accepted risk of people entering the work force, and constituted a significant proportion of the Nation's morbidity pattern. Recognizing the severity of occupational diseases and the impact that this was having on industry and labor, the Public Health Service, in 1910, organized a small unit to study several acute areas. The first studies were made in the garment industry of New York, where an excessive rate of tuberculosis was known to exist. This study paved the way to the abolition of the sweatshop and resulted in the establishment of the first union health center, which is still active and providing services to the garmentworkers of New York.

Because of the competence that this group had developed in chest diseases, it was logical that their next studies would be devoted to silicosis, which was rampant in the mining and construction industries and other dusty trades. In 1914 the Public Health Service first established an organized activity in occupational health which was designated as the Office of Industrial Hygiene and Sanitation. This unit has been active for the last 50 years; however, it has had several changes in title as well as administrative location within the Public Health Service.

The early work of the program developed the epidemiology technique for the study of occupational diseases in industry. Such studies were carried out in the pottery industry, the brass foundries, glass and chemical industries, steel plants, textile mills, and others. Through the use of this technique, the program developed an international reputation for the study of occupational diseases. The dust studies undertaken between 1914 and 1940 developed the fundamental principles of prevention, which are in use throughout the world, for the prevention of silicosis and the pneumoconioses. Other milestones were established by the Division during its early years. In 1914 the first investigation of radioactive hazards was initiated in the radium dial plants of New Jersey. In 1931 a full-scale study of industrial dermatoses was launched which led to their recognition as a major health problem of industrial workers. Studies of air pollution in such places as Los Angeles, Donorra, New York, and other major metropolitan centers laid the groundwork for the large-scale program of the Public Health Service regarding air pollution, which came into being in 1956.

With the advent of World War II, the occupational health program turned its attention almost completely to war-related activities. It

was designated as the coordinating agency for industrial hygiene activities in the national defense effort. The program worked closely with the Army, the Navy, the Maritime Commission, the War Production Board, the War Manpower Commission, the Department of Labor, and other agencies in providing adequate protection for industrial manpower. One of the program's major activities was the protection of employees in Government-owned, contractor-operated munitions plants. During the war years, the program also initiated pioneer studies in aviation medicine, effects of exposure to elevated and reduced pressures, and the efficacy of breathing apparatus.

At the end of World War II, emphasis was shifted from a strong research effort to the development of programs in State and local governments. As a result of this activity, occupational health programs are found in 86 jurisdictional units in 41 States. Because of this shift of emphasis, the administrative location of the program was changed from the National Institutes of Health to the Bureau of State Services. In 1949 the program established a regional center in Salt Lake City, Utah, to provide services to the Western States. In 1951 the research and investigation activities of the program were moved from Washington to Cincinnati, Ohio.

There is little doubt that the work of the program has a significant role in bringing about improved health conditions in industry. In addition to its research and investigative activities, it has served as a training ground for many individuals who were ultimately to become outstanding leaders in the field of occupational medicine and hygiene. The training of these individuals, who later went into private industry and universities, was probably the dominant factor in elevating industrial medicine from a first-aid endeavor to the high-prestige level that it has today in providing total preventive health services for workers. Although much remains to be done in the provision of medical services for workers in small plants, the Nation can look with pride to the occupational health services which are being provided by our major corporations.

Changing times bring about changing concepts and problems. Although the program is yet concerned with the classical occupational diseases which have not been totally eliminated, its present planning embraces the concept of the total health of the industrial worker. It is known that although occupational diseases constitute a part of the total morbidity-mortality problem, a much larger proportion is due to those diseases in which the occupational component has not been fully defined. With this in mind, the program is now planning attacks on broad disease entities rather than isolated disease problems. For example, a respiratory disease research unit is being established which plans to attack the total problem of occupational respiratory diseases rather than directing concentrated effort to specific disease conditions such as silicosis or coalworkers' penumoconiosis.

4. Level of operations. (See table 1.)

Program: Division of Occupational Health.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Environmental Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

[Dollars in thousands]

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966, estimate	Fiscal year 1967, estimate
(*a*) Magnitude of the program (thousands of persons affected)	4,565	4,705	5,305	5,835
(*b*) Applicants or participants (occupational health staff): [1]				
State government agencies	519	540	575	600
Local government agencies	162	151	170	175
Other	(2)	(2)	(2)	(2)
(*c*) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$5,022	$5,174	$5,837	$6,345
Allotments or commitments made	0	0	0	0
(*d*) Matching or additional expenditures for the program	(2)	(2)	(2)	(2)
(*e*) Number of Federal Government employees administering, operating, or supervising the activity, total (man-years)	200	209	213	240
Research (man-years)	136	145	149	169
Training (man-years)	27	27	27	30
Technical service (man-years)	37	37	37	41
(*f*) Non-Federal personnel employed in the program, total (estimated man-years)	171	171	213	236
Contracts (estimated man-years)	25	14	28	36
Research grants (estimated man-years)	146	157	185	200
(*g*) Other measures of level or magnitude of performance	(2)	(2)	(2)	(2)

[1] Not funded through Division of Occupational Health.
[2] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The success of the program has been largely dependent upon its cooperative efforts with industry, State and local governments, labor unions, nonprofit organizations, foreign governments and international organizations, and professional societies. The principle of cooperation and coordination has been basic to the execution of the scientific and technical assistance program. The following are given as examples but are not intended to be all inclusive:

(*a*) Informal agreements with the Division of Air Pollution, PHS, relate to the respective responsibilities for research and studies on the health effects of exposure to asbestos and to bituminous coal, and with the Division of Radiological Health regarding radiation exposures of workers, especially uranium miners.

(*b*) By direction of the Bureau Chief, the Division of Occupational Health has the responsibility for the initial development, support, and housing of specified environmental health sciences activities.

(*c*) There has been a cooperative agreement between the Division of Occupational Health (and its predecessor organizations) and the Bureau of Mines, Department of the Interior, since about 1914. When the Bureau of Mines was organized, it was given responsibilities for health and safety in the minerals extraction industries. Because of the availability of medical talent in the Division of Occupational

Health, many cooperative studies have been carried out by these two agencies in the metal- and coal-mining industries, as well as in the training and other related fields. Through this cooperative arrangement, a better quality of investigation has been possible, which has been of economic advantage to each agency. A written memorandum of agreement exists between the Division of Occupational Health and the Health and Safety Activity of the Bureau of Mines. Examples of recent studies conducted by the two agencies are (1) a re-evaluation of silicosis in the metal-mining industry; (2) a study of pneumoconiosis in the bituminous coal mines of the Appalachian region; and (3) cooperative activities in evaluating the health hazards associated with radioactive gas and nucleii in the uranium mines. Cooperative studies which are in the planning stage at the present time include an evaluation of dust conditions in bituminous mines and a long-term followup study of silicosis and dust conditions in the metal-mining industry. Upon request, this Division also carries out certain medical functions for the Bureau of Mines, such as the medical evaluation of Federal coal mine inspectors; the toxicologic appraisal of chemicals being introduced into the mining environment; and the assessment of health effects resulting from mining operations such as diesel fumes, nitrous oxides, and other gases resulting from the use of internal combustion engines.

Because of certain health problems that have recently become apparent in the coal-mining industry, the two agencies are sponsoring a training program for management level personnel in mining companies, professional and technical organizations, and labor unions. Through a joint technical committee, a communication channel has been established with the coal- and metal-mining industries as well as allied professional and technical organizations. This committee has been successful in solving several major problems in the industry before they became national issues.

Almost since the inception of the Department of Labor, there has been a close working relationship between that Department and the Division of Occupational Health. An agreement between the Bureau of Labor Standards and the Division of Occupational Health results in the cross-referral of problems, technical assistance by this Division to the Bureau in performing its responsibilities under the Walsh-Healey Act, and cooperation in the training of labor inspectors in the recognition of industrial health problems. The two agencies also work cooperatively in the training of foreign students in health and safety, the assignment of specialized personnel to foreign countries for consultation in program development, and provision of expert assistance to the International Labour Office.

(*d*) and (*e*). The entire program of the Division of Occupational Health depends upon a close working relationship with State and local governments, through their departments of health and labor. It has been a basic premise that the responsibility of the Federal program was to perform research, develop data for the establishment of standards, and provide technical assistance. The provision of direct services to industry, including inspection, consultation, guidance, and the establishment of standards, has been viewed as a State and local responsibility. There are presently 86 jurisdictional units providing occupational health services in 41 States. This Division has provided the necessary technical backup services for these State and local units

and provides a wide range of professional services including the short-term assignment of personnel for investigation of special and unusual health problems, the short-term loan of scientific equipment for evaluation purposes, and the performance of laboratory services. In addition, the Division provides administrative and technical consultation and short-term training, and sponsors a biennial training seminar for directors of State units. Through our communications channels, the State and local authorities are constantly kept abreast of new problems, new techniques, and other developments of interest in the field. Through a technical information service provided by the Division of Occupational Health, the State may receive answers to almost any problem that arises within its jurisdiction.

(*f*) Although there is no formal method of cooperation or coordination between this Division and foreign governments or international agencies, channels of communication have been established which permit an exchange of information with a number of foreign governments and international agencies. This Division has for many years been recognized by many foreign governments for the excellence of its work and for its leadership, especially in the field of the epidemiology of occupational diseases. The Division provides training, at some level, for an average of 25 foreign representatives each year.

More recently, the Division has engaged in a program of information exchange relative to chest diseases among coal miners with counterpart agencies in the United Kingdom, Holland, Belgium, and West Germany. The exchange of information on this subject has doubtless saved this Division as well as this Government many years of research efforts and permits the research data of these countries to be pooled. An informal conference was recently held by the representatives of the above Governments to compile research information which would permit the establishment of an international dust standard in the bituminous-coal-mining industry. The pooling of such data will doubtless result in a considerable saving of money to each of the participating countries. Cooperative working relationships have been established with the following international organizations: the Occupational Safety and Health Branch, and the Information Exchange Center, International Labor Organization (ILO), the Section on Occupational and Social Medicine, World Health Organization; and the Division of Work Problems, European Coal and Steel Community. Informal working relationships exist with professional organizations, research institutes, and quasi-governmental agencies of many of the Western European countries. Exchange missions in areas relating to occupational health have been developed with the U.S.S.R.

(*g*) There are few nonprofit organizations which relate to the occupational health field. However, the Division has for many years been in close association with nonprofit organizations which impinge on its activities, such as the National Tuberculosis Association, the American Cancer Society, and similar organizations. These relations are generally of short duration for the solution of specific problems.

(*h*) One of the basic programs of the Division is the epidemiologic study of occupational diseases at their place of origin. To accomplish this mission, it is dependent upon a close working relationship with business enterprises throughout the country, since they must volun-

teer their establishments as sites for carrying out medical examinations of workers and evaluations of the work environment. As an example, the recent study of coal pneumoconiosis involved the examination of over 2,000 employees in 75 mining companies. The re-evaluation of silicosis in the metal-mining industry involved the examination of 15,000 miners and the study of the work environment of 69 metal mines. Other recent studies include those on the effect of heat, which was carried out in aluminum reduction and glass manufacturing plants, and at construction sites. The conduct of epidemiologic studies in these industries results from the smooth working relationship which has been established with the industries of the United States but does not call for any signed agreement, reimbursement, or document which would obligate the Federal Government to a set course of action. In any one year, our studies call for admittance to about 100 different businesses or industrial enterprises.

(*i*) The successful pursuit of the mission of the Division of Occupational Health calls for cooperation with many other kinds of organizations and enterprises, including professional and trade organizations, societies for the development of standards, universities, and other professional groups. In this category there exist no agreements or formalized statements of cooperative effort. However, joint interest and the sharing of common missions have brought informal working relationships which are in the best interest of the Government and the Division. Examples of these organizations are:

American Industrial Hygiene Association.
American Conference of Governmental Industrial Hygienists.
Industrial Medical Association.
American Medical Association.
Industrial Hygiene Foundation.
American Standards Association.
Manufacturing Chemists Association.
American Mining Congress.
American Public Health Association.
American Association of Industrial Nurses.
American Nurses Association.
National League for Nursing.

8. Laws and regulations

The program has no specific or enabling legislation but operates under the legal basis of the Public Health Service Act, as amended, particularly sections 301, 311, 314 (42 U.S.C. 241, 243, 246).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Since its inception in 1914, this program has had many significant economic effects and impacts on the working population of the United States. Statistics and figures, however, are not maintained or available which would measure the various economic aspects that are outlined in this question. Some examples may nevertheless be offered of the economic aspects and impact of occupational health on certain disease problems, as well as on the general health of the American worker. Although no single organization or event can be isolated as the sole source of these improvements, the research and

investigative work of this Division are known to have made important contributions.

Example A. Work life expectancy of American males at birth.[1]—

	Years		Years
1900	32. 1	1950	41. 9
1940	38. 3	1960	41. 4

[1] "The Length of Working Life for Males, 1900-60," Manpower Report No. 8, Manpower Administration U.S. Department of Labor, July 1963, p. 7. The report explains (p. 1): "During the decade of the 1950's, the length of working life—a key indicator of economic and social development—reversed its long-term rise. Work life expectancy for men declined by one-half year between 1950 and 1960. This decline is associated with a longer training period prior to entering upon a work career and a drop in the age of retirement, both of which are hallmarks of modern industrial society. During past periods the effects on the length of working life of the longer training period and earlier retirement had been offset by large increases in life expectancy, and work life expectancy had continued to increase. Between 1900 and 1950 life expectancy for a male child increased 18 years, from 48 to 66 years. Work life expectancy also rose but only by 10 years, from 32 to 42 years."

Example B. Silicosis prevention.—In the early studies of this Division conducted between 1914 and 1930, silicosis-prevalence rates as high as 75 percent were common in many industries, especially metal mining. A re-evaluation of the silicosis problem in the metal-mining industry between the years 1958 and 1961 demonstrated a prevalence rate of 3.4 percent. The continued application of engineering and medical control procedures could lead to the total elimination of silicosis in the mining industry.

In the mid-1930's this Division made a detailed study of the granite-cutting industry of Vermont and recommended control procedures. A re-evaluation study of the granite-cutting industry in 1955 indicated that not a single case of silicosis had developed in this industry among employees who started work subsequent to the installation of dust control procedures.

Example C. TNT poisoning.—As a result of this Division's work, disability and death rates during World War II from toxic exposure were lowered to a point never before achieved. The progress may be illustrated by comparison of the number of occupational diseases arising from the manufacture of TNT during World Wars I and II. During the 17½ months of World War I, 475 workers in American arsenals died and 17,000 were disabled because of TNT poisoning. In that war, the United States was supplying only 40 percent of the ammunition for its allies. In World War II, when the United States provided 95 percent of the ammunition for its allies, close supervision of TNT operations by industrial hygienists of the Division of Occupational Health succeeded in controlling the hazard so well that there were only 22 deaths in 35 months.

Example D. Lead poisoning.—In 1920 lead poisoning was a serious occupational disease in many major industries, including lead mining and refining, pottery, battery manufacture, tetraethyl lead manufacture, and others. At present, clinical lead poisoning is rare among industrial workers, although some cases of borderline lead intoxication are reported.

Example E. Mercury poisoning.—Disability due to mercury poisoning in the felt hatting industry was extremely high during the 1930's and early 1940's. Mercury causes a severe neurological disability which ultimately leads to death. Through studies of this industry the incidence of mercury poisoning was greatly reduced. Subsequently, through research, a substitute for mercury was found which totally eliminated the problem. At the present time, mercury poisoning is also a clinical rarity in the United States.

Example F. Lung cancer among chromate workers.—In recent years it was found that there was an abnormally high incidence of lung cancer among chromate workers. Studies of the industry identified the responsible component of chromate ore. As a result, most of the major chromate-ore processers have modernized or completely rebuilt their plants to eliminate this exposure. Since this disease is slow in developing, the effect of this control measure may not be apparent for several years. It is anticipated that with the application of control measures no new cases will develop.

Example G. Growth of health personnel in industry.—

Number of physicians specializing in occupational medicine (full time):

1934	232	1956	1,141
1944	574	1962	1,751

Number of registered nurses employed by industry (full time):

1948	9,560	1964	18,700
1952	11,096		

Number of industrial hygienists employed by industry:

1939 (estimated)	10	1964	1,400
1940 (estimated)	80		

Example H. Sickness absence.—At present the average worker is away from his job five and a half days each year due to illness. On August 18, 1965, President Lyndon B. Johnson pointed out that a reduction of 1 day in this annual rate would add $10 billion to the gross national product. Although there are no national figures for the past decades, the evidence of scattered studies in various industries suggests that there has been a reduction in days lost due to illness. The industrial sickness absence rate is the lowest of the major industrial nations.

10. Economic classification of program expenditures. (See table 2.)

Program: Division of Occupational Health.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Environmental Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	1,928
Other	724
Grants to State and local governments	615
Transfer payments to individuals and nonprofit organizations	1,060
Total Federal expenditures	4,327
Non-Federal expenditures financed by—	
State and local governments [1]	3,000
Individuals and nonprofit organizations [2]	2,000
Business enterprises [3]	345,000
Total expenditures for program	354,327

[1] The figure of $3,000,000 refers to amounts spent by State and local governments on occupational health prevention and control services, primarily to industries.

[2] Estimated amount spent by private foundations, universities, and professional organizations on occupational health services.

[3] Estimated employment covered is 15,200,000. Estimated amount spent by private industry primarily for company medical programs and some industrial hygiene programs.

Division of Radiological Health

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To plan, conduct, and coordinate a national program directed to the understanding and prevention of health impairments resulting from exposures to ionizing radiations, and the application of ionizing radiations and their sources to the preservation and betterment of health.

2. Operation

The rapid increase in peacetime uses of nuclear energy, including military and industrial use of power reactors, introduces problems of radiation exposure and radioactive waste disposal; the use of radioisotopes and X-rays in medical diagnosis and therapy touches all segments of the population. Radioactivity levels from nuclear weapons tests in previous years have indicated the need to improve nationwide surveillance and studies of methods to reduce and control exposure from those sources which are susceptible to control. For the most part, health agencies lack trained personnel, equipment, funds, and legislation adequate to meet these problems.

Program activities include:

State assistance.—Assist State and local health agencies in the development of radiological health program, including State program development grants; conduct demonstrations in the application of new methods and equipment for surveillance and control of health hazards from radiation.

Training.—Develop a national training program to increase the supply of professional personnel serving State, local, and Federal agencies, industry, and universities through conduct of short courses and provision of training grants to support university curriculums.

Research.—Study the biological effects of radiation through human epidemiological studies with appropriate radiological support; collate, analyze, and interpret radiation exposure data and develop control techniques; provide research grants to private investigators.

Technical operations.—Conduct nationwide environmental monitoring programs. Administer laboratories at Las Vegas, Nev., Montgomery, Ala., Rockville, Md., and Winchester, Mass. Provide technical laboratory services and training. Administer safety programs in conjunction with the Atomic Energy Commission, Department of Defense, and other Federal agencies.

3. History

In July 1958, the Surgeon General established the Division of Radiological Health in the Public Health Service. The new division was assigned the mission of developing a comprehensive program of radiological health in the Public Health Service in collaboration with other related programs of the U.S. Department of Health, Education, and Welfare.

In the development of a comprehensive program, three major tasks have been undertaken:

A nationwide system of radiation surveillance;

An evaluation of the long-term health effects of radiation;

Development of methods and programs by which radiation exposure can be reduced or prevented.

4. Level of operations. (See table 1.)

Program: Division of Radiological health.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Environmental Health).

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 estimates
(a) Magnitude of the program:				
Research grants	98	95	101	99
Training grants	46	44	46	44
State program grants	53	53	53	53
Milk sampling locations (cities)	63	63	63	63
Air sampling stations	74	79	79	79
Diet sampling institutions	44	50	28	28
Laboratories	5	6	6	6
(b) Participants:				
States	50	50	50	50
Territories	3	3	3	3
(c) Federal finances:				
Unobligated appropriations available:				
Direct appropriations	$19, 377, 000	$19, 720, 000	$21, 044, 000	$20, 404, 000
Reimbursement	2, 300, 000	2, 300, 000	2, 800, 000	2, 800, 000
Total	21, 677, 000	22, 020, 000	23, 844, 000	23, 204, 000
Obligations incurred:				
Direct appropriations	19, 201, 000	19, 322, 000	21, 044, 000	20, 404, 000
Reimbursement	1, 334, 000	1, 817, 000	2, 800, 000	2, 800, 000
Total	20, 535, 000	21, 149, 000	23, 844, 000	23, 204, 000
Funds available for:				
Direct operations	14, 968, 000	14, 898, 000	16, 298, 000	15, 827, 000
Grants:				
Research	2, 209, 000	2, 122, 000	2, 546, 000	2, 377, 000
Training	2, 500, 000	2, 500, 000	2, 500, 000	2, 500, 000
State program development	2, 000, 000	2, 500, 000	2, 500, 000	2, 500, 000
(d) State matching funds	2, 990, 000	3, 351, 000	(1)	(1)
(e) Federal Government:				
Employees administering and operating (man-years):				
Appropriation	782	788	788	795
Reimbursement	129	166	198	248
Total	911	954	986	1, 043
(f) Non-Federal personnel (State personnel)	297	346	(1)	(1)
(g) Other measures of magnitude or performance:				
Training:				
Short courses:				
Resident (trainees)	1, 044	357	350	350
Field (trainees)	536	317	400	400
Students supported by stipends from grants	296	360	425	425
Surveys of dental X-ray machines:				
Number of States	48	52	52	53
Number of machines	7, 000	9, 400	9, 400	9, 400
Surveys of medical X-ray machines:				
Number of States	30	35	40	45
Number of machines	20, 000	22, 000	25, 000	29, 000
Milk samples analyzed	2, 076	2, 076	2, 076	2, 076
Air samples analyzed	25, 000	25, 000	25, 000	25, 000
Diet samples analyzed	600	600	300	300

[1] Not available.

Notes for question No. 4:

(d) Data on State expenditures are furnished by the States after the close of each fiscal year. Data for fiscal year 1965 are not yet all available. Therefore the figure given for fiscal year 1965 is an estimate based on partial returns.

(f) Same comment as for (d). State reporting for fiscal year 1965 not yet complete.

(g) Figures given for numbers of medical and dental X-ray machines surveyed by States in fiscal year 1965 are estimates based on an as yet incomplete report by States.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) Milk- and food-sampling programs are conducted cooperatively with the milk and food program of the Division of Environmental Engineering and Food Protection. Technical aspects of all programs related to radiation in the environment are coordinated through an interlaboratory technical advisory committee. Medical and dental X-ray activities include services to and cooperation with the Division of Hospitals and Division of Indian Health.

(*b*) Milk and food collection and analyses programs are coordinated with the Food and Drug Administration.

(*c*) i. *Federal Radiation Council.*—The Secretary of Health, Education, and Welfare was designated chairman of the FRC when it was established in 1959. The Deputy Chief, Division of Radiological Health, is the Department's representative on the working group of the Council.

ii. *Atomic Energy Commission.*—A number of formal and informal coordination and cooperation points exist between the Department and the Service and the Atomic Energy Commission. Designated contact points exist in the Office of the Secretary, the Surgeon General's Office, and their counterparts in the Commission. The Division of Radiological Health has a variety of contacts as outlined below.

AEC Division of Biology and Medicine—Scheduled meetings of senior staff to exchange program information and provide for coordination on projects of mutual interest.

AEC Nevada Operations Office—Under a memorandum of agreement, provide off-site radiological safety support for testing activities at the Nevada Test Site and for events conducted at other locations. Also conducting a research effort related to radioiodine releases from testing activities at NTS. These activities are funded by AEC at a current level of about $1.9 million with a personnel strength authorized at 188 officers and employees.

Less formal working level contacts exist with the following AEC divisions: Safety Standards; Materials Licensing; Reactor Licensing; State and Licensee Relations; Military Applications; Operational Safety; Production; Raw Materials; Peaceful Nuclear Explosives; Isotopes Development; Reactor Development and Technology; and Public Information.

iii. *Department of Defense.*—Joint Task Force Eight—A memorandum of agreement to conduct off-site radiological safety operations during Pacific test operations and to maintain a standby capability to conduct such operations in the event testing is resumed in the Pacific area. This work is done under reimbursement from JTF–8 and AEC.

Defense Atomic Support Agency—Maintain program planning liaison.

Department of the Air Force—Member of the Nuclear Reactor Systems Safety Group. Under memorandums of agreement, conduct off-site radiological safety activities during launches involving nuclear power sources from Cape Kennedy and Vandenberg Air Force Base. Have a liaison officer on detail to Eastern and National Test Ranges, Patrick Air Force Base, to plan and coordinate these activities.

Department of the Navy—Working with the Bureau of Ships (also AEC Division of Naval Reactors) on radiation standards and operational procedures for nuclear-powered ships and related shore installations. In this regard have an officer detailed on a reimbursable basis to the Pittsburgh Naval Reactors Office. Have acted as liaison between the Navy on this program and State health agencies in developing mutually acceptable environmental surveillance operations in the vicinity of shore installations.

iv. *Maritime Administration.*—Provide backup health physics personnel for the NS *Savannah.* Also develop radiological safety and surveillance criteria for ports of call. This is done under a memorandum of understanding that provides for reimbursement.

(*d*) *State governments.*—The Division of Radiological Health's State Assistance Branch administers the grant-in-aid program for States and territories. It provides program consultation and assistance (including the detail of personnel) through regional program directors located in each of the nine DHEW regional offices.

The Division's three regional laboratories located at Winchester, Mass., Montgomery, Ala., and Las Vegas, Nev., provide technical consultation, assistance, and training.

(*e*) *Local governments.*—In general, assistance is provided through or on behalf of the State agency.

(*f*) *Foreign governments and international organizations.*—Have provided expert consultation on radiological health matters to the World Health Organization and the Food and Agriculture Organization of the United Nations. Also participate on special advisory panels for these organizations and the International Atomic Energy Agency. Equipment and laboratory services for radiological surveillance are furnished on a limited basis to some Latin American governments through the Pan American Health Organization. A regular exchange of surveillance information is maintained with Canada and Mexico.

(*g*) Nonprofit educational and research organizations receive training and research grants. Directors of programs receiving training grants meet periodically with Division of Radiological Health staff to exchange information and discuss problems of mutual interest. A number of educational and research organizations have research contracts with the Division.

(*h*) *Business enterprises.*—No formal program element involves business enterprises except as program operations affect radiological health standards of their operations. Members of the staff work actively with the Atomic Industrial Forum with, for example, membership on their public understanding committee.

(*i*) *Others.*—Cosponsorship of meetings, seminars, publications, etc., with professional organizations such as the American College of Radiology, American Hospital Association, State Medical and Dental Societies, etc.

8. Laws and regulations

(*a*) Public Health Service Act, as amended, particularly sections 301, 311, 314 (42 U.S.C. 241, 243, 246); Public Law 87–582.

(*b*) Public Law 86–373.

(*c*) Executive Order 10831.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic effects of the radiological health program would be difficult if not impossible to quantify except for actual program expenditures. In considering benefits to individuals, it is undoubtedly true that those who receive education and research experience through training and research grants do have their earning power enhanced and will be more productive in their chosen professions.

In considering the impact of the program, one must consider that one of its objectives is to assure that the many benefits that may occur through the use of radiation and atomic energy will not be denied because of unwarranted public fear. In this context the existence of a competent and active radiological health program within the public health structure of the Nation to evaluate the risks involved should do much to allay such fear. This should, in turn, have an economic effect, though indirect.

That part of the program dealing with the clinical radiological sciences has the potential of contributing to the availability of improved medical care to the population, by allowing more efficient use of the unique talents of available radiologists and increased use of diagnostic X-rays without a corresponding increase in radiation dose to the population. This contribution to the preservation of public health is a part of the whole which should contribute to the productivity of the country.

The program does have geographical differentials. The Nevada Test Site requires that the surrounding area be given a more concentrated radiological surveillance coverage than the balance of the Nation. This is particularly true of northern Nevada and southern Utah. However, all of the States in the western part of the country are covered by supplemental, standby milk- and air-sampling stations which can be activated as necessary.

The effect of program expenditures is probably most pronounced in those cities in which field laboratories are located; that is, Montgomery, Ala., Winchester, Mass., Cincinnati, Ohio, and Las Vegas, Nev. The relative effect of the Rockville, Md., laboratory would be somewhat less.

10. Economic classification of program expenditures. (See table 2.)

Program: Division of Radiological Health.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of State Services (Environmental Health).

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	5, 280
Other	5, 257
Grants to State and local governments	5, 743
Transfer payments to individuals and nonprofit organizations	2, 399
Total Federal expenditures	18, 679

BUREAU OF MEDICAL SERVICES—DIVISION OF HOSPITALS: MEDICAL CARE FOR FEDERAL BENEFICIARIES

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

(*a*) Provide health services for persons designated by Congress as Public Health Service beneficiaries; e.g., American seamen, uniformed services personnel and their dependents, narcotic addicts, persons afflicted with leprosy, and others.

(*b*) Conduct programs of training and research aimed toward improved resources for preserving and protecting health;

(*c*) Consult with other Federal agencies on employee health activities; and under contract, establish and operate Federal employee health programs for other Federal agencies.

2. Operation

Operates primarily on the basis of appropriated funds which are augmented by reimbursements from other Federal agencies and other nonbeneficiaries for services rendered under law and regulation; provides direct medical services through a system of general-medical-surgical (11), narcotic addiction (2), leprosy (1), and Public Health Service hospitals; outpatient clinics (27); and private physicians (205), under contract on a fee-for-services basis; also makes payments to the State of Hawaii for the care and treatment of persons afflicted with leprosy.

3. History

Medical care to American seamen was initiated through legislation signed by President John Adams entitled "An Act for the relief of sick and disabled seamen," on July 16, 1798. Initially, the program was supported by assessments against the pay of seamen. In 1884, a tonnage tax replaced the hospital tax and in 1905, the tonnage tax was rescinded and the program financed henceforth entirely by congressional appropriations.

Since the inception of the program numerous other categories of Federal beneficiaries were added to the original seaman group.

HISTORY OF THE DIVISION OF HOSPITALS

LIST OF BENEFICIARIES

1798: American seamen—for medical care.
1802: Foreign seamen—for medical care (on pay basis).
1894: Revenue cutter service and lifesaving service (Now U.S. Coast Guard)—for medical care.
1906: Federal employees suspected of having tuberculosis—for medical examination.
1911: Special study patients—for medical care.
1913: Field personnel of the Public Health Service injured or taken ill in line of duty—for medical care.
Commissioned officers of the Public Health Service—for medical care.
1915: Seamen applying for certificates and licenses—for physical examination and instruction in first aid.
1916: Federal employees (beneficiaries of the Employees' Compensation Commission) injured or taken ill in line of duty—for medical care.
Lighthouse keepers and assistant lightkeepers—for medical care.
1917: Hansen's disease patients—for medical care.
Arriving aliens—for medical examinations.
Beneficiaries of War Risk Insurance Bureau (now Veterans' Administration)—for medical care (on pay basis).

1918: Officers and men on vessels belonging to the Bureau of Fisheries (now Fish and Wildlife Service)—for medical care.
1919: Civilian seamen on vessels of the Mississippi River Commission, the Army Engineer Corps, Coast and Geodetic Survey, and Army transports—for medical care.
Officers and crew members of the Coast and Geodetic Survey—for medical care.
1920: Retiring civil employees—for medical examinations.
Dependents of PHS commissioned officers—for medical care (hospitalization on pay basis).
Arriving aliens—for medical care (on pay basis).
1924: Applicants for Federal employment—for medical examination when referred by the Civil Service Commission.
Federal employees—medical examination to determine fitness for duty.
1928: Retired officers and enlisted personnel of the U.S. Coast Guard—for medical care.
1930: Retired lightkeepers and assistant lightkeepers—for medical care.
1936: Seamen on Government vessels and State school ships—for medical care.
1937: Dependents of active and retired Coast Guardsmen—for medical care (hospitalization on pay basis).
1939: Retired personnel of the Coast and Geodetic Survey—for medical care.
Dependents of active and retired personnel of the Coast and Geodetic Survey—for medical care (hospitalization on pay basis).
1944: Maritime service enrollees on active duty—for medical care.
Retired commissioned officers of the Public Health Service—for medical care.
Dependents of retired PHS commissioned officers—for medical care (hospitalization on pay basis).
1956: Active duty and retired members of the Armed Forces—for medical care.
Dependents of active duty and retired members of the Armed Forces—for medical care (hospitalization on pay basis).
Dependents of deceased members of the Armed Forces—for medical care (hospitalization on pay basis).

4. Level of operations. (See table 1.)

Program: Medical care for Federal beneficiaries.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of Medicinal Services—Division of Hospitals.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year			
	1964	1965	1966 estimate	1967 estimate
Medical care (total program inclusive of training and research):				
Inpatient days, average daily patient load	4,919	4,770	4,832	4,338
Outpatient visits	1,384,092	1,449,788	1,492,350	1,516,825
Direct funding (obligations)	$51,293,000	$55,064,000	$59,038,000	$61,643,000
Employees	7,027	6,595	6,900	7,183
Training:				
Employee participants	293	307	389	487
Direct funding (obligations)	$1,583,087	$1,607,766	$1,910,766	$2,245,000
Research:				
Projects	102	77	93	129
Direct funding (obligations)	$1,380,000	$995,000	$1,093,000	$1,402,000
Employee participants	142	105	121	141

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation. (The distinction between (i) and (ii) is that noted in the committee print, question 7.)

(*a*)(i) Establishment of joint facilities in selected areas with the Division of Indian Health for beneficiary care, for example, Alaska; also with the Foreign Quarantine Division. (ii) By formal agreement between divisions.

(*b*)(i) Participate as treatment and demonstration centers for PHS programs requiring "laboratory" facilities and patient populations.

(ii) By formal agreement and grants from other PHS Divisions and the National Institutes of Health.

(*c*)(i) Provides direct service and consultation to the Bureau of Employees' Compensation, Maritime Administration, Coast and Geodetic Survey (ESSA), and other Federal agencies as requested. (ii) On basis of statute and Economy Act.

(*d*) Not applicable except in respect to supporting treatment of leprosy in Hawaii as provided in appropriation act.

(*e*) Not applicable.

(*f*) Not applicable except for orientation and training provided nationals of foreign countries as arranged by AID, State Department, and other Federal agencies operating in the international area.

(*g*)(*i*) Not applicable except in respect to affiliated training and research programs with university medical schools and community hospitals. (ii) Arrangements consummated through affiliation agreements for residency training in medical and adjunctive areas and collaborative research.

(*h*)(*i*) Not applicable.

8. Laws and regulations

Public Law 410, 78th Congress, as amended (PHS Act) title III, part C. Section 301 in respect to research.

Public Law 569, 84th Congress, Dependents' Medical Care Act.

Public Law 156, 89th Congress, Appropriation Act.

Public Law 71, 88th Congress, C. & G.S. retired ships' officers and dependents.

Public Law 658, 79th Congress, as amended, Federal employee health program.

Public Law 89–74, Drug Abuse Control Amendments of 1965.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) Persons served are provided free medical care. To that extent, personal incomes are not used for medical care expenses. The families of seamen are not eligible for similar benefits. The families of uniformed service personnel, active duty and retired, receive varying and limited benefits. To the extent that dependents must procure medical and dental benefits at their own expense, the disposable personal income of their sponsors is affected.

(*b*) Medical benefits provided seamen, uniformed service members, and other beneficiaries help these persons to maintain their employability and productive years of life in the maritime industry, the uniformed services, and the Federal establishments. Both the size and productivity of the labor force are maintained as a result of the program with the broader effect of a reduction in the economic loss from sickness absenteeism.

(*c*) The availability of medical care to seamen represents an inducement to maritime employment and recruitment in the maritime industry. The training of medical and paramedical personnel has its impact by way of an increase in the supply of trained manpower in and out of the Federal Government.

(*d*) Economic activity in the maritime industry and in the Federal Government is stabilized through the fringe benefits made available to employees in those employment categories. In the maritime industry, those benefits represent a cost of transportation which thus does not have to be borne as a part of the direct operating cost of the carriers.

(*e*) In respect to the treatment of leprosy patients (Carville), and narcotic addicts (Lexington, Ky., and Fort Worth, Tex.), the States and communities throughout the country are benefited to the extent that care and treatment are provided without reimbursement from such States or communities.

(*f*) Medical care facilities of the communities in which PHS medical facilities are existent are not overtaxed to the extent that Service beneficiaries utilize Service accommodations in those areas. In the case of dependents of active duty uniformed service personnel, there is some impingement on community hospitals when nearby Federal facilities are not adequate for their requirements.

(*g*) The maintenance of the health of beneficiaries tends to support the growth of the gross national product through the continuing employability of beneficiaries in their respective vocations.

(*h*) Essentially the total economic impact of the program is covered above. In addition, it is significant that approximately 307 medical, dental and paramedical students are being trained (fiscal year 1966) through programs in the hospitals and outpatient clinics operated by the Public Health Service. As previously mentioned, training is provided in accordance with and in support of affiliations with university programs. The research activities carried on in PHS hospitals in collaboration with other Federal programs and medical schools and institutions tend to enlarge the knowledge of the causes and treatment of disease. This activity also fosters the creation of new ideas, methodologies, and other forms of innovation in the field of medical and hospital administration.

10. Economic classification of program expenditures. (See table 2.)

Program: Medical care for Federal beneficiaries.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of Medical Services—Division of Hospitals

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	41,297
Other	11,990
Grants to State and local governments	1,194
Total Federal expenditures	54,481
Non-Federal expenditures financed by: State and local governments	251
Total expenditures for program	54,732

DIVISION OF FOREIGN QUARANTINE

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The objective of the Division of Foreign Quarantine is to prevent the introduction, transmission or spread of communicable disease from abroad. The programs carried out to meet these objectives are divided into two direct responsibilities:

(*a*) To prevent the introduction of quarantinable and other dangerous, contagious diseases into the United States by quarantine measures, such as—inspection and vaccination of persons and animals, and inspection of conveyances and things specified by quarantine law.

(*b*) To evaluate for excludable conditions all aliens with mental or physical defects specified under immigration law.

2. Operation

The Division of Foreign Quarantine is a direct Federal operation, conducted through 52 local Public Health Service quarantine stations, which serve 408 ports of entry in the United States. The Foreign Operations Branch has 25 staffed stations, 6 of which operate as area headquarters abroad. In addition to the Public Health Service stations there are contract facilities which function under the support and direction of area offices and are supervised by the Division of Foreign Quarantine headquarters staff. The Division of Foreign Quarantine gives technical assistance to State, local and private health organizations and to segments of private industry as well as to the activities of the Departments of Justice, State, Labor, Agriculture, Treasury, Defense, and other Federal agencies as they apply to quarantinable and certain other infectious diseases, and to aliens, foreign workers, and certain other segments of the traveling populations. It contracts with local foreign national physicians, medical groups and laboratory facilities for the medical evaluation of aliens seeking admission to the United States.

The Division of Foreign Quarantine serves as a manpower resource in the area of its specialty for numerous segments of other Federal agencies in times of emergency and to the World Health Organization, Pan American Health Organization, and Pan American Sanitary Bureau. In the forthcoming year it is undertaking to develop, on a continuing basis, a program of training for foreign and domestic assignments, commissioned personnel to fill the professional needs of the Division of Foreign Quarantine and related organizations; and it continues to train quarantine inspectors and related personnel on an annual basis to fill its requirements for border inspectional staff. It acts as the central coordinating agency for the collection and distribution of knowledge concerning epidemic diseases which occur throughout the world. It serves as a model for quarantine activities to the emerging nations and works in close cooperation with other established quarantine services in the more advanced nations.

3. History

In 1794 Congress initiated an act, limited to 2 years, enabling the appointment of a quarantine health officer for the Port of Baltimore. In 1796 it authorized the President " * * * to direct the revenue officers and the officers commanding forts and the revenue cutters

to aid in the execution of health laws of the States, respectively, in such manner as may to him appear necessary." In 1799 Congress repealed the act of 1796 and placed Maritime Quarantine under the Secretary of Treasury. In 1875 Surgeon General Woodworth centralized the quarantine services of the marine hospitals as the first coordinated Federal act for the control of disease from abroad. In 1878 he stimulated Congress to pass " * * * an act to prevent the introduction of contagious, infectious diseases into the United States." With a 4-year hiatus, during which the "National Board of Health" functioned in quarantine, the quarantine activities of the Marine Hospital Services continued with increasing responsibility, as State quarantine functions were assumed by it. The act of 1893 established the legal basis for the quarantine activities of the Service and provided for the assignment of officers to foreign duty. Since this act, additional responsibilities including rat-proofing, aircraft inspection, insect and other vector control, animal and bird import restrictions, immigration examinations and the assumption of numerous other activities have continued to the present.

4. Level of operations. (See table 1.)

Program: Foreign quarantine.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of Medical Services, Division Foreign Quarantine.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Unit	Fiscal year			
		1964	1965	1966 estimate	1967 estimate
(a) Magnitude of the program in—					
Persons inspected	Persons	117,776,152	122,956,928	128,800,000	133,626,000
Visa applicant medical examinations	do	170,073	190,699	243,300	259,100
(b) Applicants or participants:					
State government agencies					
Local communities or governments					
Individuals or families	Individuals	117,946,225	123,147,627	129,043,300	133,885,100
Other					
(c) Federal finances:					
Unobligated appropriations available					
Obligations incurred	Dollars	6,546,826	7,006,508	7,525,000	8,030,000
Allotments or commitments made	Number of allottees	27	30	32	32
(d) Matching or additional expenditures for the program (reimbursable overtime) [1]	Dollars	464,522	525,071	570,000	584,000
(e) Number of Federal Government Employees administering, operating, or supervising the activity:					
Examination of aliens and quarantine inspections at U.S. ports	Man-years	511	517	517	511
Examination of visa applicants in foreign countries	do	102	119	127	123
Headquarters	do	26	26	26	26
Total		639	662	670	660
(f) Non-Federal personnel employed in the program	Number of fee basis contracts	266	271	289	280
(g) Other measures of level or magnitude of performance:					
Vessels cleared	Carriers	34,982	35,420	35,900	36,300
Aircraft cleared	do	72,437	78,696	83,000	87,000

[1] Reimbursement from water and air transportation firms.

5. Estimated magnitude of the program in 1970
Not answered.

6. Prospective changes in program orientation
Not answered.

7. Coordination and cooperation
7(a) Within the Bureau:—
Division of Hospitals:
1. Professional consultation and services; hospital medical officers in charge acting as quarantine medical officers in charge.
2. Isolation facilities for suspects picked up at ports of entry.
3. Medical laboratory services in diagnosis.
4. Accounting, budget, and supervisory services for local stations of the Division of Foreign Quarantine.

Division of Indian Health:
1. Supply services.

7(b) With other units of your department or agency.—
1. Office of International Health:
(a) Matters pertaining to World Health Organization.
(b) Advisory relationship with certain other countries.
2. Communicable Disease Center:
(a) Medical laboratory services for diagnosis and quarantine suspects.
(b) *Aedes aegypti* eradication program collaboration.
(c) Rabies control program consultation.
(d) Exchange of epidemiology information.
(e) Surgeon General's Committee on Immunization Practice.
(f) Inservice training for entomologists and biological aids.
3. Division of Environmental Engineering and Food Protection:
(a) Water sanitation studies advice.
(b) Assisting foreign shipbuilders and owners regarding sanitation factors in vessel construction.
(c) Inspection of catering points at international ports.
(d) Inservice training for quarantine personnel.
(e) Advising regional health officers of insanitary conditions noted at international ports.
4. Division of Occupational Health:
(a) Air pollution studies at inspection stations on the Mexican border.
(b) Occupational hazards of imported raw material.
5. Division of Radiological Health: (a) Radiation exposure in chest X-ray work at quarantine stations.
6. Division of Biological Standards (NIH): (a) Vaccine and immunization standards.
7. Office of Assistant Secretary (Health and Scientific Affairs) Department of Health, Education, and Welfare: (a) Special medical issues.
8. Welfare Administration—DHEW: (a) Matters dealing with Cuban refugees.

7(c) With other Federal Government departments or agencies.—
1. Department of State: (a) Medical examinations of immigrants requiring visas to the United States.
2. Department of Justice: (a) Immigration laws and procedures for persons entering this country.

3. Department of Commerce: (*a*) Facilitation Committee on International Air and Sea Traffic.

4. Department of Labor: (*a*) Medical examination of Mexican laborers entering the United States.

5. Department of Treasury: (*a*) Practices and procedures of the Bureau of Customs as they relate to international travelers.

6. Department of Agriculture: (*a*) Practices and procedures as they relate to international traveler.

7(*d*) *With State governments or their instrumentalities.*—With State governments or their instrumentalities within the quarantine operation, this Division contacts State health officers as necessary.

1. Issuances of surveillance orders to persons who are suspected of having been exposed to quarantinable diseases.

7(*e*) *With local governments or communities.*—Within the quarantine operation, the Division contacts local health officers or physicians as necessary.

1. Issuance of surveillance orders to persons who are suspected of having been exposed to quarantinable diseases.

7(*f*) *With foreign governments or international organizations.*—World Health Organization and Pan American Health Organization: (*a*) Coordinate and exchange medical information.

7(*g*) *With nonprofit organizations and institutions.*—See above.

7(*h*) *With business enterprise.*—See above.

7(*i*) *With others.*—See above.

8. Laws and regulations

Quarantine function.—Law:

Excerpt from Public Health Service Act, as amended: Part G—quarantine inspection, sections 361–369 (42 U.S.C. 264–272). Basic provision—section 361(a):

> The Surgeon General, with the approval of the Secretary is authorized to make and enforce * * * regulations * * * to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or or possessions * * *.

U.S. regulations: Foreign quarantine regulations of PHS, DHEW (title 42 Code of Federal Regulations, pt. 71).

International regulations: International Sanitary Regulations issued by the World Health Organization.

U.S. Executive orders:

No. 9708 of March 26, 1946, as amended by No. 10532 of May 28, 1954, and by No. 11070 of December 12, 1962:

> Specifies communicable diseases for purpose of regulations providing for apprehension, detention, or conditional release of individuals (such Executive order is required by sec. 361(b), PHS Act).

No. 10399 of September 27, 1962:

> Designates Surgeon General as "Health Administration" to implement international sanitary regulations.

Immigration-medical function.—Law:

Excerpt from Public Health Service Act, as amended—section 325 (42 U.S.C. 252):

> The Surgeon General shall provide for making, at places within the United States or in other countries, such physical and mental examinations of aliens as are required by the immigration laws, subject to administrative regulations prescribed by the Attorney General and medical regulations prescribed by the Surgeon General with the approval of the Secretary.

Provisions of the Immigration and Nationality Act, as amended through June 30, 1964 (8 U.S.C. 1182, 1201, 1224):

Especially sections 212(a)(1)–(7) (excludable medical conditions); 212(g) (admission of certain aliens with tuberculosis subject to controls prescribed by Attorney General in consultation with Surgeon General); 221(d) (medical examination of visa applicants); and 234 (medical examination of arriving aliens).

Regulations:

Public Health Service: Regulations for medical examination of aliens (title 42 Code of Federal Regulations, pt. 34).

Immigration and Naturalization Service: Title 8, Code of Federal Regulations, paragraph 212.7(b) (control provisions for admission of tuberculous immigrants under waiver; requires assurance of adequate care, with reports to New York quarantine station).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

9(*c*) *Effects on business and industrial organization.*—The program has significant direct and indirect effects on business activities. International travel of persons has increased markedly in recent years and is likely to continue to expand; the effective and rapid conduct of quarantine procedures facilitates these movements while maintaining the necessary level of protection against the importation of dangerous diseases. Similarly, the facilitation of clearance of commercial carriers (i.e., vessels and airplanes) contributes to the ease and efficiency with which these business activities are carried on; to this end, the program participates in the work of the National Facilitation Committee of the Department of Commerce.

9(*e*) *Other benefits.*—The primary benefit of the quarantine program to the public is in the prevention of the importation and spread of communicable disease from foreign countries. As in the case of other successful preventive programs, its economic benefits are difficult to measure. However, examples of costs resulting from failure of the program may be estimated from an analysis of a hypothetical case of smallpox imported into the United States with 15 secondary cases; this was estimated at $720,000 in direct costs. (In 1962, according to the London Times, in a smallpox epidemic in England comprising 66 primary and secondary cases, of whom one-quarter died, the direct economic costs were estimated to be approximately $3 million.) The additional indirect costs of disruption of business and personal activities, as well as the human discomfort and anxiety, are immeasurable.

Other economic effects relate to the importation of animals and other things. For example, the importation of psittacine birds for commercial purposes is controlled. Similarly, other items involving potential health risks are evaluated and, as indicated, restricted.

9(*f*) *Pertinent geographical differentials.*—The quarantine program is focused at "ports of entry" into the United States. While originally quarantine was centered on major coastal cities, the growth of air travel has dramatically altered conditions and needs. In 1965, quarantine procedures were provided at over 400 locations across the United States.

10. Economic classification of program expenditures. (See table 2.)

Program: Foreign quarantine.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of Medical Services, Division of Foreign Quarantine.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government: [1]	
Purchase of goods and services:	
Wages and salaries	5.9
Other	1.1
Total Federal expenditures	7.0
Non-Federal expenditures financed by business enterprises	.5
Total expenditures for program	7.5

[1] Expenditures here refer to obligations. Actual disbursements were $6,900,000.

DIVISION OF INDIAN HEALTH

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The goal of Federal programs for Indians is to provide them with the means to attain economic and social self-sufficiency within the mainstream of American life. In order to achieve this goal it is necessary to improve the health of the Indian communities and provide the Indians with a general understanding of the nature and purpose of scientific medicine.

2. Operation

Almost wholly a Federal operation conducted through area offices, hospitals, and health centers with headquarters supervision. Some services for Indians are purchased from community hospitals or from private physicians and dentists. Also, some services are purchased from State or county governments.

3. History

The Indian health program was transferred to the Public Health Service from the Bureau of Indian Affairs effective July 1, 1955, under the act of August 5, 1954 (68 Stat. 674). There are more physicians, dentists, nurses, and other health personnel on duty now than ever before and there have been many program improvements since 1955, but the essential mission of conservation of health of Indians is a continuation and improvement of work begun in the early 1800's under the War Department and continued from 1849 to 1955 in the Bureau of Indian Affairs of the Department of Interior.

4. Level of operations. (See table 1.)

Program: Indian health program.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; Bureau of Medical Services—Division of Indian Health.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	1965	1966 estimate	1967 estimate
(a) Magnitude of the program:				
Average daily inpatients	3,211	3,127	3,140	3,206
Outpatient visits	1,294,400	1,330,012	1,399,000	1,493,700
(b) Applicants or participants:				
State government agencies				
Local communities or governments				
Individuals or families (individuals)	380,000	380,000	380,000	380,000
Other				
(c) Federal finances:				
Unobligated appropriations available (millions of dollars) [1]	74.0	76.6	86.4	88.6
Obligations incurred (millions of dollars)	69.6	72.5	85.8	87.8
Allotments or commitments made				
(d) Matching or additional expenditures for the program				
(e) Number of Federal Government employees administering, operating, or supervising the activity	5,210	[2] 5,275	5,444	5,832
(f) Non-Federal personnel employed in the program				
(g) Other measures of level or magnitude of performance [3]				

[1] For each year, this amount includes what is on the obligations incurred line. The difference is chiefly construction funds, available until expended. Thus, for 1964, approximately $4,400,000 of what was available was not obligated.
[2] Includes 325 physicians, 104 dentists, 1,011 nurses, and 55 sanitary engineers.
[3] Attached exhibit A portrays Indian health problems and exhibit B shows some of the trends in the program.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) Within your bureau, division or office:

We have cooperative agreements with the Division of Hospitals and Division of Foreign Quarantine for the operation of clinics serving Indian beneficiaries and merchant seamen on a combined basis and for coordination of quarantine functions in Alaska.

(*b*) With other Federal Government Departments or offices:

We cooperate with the Bureau of Indian Affairs on matters related to work on Indian reservations. We cooperate with the office of Economic Opportunity on projects developed by Indian groups, surveys of job camp sites, and physical examinations. Our supply program is conducted in strong cooperation with Federal Supply Service of General Services Administration and with the Veterans' Administration.

8. Laws and regulations

68 Stat. 674, 73 Stat. 267, and 71 Stat. 370, 371 are the specific laws governing the Indian health program. Our operations are covered, of course, by parts of title 42, United States Code, the Public Health Service Act, and by general legislation such as the Civil Service Act.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) Effects on personal incomes of persons:

An Indian or Alaska native whose health is good is better equipped for work to earn an income. Our responsibility is limited to health. We do cooperate with efforts such as those of the poverty program by giving physical examinations to our beneficiaries and referring those whose physical condition insures the best chance of success.

(*b*) Effects on the placement or productivity of workers:

The answer to (a) applies here. Healthy individuals with proper motivation are usually most productive and have the best chance of increased earnings. We have no measurement of the effect of our health work in this regard but we are certain that many Indians benefit in this way as a result of health improvement.

(*c*) Effects on business or industrial organization and management:

Effect of our program in this respect is general and results from location of facilities and overall Federal regulations.

(*d*) Effects on the stability, level, volume, or other aspects of employment, wages, costs, productions, sales, prices, or other phases of economic activity:

No measurable effect.

(*e*) Other benefits resulting from the particular governmental program:

The major operation of the program is in the Western States including Alaska where the Indians and Alaska natives live.

(*f*) Pertinent geographic differentials:

See (*e*).

(*g*) The measurable contribution of the program to either the magnitude or the rate of growth of the gross national product, if such a contribution can be identified.

The only measurable impact is in the appropriations made to support the program. Healthy Indians who obtain gainful employment also have an impact, but we have no statistics concerning this.

Exhibits follow which illustrate the magnitude of the Indian health problem and recent trends.

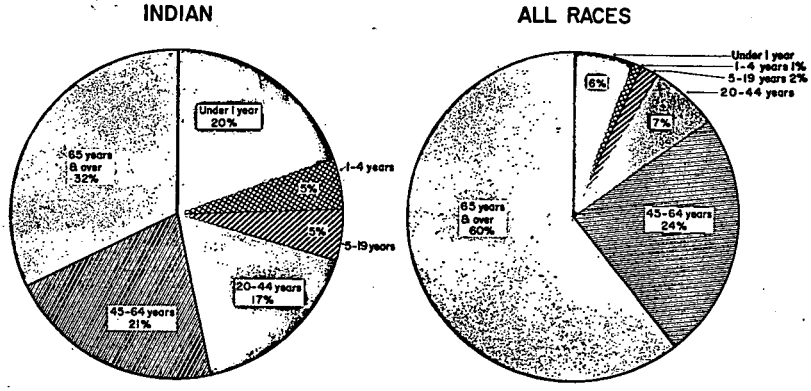
EXHIBIT A

DIVISION OF INDIAN HEALTH—CHARTS ON HEALTH TRENDS AND SERVICES

U.S. Department of Health, Education, and Welfare, Public Health Service, Bureau of Medical Services: January 1965

PERCENTAGE OF DEATHS IN SPECIFIED AGE GROUPS, 1963

Indian* and All Races, U.S.



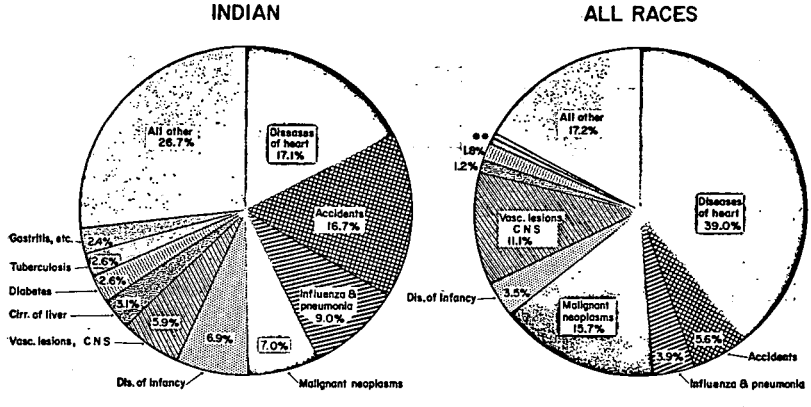
INDIAN 1953

Under 1 year	27%
1-4 years	7%
5-19 years	5%
20-44 years	18%
45-64 years	17%
65 years & over	26%

* Excludes Alaska Native.

PERCENTAGE OF DEATHS BY SPECIFIED CAUSES, 1963

Indian* and All Races, U.S.

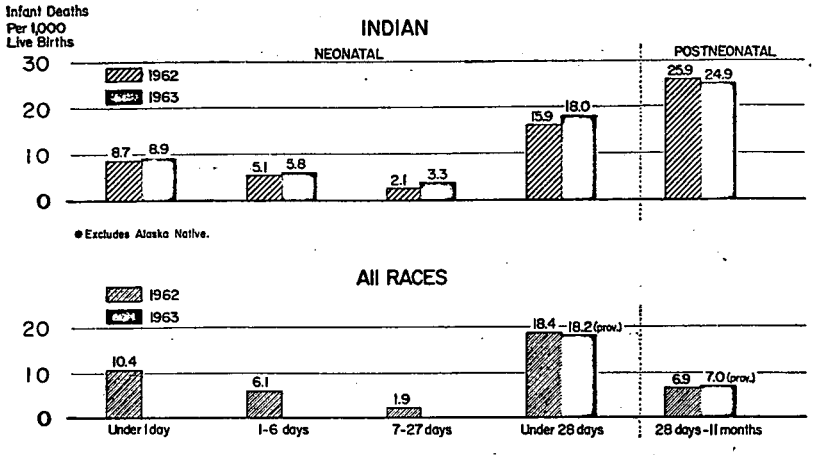


NOTE: Tuberculosis 3rd leading cause in 1951
9th leading cause in 1963
Gastritis, etc. 5th leading cause in 1951
10th leading cause in 1963

** Gastritis, etc., 0.5%
Tuberculosis, 0.5%

* Excludes Alaska Native.

INFANT DEATH RATES
Indian* and All Races, U. S.
by Age at Death



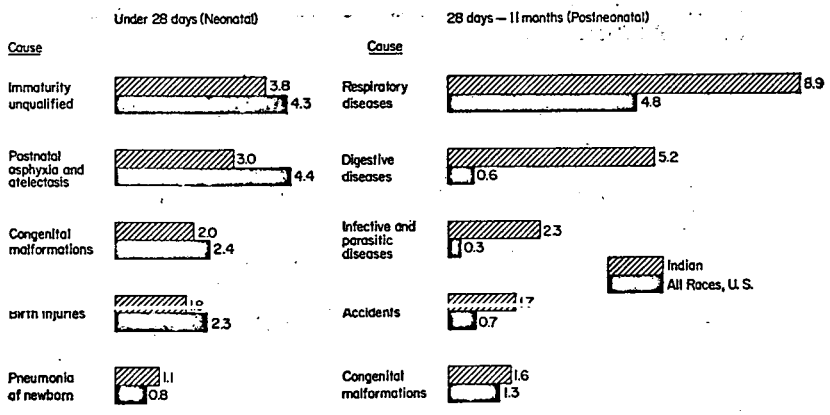
*Excludes Alaska Native.

NOTE: 1963 detail, under 28 days for all races, not available.

Infant death rates, all ages

	Indian	All Races
1962	41.6	25.3
1963	42.9	25.2

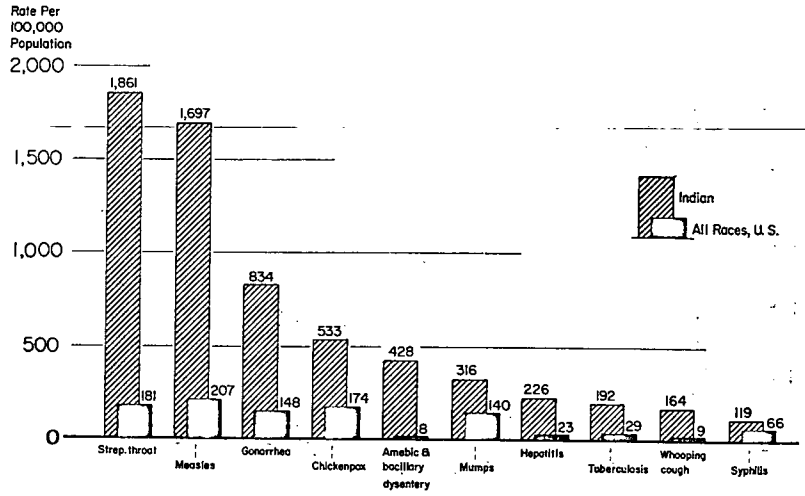
FIVE LEADING CAUSES OF INFANT DEATHS, BY AGE GROUP
Indian,* 1960-1962 Average, and All Races, U. S., 1961



*Excludes Alaska Native.

INCIDENCE RATES FOR SPECIFIED REPORTABLE DISEASES

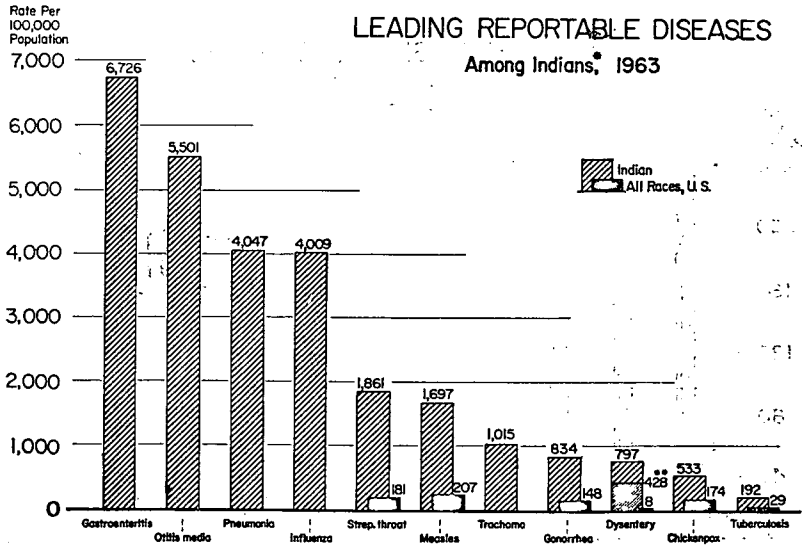
Indian* and All Races, U. S., 1963



* Excludes Alaska Native.

LEADING REPORTABLE DISEASES

Among Indians,* 1963

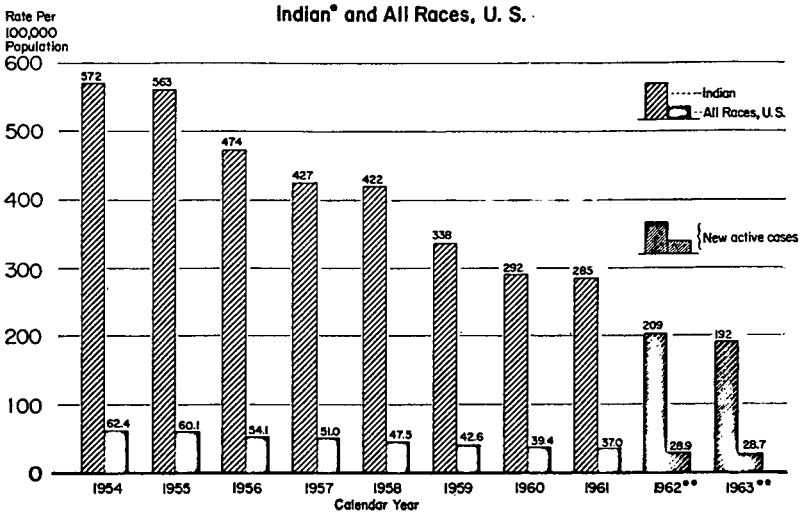


* Excludes Alaska Native.

** Comparable data for Indian and All Races available only for bacillary and amebic dysentery. Total Indian rate of 797 includes "all other forms" of dysentery.

INCIDENCE RATES FOR TUBERCULOSIS

Indian* and All Races, U. S.

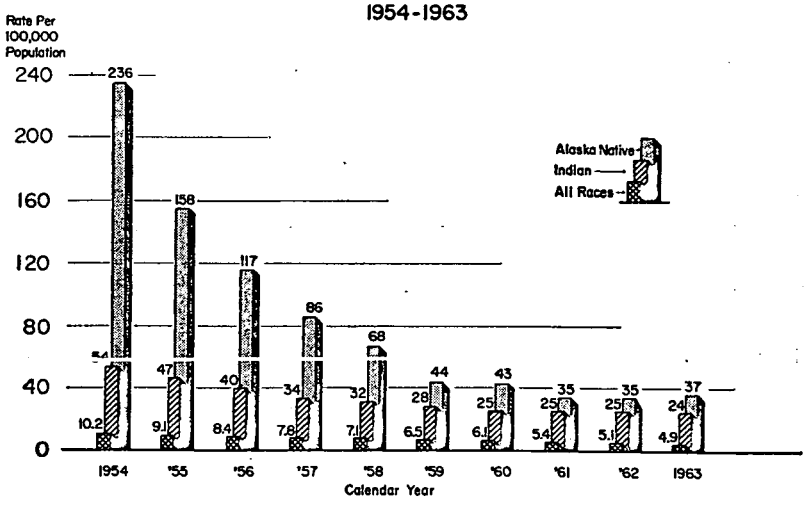


* Excludes Alaska Natives.
** 1962 and 1963 not comparable to earlier years.

Note: 1963 Alaska Native rate 535.

TUBERCULOSIS DEATH RATES

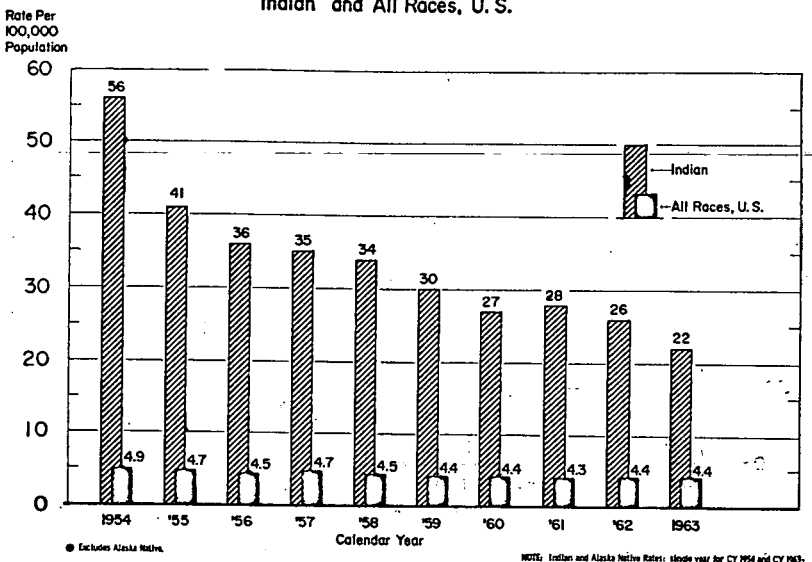
Indian, Alaska Native, and All Races
1954-1963



NOTE: Indian and Alaska Native Rates: single year for CY 1954 and CY 1963; 3-year moving averages, 1955-1962; all races are single year rates.

DEATH RATES FOR GASTRITIS, ENTERITIS, ETC.

Indian* and All Races, U. S.



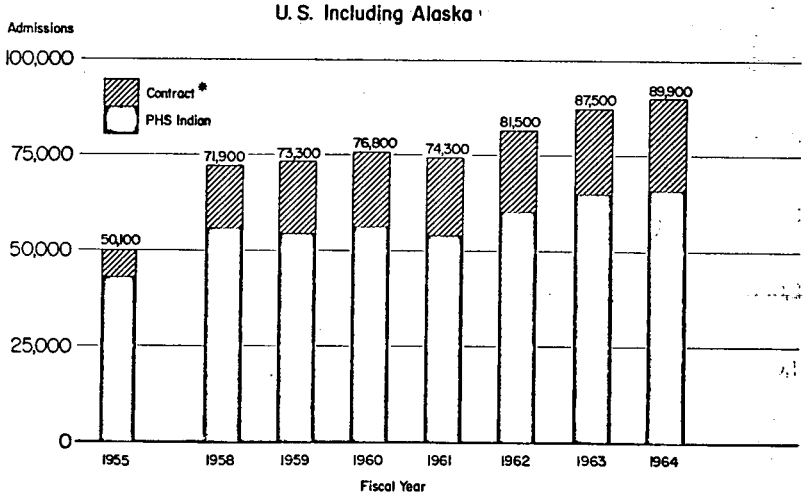
* Excludes Alaska Native.

NOTE: Indian and Alaska Native Rates: single year for CY 1954 and CY 1963; 3-year moving averages, 1955–1962; all races are single year rates.

ADMISSIONS OF INDIAN PATIENTS

PHS Indian and Contract Hospitals

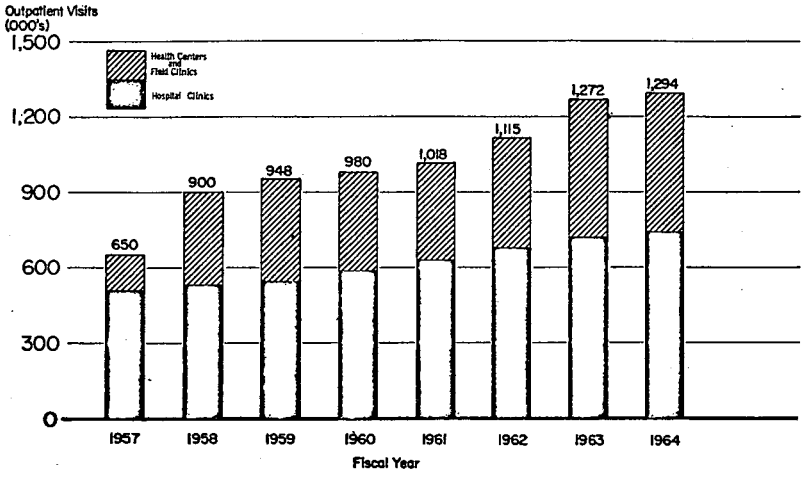
U. S. Including Alaska



* About 200 mental patient admissions each year.

OUTPATIENT MEDICAL VISITS *

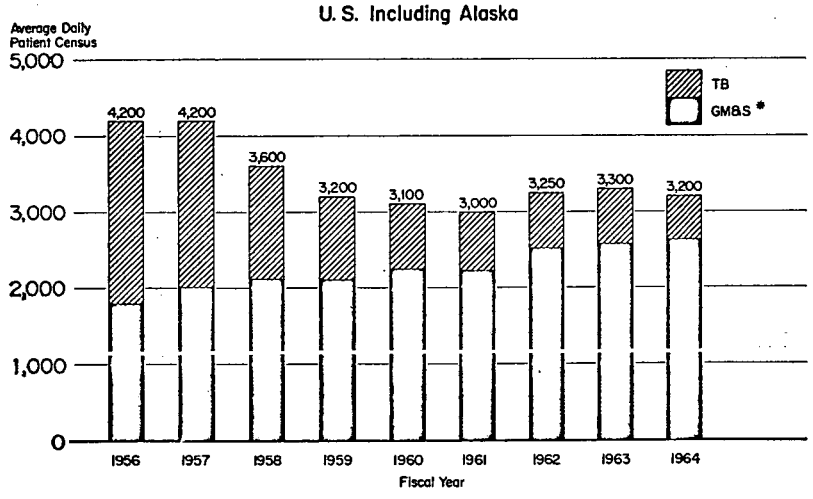
IHS Hospitals, Health Centers, and Satellite Field Clinics



* Excludes visits for dental services.

AVERAGE DAILY PATIENT CENSUS

PHS Indian and Contract Hospitals
U. S. Including Alaska

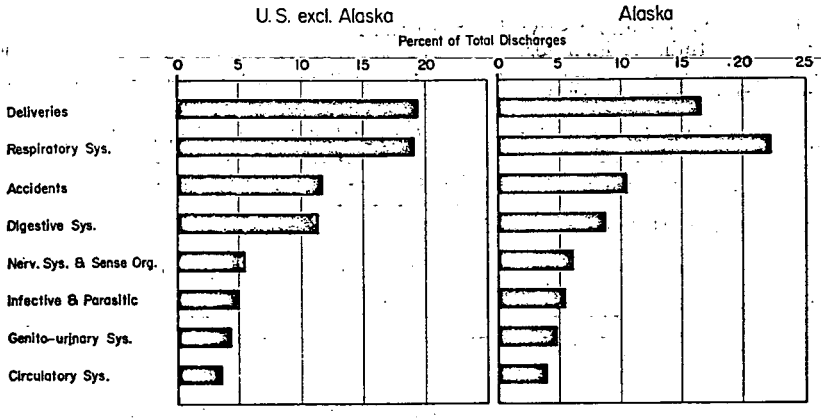


* Includes about 200 neuropsychiatric patients in contract facilities each year.

LEADING CAUSES OF HOSPITALIZATION

GENERAL PATIENT DISCHARGES

PHS Indian & Contract Hospitals, Fiscal Year 1963



DIVISION OF INDIAN HEALTH

PREVENTIVE AND CORRECTIVE DENTAL SERVICES PROVIDED

Fiscal Years 1956 and 1961 - 1964

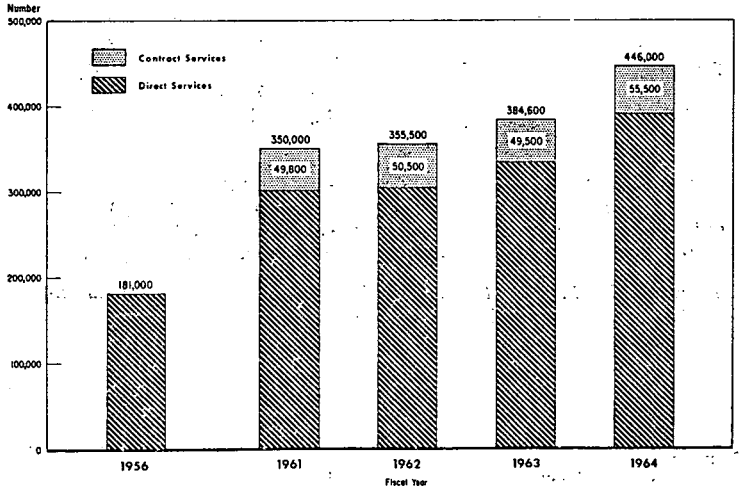


EXHIBIT B

TRENDS IN INDIAN HEALTH AND HEALTH SERVICES

Service population estimates, 1963 and 1964

Indians and Alaska natives	380,000
Indians, 23 Federal reservation States	337,000
Alaska—Indians, Eskimos, Aleuts	43,000

NOTE.—Indian—about 54 percent under 20 years of age; median age 17.3. All-races—about 38 percent under 20 years of age; median age 29.5.

Birth rates—Registered live births per 1,000 population, 1963

Indian	42.2
All races	21.7
Alaska natives	49.0

NOTE.—Indian and Alaska native, twice all races.

Births attended by physicians (majority in hospital)

	Percent
Indian	[1] 98
Alaska native	[2] 81

[1] Compared to 88 percent in 1954.
[2] Compared to 65 percent in 1954.

Mortality—Rates per 100,000 population 1963, all causes

Indian	933.9
All races	961.9
Alaska native	997.7

Leading causes of death, 1963, and rates per 100,000 population

Cause of death	Indian	Alaska native	All races	Specified ratios, Indian to all races
Heart diseases	(1) 159.5	(4) 97.4	(1) 375.4	----------
Accidents	(2) 155.9	(1) 218.1	53.4	3×
Influenza and pneumonia	(3) 84.0	(3) 102.1	37.5	2.2×
Malignant neoplasms	(4) 65.0	(5) 76.6	(2) 151.4	----------
Diseases of early infancy	(5) 64.4	(2) 109.0	33.3	2×
Vascular lesions CNS	(6) 54.9	(6) 44.1	(3) 106.7	----------

Tuberculosis—ranks ninth among leading causes of death.
Gastroenteritis, etc.—ranks 10th among leading causes of death.
Accidents—non-motor-vehicle deaths increased over 1962; leading causes were: accidental drownings, fire and explosions, falls, suffocation, and poisonings.

Infant mortality—Deaths per 1,000 live births (1954–63)—Infant mortality rates, 1963

Age	Indian	Alaska native	All races	Ratio, Indian to all races
All ages	42.9	50.7	25.2	1.7×
Neonatal (under 28 days)	18.0	24.9	18.2	----------
Postneonatal (28 days to 11 months)	24.9	25.8	7.0	3.6×

Indian neonatal rate almost same as all races; leading causes: immaturity, postnatal asphyxia, congenital malformations, birth injuries. Indian and Alaskan postneonatal rate about 3½ times all races rate; leading causes respiratory, digestive, infective and parasitic, and accidents.
Indian—practically no change over 1962; increase in neonatal death rate to 18, more than offset the drop in postneonatal rate, resulting rate of 42.9 all ages. Alaska neonatal rate up above 1962; but 1963 Alaska postneonatal rate declined sharply, by 41 percent, over 1962.

Infant mortality—1963 rates compared with 1954

[Percent drop]

Group	All ages	Neonatal	Postneonatal
Indian	−34	−10	−44
Alaska native	−39	−21	−50

Tuberculosis mortality and incidence rates per 100,000 population:

1963 mortality: Indian, 24; 5 times all races rate; Alaska native, 37; 7 times all races rate. Compared with 1954: Indian dropped 56 percent; Alaska native dropped 84 percent.

1963 incidence rate (active cases): Indian, 192; 7 times all races rate of 28.7; Alaska native, 535; 18 times all races rate. Compared with 1954: Indian dropped 56 percent; Alaska native dropped 78 percent.

Tuberculosis hospitalization—average daily census in fiscal year 1964, under 600; dropped 76 percent since peak in 1956. Now represents about 18 percent of total census (all patients) compared with 57 percent in 1956.

Gastroenteritis, etc., mortality and incidence per 100,000: 1963 mortality, Indian rate 22.3; 5 times all races. Compared with 1954, dropped 60 percent. 1963 incidence, amoebic and bacillary dysentery, 428 per 100,000 (50 times all races). Gastroenteritis, diarrhea leading among reported diseases.

Trachoma incidence rate, 1,015 compared with 1,060 in 1962. (Resurvey indicated a rise in rate during 1964.)

Measles incidence rate, calendar year 1963, 1,697 per 100,000 population. Measles incidence is dropping in 1964, following the use of vaccine in the Southwest, Phoenix, and Window Rock areas. For first 9 months of 1964 (January–September) the provisional rate is below 700, for all DIH reporting units, outside of Alaska; drop to 328 in Southwest areas, offset by rise in other areas (Northwest and Plains States).

Otitis media, reported cases rising, compared with last year (through first 9 months) and noted particularly in areas where there was a rise in measles cases.

Broadening of services; increasing workloads since fiscal year 1955, last year before transfer, compared with fiscal year 1964:

Hospital admissions (DIH and contract) rose 80 percent from 50,000 to 90,000, 98 percent of admissions are general patients.

Births in DIH hospitals rose 37 percent from 6,900 to 9,458. Contract hospitals from a small (unknown) number to 2,680 (estimate). Total ADPC of 3,211; 75 percent general; 18 percent TB; 7 percent mental. TB patient census (584) dropped from 21 percent of total in 1963.

Hospital outpatient clinics, medical visits 742,400, more than doubled since 1955. Health centers, satellite clinics, and itinerant clinic visits reached nearly 545,000. Dental corrective and preventive services provided, about 446,000 (DIH and contract).

Construction of facilities since 1955—hospital, health centers, and field clinic construction; 7 new and/or replacement hospitals; 4 hospitals had major modernization, others underwent major alterations; 9 health centers newly constructed; 25 health stations (field clinics).

Public Law 85–151 (1957), 15 projects completed, participation in construction of a total of 110 beds at community hospitals, for Indian use.

Sanitation facilities construction: Public Law 86–121 (1959), provides a mechanism under which PHS and Indian groups can work jointly to correct gross deficiencies in essential sanitation facilities, and thus alleviate the substandard environmental conditions in the homes and communities. In the 5 years since this program has been authorized, 208 construction and 96 emergency and study projects have been authorized. These include construction of domestic water supplies and waste disposal facilities.

10. Economic classification of program expenditures. (See table 2.)

Program: Indian health program.

Department, or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Bureau of Medical Services, Division of Indian Health.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:[1]	
Purchases of goods and services:	
Wages and salaries	$37,094
Other	35,374
Total Federal expenditures	72,468
Non-Federal expenditures financed by: Contributions of money, materials, and labor by Indians and Alaska natives in support of sanitation facility projects	1,000
Total expenditures for program	73,468

[1] Expenditures here refer to obligations; actual Federal expenditures were $71,373,000.

NATIONAL INSTITUTES OF HEALTH

THE RESEARCH PROGRAM

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The research program of the National Institutes of Health is a multifaceted effort to advance the health and well-being of the American people through science. To this end, the program seeks—

(*a*) Greater understanding of man's biological and behavioral processes through a broad program of investigation of life processes;

(*b*) Advancement of the existing capability for the diagnosis, treatment, and prevention of disease through expanded and enhanced scientific, academic, and technologic efforts and resources; and

(*c*) Acceleration of the application of new knowledge and technological capability to the universe of health practice.

2. Operation

The objectives of the NIH research program are sought through direct in-house (or "intramural") research, and through support (by grants or contracts) for research of non-NIH scientists in academic, industrial, or other settings. (These latter activities are referred to as "extramural.") Roughly 80 percent of the NIH research program is extramural; 20 percent is intramural.

The research program of the NIH is organized and conducted through nine separate Institutes, three major program divisions, a 500-bed clinical center, an Office of International Research, several supporting divisions, and field research activities both in the United States and abroad.

The present organization for research—which has evolved almost entirely since World War II—is a reflection of the advancement in health knowledge, the growing significance of chronic and degenerative diseases, and broad concern with the health of man and the multifaceted processes of human development. The organization, once oriented along lines of scientific disciplines, has changed markedly. Six of the nine Institutes conduct and sponsor research in relation to the causes, prevention, diagnosis, and treatment of designated broad disease areas—cancer, heart, dental, metabolic, infectious, and

neurological. Three Institutes have as their focus the solution of health and medical problems not peculiar to a given disease category:

The National Institute of General Medical Sciences (NIGMS) supports fundamental or multidisciplinary research in biomedical, physical, and behavioral sciences where relevance to a specific disease category is not clear or several such disease categories are involved.

The National Institute of Child Health and Human Development (NICHD) —with special responsibilities for child health and problems of aging—seeks understanding of normal and abnormal developmental processes across the full life cycle of man.

The exceptionally wide-ranging programs of the National Institute of Mental Health (NIMH) are integrated by a common unifying objective—improvement in the mental health of the American people.

The NIH "program" divisions fit into the research picture in this way:

The Division of Research Facilities and Resources (DRFR) administers the grants programs providing funds for—

(1) The general research support of institutions;

(2) The establishment and operation of:

General clinical research centers

Primate centers

Special research resource centers

(3) Grants on a matching basis for construction of health research facilities.

The recently established Division of Computer Research and Technology (DCRT)—which is strictly an intramural resource—provides modern computer facilities for NIH scientists, enabling them to do research on the application of advanced mathematics and computer theory to biomedical research problems; also on automation of certain routine laboratory and clinical procedures.

The Division of Biologics Standards (DBS)—which like the DCRT awards no grants—does research relevant to its control responsibilities; which include insuring the safety, purity, and potency of biologic products used throughout the Nation in prevention and treatment of disease.

The Office of International Research (OIR) has a dual research role: It coordinates policies of the nine NIH Institutes in their support of overseas research activities; and it is responsible for administering several programs of its own, including international centers for medical research and training, international postdoctoral fellowships, and the special foreign currency program.

Key supporting components include the Division of Research Services (DRS) which provides technical, engineering, and scientific support for the intramural research program; and the Division of Research Grants (DRG) which provides for scientific and technical review of grant applications, and coordinates financial and administrative procedures relating to research grants.

For both intramural and extramural components of the NIH research program, the Office of Administrative Management (OAM) provides administrative support.

Intramural activities.—The intramural portion of the NIH research program is the largest single biomedical research effort in the world.

Of the nine NIH Institutes, seven have substantial intramural activities, and an eighth (NICHD) has already made a modest start and plans expansion. At the core of NIH intramural effort are 1,500 doctor of philosophy or doctor of medicine scientists engaged in full-time research, with facilities and supporting staff on appropriate scale. Among the supporting facilities are a 500-bed clinical center and a farm for research animals. For each Institute, intramural scientists are organized (under a scientific or clinical director) in sections and laboratories or clinical branches. Within Institute objectives, each scientist is allowed considerable latitude in his choice of research projects. Each Institute receives disinterested scientific advice on its intramural activities from non-NIH science leaders appointed to boards of scientific councilors. Overall coordination of intramural activities is provided by Institute scientific directors, who meet regularly under the chairmanship of the NIH Director of Clinics and Laboratories. This group must approve promotions for all intramural research staff.

Extramural activities.—Through its research grants and contracts, NIH now supports 40 percent of all medical research conducted in the United States; this also constitutes one-third of all Federal funds for the support of research in colleges and universities, proper.

Contracts are used in dealing with institutions organized for profit, or for the purchase of specific research goods or services. Only 8 percent of NIH extramural research funds is spent on contracts. Because of the many intangibles incident to research and development work, the cost-reimbursement and cost-plus-fixed-fee methods of contracting are utilized to a large extent.

When it appears to an NIH institute that its interests will be best served by a research contract, formal proposals are solicited from prospective contractors. The prospective contractor furnishes information in the proposal about the nature, structure, capacity, and qualifications of his organization, the terms under which he can undertake the Government work, and an estimate of the costs (or price) and time which he feels necessary to accomplish the task. Each prospective contractor's proposal is reviewed by program staff and by the contracting officer.

Research grants.—Several types of research grants are used by NIH in awarding funds to nonprofit institutions when the proposed research ties into NIH program needs. The research project grant is awarded to an institution for a discrete project representing the investigators' interests and competencies. The research program-project grant is awarded to an institution solely for the support of basic physical resources or an integrated system of resources and services essential to the conduct of a broad program of research.

The method of distributing research grant funds has been designed to assure that funds are awarded only to research projects and programs that are competently judged to have high scientific merit and in only such amounts as are necessary for their support.

Applications are uniformly investigator initiated, with the exception of the few instances in which the Institute, on the advice and with the concurrence of a study section or other initial review group and the appropriate national advisory council or committee, has taken the initiative to make known to competent investigators areas in which research is much needed.

The usual steps by which a grant-supported research project comes into being are:

(*a*) The responsible officer of an eligible institution submits to the Public Health Service, on behalf of the principal investigator, an application for a research grant. The application outlines the nature of the research contemplated, as well as the resources and facilities available or needed, and indicates the budget proposed and the years of support requested.

(*b*) A grant application is received and identified with a particular NIH research area. The application is then referred to the appropriate NIH Institute or division and to a study section or an initial review group consisting primarily of non-Federal scientists expert in that research area. The group reports its evaluation of the proposal, including its scientific merit and the requested financial support, with a recommendation for action, to one of the national advisory councils or committees.

(*c*) The Surgeon General, at his discretion, may award support to any application recommended for approval by a national advisory council, in the amount recommended or in a lesser amount. The criteria applied by the committees and councils in considering applications are (1) that the proposed research shall have high scientific merit; (2) that the principal investigator shall be competent to undertake and pursue the research; and (3) that the facilities available to him shall be adequate.

General research support (GRS) grants are designed to provide institutions a measure of increased control over the quality, content, emphasis, and direction of their own research and training programs. They allow increased institutional initiative in developing the institution's best research and research training capabilities, for consolidating scattered elements of research support, and for bettering the general research environment. The program is thus complementary to other forms of NIH grants-in-aid. The appropriation level for this program is set annually by Congress, within a statutory ceiling for this purpose of 15 percent of total NIH research grants. The program is administered by DRFR from funds made available by assessments against each NIH appropriation for research grants.

Four types of health professional schools (medicine, dentistry, osteopathy, and public health) are considered automatically eligible for GRS grants. Other types of institutions active in health research (such as hospitals or research foundations) are eligible if they have been awarded $100,000 or more in PHS research grants within the past year. Following acceptance of NIH guidelines for an extension of this program, graduate academic departments (apart from health professional schools) will also be eligible for awards, beginning in the current fiscal year; this proposed university program, entitled the "Biomedical Sciences Support Program," is conceptually identical with the current general research support program. The amount of an individual award is based on a formula which is computed according to the health-related research expenditures of the institution from all funding sources.

A part of GRS funds will be used from now on to make health sciences advancement awards—a new program to encourage institutions with high health-research potential to deliberately plan an upgrading of their research capabilities.

3. History

NIH intramural research activities extend in an unbroken tradition from the one-room bacteriological laboratory established by the PHS at the Staten Island Marine Hospital in 1887. This Laboratory, subsequently designated as the Hygienic Laboratory, was moved to Washington in 1904. There, it expanded into a small but renowned in-house research organization with separate divisions for chemistry, bacteriology, pathology, zoology, and pharmacology. It was concerned mainly with control of communicable and infectious diseases, but emphasized fundamental investigations also. After 1930, when the Hygienic Laboratory became the National Institutes of Health, its research activities retained their former scope and character for some years.

Passage of the National Cancer Act in 1937 (Public Law 75–244)—and through it the creation of the National Cancer Institute (NCI)—marked two important beginnings for NIH: Though, for the moment, NCI remained independent of NIH, its creation marked a new research emphasis on the chronic and degenerative diseases, which increasingly were revealed as the main killers against which NIH had to organize its research efforts; it also marked the beginning of the extramural component which now represents 80 percent of total NIH program. By this Act, NCI was directed not only to conduct research, but to assist and to steer similar research activities by other agencies, public and private; and to this end, the Surgeon General was authorized to make grants-in-aid for research projects in the field of cancer. In the other major event immediately prior to World War II, NIH and NCI moved, in 1938 and 1939, into newly constructed facilities at a donated site in Bethesda which NIH now occupies.

Organizational structure.—With the war's end, the development of NIH toward its present organizational pattern was rapid. Broadened research authorities in the Public Health Service Act of 1944 (Public Law 78–410) provided the basis for this expansion. (Under this act, the Surgeon General was given broad power to support research into the "diseases and impairments of man," and specifically to make grants-in-aid for research projects recommended by the Advisory Councils.) Subsequent to that enactment, in the period 1946–55, five categorical Institutes plus NIMH were added as (in effect) divisions of a National Institute of Health. The additions:

1948: The National Heart Institute (NHI). Authority: National Heart Act (Public Law 80–655). This same act pluralized the NIH title to "National Institutes of Health."

1948: The National Institute of Dental Research (NIDR). Authority: National Dental Research Act (Public Law 80–755).

1948: The National Institute of Mental Health (NIMH). Authority: National Mental Health Act of 1946 (Public Law 79–487).

1950: The National Institute of Neurological Diseases and Blindness (NINDB); the National Institute of Arthritis and Metabolic Diseases (NIAMD). Both established under authority of Omnibus Medical Research Act of 1950 (Public Law 81–692).

1955: The National Institute of Allergy and Infectious Diseases (NIAID) was established from its predecessor, the National Microbiological Institute. Authority: Public Law 81–692.

With the opening of the 500-bed Clinical Center in 1953, the Bethesda facility achieved capability for a well-balanced biomedical research program. Other major program components added to NIH:

1955: Division of Biologics Standards (DBS).

1958: Division of General Medical Sciences (DGMS).

1962: Division of Research Facilities and Resources (DRFR).

1963: National Institute of General Medical Sciences (NIGMS) taking place of DGMS; National Institute of Child Health and Human Development (NICHD). Authority for both Institutes: Public Law 87–838, October 1962.

1965: Division of Computer Research and Technology (DCRT).

Intramural research.—As the various Institutes became a part of the NIH structure, each—with the exception of NIGMS—developed an intramural component to its program. Among the program divisions, DRFR conducts no in-house research; but DBS is completely intramural in its orientation, as is expected to be the new Computer Research Division. Several off-site operations are also important to NIH intramural research. These include the gerontology research activities in the Baltimore City Hospital (under NHI); the Rocky Mountain Laboratory at Hamilton, Mont. (under NIAID); and the Middle American Research Unit (jointly supported by NIAID and the Army).

Extramural.—The first PHS grants-in-aid to support research in academic and other non-Federal settings were made by the National Cancer Institute in 1937 to support studies in diagnosis and treatment of cancer. This was an authority specific to NCI, deriving from the National Cancer Act. Not until 1944—with the enactment of the Public Health Service Act—did NIH gain similar basic authority to make such grants, "to support research into the diseases and impairments of man." These authorities were used sparingly, so that, by 1946, the annual level was only $780,000. However, with the war's end, and the dissolution of the wartime Office of Scientific Research and Development (OSRD), NIH took over responsibility for residual OSRD university contracts in the area of the medical sciences. This constituted the beginning base of the present-day NIH extramural research program. By 1950, with seven Institutes making awards, over $20 million in a total budget of $50 million was being expended in the form of extramural grants and awards for research and training.

By 1955, total appropriations reached $82 million, an increase of only $30 million over 1950; however, the increase in extramural funds was twice that of intramural. During this period the major effort was centered in forging the mechanisms, policies, and procedures of extramural support; the processes of review, selection, and award of grants; and the relationships with outside advisory groups which still comprise the essential framework for the administration of NIH extramural activities. The key element in this period of development was the decision, implicit in the study section review and priority rating process, to concentrate resources upon meritorious research projects emerging for the most part from the fundamental science programs of academic institutions. By the end of fiscal year 1955, 80 percent of NIH research grant funds was going to colleges and universities.

The next 5 years (1956–60) were years of maximum growth rate. The guiding principle of this period was the concept that the expansion of medical research in the national interest should not be restricted by lack of funds and that the necessary resources for this expansion should either be made available or created for this purpose. This principle was initiated by Secretary Folsom in fiscal year 1956, ratified by the Bayne-Jones Report in 1958, and acted upon with vigor and swiftness by the Congress throughout this period. Between 1955 and 1960, NIH programs expanded over fivefold, reaching a level of $430 million in the latter year, including construction grants. The NIH investment in the development of resources was substantially enlarged. New fields of scientific endeavor were cultivated, including biophysics, mathematics, and behavioral sciences. Engagement with science on an international basis became an essential component of NIH programs. The problem of stable support for the institutional base of research and training was diminished by the enactment of general research support authority and the initiation of the general research support grant program in 1961.

In most recent years—with growth rate slowed to a more mature stage of development—the long-term principles, terms, and conditions guiding the conduct of the extramural program were subjected to searching examination and reassessment, stimulated largely by congressional inquiry. From this inquiry has emerged a more structured, articulated, and formal framework for grant administration.

4. Level of operations. (See tables 1 and 2 at the end of NIH section.)

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(a) Within NIH:

i. The need for coordination and cooperation: The health research objectives of NIH are sought through the interrelated efforts of nine Institutes and three program divisions—each with separate areas of responsibility as defined by distinctive missions. Two factors explain the need for this somewhat complex structuring of NIH program: (1) The number and variety of health research goals pertinent to NIH mission; and (2) recognition that progress toward these goals depends to a considerable degree on the sensitivity with which program interest can be focused on research needs and opportunities in each goal area. Clearly, with such structuring, there is potential for program overlap or gaps, and for cross-purpose or competing activities. Consequently, increased effectiveness is sought through a variety of coordinating mechanisms.

ii. Existing arrangements: The Director, NIH, is responsible for coordinating the total NIH program. In this, his principal concerns are for best distribution of total resources available for health research; also for integration of current and longer range plans, particularly in their impact on resources. The identification and elimination of gap areas and unnecessary overlap on cross-purpose activities are other concerns.

This coordination is achieved mainly through the annual budget and apportionment process. Also important, though, are weekly meetings at which the Director, NIH, and his key staff discuss common-interest matters with Institute Directors and division chiefs; and the requirement of administrative approval at the Office of Director, NIH level for Institute-division program needs for space, personnel, organizational changes, various services, etc. Individual staff members and staff components in the Office of the Director support the Director, NIH, in his coordinating role. These are the key arrangements:

1. There is a principal staff assistant to the Director, NIH, to coordinate each of the two major facets of the total program, intramural and extramural. For the intramural area, a director of laboratories and clinics is responsible for approval of budgets as well as current space and personnel allocations. Coordination is also effected through highly structured biweekly meetings with the scientific directors, who are in charge of the respective intramural research program for each Institute/division. Similarly, for the grants area, coordinating responsibilities are assigned to a staff official (the NIH Associate Director for extramural program) who provides a focus at the Office of the Director level for intelligence on grants problems and policy matters and for substantive review of overall NIH grants programs. He is supported in his tasks by data and analyses across grant activities provided by the Division of Research Grants. Also, he chairs monthly meetings of an executive committee for extramural affairs (ECEA), to which each Institute and division sends its extramural grants head, for information exchange and review of common-interest policies and problems.

2. Other staff or service components contribute to program coordination at the level of the Office of the Director, NIH:

The Office of International Research is responsible for policy formation, program analysis and other aspects of coordination for foreign or international components of NIH programs.

The Office of Program Planning is responsible for coordinating legislative planning for NIH activities; also for providing definitive data on present and future availability of research resources.

The Office of Administrative Management coordinates administrative servicing of NIH programs in terms of financial, personnel, and supply management; also office services.

The Division of Research Services provides centralized library, graphic art, and photographic services; also instrument engineering and development; animal breeding, supply and care; computation and data processing services, etc.

3. An important new mechanism to assist in coordinating the total NIH program is the recently approved outside advisory group to the Director of NIH. This group—to be drawn from science and public affairs leaders throughout the Nation—will advise on longer range planning, best distribution of available resources across total activities, new programs needed, and similar matters.

4. For the extramural area, coordination in terms of the quality of research supported is provided by the study section system. This assures peer group scientific review for all grants applications, irrespective of the program component from which support would come.

5. The Division of Research Grants is responsible for assigning each incoming grant application to a specific Institute or division, follow-

ing assignment criteria (based on respective program missions) approved by the Director, NIH. Special coordinating arrangements are made as needed when two or more Institutes share interest in a research area too widely ramified to fit neatly within a single organization's mission. Examples of this are NINDB and NHI cooperation in the area of stroke research; the NIH Staff Group on Mental Retardation (which coordinates respective interests of NICHD, NIMH, NINDB, and DRFR in problems of the mentally retarded); and ad hoc coordinating arrangements worked out among NIMH, NIGMS, and NICHD for the behavioral sciences.

(*b*) *With other units of the department or agency:*

i. The need for coordination and cooperation: In its impact on health and education goals, the NIH research program shares common ground with many other program components within the Department of Health, Education, and Welfare. In terms of health, there are points of interface (and therefore a need for one degree or another of coordination or cooperation) with each of the other Bureaus of the Public Health Service; also with the Food and Drug Administration, the Children's Bureau, the Office of Vocational Rehabilitation, and the Aging Administration recently established at the departmental level. In relation to NIH's important impact on graduate education, the prime concern is for more effective coordination with the rapidly growing programs of the Office of Education.

Within the Public Health Service, the search for more effective program groupings has led in recent years to deliberate shifting of traditional dividing lines among PHS components. Such shifts increase the need for sensitively informed coordination. For example, while NIH retains its traditional role as the research arm of the Public Health Service, that role is no longer exclusive. Other PHS bureaus now award research grants—notably the Bureau of State Services, which supports and conducts research on a range of community health and environmental health problems. Similarly, responsibility for State formula grants for prevention and control of cancer, cardiovascular disease, diabetes, and other NIH disease research areas has passed for the most part from NIH to the Bureau of State Services. Only in the mental health area does NIH still retain programs of this type.

Construction programs also generate coordination needs across PHS components. For example, the hospital construction programs of the Division of Hospital and Medical Facilities (BSS) affect long-range capabilities in many PHS program areas. There is repeated interface between activities of that Division and NIH's Health Research Facilities construction, also shared responsibilities between that Division and NIMH for the Community Mental Health Center program.

Finally, the new regional medical program presents an unprecedented challenge for coordination of diverse program efforts, both within and beyond the Public Health Service.

ii. Existing arrangements: At the departmental level, the key staff role in coordinating NIH and other health-oriented activities of HEW is assigned to the Office of the Assistant Secretary for Health and Scientific Affairs. Also at the Department level, a variety of staff offices and line or staff assistants to the Secretary are assigned responsibilities with coordinating impact on NIH program. The major roles

are those of: (1) the Comptroller, who is the Department budget officer; (2) the Assistant Secretary for Legislation; and (3) the Assistant Secretary for Program Coordination.

In common interest areas, a variety of informal information exchange and similar coordinating arrangements have been worked out among program managers in NIH and other departmental components. Infrequently—but on occasion—these arrangements are committed to writing. For example, there is a formal memorandum of understanding defining respective research roles in child health for the Children's Bureau and the National Institute of Child Health and Human Development.

Apart from informal coordinating arrangements made between individual Office of Education and NIH program managers, these two agencies have been working closely for some months to develop a coordinating mechanism that would be effective across a broad range of agency programs with similar or compatible objectives. Results here are promising, though further work will be needed. Special coordinating arrangements may be set up when a number of departmental components share interest in one or another aspect of a "high-visibility" program such as mental retardation.

(The Secretary's Committee on Mental Retardation has representation from the Office of the Secretary, the Office of Education, Food and Drug Administration, Social Security Administration, and Welfare Administration, as well as the PHS—with members from the latter agency representing the Surgeon General's echelon, Bureau of State Services, and three NIH Institutes.)

Within the Public Health Service, the Surgeon General—supported by his immediate staff offices and by the National Advisory Health Council—is responsible for program coordination. This responsibility with respect to NIH programs extends to all of the usual aspects of coordination by a higher echelon, including budget and legislative review, organization and other administrative approvals, etc.

Apart from these usual means for coordination, several special coordinating mechanisms exist at the PHS level. These include:

1. An Office of International Health, for overview and coordination of PHS international activities.

2. An Interbureau Advisory Committee on Extramural Affairs (IACEP), which reviews all proposed grant policies and recommends action to be taken by the Surgeon General. No grant policies affecting more than one PHS Institute or Division may be issued without the approval of this Committee. Its membership includes the grants policy officer in the Office of the Surgeon General as chairman, one representative from each of the granting Bureaus in the PHS, and the Chief, Division of Research Grants, NIH, as executive secretary.

3. In the Office of the Surgeon General, a grants policy officer and a small staff provide a full-time PHS focus for resolving grants policy questions of an interbureau nature.

4. A grants manual—which provides definitive guidance on grants policies and procedures across PHS programs—is maintained for the Surgeon General by the NIH Division of Research Grants. As changes in grants policies or procedures are approved by the IACEP, the DRG Policy and Procedures Office issues these changes and incorporates them in the grants manual.

(c) *With other Federal Government departments or agencies:*

i. The need for coordination and cooperation: For several years now, Congress, the higher executive branch, and the scientific community at large have watched with increasing concern the growth of Federal Research and Development (R. & D.) investment, now at the $15 billion annual level. On many fronts, improved means of coordination across this investment area are being sought, with one or more of these objectives in mind:

To better understand what now is being done through science programs, and why; what is being achieved by this, and how many parts interrelate.

To provide a better rationale for future investment in science—both in terms of overall growth and of differential growth in different science areas, and for differing science or social purposes.

To minimize competition for existing science resources.

To better assure that program impact on the capabilities and purposes of higher education institutions is constructive rather than otherwise.

To provide stimulus for more equitable distribution of academic and economic capabilities in the various regions of the country.

Relevant to these considerations, the NIH share in Federal R. & D. investment has remained about 5 percent through most of these rapid-growth years. But even in the area of health research, NIH has no prescriptive claim to support responsibilities. Significant health research support ($25 million or more annually) is given by each of these agencies: the Veterans' Administration, Department of Defense, Atomic Energy Commission, National Aeronautics and Space Administration, National Science Foundation, and Department of Agriculture. Smaller amounts are contributed by the Federal Aviation Agency, State Department, and Department of the Interior.

The programs of most of these same agencies also have an impact on graduate education and on higher education institutions. Apart from NIH, the key agencies here are: Office of Education, NSF, NASA, DOD, and AEC.

ii. Existing arrangements: At higher executive branch levels, the formal coordinating entities for NIH and other Federal R. & D. programs are these: The President's Science Advisory Committee, the Office of Science and Technology and the Bureau of the Budget (all in the Office of the President); also the Federal Council for Science and Technology (FCST) with representatives from each of the main Federal agencies supporting science.

NIH, as a third echelon component within DHEW, does not participate directly in the activities of the Federal Council for Science and Technology; but is represented by the Department's member, the Assistant Secretary for Health and Scientific Affairs. However, NIH staff, when called upon, participate fully in the subcommittees and panels of the FCST and other ad hoc groups advisory to the Office of Science and Technology (OST). The Director, NIH, serves in a technical capacity as consultant-at-large to the President's Science Advisory Committee and its chairman, the Director of OST. Also, the NIH Director of Laboratories and Clinics serves as a member of the Standing Committee of the FCST.

For coordination of NIH and other Federal programs with impact on national education goals, the President last year, by Executive

Order 11185, set up a Federal Interagency Committee on Education (FICE). This group is chaired by the Commissioner of Education (from DHEW), and includes a representative from each of the following agencies: The Department of State, the Department of Defense, the Department of Agriculture, the Department of Labor, the National Science Foundation, the Atomic Energy Commission, and the National Aeronautics and Space Administration.

Again (as with the FCST), NIH as a third-echelon component in DHEW, is not a member of the Committee. However, because of its substantial educational involvement, NIH expects to be called upon for staff assistance to FICE and to participate in at least some of the Committee's activities. Also relevant to this Committee, NIH has been intimately involved with NSF, AEC, NASA and OE representatives in developing a tentative proposal for a formal interagency working group. This group, if established in proposed form, would advise FICE on what progress could be achieved toward common education goals through voluntary interagency cooperation and information exchange.

Another formal mechanism for coordination across Federal science programs is provided by the Science Information Exchange, a component of the Smithsonian Institution. The SIE acts as a central repository for information on current and past research projects, whether supported by NIH, other elements of the PHS, other Federal agencies, or by private foundations. While SIE sources of data are not as comprehensive as might be wished for, NIH has found it a continuing and ready source of needed information on the support of specific research areas and of specific scientific investigators.

A variety of other means—some formal but most of them informal—assist in the coordination of NIH activities with those of other Federal agencies:

(1) Annual reports and other periodicals and special publications of each agency become useful resources. Specific mention here should be made of the "Federal Funds for Science" series issued by the National Science Foundation.

(2) The National Register of Scientists and Engineers (maintained by the NSF through the use of biennial questionnaires) is used by NIH in assessing research manpower resources.

(3) At meetings of NIH National Advisory Councils, voting members are present from the Department of Defense and Veterans' Administration. Also, an NSF representative is a member of the NIH Health Research Facilities Council.

(4) More than 80 representatives from other Federal agencies sit as liaison members on NIH study sections. These liaison members are selected by their own agencies because of their competence in the study section area, and generally take vigorous part in all study section activities.

(5) Observers from other agencies (as well as from other parts of DHEW) may attend NIH Council and study section meetings. When common-interest areas are known to be involved, executive secretaries of study sections will make a point of inviting specific observers.

(6) An informal interagency group meets semiannually to work out agreements on stipends and fellowship support levels. These meetings so far have been chaired by the NSF representative, but

it is anticipated that this task will be rotated to NIH and OE representatives in the future. Other informal and formal coordinating arrangements are even more fully developed in the facilities program area. NASA, AEC, NSF, and NIH have been actively engaged in information exchange on requests from various institutions for research renovation or construction of research facilities of one kind or another.

Informal coordination generally takes the form of information exchange—either on common-interest problems or institutions. Some of this is accomplished through liaison arrangements described above; probably more is done through direct or written contact between the program officials involved. Obviously the effectiveness of these coordinating activities will vary through time, and with particular programs and the various agencies. But from these activities, a number of joint funding arrangements result, as well as many referrals of project requests from one agency to another.

(*d*) *With State governments or their instrumentalities and* (*e*) *with local governments or communities:*

In most NIH program areas, there is no occasion and no need for coordination with State or local governments. While NIH program funds go to many State-supported universities, medical schools, hospitals, and public health departments, etc., the NIH relationship in these instances is what it would be with any other grantee institution. However, in certain program areas under the National Institute of Mental Health, the situation is quite different:

(1) By the very nature of the community health centers program, NIMH has continuing contact with every State government—usually through both the mental health agency and the hospital construction agency.

(2) The mental health staffs in the DHEW regional offices are continually called upon by State governments for consultation in regard to such things as the State plan for community mental health centers, plans for improving the State mental hospital system, etc.

(3) Most NIMH resources in the services area (consultation, mental health project grants, technical assistance projects, demonstrations, program studies) are devoted to continuous work with State or local agencies or organizations.

Also, the regional medical program—recently authorized and assigned to NIH—will require extensive coordination with all groups concerned with delivery locally of improved health services. This coordination will certainly involve representatives of State and local governments.

(*f*) *With foreign governments or international organizations:*

i. The need for coordination or cooperation: Each of the nine NIH institutes is responsible for assessing the importance to its own program goals of distinctive research capabilities or resources found in foreign countries. (This assessment is from intramural as well as grants program perspective.) Other PHS elements similarly look outward toward the world. Yet, as national boundaries are crossed, a reasonably integrated and consistent program image becomes more rather than less important.

While NIH research support overseas represents a relatively small percent of total NIH extramural program (roughly 3 percent), these

funds—in particular countries—may represent a significant or even a main part of the research support given to scientists. These funds may also be the best or the only chance for gifted scientists in developing countries to gain access to resources and advanced training in the United States.

Several special factors sensitize NIH program relationships with foreign governments:

(1) The loss of intellectual resources suffered by various countries through emigration to United States of scientists drawn by more attractive research careers here.

(2) The potential for individual and governmental misunderstandings arising from recent NIH need to reduce levels of overseas research support to counter U.S. "gold drain" problems.

(3) The opportunity to negotiate specific research uses of foreign-blocked currencies, generated by the Public Law 480 (agricultural surpluses) program.

ii. Existing coordinating arrangements: Assuring a reasonably consistent NIH program image before the non-U.S. world is a responsibility of the Director, NIH, exercised through the Office of International Research. At the Public Health Service level, a similar office broadens and supports this unifying role.

In terms of coordinating activities with foreign governments, foreign research communities or international organizations, neither NIH nor the PHS has formal or continuing responsibilities. (These are State Department responsibilities, necessitating certain policy clearances with that Department on specific NIH support proposals.) Yet a number of useful coordinating arrangements have in fact been worked out informally by NIH; and NIH negotiates use of Public Law 480 funds on an ad hoc basis, as opportunities arise. NIH maintains overseas offices and scientific representatives in Paris for Western Europe, Rio de Janeiro for Latin America, and Tokyo for the Pacific area. Special coverage is also provided in London and New Delhi. Through these liaison points, NIH is kept informed of medical research underway in other countries; also of research opportunities and scientific manpower resources not available in the United States.

A number of informal agreements exist for advance "clearance" of NIH support proposals with one or more members of national Medical Research Councils (or similar entities).

Also, in award of international postdoctoral fellowships to foreign scientists, special arrangements are of some interest. For this program, scientists are nominated to NIH by ad hoc research committees set up in each nation, with NIH designating the first member.

(*g*) *With nonprofit organizations or institutions:*

i. The need for coordination or cooperation: In its efforts to achieve health research goals, NIH has developed very special relationships—in fact a state of interdependence—with several categories of nonprofit institutions which constitute the core of our national health research community. (NIH depends on these institutions for research progress; and they in turn on NIH funds to sustain and extend their research capabilities.) The closest of these relationships is with the Nation's medical schools and their associated teaching hospitals. But NIH support through its extramural programs is similarly critical to research levels in dental and other health professional schools; also

in various disease-oriented research foundations, independent hospitals, State, and local departments of public health, etc. Overall, it is fair to say that in U.S. graduate academic institutions, the level and future promise of health science capabilities depend to a considerable degree on what resources are made available through NIH programs.

ii. Existing arrangements: Strictly speaking, there are no "formal" mechanisms for coordinating interdependent interests of NIH and associated nonprofit health or academic institutions. Yet at an informal level, innumerable and ubiquitous coordinating arrangements exist. A full summary of these, therefore, would be pointless to attempt.

In terms of overall funding levels, nature of program parts, use of support mechanisms, and distribution of effort, the total NIH program has come to approximate a kind of consensus within the health research community on what is most needed and feasible. The main advisers on NIH program—members of the various national advisory councils and boards of scientific councilors—are drawn mostly from these closely associated institutions. Eminent individuals from these same institutions have a major role, also, in clarifying NIH program needs for appropriation and other congressional committees.

The elaborate structure of NIH study sections and training committees—made up of hundreds of the leading scientists from these same institutions—serve to set NIH and total community standards for research quality, and to unify thinking on research needs and opportunities.

(*h*) *With business enterprises:*

At the present time, coordination with business enterprises is not a significant element in the NIH research program. NIH does not make grants to such enterprises; and so far, contracting for specific research needs has not been of the type or on the scale warranting coordinating mechanisms beyond minimal setting up of contract purchase offices. Main areas of involvement have been with pharmaceutical concerns (for example, in vaccine development); or (in chemotherapy) with a range of pharmaceutical, animal production, and industrial-chemical concerns. NIH contract involvement with business enterprises almost certainly will increase rapidly in the years ahead; but the nature of coordinating arrangement needed then is not clear at this time.

(*i*) *With others (specify):* None.

8. Laws and regulations. (See general answer to this question for all NIH programs.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See general answer to this question for all NIH programs.)

10. Economic classification of program expenditures. (See table 8 at end of NIH section.)

The Training Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The training program of the National Institutes of Health seeks:

A. The career development of young scientists of promise;

B. The expansion of the pool of the physicians and paramedical personnel qualified to provide—at a high level of excellence—the particular and specialized services (diagnostic, therapeutic, etc.) related to specific categories of disease; and

C. The creation of the institutional forms and mechanisms to insure an adequate supply of manpower to meet the needs of a growing national commitment to health and health research.

2. Operation

This is largely an extramural effort, though there is a small intramural component also. Each of the nine NIH Institutes seeks on a continuing basis to relate estimated available manpower to present and projected needs of its programs. As manpower shortages are indicated, the Institute may plan to meet them through whichever of the available training grant or fellowship options appears most appropriate.

Extramural.—These are the main training options:

Fellowships: There are fellowships of several different types with slightly different objectives:

(*a*) Predoctoral fellowship: Designed to assist promising young students to obtain training in a department oriented to medical research.

(*b*) Postdoctoral fellowship: Designed to give additional training to Ph. D.'s and those holding other academic or doctoral degrees.

(*c*) Special fellowships: Designed for those who can demonstrate the need for additional training in order to increase their value as individual investigators and whose needs are not met by other fellowship programs.

(*d*) Research career awards: Designed to provide stable career opportunities for scientists of superior potential and capabilities early in their careers related to health.

(*e*) International postdoctoral fellowship: Designed to provide for scientists of other countries a scientific experience in the United States in order to strengthen medical research as a universal science by mutual exchange of research methods, scientific fellowship, and cultural values.

An applicant for fellowship programs must arrange for training with an institution where he will study and must have a sponsor under whom he will train. (This training may be in basic, clinical or other applied sciences in the health field.) Predoctoral training is possible in any recognized institution providing research and academic training leading to graduate degrees (but must be in the United States except in unusual circumstances). Postdoctoral and special fellows are expected to have arranged for training in any recognized institution in the United States, including Government research labs where resources are appropriate to the training to be undertaken.

Review: The applications and recommendations from references are given dual review. (Applications are structured to show applicant's academic and employment record, any honors, record of research to date, publications, and proposed educational program including the research project.) The Division of Research Grants provides the technical review, using fellowship review panels analogous to study sections. For the program review, practices vary; but generally this is made by Institute staff or the Institute training committee. However, research career awards go to the appropriate National Advisory Council. Final selection is based on relevance of the field of study to Public Health Service program interests, applicant's qualifications, qualifications of the training institution (and sponsor, where pertinent) and availability of funds.

Somewhat special procedures exist for the international postdoctoral fellows. Applications are accepted from persons in countries in which a national committee has been established by the Public Health Service for the purpose of nominating candidates. It is the responsibility of the candidate to ascertain the deadline date set by a particular committee for acceptance of applications. National committee nominations are pooled and then reviewed on a competitive basis by an advisory body at the National Institutes of Health. Fellowships are thereafter awarded according to priority score within the limitation of available funds. Requests for extension or renewal are also competitively reviewed with the award subject to concurrence of the national nominating committee. Training institutions, other than Federal Government laboratories, receive a research fellowship award on behalf of each international fellow. This award includes funds for the payment of the fellow's stipend, dependency and travel allowances, and training expenses. Stipend and allowance payments are paid to the fellow by the sponsoring institution in accordance with its institutional practices.

Training grants and direct traineeships:

(*a*) Undergraduate training grants: These are awarded (within annual maximum amounts) to certain categories of health professional schools to enable them to establish, expand, or improve instruction relating to prevention, diagnosis, and treatment of various diseases. (Only NCI, NIMH, and NHI make these grants.)

(*b*) Direct traineeships: These are provided as individual stipend awards to qualified physicians and other scientists for advanced training in one of the fields of the health sciences. (Made only by NINDB.)

(*c*) Graduate training grants: These are awarded mainly to assist public and other nonprofit institutions to establish, expand, or improve their research and academic training programs and to increase the number and caliber of trained research investigators in fields constituting the primary interest of the various NIH Institutes. The bulk of NIH training expenditures are made through this mechanism. These grants provide a wide range of support for the institution's training program; also stipends and allowances for students selected. The grantee institution selects the student trainees and has some latitude in setting stipend levels.

In addition to administrative review by NIH staff, graduate training grant applications receive dual review by advisory bodies

composed primarily of non-Federal scientists: first, by a training committee; second, by the appropriate National Advisory Council. Primary factors in evaluating training grant applications are: significance and relevance of proposed training program; adequacy of the leadership, faculty, and facilities; and training record of the institution and department concerned.

Intramural training.—Three distinct training programs are conducted in connection with intramural research. Two of these, the clinical and the research associate programs, are designed for the advanced training of young physicians. The former is oriented to the training of clinical investigators, the latter toward the nonclinical sciences; both of these programs are under the commissioned officer personnel system. Selection of incumbents is made by the scientific directors; appointments are of 2 to 3 years' duration. The staff fellowship program is primarily for the advanced training of young Ph. D'.s. It is under the civil service personnel system; appointments are for 2 to 3 years.

Intramurally, there is also the visiting program. Highly competent, foreign scientists at all levels of seniority participate in this program. These appointments provide to the visiting scientist special facilities, resources, and consultation that may not have been available in his own country. At the same time they provide to the United States an additional source of new techniques and special talents and procedures. The general intent of the visiting program is to provide conditions under which the participants and the NIH staff will derive mutual profit. The categories for appointment are fellow, associate, scientist, and distinguished scientist. They are appointed only on individual invitation by a supervisor or senior staff member at NIH. Criteria are a doctoral degree or equivalent experience, plus specialized training or experience differing by category. Fellows must be considered unusually promising, while those in other categories must offer special talents which NIH cannot obtain through usual domestic employment channels.

3. History

The legislative history of NIH includes the authorization of three basic instrumentalities for the support of training. Public Law 71–251, which created the National Institutes of Health in 1930, authorized the Suregon General to prescribe regulations for the appointment of fellows for duty at the National Institutes of Health and elsewhere. The National Cancer Act of 1937 extended this in authorizing the Surgeon General to support training in the diagnosis and treatment of cancer. Authorization to make grants to nonprofit institutions for training became available in the National Mental Health Act of 1946 (Public Law 79–487). Subsequent enactments, with minor variations, embodied authority in the institutes for training through the use of these instrumentalities.

It is important to recognize that these basic authorities do not limit the training programs of the institutes to the support of research training; the Congress specifically and repeatedly sanctioned training for health service. As a result of this, the training programs of the institutes have evolved with more variety in philosophy, in objectives, in administrative procedures, and in mechanisms of support than other functional activities of the NIH. Even within a single institute,

the characteristics of the training activities have shown important variations over the years.

To set manageable limits to detail on training program additions and changes through time, a selection of just the high points is set down below, chronologically:

In the period 1937–46, NCI focused its training efforts on two aspects: (*a*) postdoctoral research fellows, and (*b*) clinical traineeships in diagnosis and therapy. For both of these programs, NCI made awards to individuals based on selection by NCI staff. In 1946 NCI added predoctoral research fellowships to its training efforts.

The first departure from the pattern of individual award and central review was in 1948. In that year, undergraduate training grants were initiated, these going to institutions to strengthen their undergraduate teaching capabilities in special fields.

During the late 1940's and early 1950's—as each of the NIH categorical institutes was established—the institutes set up training programs to develop the manpower pool where critical shortages existed; also for professional fields broadly related to the institute's statutory responsibilities.

In 1948, NIMH set up its graduate training grant program to support specific departments (psychiatry, psychology, nursing, and social work), providing direct departmental subsidy, as well as support of individual trainees. This was the first training program to use a committee of external advisers to review proposals. The role of Institute staff, therefore, was to invite proposals and to establish program goals for guidance of institutions.

In 1950 the National Heart Institute modified the graduate training grant mechanism to give the grantee institutions greater latitude in several respects: Institutions were allowed to set the level of individual stipends; also to select trainees for the program without central NIH review. This established the general pattern for NIH programs of this type. Also in 1950, on the intramural training side, the NIH visiting program was established. Its purposes were to strengthen the mutually productive relationships of scientific centers throughout the world with that part of the American scientific community represented by NIH, and to increase the utility of the facilities and environment of NIH as a national research resource. (From 1950 to 1955 only about 60 appointments were made under this program. Currently, however, the average number of participants in the visiting program on duty each month runs close to 130.)

In 1954, NIMH initiated career investigator grants. These were intended to support promising scientists in the interval between the completion of their formal training and attainment of tenure appointments. They also were intended to encourage research as a component in an academic career in psychiatry.

In 1955 part-time fellowship programs were initiated for predoctoral students in medicine. (This usually was for summer work.) Purposes of the new program:

(*a*) To stimulate student interest in research;

(*b*) To permit early identification of research talent;

(*c*) To expose selected individuals to research experience as part of their formal education.

In 1958 the creation of the Division of General Medical Sciences (now NIGMS) provided an institutional focus for programs to support

training in a broad range of fundamental scientific disciplines relevant to health, but with limited immediate pertinence to categorical programs.

In 1960 the establishment of general research support grants (as authorized under Public Law 86–98) made possible discontinuance of several training programs; for example, postsophmore and part-time student fellowship programs.

In 1961 the research career program was initiated to provide stable support over extended periods for academic research careers. This program incorporated senior research fellowship programs started earlier by several of the institutes. It had two levels: (1) research career development awards, for promising and mature scientists just getting well launched in their research careers; and (2) research career awards, to permit fully established research scientists to devote maximum time to their research activities.

In fiscal year 1963, NIMH initiated inservice training activities in mental health facilities across the country, designed to increase numbers of fully trained aids, attendants, house parents, and other service personnel needed for staffing of community mental health centers and mental hospitals.

4. Level of operations. (See table 3 at the end of NIH section.)

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

NOTE.—With relatively unimportant differences in detail, the discussion of coordination presented for the NIH research program applies equally to the NIH training program. These differences are not felt to warrant a separate presentation on training.

8. Laws and regulations. (See general answer to this question for all NIH programs.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See general answer to this question for all NIH programs.)

10. Economic classification of program expenditures. (See table 8 at the end of NIH section.)

MENTAL HEALTH SERVICES

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The following three papers deal in specific detail with major aspects of the National Institute of Mental Health program directed at the improvement of health services: (1) Diverse programs involving community research and services—e.g., the mental health projects grant program and technical assistance projects; (2) the mental health grant-in-aid program for support of State control programs; and

(3) the community mental health centers program. (The third of these programs is also included in the summary of NIH grants for construction of health research facilities and community mental health centers.)

Although the foregoing represent the major elements of the NIMH effort with a specific service orientation, in the final analysis the improvement of mental health services is the ultimate goal of the entire Institute's activity. For this reason the following information is offered as a summary of the NIMH services activities.

The NIMH effort traverses the varied endeavors of research scientists, clinicians, community agencies, and training institutions. In its substance, the program includes work in the most basic sciences—for example, in biochemistry, genetics, and experimental psychology—along with clinical studies—e.g., of the alcoholic, of the retarded, the delinquent, and the autistic child, together with work designed to translate and apply acquired knowledge to the many areas of service. Reflected here is a recognition by the Institute that if we are to build a continuum of services to enhance the mental health of Americans, we must buttress the effort with a continuum of scientific endeavor—from basic, normative studies of human development to community-based evaluations of new approaches to the care of the severely disturbed. It would hardly profit citizens, for example, if we were to design, plan, and build new facilities to house services without having available the basic knowledge and techniques which are the core of any helping process.

Underlying all of the Institute's varied efforts—from basic research to community consultations—is the endeavor to improve the mental health services required to meet the needs of our citizens. These needs define our goals: to provide knowledge, techniques, and services that will reverse the tide of mental illness and, ultimately, enhance the well-being and productivity of all of our people.

2. Operation

The program of the National Institute of Mental Health is action oriented. Its activities include making inventories of existing resources, planning for provision of adequate mental health services, constructing and staffing community-based centers, supporting training of mental health personnel to provide services, utilizing current knowledge in prevention and treatment, and accelerating basic and clinical research to obtain new knowledge. This work is accomplished through a variety of efforts, administered under the extramural and intramural programs of the Institute, as well as through a number of special offices.

3. History

Although the National Institute of Mental Health officially came into being in 1946, the Federal Government's interest in mental health reaches at least as far back as 1928. At that time a bill was introduced into the Congress to authorize the construction of two hospitals for the confinement and treatment of persons addicted to the use of habit-forming drugs. The act, which was signed into law the following year, created within the Office of the Surgeon General of the Public Health Service a division charged with the administration of the two hospitals and with other responsibilities concerning narcotics, including research, information dissemination, and development

of care and treatment facilities in cooperation with State and local jurisdictions.

Only a year later, the name of the Division was changed to the Division of Mental Hygiene, and its scope of functions was enlarged to include studies and investigations of the causes, prevalence, and means for the prevention and treatment, of mental and nervous diseases.

A decade passed, and World War II brought into sharp focus the mental health needs of the Nation. More than a million men were rejected by Selective Service for neuropsychiatric disorders, and those rejected for mental and educational deficiencies brought the total to 1,767,000—some 17 percent of American men in their prime of life. Concomitant manpower shortages also emphasized the alarming shortage of personnel in the mental health professions, a lack which precluded adequate treatment and prevention services.

Out of these needs, the National Mental Health Act was passed in 1946. This act, Public Law 487 of the 79th Congress, authorized the establishment of the National Institute of Mental Health. Since then, three acts have extended the basic authorizations for the NIMH program.

The Mental Health Study Act (1955, Public Law 82, 84th Cong.), called for "an objective, thorough, nationwide analysis and reevaluation of the human and economic problems of mental illness." This resulted in the historic study which yielded the report, "Action for Mental Health."

The second act, the Health Amendments Act (1956, Public Law 911, 84th Cong.), authorized a competitive grant program for applied research and evaluative studies, to provide a basis for translation of research findings to the treatment and rehabilitation of the mentally ill.

The third act, the Community Mental Health Centers Act (1963, title II, Public Law 88–164, 88th Cong.), was the response to President John F. Kennedy's special message to Congress, in which he transmitted the recommendations of a Cabinet-level panel and the Joint Commission on Mental Illness and Health and called for a "bold new approach" to end neglect of the mental illnesses.

This profoundly significant legislative step, marking a new era in Federal Government support for mental health services, authorized $150 million over 3 years for grants to States to construct public and other nonprofit community mental health centers. The National Institute of Mental Health carries the responsibility for assisting the States in this venture to make the "bold new approach" to the prevention and treatment of mental illness a reality for those among us in need of help.

4. Level of operations. (See table 4 at the end of the NIH section.)

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Because the ramifications of mental health and illness are so extremely broad, coordination and cooperation with other programs

and agencies—varying in their orientations and missions—are frequent. An individual's behavior is inextricably intertwined with that of the setting and activity in which he finds himself—at home, school, work, or leisure time activities—and his behavior has widespread and significant social repercussions. This is most apparent in the manifestation of mental disorders, which overwhelmingly involve disturbances of the individual's overall behavior and his interpersonal relations. The phenomena of mental illness make themselves known—as do no other pathological states—primarily through behavior.

The Institute, as the Federal Government's major agency and instrument in enhancing the mental health and alleviating the mental ills of the population, develops and maintains a variety of relationships—both formal and informal, ad hoc and continuing—with other Federal agencies having programs bearing upon the field of mental health. Numerous Federal agencies have a stake in the field of mental health and mental illness, particularly in view of some of the more recent developments in areas such as comprehensive community mental health centers, mental retardation, and aging. Each of these fields, as examples, has expanded or will expand the Institute's contacts with other Federal operations.

In addition, the Institute works with States, professional societies, academic institutions, hospitals, voluntary associations, and international organizations. Legislation such as that for the comprehensive community mental health centers also, of course, widens the working relationship of the NIMH with State and local agencies.

The relevance of social considerations to the study of illness and health has become increasingly apparent to all. The Institute has taken cognizance of, and necessarily must become more intensively involved with, the psychosocial implications and ramifications of such major national problems as desegregation and more effective civil rights, broader educational opportunities, the effects of automation, the population explosion, and the elimination of pockets of poverty. As congressional and executive action becomes increasingly aggressive in coming to grips with these wide-ranging problems which touch so crucially on mental health, the Institute's area of coordination with other agencies may be expected to expand.

8. Laws and regulations. (See general answer to this question for all NIH programs.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

President Lyndon B. Johnson, in his 1965 health message to Congress, indicated that mental health programs are a continuing concern. In illustrating the extent of the problem, he said:

> Mental illness afflicts one out of 10 Americans, fills nearly one-half of all the hospital beds in the Nation, and costs $3 billion annually.

To cite a few statistics:

> The number of outpatient psychiatric clinics increased from about 1,200 in 1954 to about 1,800 in 1963; the number of patients under care in those clinics increased in that same period from 379,000 to 862,000.

Twenty years ago only 48 general hospitals were known to admit mental patients; in 1964 there were 1,005 general hospitals admitting an estimated 413,000 psychiatric patients.

In 1964 the average daily resident population in State and county mental hospitals dropped to below 500,000 for the first time in 15 years. However, in the same year there were 300,000 admissions to these hospitals, the largest number in history.

Mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single condition.

The total cost to the taxpayers is over $2.4 billion a year in direct public outlays for services—about $1.8 billion for mental illness and $600 million for mental retardation. Indirect public outlays, in welfare costs and in the waste of human resources, are even higher. But the anguish suffered both by those afflicted and by their families transcends financial statistics—particularly in view of the fact that both mental illness and mental retardation strike so often in childhood, leading in most cases to a lifetime of disablement for the patient and a lifetime of hardship for his family.

Also see general answer to this question at the end of the NIH section.

10. Economic classification of program expenditures. (See table 8 at the end of the NIH section.)

Community Research and Services Branch Program

(Including Mental Health Project Grants)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The primary functions of the Community Research and Services Branch, National Institute of Mental Health, are to encourage and foster—

1. the development of comprehensive community mental health programs in the Nation;
2. experimentation with new methods in pilot projects, demonstrations, and operational research and evaluation in mental health services;
3. communication of new knowledge to mental health practitioners and absorption of validated methods into everyday practice.

Staff assist National, State, and local agencies and organizations in improving and extending their programs for the promotion of mental health, prevention of mental disorders, and care, treatment and rehabilitation of the mentally ill and mentally retarded. A major emphasis is helping in the development of a coordinated continuum of mental health services at the local level which will work closely with other community agencies in health, welfare, education, etc. Assisting in the establishment of community mental health centers has high priority.

The ultimate purpose is the "improvement of the mental health of the people of the United States" (National Mental Health Act of 1946).

2. Operation

A wide range of methods is used including: Consultation with State and local programs, operation of demonstrations and pilot projects, conferences to communicate new knowledge (technical assistance projects and research utilization conferences), scientific reviews of current knowledge, program research and evaluative studies, surveys of State programs, and the administration of the mental health project grants programs, including hospital improvement projects.

A staff of national experts in mental health services and mental health program administration is located in the headquarters office. The staff includes consultants specializing in the following areas: Clinical facilities, social psychiatry, child mental health, aging, alcoholism and drug abuse, crime and delinquency, and mental retardation.

The mental health project grants program (title V of the Health Amendment Act of 1956, Public Law 911) makes grants for "investigations, experiments, demonstrations, studies, and research projects with respect to the development of improved methods of diagnosing mental illness and for care, treatment, and rehabilitation of the mentally ill, including grants to State agencies responsible for administration of State institutions * * * for developing and establishing improved methods of operation and administration of such institutions." The two parts of this program are (1) the "comprehensive" mental health project grants and (2) the hospital improvement project grants program. Both grants programs are viewed as vehicles for program development in mental health services.

The "comprehensive" mental health project grants ($18 million in fiscal 1966) provide support for a wide range of program studies, experiments, demonstrations, and operational research projects designed to develop and evaluate improved methods of care, treatment, and rehabilitation of the mentally ill. The program supports community services, including projects concerned with prevention and with new psychosocial and psychoeducational approaches to mental health services. Emphasis is on experimentation with and demonstration of new program ideas, systems, and techniques and on the application of new knowledge from the behavioral sciences.

Among the major program areas supported are: (1) Alternatives to institutional care; (2) new techniques of prevention and rapid treatment, such as early case finding, crisis intervention, short-term therapy and family therapy; (3) innovations in services for the aged, alcoholic, and drug addict, delinquent and mentally retarded; (4) multipronged approaches to mental health problems of low-income groups; (5) epidemiologic and evaluative studies; (6) new therapeutic services for children and adolescents; (7) experimentation with new ways of utilizing mental health manpower, particularly nonprofessionals; (8) new methods of organization, administration, and coordination of existing resources which move toward a continuum of care through prevention, treatment, and rehabilitation.

The second part of the mental health project grants program is the hospital improvement project grants which also has an allocation of

$18 million in fiscal 1966. This program began in fiscal 1964 as the result of appropriation language. The hospital improvement project grants program initiates and supports demonstrations to improve the treatment, training, and rehabilitation programs of State mental hospitals and institutions for the retarded. Beginning with the $6 million appropriation in fiscal year 1964, the program was planned to grow in regular steps of $6 million increments each year until a maximum of $36 million is reached in fiscal year 1969. Each of the Nation's approximately 430 State mental hospitals and institutions for the mentally retarded is eligible to apply for a grant, up to a maximum of $100,000 a year for a 10-year period.

The purpose of these grants is to make it possible for an institution to initiate a series of changes which will produce improvement in patient care throughout the entire program of the institution. They are also designed to help the State hospitals and institutions for the retarded achieve a strengthened role as an integral part of comprehensive community-based services.

In the overall mental health project grants program, professional and technical assistance staff have been involved in stimulating, developing, and improving applications and consulting with investigators while the project is underway.

In addition to grants, contracts are used for staff-initiated demonstrations, pilot projects, and program studies; for technical assistance projects or conferences held by States; and for consultation provided by outside experts.

3. History

Following the passage of the National Mental Health Act in 1946, the Community Services Branch was organized in 1947 in the Mental Hygiene Division of the Bureau of Medical Services, Public Health Service. (In 1949 the Mental Hygiene Division became the National Institute of Mental Health.) The prime objective at that time was to extend and strengthen State programs of mental health services. This objective was carried out through (1) grants-in-aid to States for community mental health services; (2) demonstrations and program studies; and (3) professional and technical assistance to State and local programs. Professional and technical assistance was provided on State program administration, outpatient psychiatric clinics and mental hospitals. From that time to the present the public health approach was employed; consultation with nonpsychiatric agencies and groups and mental health education were considered essential for an effective mental health program.

In 1955, the first technical assistance project was initiated, a unique administrative invention financed through contracts. In these projects, outstanding national experts, researchers, and practitioners, meet with staff in an institute or workshop focused on a specific mental health problem. Technical assistance projects have become an essential part of the National Institute of Mental Health program; 20 projects were conducted in fiscal 1965.

In 1956 the Health Amendments Act of 1956 (Public Law 911) established the mental health project grants program (title V). This program provides competitive grants for pilot projects, demonstrations, applied research, and evaluative studies. During the first year of operation (1958), 64 grants were made totaling $1.9 million. It was the first such program in the Public Health Service.

Through appropriation language, in fiscal 1964 the mental health project grants program was expanded to include the hospital improvement project grants program. In fiscal 1965, 295 "comprehensive" mental health project grants were paid, totaling $16.8 million; 159 hospital improvement project grants projects were paid totaling $12 million.

The mental health project grants program started with one review committee of nongovernmental consultants. By 1964, four committees were operating—committees on (1) community programs, (2) mental hospitals, (3) special areas (aging, alcoholism, mental retardation, etc.), and (4) juvenile delinquency.

With the passage of the Community Mental Health Centers legislation, National Institute of Mental Health staff concerned with services have increasingly focused efforts on assisting staff responsible for the administration of the community mental health centers programs. The contribution of Community Research and Services Branch staff has been in providing specialized expert knowledge on the program components of centers (e.g., children's services, alcoholism services, etc.) and also on general mental health program administration.

Current activities are based on the following guidelines:

(*a*) Much of our knowledge about mental health is fragmentary. Final answers to problems are generally not yet available so that there is continuing need for experimentation, research, pilot projects, and evaluation. The trying out of new approaches, methods and techniques should be encouraged.

(*b*) The gap between present knowledge and present practice should be reduced.

(*c*) As a long-range goal, comprehensive mental health services in communities should be available for all in the population who need these services, regardless of where they live, their age, race, religion, or condition. Large areas of the country, large segments of our population still have little or no mental health services, so that strenuous efforts are necessary to expand services. Communities should have a coordinated continuum of services for patients, beginning with preventive services and including care for the mentally ill as they move from the prehospital period, through inpatient care and back to the home. With new methods of treatment such as emergency home care, day care, etc., many seriously ill mental patients can avoid hospitalization. For most patients, maintaining community ties with family, job, friends, etc., is therapeutically desirable.

(*d*) Community mental health programs should have a public health approach to prevention and control; they should be concerned with the total population and with the community, its organizations, and groups. Mental health concepts and knowledge should be incorporated into the practices of the many different community agencies and institutions dealing with people. Mental health education, mental health consultation to health and welfare agencies, courts, schools, general practitioners, volunteer agencies, etc., should be an essential part of the activities of State and local mental health personnel. The tools and techniques of public health (i.e., epidemiology, early case findings, prevention, etc.) seem to offer a fruitful approach to the development of community mental health services.

(*e*) The development of mental health services is a joint responsibility of Federal, State, and local, public and voluntary organizations.

Local support tends to assure the continuation and growth of mental health programs.

4. Level of operations. (See tables 5 and 6 at the end of the NIH section, relating to grants for construction and staffing of community mental health centers.)

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Besides the traditional administrative reasons for coordination (avoidance of duplication and overlap, increased efficiency, etc.), National Institute of Mental Health staff in mental health services have a special reason for working with other organizations. The acute shortage of mental health manpower will not be relieved in the foreseeable future so that mental health programs must rely on other types of organizations such as welfare agencies, courts, schools, etc., to carry part of the load. More than that, these other agencies and institutions probably have an important impact on the mental health of the large numbers of people that they reach.

(*a*) Within the National Institute of Mental Health, Community Research and Services Branch staff review and advise on State and local plans for community mental health centers. Regional staff help in the administration of the mental health project grants program, by visiting applicants and giving oral reports at meetings of review committees which make decisions on projects.

(*b*) In relation to medicare, National Institute of Mental Health staff have been working intensively on the development of standards for mental health services with the Social Security Administration, Bureau of Family Services, and Bureau of State Services, Public Health Service.

(*c*) In a formal arrangement with the Office of Economic Opportunity, National Institute of Mental Health staff regularly review proposals for antipoverty projects which have mental health components. National Institute of Mental Health staff participate on the President's Committee on Juvenile Delinquency and Crime, review legislative proposals of the Department of Justice and cooperate with the National Crime Commission.

(*d*, *e*, and *g*) The major effort of the total National Institute of Mental Health program of mental health services is in the development of State and local services by public or nonprofit organizations. By far most of the National Institute of Mental Health resources in the services area (consultation, mental health project grants, technical assistance projects, demonstrations, program studies) are devoted to continuous work with these organizations.

Considerable support also is provided to universities and professional schools because of the leadership they can provide in innovating, trying out and testing new methods of prevention and treatment and because of their competence in research design.

(*f*) A few mental health project grants have been made to investigators in foreign countries. A staff member is currently repre-

senting the National Institute of Mental Health in a World Health Organization Committee on mental retardation.

(*h* and *i*) One staff member is a specialist in occupational mental health and consults with business enterprises on their mental health services for employees. A few grants have been made to labor unions in relation to their health programs.

8. Laws and regulations

(42 U.S.C. 241 et seq.)

Mental health project grants: Section 303, Public Health Service Act; Health Amendments Act of 1956, Public Law 911; DHEW Appropriations Acts, fiscal years 1964, 1965, 1966.

Professional and technical assistance: Section 301, Public Health Service Act.

Also see general answer to this question at the end of the NIH section.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Mental illness is one of the most costly health problems faced by the Nation. It constitutes an enormous drain on the Nation's resources and energies, both economic and noneconomic.

Mental illness cost the Nation about $3.5 billion in 1962. Direct costs for the care and treatment of the mentally ill were over $1.8 billion, indirect costs (losses in salaries and wages, etc.) $1 billion, and other costs (research and training, pensions and compensation) $½ billion. All of these costs increased sharply in recent years. For example, direct costs increased 63 percent between 1956 and 1962. These estimates by the Blue Cross Association are described as a substantial understatement of the total economic cost.

10. Economic classification of program expenditures. (See table 8 at the end of the NIH section.)

Included in report on research grants prepared by the National Institutes of Health and discussed later.

Mental Health Grant-in-aid Program

(State Control Programs)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The purpose of this grant is to assist the States in establishing, maintaining, and expanding community mental health services in an effort to improve the mental health of the people of the United States and to prevent and curtail the need for hospital care of the mentally ill.

2. Operation

The funds appropriated annually for the program are allotted among the States by a formula which, as provided by law, takes into consideration the population, financial need, and extent of the mental health problem in the various States. By administrative

determination, 30 percent of the funds is allotted on the basis of population weighted by the reciprocal of per capita income and 70 percent on the basis of the extent of the mental health problem, which is considered to be directly proportional to population. Allotments are administratively adjusted to insure that each State receives a minimum grant based on the amount of the total appropriation. In weighing the population by the reciprocal of per capita income, funds are channeled into those areas least financially able to promote community mental health services.

Since 1960, the expenditure of mental health grants must be matched by expenditures of an equal amount of State and local funds. Mental health authorities, designated by the States, are eligible to receive formula grants upon submission and approval of a State plan for their use. Funds are allocated to the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

3. History

Beginning with fiscal year 1948, annual appropriation acts have included in the appropriation for mental health activities an amount for State grants (State control programs). For fiscal year 1948 an amount of $3 million was appropriated. Lesser amounts were made available during the period 1951–55. The appropriation was restored to its 1948 level in fiscal 1956. The amount made available by Congress for this program was increased in later years to $6.75 million in fiscal 1962. For each of the fiscal years 1963 and 1964 an additional $4.2 million was appropriated to support interagency State planning of comprehensive long-range mental health services.

During the early years of the program many States could not match the requirement of $2 of Federal funds with $1 of State and local funds without recourse to a temporary provision allowing them to credit up to 1 percent of their funds being spent on mental hospitals. The ratio of the total expenditures of State and local funds to the expenditures of Federal funds for community mental health services rose from 1.45 in 1948 to approximately 15.7 in fiscal 1964. The ratios of such expenditures for the individual States and territories vary widely. In New York the expenditures of State and local moneys in fiscal 1964 were over 65 times the amount of Federal grant-in-aid funds expended.

In 1948 less than half of the States had organized community mental health programs; by 1951 all States had such programs. Most of the funds were used to establish or expand outpatient psychiatric clinics in communities. The public health approach was emphasized; consultation with nonpsychiatric agencies and groups and mental health education were considered as important preventive services which should be part of clinic programs. National Institute of Mental Health staff urged that larger proportions of the Federal grants be used for demonstrations which would eventually be taken over by State and local funds.

4. Level of operations. (See table 4 at the end of the NIH section.)

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) *Within NIMH.*—In reviewing State plans for use of formula grant funds NIMH regional office staff will be concerned with the extent to which the plan is consistent with the State's plan for comprehensive mental health services. Regulations also require that the State plan for the construction of comprehensive mental health centers be consistent with the comprehensive State planning. The use of funds for initial support for staff of mental health centers must be described in the State's plan for community mental health services.

(*b*) *With other units in the department or agency.*—The centralized administrative responsibility of the Office of Grants Management in the Bureau of State Services (CH), PHS, integrates the administrative aspect of the program. The responsibility of the regional health directors for approval of all State plans for use of Public Health Service grant-in-aid programs provides a substantial coordinating effect. The accessibility of staff of other component agencies of the Department in the regional office facilitates collaboration and cooperation in the administration of this grant program and other programs of the Department of Health, Education, and Welfare.

(*c*) *With other Federal departments or agencies.*—Coordination with other Federal departments is accomplished through representation of the Veterans' Administration and the Department of Defense on the National Advisory Mental Health Council.

(*d*) *With State agencies.*—Staff of NIMH works directly with State mental health authorities to give professional and technical assistance in the development of comprehensive State community mental health programs.

(*e*) *With local governments or communities.*—Institute staff also works with local governments and local communities, usually with the collaboration or knowledge of State agency staff, in the development of community mental health programs.

(*f*) *With foreign governments.*—This program has no contact with foreign governments.

(*g*) *With nonprofit organizations.*—NIMH personnel offer professional and technical assistance to both public and voluntary agencies with respect to program development.

(*h*) *With business enterprises.*—In the administration of this program there is no contact with business enterprises.

(*i*) Not applicable.

8. Laws and regulations

Public Health Service Act, section 314, as amended. Department of Health, Education, and Welfare Appropriations Act of 1966. The National Mental Health Act, Public Law 487, 79th Congress, approved July 3, 1946, amended section 314(c) of the Public Health Service Act to provide for grants to States. Section 314(d) of the Public Health Service Act as amended (42 U.S.C. 246(d)) cites the basic allotment factors of population, financial need, and extent of the mental health problems. Section 18, Public Law 896, 84th Congress, approved August 1, 1956, extended the mental health grant to Guam. Sections 51.1(c), 51.1(i), and 51.2(d) of the Public Health Service Regulations (42 CFR) define these factors and section 51.3(d) prescribes the range

of percentage distribution for each factor. Section 51.9(a) prescribes the matching ratio.

Also see general answer to this question for all NIH programs.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

There is no doubt but that the use of mental health formula grant funds in the community programs of the 54 State and territorial mental health authorities improves the personal incomes of persons served and their placement and productivity. The use of these funds assists in the prevention and treatment of mental illness and in the rehabilitation of the mentally ill. It is impossible, however, to identify the economic effects of the use of these funds in mental health programs supported jointly by State and local, public and private funds. It is also impossible to separate the economic effects of inpatient and outpatient (community) mental health services.

Also see general answer to this question at the end of the NIH section.

10. Economic classification of program expenditures. (See table 8 at the end of the NIH section.)

Community Mental Health Centers Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The community mental health centers program is designed to foster the nationwide development of local community programs of comprehensive mental health services. In carrying out this program grants are made to assist States and communities in both the construction and the initial staffing of community mental health centers.

2. Operation

The construction grant funds are allocated by formula among the States (based on population and per capita income). Each State has designated a State agency responsible for drawing up a State plan for the construction of community mental health centers and for assigning priority ratings to the applications submitted to it by all potential grantees. The Federal administrative responsibility is carried out by the National Institute of Mental Health in cooperation with the Division of Hospital and Medical Facilities.

The initial staffing grants will be made on a project basis against a State allotment. As this legislation was enacted in August, 1965, the Secretary has not yet promulgated the regulations which will specify the conditions of award.

3. History

Following a study of the findings and final report of the Joint Commission on Mental Illness and Health, in early 1963, President Kennedy sent to the Congress, his special message on mental illness and mental retardation. In that message the President asked for a "bold new approach" to replace the State mental hospital system with a system for providing comprehensive mental health services

at the community level. This system would emphasize service which was short term and intensive rather than long term and custodial. It would also emphasize the prevention of mental illness through consultation and education, as well as the full rehabilitation of those who have been mentally ill.

Hence it was a comprehensive approach, one which could be successful only if undertaken at the community level, i.e., close to the homes, families, and jobs of those who need help.

In the fall of 1963, Congress passed Public Law 88–164, title II of which is the "Community Mental Health Centers Act". This act authorized a total of $150 million for the fiscal years 1965–67 for grants to assist in the construction of community mental health centers. The appropriation authorized for each year ($35 million for fiscal year 1965, $50 million for fiscal year 1966, and $65 million for fiscal year 1967) is to be allotted among the several States and is to remain available for 2 years.

Regulations implementing the act were issued in the spring, 1964. Thereafter, the States began to bring together material from their comprehensive mental health planning programs (supported by the NIMH in fiscal year 1963 and fiscal year 1964) in order to develop a plan for the construction of community mental health centers. These plans, which must be approved before any projects can be awarded, are now being submitted to the National Institute of Mental Health. To date, 10 plans have been approved, 14 others are now under review, and the remaining 30 (including the District of Columbia and territories) are in various stages of preparation. The first two construction grant applications have been approved, and others are being submitted.

In enacting the Community Mental Health Centers Act, the 88th Congress accepted only a part of President Kennedy's proposal. In addition to the construction grant program, the President had recommended a program of providing initial staffing grants to enable mental health centers to begin operation. Following congressional action which resulted in the passage of the Community Mental Health Centers Act of 1963 it became apparent that a great many centers would need such assistance and thus the 89th Congress in 1965 amended the Community Mental Health Centers Act to include such a staffing grant program. The regulations implementing the staffing grant program will be issued within 6 months following the enactment of the legislation.

The average Federal share in all construction grants is 50 percent. This percentage figure varies by State between 33⅓ percent and 66⅔ percent.

Staffing grants will be at a level of 75 percent Federal assistance for the first 15 months, 60 percent for the next year, 45 percent for the third year, and 30 percent for the fourth year.

4. Level of operations. (See tables 5 and 6 at the end of the NIH section.)

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) While the Community Mental Health Facilities Branch of the NIMH is primarily responsible for the administration of the centers program, nearly every area of the Institute becomes involved in the planning for the program and in the review of State plans and project applications.

(*b*) Within the Public Health Service the NIMH carries out its responsibilities for the centers program in cooperation with the Division of Hospital and Medical Facilities.

Within the Department of Health, Education, and Welfare the NIMH has consulted with the Office of Education and the Vocational Rehabilitation Administration in regard to elements of the centers program which might fall within the interests of those two agencies. Arrangements are also being made to consult at length with the Social Security Administration with a view toward implementing the mental health aspects of the Social Security Amendments of 1965 (Public Law 89–97).

(*c*) The NIMH has also had conferences with staff in the Office of Economic Opportunity in regard to possible utilization of funds from the war on poverty for use in community mental health centers. Further, the NIMH has had exploratory contact with the staff of the Appalachian Regional Commission in regard to the Appalachian Regional Development Act which authorizes funds for the construction and staffing of community mental health centers.

(*d*) By the very nature of the centers program, the NIMH has continuing contact with every State government (usually through both the mental health agency and the hospital construction agency). The mental health staff in the DHEW regional offices are continually called upon by State governments for consultation in regard to such things as the State plan for community mental health centers, plans for improving the State mental hospital system, etc.

(*e*) By the nature of the program, the NIMH has had continuing contacts with many local communities on a consultation basis.

(*f*) Foreign governments and international organizations are generally outside the boundary of the community mental health centers program.

(*g*) A great many applicants for centers construction and staffing funds have been and will be nonprofit organizations and institutions such as general hospitals, mental health clinics, universities, and various voluntary mental health associations.

(*h*) and (*i*) not applicable.

8. Laws and regulations

The basic authorizing legislation for the centers program is Public Law 88–164, "The Community Mental Health Centers Act" (cf. 42 U.S.C. 2681–2687), as amended.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

It is estimated that at the present time the direct and indirect costs of mental illness are upward of $4 billion annually.

10. Economic classification of program expenditures. (See table 8 at the end of the NIH section, which combines grants for mental health center construction with those for health research facilities construction.)

GRANTS FOR THE CONSTRUCTION OF HEALTH RESEARCH FACILITIES

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The objective of this program is to raise the quality and capacity of the facilities for health and health-related research by supporting the construction, renovation, and equipping of modern facilities for research and related activities in the sciences related to health. This support is provided to both public and nonprofit private institutions. The activity was initiated in recognition of the need (1) for a program of modernization to overcome the problems of obsolete, overcrowded, and poorly equipped research laboratories, and (2) to expand research facilities resources as the Nation's support of medical research performance grows, new institutions with research capability are created, and the supply of qualified personnel for research training increases.

2. Operation

Grants for the construction of health research facilities are awarded by the Surgeon General of the Public Health Service upon recommendation for approval by the National Advisory Council on Health Research Facilities.

The applicant for a construction grant must be a public or a nonprofit institution determined to be competent to engage in the type of research for which the facility is to be constructed.

The amount of the grant may not exceed 50 percent of the cost of the construction of the facility; in the case of multipurpose facilities the award is based on the proportionate cost of the part of the facility to be used for research or related activities.

Furthermore, the facility, for 10 years after completion, must be used for the purpose for which it was constructed. In the event that the facility, within 10 years, is not being used for the research purposes for which it was constructed, the regulations provide for the recovery by the Federal Government of an amount proportionate to the value of the facility (at the time of recovery) in the same ratio as the Federal grant for construction bore to the total cost of the construction of the research facility.

In approving awards, particular consideration is given to facilities that (a) will be used for research in disciplines or diseases which have the most urgent needs; (b) are adaptable to the various methods by which research is organized or advanced; (c) will be in institutions or localities with broad research programs and potentials; (d) will promote a better geographic distribution of research through assistance of established or promising new research activities in various areas of the Nation having at present relatively few such research facilities.

The award process.—The National Advisory Council on Health Research Facilities is composed of the Surgeon General of the Public Health Service, an official of the National Science Foundation, and 12 members appointed by the Secretary, Department of Health, Educa-

tion, and Welfare—4 of them selected from the general public and 8 from among leading medical, dental, or scientific authorities.

To assist the Council in the review process, a scientific review committee composed of expert scientists from varied disciplines, performs the initial outside-NIH review of applications, participates in site visits, and, on the basis of its evaluation, makes recommendations to the Council.

To assist the applicant, architects and engineers of the Division of Research Facilities and Resources (NIH), review all construction plans and work with the applicant institution through the planning and construction phases.

3. History

Title VII, part A, of the Public Health Service Act, under which this program operates, at first authorized $30 million annually for 3 years beginning July 30, 1956. In August 1958 the authorization was extended for 3 more years at $30 million, and in October 1961 it was extended for a 1-year period with authorization for an increased appropriation of $50 million. At the same time the law was changed to broaden the term "research facilities" to include research and related purposes, including research training. In October 1962 the authorization was extended for 3 additional years, through June 30, 1966, at $50 million a year. In August 1965, the authorization was again extended for 3 additional years, with aggregate appropriations not to exceed $280 million over the 3-year period. The program is administered by the Division of Research Facilities and Resources which was established by the Public Health Service in 1962 at the National Institutes of Health for the purpose of administering large-scale, broad, institutionwide applications for grants.

Modern medical research possesses the capability of mounting a full-scale attack on the major killing and crippling diseases of mankind with all of the armamentarium of science. New techniques of instrumentation require new standards in operating rooms, in patient monitoring, and in research data analysis. Sophisticated techniques for better research and diagnosis demand better and more precise laboratory design. Chromatographic and radioisotope procedures for the study of heart disease and cancer require closer study of the conditions of air conditioning and environmental control. Tissue and organ transplantation studies require specialized operating rooms and recovery room suites, designed to protect patients from every possible type of infection; specialized laboratory animal colonies in which similar protective measures have been incorporated; and experimental facilities for research with germ-free animals.

The approximately $900 million in health research facility construction, of which the Public Health Service provided more than $350 million, or about 40 percent, has stimulated many major developments in medical science. Without adequate facilities, the newer advances in biophysics, biomedical engineering, enzyme technology, and clinical research could not have been accomplished. The development of new techniques in the diagnosis of brain and heart disorders, in the study of lipid metabolism and atherosclerosis, and in rehabilitation has been stimulated by facilities designed and constructed to provide the maximum enhancement of the research program. Most of the medical schools of the Nation have relied upon this program

to supply additional funds needed to provide the research space and laboratory equipment required to implement the development of their basic science and clinical research programs.

Positive contributions to the grantee institutions under the health research facilities program are many. Construction grant awards have significantly—

(*a*) Improved the quality of research by providing modern equipment and laboratories.

(*b*) Broadened the base of research across interdisciplinary lines by the provision of institutional or multidepartmental space.

(*c*) Increased the quantity of research.

(*d*) Effected greater savings in spending research dollars invested by providing multicategorical space in which central laboratory equipment of interest to several programs could be more economically housed.

(*e*) Facilitated recruitment of qualified scientific personnel by providing modern laboratory space.

4. Level of operations. (See table 5 at the end of the NIH section. The table includes grants for construction of community mental health centers.)

5. Estimated magnitude of program in 1970.

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Of major consequence to the health research facilities program were two measures passed by the Congress and signed into law in 1963. One, Public Law 88–129, the Health Professions Educational Assistance Act of 1963, authorizes grants to schools of the health professions for the construction of teaching facilities. Because many institutions plan to construct both their educational and their research facilities simultaneously, close liaison has been established between the Division of Research Facilities and Resources and the Division of Hospital and Medical Facilities to enhance implementation of the law. Awards have been made under title VII–A of the Health Research Facilities Act for the health-related research portion of joint educational and research facilities; and awards are now beginning to be made under the recently prescribed joint application form.

A second law of special concern to the health research facilities program is Public Law 88–164, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, which authorizes, under part A of title I, a construction program for "centers for research on mental retardation and related aspects of human development." The law authorizes $26 million over a 4-year period, beginning in fiscal year 1964, specifically earmarked for construction of centers for "research, or research and related purposes, relating to human development whether biological, medical, social or behavioral, which may assist in finding the causes, and means of prevention, of mental retardation, or in finding means of ameliorating the effects of mental retardation." Administration of the program to provide grants for construction is the responsibility of the Division of Research

Facilities and Resources in close collaboration with the National Institute of Child Health and Human Development. Before grants can be awarded, the applications for construction grants for the centers must be reviewed and recommended by the advisory groups of both the Division and the Institute. NIH is also actively engaged in exchanging information with NASA, AEC, and NSF, on requests from various institutions for funds for renovation or construction of research facilities.

8. Laws and regulations. (See general answer to this question for all NIH programs.)

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects. (See general answer to this question for all NIH programs.)

10. Economic classification of program expenditures. (See table 8 at end of NIH section.)

Regional Medical Programs

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The objective of the regional medical programs is to provide the medical profession and medical institutions a greater opportunity to make the latest advances in the diagnosis and treatment of heart disease, cancer, and stroke more widely available to their patients throughout all regions of the Nation. To accomplish this goal, Public Law 89–239 authorizes grants for the planning and operation of "regional medical programs," which are defined as cooperative arrangements among a group of institutions engaged in research, training, diagnosis, and treatment to combat heart disease, cancer, and stroke—diseases that together account for more than 70 percent of all deaths in this country.

The region to be served must be a geographic area composed of part or parts of one or more States which the Surgeon General determines to be appropriate for the purposes of this program. The plan for the development of a regional medical program must include the participation of one or more medical centers (i.e., medical school or other medical institution engaged in postgraduate medical training and its affiliated hospitals), one or more clinical research centers, and one or more hospitals, involved in cooperative arrangements which the Surgeon General finds to be adequate to carry out the purposes of the program. The particular activities to be undertaken through the regional medical programs will be varied and will be determined in the region by mobilizing existing resources to meet local needs and goals.

2. Operation

The regional medical programs will be supported through a program of grants to be administered by the National Institutes of Health. Grants may be made to public or nonprofit private university, medical school, research institution, or other public or nonprofit private institution or agency interested in planning, conducting feasibility studies, and in operating a regional medical program of research, training, and demonstration activities for their region of the Nation.

3. History

In March 1964, President Johnson appointed a Commission on Heart Disease, Cancer, and Stroke chaired by Michael E. DeBakey, M.D. The Commission was to recommend practical steps to reduce the heavy toll exacted by these diseases through the development of new scientific knowledge and through the delivery, to all of our citizens, of the medical knowledge we now possess. During the following months, the Commission heard testimony from scores of leaders in medicine and public affairs, and it was the overwhelming conviction of the Commission that something could and must be done to alleviate the suffering and death occasioned by heart disease, cancer, and stroke. The major innovative thrust of the Commission's first three recommendations is embodied in the regional medical programs concept in Public Law 89–239.

4. Level of operations

The legislation which authorizes the regional medical program, Public Law 89–239, was signed into law on October 6, 1965, and funds have just been appropriated for this purpose. The National Advisory Council on Regional Medical Programs has not yet been appointed, and regulations have not yet been established, nor applications prepared. Therefore, very little information is available concerning the level of operations of this new program.

(Also see table 7 at the end of the NIH section.)

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The concept of the regional medical programs provides a unique opportunity for coordination and cooperation within the National Institutes of Health, within the Public Health Service, within the Department of Health, Education, and Welfare, with other Federal agencies, and with nonprofit institutions and agencies throughout the Nation. The authorizing legislation (Public Law 89–239) specifically requires "coordination of programs assisted under this title with programs for training, research, and demonstrations relating to the same diseases assisted or authorized under other titles of this act or other acts of Congress." Regulations covering this coordination are now being prepared.

(a) Within the National Institutes of Health, there are clear opportunities for coordination of the development of regional medical programs with the existing programs of the National Heart Institute, the National Cancer Institute, the National Institute of Neurological Diseases and Blindness, and the National Institute of General Medical Sciences which relate directly to the three disease groups, heart disease, cancer, and stroke. An important new program such as this one is of obvious relevance to all of the programs at the National Institutes of Health. Therefore, in the early phases of this program, meetings have been held with the Institutes to convey generally the progress being made in the development of program guidelines and regulations and in the administration and staffing of a new kind of endeavor for

the NIH. Further coordinating mechanisms will be developed when the regional medical programs become functional.

(*b*) The National Institutes of Health has been carrying on a great deal of coordination with the Office of the Surgeon General, Public Health Service. This coordination has now been made formal in a series of weekly reports to the Surgeon General on the status of the regional medical programs. In addition, the Bureau of State Services, whose programs bear the greatest relevance to the regional medical programs, has appointed a top level member of its staff to serve as permanent liaison between these bureaus of the Public Health Service. This liaison staff member will help to insure maximum cooperation and to eliminate duplication of the two related programs.

To insure coordination of this program with other programs in the Department, the Under Secretary has requested monthly reports on the activities and progress of the regional medical programs. The regional medical programs bear a particular relationship to the Vocational Rehabilitation Administration, and close coordination will be carried on with the VRA. Appropriate coordination will also be established with the Children's Bureau.

(*c*) The regional medical programs will be coordinated with relevant programs of the Veterans' Administration.

(*d*) and (*e*) The regional medical programs are to be regional cooperative arrangements which may include relevant health agencies of States and local communities, such as health departments, hospital planning bodies, or other interested agencies. Such groups can be represented on the advisory body designated by the grant applicant to advise in formulating and carrying out the plan for a regional medical program in that region.

(*f*) Not applicable.

(*g*) Public Law 89–239 authorizes grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private institutions and agencies to assist them in planning, in conducting feasibility studies, and in operating pilot projects for the establishment and operation of regional medical programs. These programs are defined in the law as involving regional cooperation among such institutions.

(*h*) and (*i*) Not applicable.

8. Laws and regulations

Public Law 89–239 is the authorizing legislation for regional medical programs. The first appropriation is in Public Law 89–309, chapter VI. No regulations have, as yet, been promulgated.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The President's Commission on Heart Disease, Cancer, and Stroke, which provided the initial impetus for the regional medical programs, asserted that—

> Americans need no longer tolerate several hundred thousand unnecessary deaths each year from heart disease, cancer, and stroke.
>
> By bringing to all the people the full benefit of what is now known of prevention, detection, treatment, and cure, we could save, each year a number of lives equal to the population of a major city.

With the realization of this goal, it would be possible to reduce the death toll from these disease groups nearly 20 percent. The economic costs of these diseases, which reach nearly $31.5 billion each year, could be significantly reduced. To support its recommendations, the Commission presented a source paper on the economics of these problems. (See vol. II of the Report of the President's Commission on Heart Disease, Cancer, and Stroke, published in February 1965.)

The regional medical programs also provide a unique opportunity for increasingly efficient and effective utilization of the medical resources of the Nation. Through planning, programs of specialized training, continuing education, complex diagnostic and treatment services can be carried on through regional cooperative arrangement among medical schools, research institutions, and hospitals.

10. Economic classification of program expenditures

Not in operation in fiscal 1965.

General Answers for NIH

4. Level of operations. (See tables 1 through 7.)

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service; National Institutes of Health.

Program: Research grants and contracts.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of program (grants or contracts)	15,850	15,650	15,650	15,300
(b) Applicants or participants:				
Numbers of grants or contracts, by participant, total	15,850	15,650	15,650	15,300
Educational institutions, total	12,700	12,500	12,500	12,250
Public	(7,200)	(7,100)	(7,100)	(6,900)
Private	(5,500)	(5,400)	(5,400)	(5,350)
Hospitals	2,100	2,100	2,100	2,000
State and local [1]	200	200	200	200
Nonprofit research institutions	800	800	800	800
All other	50	50	50	50
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred (in thousands)	$542,720	$589,748	$660,596	$695,826
Allotments or commitments made				
(d) Matching or additional expenditures for the program				
(e) Number of Federal employees administering, operating, or supervising the activity [2]	2,100	2,300	2,500	2,600
(f) Non-Federal personnel employed in the program	(3)	(3)	(3)	(3)
(g) Other measures of level or magnitude of performance:				
Numbers of institutions receiving grants or contracts, total	(4)	1,350	(4)	(4)
Educational institutions		400		
Hospitals		300		
State and local		150		
Nonprofit research institutions		100		
All other		400		

[1] Government agencies, other than educational institutions or hospitals.

[2] The numbers of personnel include members of study sections and advisory councils who serve as consultants to the PHS, and those NIH employees directly and exclusively concerned with administering extramural programs. It is not feasible to report the man-years of staff time allocable to extramural activities for those NIH employees who are concerned with overall program direction and administration; this group is reported in entirety in the response, item (e), for intramural research and other activities (table 2 below). Dollar amounts reported under Federal finances (c) do not include wages and salaries paid to the employees in (e); compensation for all NIH employees is included in the response, item (c), for intramural research and other activities (table 2, below).

[3] Approximately 100,000 non-Federal employees are engaged in performing research under grant or contract; many are employed part time. This group includes professional and supporting personnel.

[4] Data reported for 1965 only; distributions for the other years follow the same pattern.

Program: Intramural research and other activities.[1]

TABLE 2.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred (in thousands):				
Total [2]	$120,820	$138,519	$166,030	$180,563
(Research and development)	(108,690)	(125,324)	(147,642)	(159,951)
Allotments or commitments made				
(d) Matching or additional expenditures for the program				
(e) Number of Federal Government employees [3] administering, operating, or supervising the activity	9,200	9,400	9,500	9,800

[1] Includes intramural research and collaborative studies, review and approval of grants and contracts, program direction and administration.
[2] Includes compensation for all NIH employees.
[3] Includes those NIH employees whose responsibilities embrace both intramural and extramural activities. See footnote 2 for table 1, above, "Research grants and contracts."

NOTE.—Does not include obligations for construction of facilities for conduct of research and administration of NIH programs at Bethesda and other locations. In thousands of dollars, these amounted to: Fiscal year 1964, $2,892; fiscal year 1965, $7,626; fiscal year 1966, $38,745; fiscal year 1967, $12,710.

Program: Fellowships, traineeships, and training grants.

TABLE 3.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude (grants or contracts)	8,727	9,376	10,061	10,286
(b) Applicants or participants, total	8,727	9,376	10,061	10,286
Educational institutions	7,855	8,438	9,055	9,257
Other	872	938	1,006	1,029
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred (thousands)	$207,121	$226,265	$266,029	275,718
Allotments or commitments made				
(d) Matching or additional expenditures for the program				
(e) Number of Federal Government employees administering, operating, or supervising the activity	(1)	(1)	(1)	(1)
(f) Non-Federal personnel employed in the program				
(g) Other measures of level or magnitude of performance:				
Number of institutions awarded, total	(2)	350	(2)	(2)
Educational institutions		160		
Hospitals		115		
Government (Federal, State, and local)		25		
Nonprofit research institutions		50		

[1] Numbers of Federal employees are included in item (e), "Intramural research and other activities," table 2, above. See also footnote 2, "Research grants and contracts."
[2] Data reported for 1965 only; distributions for other years follow the same pattern.

Program: Mental health State control programs.

TABLE 4.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(*b*) Applicants or participants:				
State government agencies [1]	54	54	54	54
Local communities or governments				
Individuals or families				
Other				
(*c*) Federal finances:				
Unobligated appropriations available				
Obligations incurred (thousands)	$6,750	$6,750	$6,750	$6,750
Allotments or commitments made				
(*d*) Matching or additional expenditures for the program (thousands)	$106,599	$134,845	$148,300	(2)
(*e*) Number of Federal Government employees administering, operating, or supervising the activity	(3)	(3)	(3)	(3)

[1] All 50 States; the District of Columbia; and Guam, Puerto Rico, and the Virgin Islands.
[2] Cannot be estimated at this time.
[3] Included in intramural activities, table 2, above.

Program: Grants for construction of health research facilities and community mental health centers.

TABLE 5.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(*a*) Magnitude of program (awards)	122	120	195	(1)
(*b*) Applicants or participants (awards)	122	120	195	(1)
State government agencies	60	53	71	
Local communities or governments	2	6	19	
Individuals or families				
Other, private nonprofit organizations	60	61	105	
(*c*) Federal finances:				
Unobligated appropriations available				
Obligations incurred (in thousands)	$49,990	$63,719	$141,293	$71,000
Allotments or commitments made				
(*d*) Matching or additional expenditures for the program (in thousands):				
Total	73,500	69,200	157,100	(1)
State	33,000	25,900	46,400	
Local	1,500	600	18,200	
Other	39,000	42,700	92,500	
(*e*) Number of Federal Government employees administering, operating, or supervising the activity	(2)	(2)	(2)	(2)
(*f*) Non-Federal personnel employed in the program				
(*g*) Other measures of level or magnitude of performance [3]				

[1] Cannot be estimated at this time.
[2] Included in intramural activities, table 2, above.
[3] Approximately 2,150,000 net square feet of new construction estimated each year for the health research facilities construction program; estimate of square feet of space is not available for community mental health centers. For the community mental health centers program it is estimated that when the construction funds for both 1965 and 1966 have been utilized, the services of these centers should be made available to between 25,000,000 and 30,000,000 people.

Program: Staffing of community mental health centers.

TABLE 6.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of program (awards)			63	[1] 122
(b) Applicants or participants			15	29
State government agencies			15	29
Local communities or governments				
Individuals or families			33	64
Other				
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred (thousands)			$18,899	$33,907
Allotments or commitments made				
(d) Matching or additional expenditures for the program (thousands)			[2] [3] $6,300	[2] [3] $15,000
(e) Number of Federal Government employees administering, operating, or supervising the activity			[4]	[4]
(f) Non-Federal personnel employed in the program			2,500	4,900
(g) Other measures of level or magnitude of performance				

[1] Includes 63 continuation awards from 1966 and 59 new awards in 1967.
[2] Minimum estimate.
[3] Includes matching expenditures for 63 continuation awards from 1966 and 59 new awards in 1967.
[4] Included in intramural activities, table 2, above. [The authorizing legislation was enacted during the fiscal year 1966.]

Program: Regional medical programs.

TABLE 7.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of program	[1]	[1]	[1]	[1]
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred (thousands)			$25,000	$45,000
Allotments or commitments made				
(d) Matching or additional expenditures for the program [2]				
(e) Number of Federal Government employees administering, operating or supervising the activity			[3]	[3]

[1] Not available. [The authorizing legislation was enacted during the fiscal year 1966.]
[2] Grantees will have to provide at least 10 percent of the costs of renovation of facilities or provision of built-in equipment.
[3] Included in intramural activities in table 2, above.

8. *Laws and regulations.* (General answer.)

Intramural Research

National Cancer Act (P.L. 75–244, August 1937)
PHS Act, Title IV, Sec. 402, and Title III, Sec. 301
Public Health Service Act (P.L. 78–410, July 1944)
PHS Act, Title III, Sec. 301
National Mental Health Act (P.L. 79–487, July 1946)
PHS Act, Title III, Sec. 303 and 301
National Heart Act (P.L. 80–655, June 1948)
PHS Act, Title IV, Sec. 412, and Title III, Sec. 301
National Dental Research Act (P.L. 80–755, June 1948)
PHS Act, Title IV, Sec. 422, and Title III, Sec. 301

Omnibus Medical Research Act (P.L. 81–692, August 1950)
PHS Act, Title IV, Sec. 431, 433, and Title III, Sec. 301
National Institute of Child Health and Human Development and National Institute of General Medical Sciences (P.L. 87–838, October 1962)
PHS Act, Title IV, Sec. 441, 442, 444; Title III, Sec. 301

Appropriations contained in P.L. 89–156, August 1965, "Departments of Labor and HEW Appropriation Act, 1966."

Extramural Research

National Cancer Act (P.L. 75–244, August 1937)
PHS Act, Title IV, Sec. 402, and Title III, Sec. 301
Public Health Service Act (P.L. 78–410, July 1944)
PHS Act, Title III, Sec. 301
National Mental Health Act (P.L. 79–487, July 1946)
PHS Act, Title III, Sec. 303 and 301
Amended by Health Amendment Act of 1956 (P.L. 84–911, August 1956)
National Heart Act (P.L. 80–655, June 1948)
PHS Act, Title IV, Sec. 412, 413, and Title III, Sec. 301
National Dental Research Act (P.L. 80–755, June 1948)
PHS Act, Title IV, Sec. 422, 423, and Title III, Sec. 301
Omnibus Medical Research Act (P.L. 81–692, August 1950)
PHS Act, Title IV, Sec. 431, 433, and Title III, Sec. 301
International Health Research Act (P.L. 86–610, July 1960)
PHS Act, Title III, Sec. 308
General Research Support Grants (P.L. 86–798, September 1960)
PHS Act, Title III, Sec. 301(d)
National Institute of Child Health and Human Development and National Institute of General Medical Sciences (P.L. 87–838, October 1962)
PHS Act, Title IV, Sec. 441, 442, 444; Title III, Sec. 301
Also amended Title III, Sec. 301(d)

Appropriations contained in P.L. 89–156, August 1965, "Departments of Labor and HEW Appropriation Act, 1966."

Training Grants

National Cancer Act (P.L. 75–244, August 1937)
PHS Act, Title IV, Sec. 402(c); Title III, Sec. 301(d)
Public Health Service Act (P.L. 78–410, July 1944)
PHS Act, Title III, Sec. 301(d)
National Mental Health Act (P.L. 79–487, July 1946)
PHS Act, Title III, Sec. 303(a); Sec. 301(d); Title IV, Sec. 433(a)
Amended by Health Amendments Act of 1956 (P.L. 84–911, August 1956)
National Heart Act (P.L. 80–655, June 1948)
PHS Act, Title IV, Sec. 412(g)
National Dental Research Act (P.L. 80–755, June 1948)
PHS Act, Title IV, Sec. 422(f)
Omnibus Medical Research Act (P.L. 81–692, August 1950)
PHS Act, Title IV, Sec. 433(a)
International Health Research Act (P.L. 86–610, July 1960)
PHS Act, Title III, Sec. 308(a)(b)

National Institute of Child Health and Human Development (P.L. 87–838, October 1962)
PHS Act, Title IV, Sec. 444
Appropriations contained in P.L. 89–156, August 1965, "Department of Labor and HEW Appropriation Act, 1966."

Fellowships

National Cancer Act (P.L. 75–244, August 1937)
Title IV, Sec. 402(d)
Public Health Service Act (P.L. 78–410, July 1944)
Title III, Sec. 301(c)
National Mental Health Act (P.L. 79–487, July 1946)
Title III, Sec. 303; Sec. 301(c)
National Heart Act (P.L. 80–655, June 1948)
Title IV, Sec. 412(g)
National Dental Research Act (P.L. 80–755, June 1948)
Title IV, Sec. 422; Title III, Sec. 301(c)
Omnibus Medical Research Act (P.L. 81–692, August 1950)
Title IV, Sec. 433(a)
International Health Research Act (P.L. 86–610, July 1960)
Title III, Sec. 308(a)(b)
National Institute of Child Health and Human Development (P.L. 87–838, October 1962)
Title IV, Sec. 444
Appropriations contained in P.L. 89–156, August 1965, "Department of Labor and HEW Appropriation Act, 1966."

Other Programs

Heart Disease, Cancer, and Stroke Amendments of 1965
(P.L. 89–239, October 6, 1965)
PHS Act, Title IX
Health Research Facilities Act of 1956
(P.L. 84–835, July 1956)
PHS Act, Title VII
Health Research Facilities Amendments of 1965
(P.L. 89–115, August 1965)
PHS Act, Title VII and Title III
Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1965
(P.L. 88–164, October 1963)
Provisions of this Act which amended the PHS Act were incorporated in Part D of Title VII
Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965
(P.L. 89–105, August 1965)

9. Economic effects. (General answer.)

The impact on the economy of NIH programs—in support of biomedical research, the training and education of biomedical scientists and the construction of research facilities—has not as yet been the subject of specific investigations; what follows, therefore, are some general observations pertaining to the items enumerated in question 9.

Background.—All the activities of this agency are directed toward one overriding purpose: The conquest of disease, and the advancement of human well-being through medical research and the application of research findings to the treatment and care of the sick. Thus, NIH programs have as their primary and ultimate objective the saving of human life and the reduction of human suffering; the furtherance of economic growth per se is not the target mission of this agency. These programs, however, have an effect on the economy through (1) the magnitude of the sums required for the furtherance of agency objectives, that is the direct effect of Federal funds expended for personal services, equipment, construction; and (2) the indirect economic efforts stemming from reductions in mortality and morbidity, which may be of greater economic significance because of wider potential implications for economic growth.

A. *Direct economic effects.*—The data provided in answer to question 10 indicate that 1965 NIH programs in total require an obligation of about $1 billion; of this sum, about $400 million provides funds for the payment of wages and salaries to about 100,000 research workers, many of whom are employed part time on research projects performed in the research laboratories of the Nation's universities, hospitals, nonprofit research institutions, and industry; and $200 million provides the equipment, supplies, and other services required for the performance of this research. An addition $225 million supports the training of approximately 35,000 fellows and trainees in fields of science relevant to medical and health-related research, and $150 million is obligated for the performance of research (at NIH installations in this country and abroad) and for the administration and management of the NIH program.

In addition to the immediate and direct employment required for the research and construction programs, the secondary employment of about 85,000 additional workers (at the rate of $8,000 of GNP per worker) is indicated to produce the goods and services required to maintain the research personnel and their families, and the goods and services required for the individual research projects. An additional 6,500 man-years of employment is generated by the construction projects (3,000 man-years for on-site construction, and 3,500 man-years to provide the required construction materials). These statistics are general orders of magnitude; they do not take into account the additional employment required to provide the goods and services called for by the increased secondary employment.

These direct effects are, of course, no different from the effects of the spending of Federal funds for other programs, where expenditures are made for a similar mix of personal services, equipment, and construction. It must be emphasized that NIH research programs support investigations that advance knowledge for the conquest of disease and disability. By their very nature, these research programs are different from the much larger expenditures for research and development by the Department of Defense, the National Aeronautics and Space Administration, or the Atomic Energy Commission. NIH research programs do not have as their primary objective the development of new or improved products or hardware; research programs

with the latter objectives may have a far greater direct effect on the employment of the Nation's human and physical resources.

B. *Indirect economic effects.*—NIH programs, as already indicated, have as their primary objective the improvement of the Nation's human resources by control and reduction of disease and disability through research.

The economic consequences of medical research (that is, effect on productivity, personal income, gross national product) have not as yet been subjected to intensive investigation. The reasons for this may be summarized as follows:

> Inherent conceptual and statistical difficulties, lack of general interest on the part of economists, and (perhaps of greater significance) deep-seated convictions on the part of many competent observers and dedicated administrators of programs in the health sciences that the achievement of better health is in itself a complete rationale for the Nation's health effort.

This conviction is further strengthened by the belief that the direction of this effort and increased expenditures for health objectives derive not from cold cost/benefit calculations but from the growing economic capability to afford such expenditures aimed at improving the health and well-being of the American people.

Thus, the pursuit of knowledge for the conquest of disease has as its fundamental basis the furthering of human values and improving the quality of life, and the factors which bear upon the direction and magnitude of medical research programs are not necessarily economic ones. They are, instead, first and primarily, the human desire for the relief of suffering and for the attainment of healthier more productive lives; secondly, the scientific capability for enlarging the frontiers of knowledge for the conquest of disease and disability; thirdly, the wealth of our Nation and its economic capability to support this effort; and finally, the culmination of these factors in the expressed will of the people through their political representatives.

Notwithstanding these deep reservations concerning the full applicability of economic reasoning to health programs, it is recognized that the techniques and disciplines of economics may provide some insight for developing cost-benefit and cost-effectiveness analyses. As a necessary prelude to a possible research effort in this area, NIH has supported a recent conference managed by the Brookings Institution. The purpose of this conference, attended by economists and public administrators, was to consider the feasibility of initiating a research program to measure the economic consequences of medical research. Recommendations of the conference will be submitted to NIH by the end of the year, and will include a system of research priorities and recommendations for mechanisms of support. On the basis of these recommendations and other considerations, further steps may be undertaken.

In addition, some recently published material may be of interest:

> (1) President's Commission on Heart Disease, Cancer, and Stroke, "A National Program to Conquer Heart Disease, Cancer, and Stroke" (vol. II, special section on economics, pp. 440–644).
>
> (2) "Biomedical Science and Its Administration," A study of the National Institutes of Health (app. 3, pp. 77–84).

10. Economic classification of program expenditures. (See table 8.)

Department: Health, Education, and Welfare; Public Health Service; National Institutes of Health.

TABLE 8.—*Economic classification of program expenditures for fiscal 1965* [1]

[In millions of dollars]

Program: Research grants and contracts:	
Federal Government:	
Purchases of goods and services: [2]	
Wages and salaries	247.6
Other	165.0
Grants to State and local governments	177.1
Total Federal obligations	[3] 589.7
Program: Intramural research and other activities: [4]	
Federal Government:	
Purchases of goods and services:	
Wages and salaries	83.1
Other [5]	55.4
Total Federal obligations	[3] 138.5
Program: Fellowships, traineeships and training grants:	
Federal Government:	
Transfer payments to individuals and nonprofit organizations	124.4
Grants to State and local governments	101.9
Total Federal obligations	226.3
	(144.1)
Program: Mental health State control programs:	
Federal Government:	
Grants to State and local governments	6.8
Total Federal obligations	6.8
	(6.8)
Non-Federal expenditures financed by State and local governments	134.8
Total expenditures for program	141.6
Program: Grants for construction of health research facilities: [6]	
Federal Government:	
Transfer payments to individuals and nonprofit organizations	39.0
Grants to State and local governments	24.7
Total Federal obligations	63.7
	(34.7)
Non-Federal expenditures financed by:	
State and local governments	26.5
Individuals and nonprofit organizations	42.7
Total expenditures for program	132.9
Summary for programs shown:	
Federal Government:	
Purchases of goods and services:	
Wages and salaries	330.7
Other	220.4
Grants to State and local governments	310.5
Transfer payments to individuals and nonprofit organizations	163.4
Total Federal obligations	1,025.0
(Total Federal expenditures)	(741.8)

See footnotes at end of table, p. 841.

TABLE 8.—*Economic classification of program expenditures for fiscal 1965* [1]—Con.

[In millions of dollars]

Summary for programs shown—Continued	
Non-Federal expenditures financed by:	
State and local governments	161.3
Individuals and nonprofit organizations	42.7
Total non-Federal expenditures	204.0
Total expenditures for the programs [1]	1,229.0

[1] Federal expenditures shown here refer to obligations. Where the data are available, actual expenditure figures are shown below in parentheses. A breakdown of the expenditure data by economic category is not available.

[2] In accordance with the revised national income and product structure, research grants to private nonprofit organizations are categorized as purchases of goods and services, although the former classification as transfer payments may indeed be more appropriate for this group.

[3] The sum of Federal expenditures for the two programs identified as (*a*) research grants and contracts and (*b*) intramural research and other activities was $556,200,000. The sum of obligations for these two programs was $728,200,000.

[4] Includes intramural research and collaborative studies, review and approval of grants, program direction and administration.

[5] Does not include $7.6 million for construction. (See "NOTE" to table 2, above.)

[6] Expenditures for the entire program are for the construction of facilities. Grants for construction of community health centers are included. Federal grants to State and local governments are used for State and local construction. Federal transfer payments are used for private construction.

NATIONAL CENTER FOR HEALTH STATISTICS

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The National Center for Health Statistics brings together the major components of Public Health Service competence in the measurement of health status of the Nation and the identification of significant associations between characteristics of the population and health-related problems.

The National Center for Health Statistics is the Federal Government's general-purpose statistical organization for the collection, compilation, and dissemination of vital and health statistics to serve the needs of all segments of the health and related professions. The Center stimulates optimal use of technical and methodological innovations in collecting, processing, and analyzing demographic and health statistics and provides a source for technical assistance in these areas. It carries out a program of extramural activities, both national and international, which includes technical assistance to the States and programs of research in foreign countries under the special international research program. Through the Office of Health Statistics Analysis, the Center utilizes vital and health statistics to assess the health status of the public, develops measures and indexes of health, studies problem and disease classification, and acts as secretariat for the U.S. National Committee on Vital and Health Statistics.

The Center is organized as follows: Office of the Director; Office of Health Statistics Analysis; Division of Data Processing; Division of Vital Statistics; Division of Health Interview Statistics; Division of Health Examination Statistics; and Division of Health Records Statistics. The Division of Data Processing provides data preparation and computer processing services to the entire Center and provides consultation and technical assistance to other public health programs and to the States.

2. Operation

The National Center for Health Statistics operates as a Federal program conducted primarily in Washington, D.C. Statistical data are collected for the Center in three ways: (1) Direct purchases of microfilm copies of vital records, that is, birth, death, marriage, and divorce records from States; (2) contractual arrangements under which the Bureau of the Census acts as a collection agent for some types of statistical data, and (3) direct contact between Center representatives and respondents selected as part of a national sample. Data are then compiled, analyzed, and published by personnel of the National Center for Health Statistics.

A small number of contracts are let each year with nonprofit organizations for developmental work, such as design and testing of survey questionnaires for the collection of information on selected health topics.

3. History

The National Center for Health Statistics was established as an organizational unit in the Office of the Surgeon General in August 1960. The Center was created in response to recommendations submitted by the Study Group on Mission and Organization of the Public Health Service.

The program of the Center is based on the following objectives:

(*a*) To bring together the major components of Public Health Service competence in the measurement of health status of the Nation and the identification of significant associations between characteristics of the population and health-related problems.

(*b*) Stimulate optimal use of technical and methodologic innovations in the collection, processing and analysis of health statistics.

(*c*) Create a resource for technical assistance in statistical data processing.

(*d*) Associate closely the functions of collection, analysis, interpretation, and dissemination.

(*e*) Permit expansion of health intelligence programs to correlate and interpret data from various sources.

(*f*) Give better visibility to the national and international leadership of the Public Health Service in vital and health statistics.

With regard to subject matter the responsibilities of the Center cover those types of health statistics traditionally included in vital statistics—birth, death, fetal death, marriage, and divorce—and newer types of health statistics obtained from survey sources—morbidity data, incidence of accidents, disability, health insurance coverage, medical care costs, and many others.

The vital statistics function originated in 1904 when the Federal Government began a cooperative effort with the States aimed at the improvement of vital registration. After 61 years of Federal-States cooperation the U.S. vital statistics system has achieved a high state of technical development providing comprehensive and detailed national statistics which serve as the basic statistical reference resource for planning and evaluation of health programs and for use by research workers, including demographers, sociologists, and a myriad of other

professional persons concerned with the study of mortality, natality, marriage, and divorce in the United States.

The national health survey program was begun in 1956 under authority of the National Health Survey Act passed by Congress in that year.

The Center's health survey program collects, analyzes, and publishes current information on many of the health aspects of the U.S. population including heart disease, dental care, costs of medical care, accidental injuries, and many other subjects.

4. Level of operations. (See table 1.)

Program: National Center for Health Statistics.
Department: Department of Health, Education, and Welfare; Public Health Service—Office of the Surgeon General.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year			
	1964	1965	1966 estimates	1967 estimates
(a) Magnitude (not applicable)				
(b) Applicants or participants (not applicable)				
(c) Federal finances (dollars) (obligations incurred)	5,788,000	6,278,000	7,230,000	9,312,000
(d) Matching expenditures (not applicable)				
(e) Number of Federal employees	349	384	404	444
(f) Non-Federal employees (not applicable)				
(g) Other measures of level, none. The National Center for Health Statistics is a general purpose statistical organization and makes its statistical products available to a wide range of consumers. In addition to over 8,000 regular consumers of the Center's statistical publications, over 1,600 persons per year telephone or write for special statistical data of one type or another.				

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The NCHS, serving as a national resource for general purpose health statistics, coordinates its programs with a variety of Federal and non-Federal organizations. The Bureau of the Census works closely with the Center in developing health survey designs and in collecting statistical data. The Center also cooperates with State and local officials by participating in such activities as the Public Health Conference on Records and Statistics and by providing technical advice and guidance to the States on registration problems. Whenever possible within the limits imposed by manpower and budget, the Center responds to requests from a wide variety of consumers for special types of health statistics data.

8. Laws and regulations

Public Health Service Act, as amended, particularly sections 301, 305, 312(a), 313, 314(c) and 315 (42 U.S.C. 241, 242c, 244a, 245, 246c, 247).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic effects of the Center's programs are of an indirect nature and cannot be ascertained. The statistical data produced help agencies to operate more efficiently by pointing out areas requiring concentration of effort and by providing research leads that indirectly lead to improvements in the health and welfare of the population.

10. Economic classification of program expenditures. (See table 2.)

Program: National Center for Health Statistics.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Office of the Surgeon General.

TABLE 2.—*Economic classification of program expenditures for fiscal 1965*

[In millions of dollars]

Federal Government: [1]	
Purchases of goods and services:	
Wages and salaries	4.64
Other	1.21
Aid to State and local governments [2]	.43
Total Federal expenditures	6.28
Non-Federal expenditures	(3)

[1] Expenditures here refer to obligations. Actual expenditures were $5,896,000.

[2] Includes $184,000 paid to States for microfilm records of vital certificates, plus $242,000 paid to State-supported institutions for research and development.

[3] The actual amount of funds spent in fiscal year 1965 by the States for health statistics is not available. An estimate of $9,414,000 has been provided by the Office of Grants Management, Bureau of State Services, PHS, based on information reported in State plans submitted to that office.

NATIONAL LIBRARY OF MEDICINE

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The National Library of Medicine constitutes a national resource for the collection, analysis, and dissemination of worldwide scientific information related to medicine, public health, and biomedical research. Through programs of traditional library services (such as reference assistance and interlibrary loans), a highly sophisticated computer-based medical literature analysis and retrieval system (Medlars), and through extramural grant and contract programs for correcting deficiencies in the Nation's medical libraries and library services, the NLM performs a broad supportive role in the national health efforts.

2. Operation

From a single location in Bethesda, Md., the NLM carries out a variety of local, national, and international programs:

(*a*) Reading room facilities and reference assistance are provided for medical researchers, physicians, students, technicians and others using the collections directly at the library.

(*b*) Interlibrary loans (usually in the form of photoduplicates) are made to other libraries in this country and abroad to meet requirements of their users which they cannot supply.

(*c*) Reference assistance and computerized bibliographic searches are performed upon request from individuals and institutions in this country and abroad.

(*d*) The library publishes Index Medicus, a monthly bibliographic record of current published literature in medicine and related sciences, analyzed and arranged by subject matter to facilitate use by health science workers throughout the world. Index Medicus goes to over 5,700 users at the present time.

(*e*) Beginning in January 1966, the library will also publish the National Library of Medicine Current Catalog, a computer-produced biweekly publication notifying the biomedical libraries of the Nation of the literature which has arrived and been cataloged at NLM during the previous 2-week period, thus enabling them to use the NLM as a central source for information on recently published literature and also as a central cataloging service.

(*f*) The Medical Library Assistance Act of 1965 (Public Law 89–291) authorized a greatly expanded program of assistance to the Nation's biomedical libraries and health information work force. Under this new legislation the NLM will award grants or contracts for (1) construction and renovation of medical libraries, (2) research and development in the field of library and information science, (3) training of medical librarians and related science information specialists, (4) compilation and dissemination of important biomedical information by scholars, (5) improving the basic resources of biomedical libraries, particularly their literature collections, (6) developing regional libraries, adequately equipped to supplement library resources and services throughout the country, and (7) supporting the preparation and publication of biomedical publications.

3. History

The National Library of Medicine had its origin in 1836 as the Library of the Surgeon General's Office (U.S. Army) and developed as a national resource under the leadership of John Shaw Billings, Librarian from 1865 to 1895. Named Army Medical Library in 1922 and Armed Forces Medical Library in 1952, it became the National Library of Medicine and was transferred to the Public Health Service, DHEW, in 1956.

4. Level of operations. (See table 1.)

Program: National Library of Medicine.
Department or agency, and office or bureau: **Department of Health, Education, and Welfare; Public Health Service.**

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

	Fiscal year			
	1964	1965	1966 estimate	1967 estimate
(a) Magnitude of the program:				
Direct library operations:				
Medical publications acquired	91,105	90,811	110,000	120,000
Titles cataloged	16,462	17,065	20,000	22,500
Inquiries answered	20,154	20,931	31,000	35,000
Loan requests filled	214,195	229,794	242,000	250,000
Pages photographed for orders	1,967,113	2,133,946	2,144,000	2,250,000
Pages photographed for preservation	1,290,754	692,509	2,000,000	3,000,000
Journal articles analyzed and indexed	144,057	151,635	175,000	185,000
Extramural support operations:				
Grants and contracts for research		6	20	30
Grants for construction				10
Grants for training		2	15	20
Grants for library resources			150	225
Grants for regional libraries				
Grants and contracts for publications	10	10	15	15
Fellowships and special scientific projects		1	10	10
(b) Applicants and participants				
(c) Federal finances:				
Unobligated appropriations available				
Obligations incurred	$4,055,871	$3,939,464	$9,684,000	$19,231,000
Allotment or commitments made				
(d) Private matching funds to support medical library construction				$2,500,000
(e) Number of Federal employees (man years):				
Providing library service	238	261	284	311
Administering extramural programs	8	10	26	26
(f) Non-Federal personnel employed				
(g) Significant work performance data (see item (a) Magnitude of the program)				

5. Estimated magnitude of the program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) *Within the Bureau.*—Not applicable.

(*b*) *With other units of the Department.*—Opportunities for cooperation and coordination will be numerous in the years to come, particularly with respect to meeting the specialized information needs of organizations for which our standard services (such as Index Medicus and one-time demand searches) are insufficient with respect to depth of analysis, or coverage of materials.

It is likely that the NLM can meet the specialized health information requirements of many programs of DHEW (and other Government agencies as well) through cooperative efforts more efficiently than they can meet them through independent action.

The Library now has a formal agreement with:

Food and Drug Administration involving cooperative efforts to improve the analysis and communication of published information on the effects of drugs.

National Institute of Neurological Diseases and Blindness leading to the production of a cerebrovascular bibliography.

(*c*) *With Federal Government agencies.*—The Library has formal agreements with:

Veterans' Administration to train VA staff in computer search techniques and to meet specialized information requirements of VA.

National Bureau of Standards to evaluate and improve NLM capability in the field of graphic image storage and retrieval of information.

National Science Foundation to carry out translation and publication projects abroad utilizing excess foreign currencies.

Agency for International Development to improve the communication of medical information to developing countries where AID missions are established.

(*d*) *With State governments or their instrumentalities.*—With the advent of support to libraries under the Medical Library Assistance Act (see par. 1(*f*)) it is possible that agreements will be reached with instrumentalities of State governments (such as health departments) relating to the provision of medical library services in their respective States through regional libraries. No agreements exist at the present time.

(*e*) *With local governments or communities.*—None at the present time.

(*f*) *With foreign governments or international organizations.*—It is probable that the NLM will enter into agreements with foreign governments in connection with Public Law 480 excess foreign currency programs. At the present time these programs are carried out in cooperation with NSF.

(*g*) *With nonprofit organizations and institutions.*—

(1) American Dental Association, to produce cooperatively the Index to Dental Literature.

(2) American Rheumatism Association, to produce the Index of Rheumatology.

(3) Association of American Medical Colleges to produce the Bibliography of Medical Education.

(4) American Journal of Nursing Co., to produce the International Nursing Index.

(*h*) *With business enterprises.*—None.

(*i*) *With others.*—None.

8. Laws and regulations

(*a*) National Library of Medicine Act (Public Law 84–941).

(*b*) Medical Library Assistance Act (Public Law 89–291).

(*c*) Labor-DHEW Appropriation Act (Public Law 89–156).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Not answered.

10. Economic classification of program expenditures. (See table 2.)

Program: National Library of Medicine.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	2
Other	2
Total Federal expenditures	4

Disaster Health Program

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

Preparation of the individual, the community, and the various States to increase their capability to survive and recover from health hazards introduced by major disaster.

2. Operation

In preparation for a major disaster, the Public Health Service stockpiles emergency medical supplies and equipment for use by the ongoing community medical facilities. These materials are stored both at the community level as fully equipped 200-bed packaged disaster hospitals ready for immediate use and in a national depot system that provides backup stocks to the packaged disaster hospitals and to the ongoing community hospitals. In addition, educational programs are conducted in disaster medical care for professional, technical, and lay personnel. These training programs are supported by assignment of full-time program consultants at the State and regional level, by the provision of training materials for all levels of disaster health training, and by the publication of training, technical, planning, and preparedness guides. Consultation and technical assistance are provided to State and local communities in writing plans for the provision of emergency health services in a major disaster. In addition, the Service administers a national training program of medical self-help which is funded by the Department of Defense through the Office of Civil Defense.

3. History

The Service has provided disaster relief services and assistance to the States and communities since 1874. Growing out of agency involvement in Federal mobilization activities during World War II, and in response to increased national preparedness needs, more frequent natural disasters, and increased threat of attack, a Health Emergency Planning Office was established in 1953. In anticipation of a delegation of greatly increased PHS authority and funds appropriation, an expanded Health Mobilization Organization was established in 1959. Responsibility for the civil defense medical stockpile was transferred to the Service in 1961. The nationwide medical self-help training program was developed in 1962.

4. Level of operations. (See table 1.)

Program: Disaster health program.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Office of the Surgeon General.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year			
	1964	1965	1966 estimate	1967 estimate
(a) Program magnitude:				
1. Medical self-help training:—				
Courses (thousands)	11.7	17.3	20	23
Students (thousands)	403	666	750	825
2. Packaged disaster hospital training:				
Exercises	256	363	400	450
Participants (thousands)	103	149	175	200
3. Disaster health training:				
Courses	30	142	160	178
Students (thousands)	3.4	10.5	11.5	12.5
4. Publications:				
Titles	8	21	22	23
Quantity (thousands)	133	525	2,729	3,000
5. Promotional materials (exhibits, posters, announcements, films, etc.):				
Items	1	8	8	9
Quantity (thousands)	----------	33	157	160
6. Packaged disaster hospitals:				
Prepositioned	1,879	2,186	2,486	2,573
Inspected	1,782	1,799	600	600
Sites reviewed	30	600	400	350
7. Medical stockpile supplies and equipment used (disasters)	[1] 10	[1] 44	[1] 56	50
8. Federal disaster health program representatives assigned (States and territories)	48	50	50	50
9. State plans for emergency management of health and water resources (States)	----------	7	37	46
10. Research and data collection projects completed	2	2	9	10
(b) Participating organizations:				
1. State health and related agencies (States)	50	50	50	50
2. National associations, societies, organizations, estimated (organizations)	40	50	60	70
3. Medical schools (schools)	89	89	89	90
(c) Federal finances:				
1. Unobligated appropriations available (millions of dollars)	29.9	21.5	13.4	14
2. Obligations incurred [2] (millions of dollars)	17.2	8.0	9.8	14
(d) Other finances:				
1. State disaster health budgets (millions of dollars)	[1] 1.2	[1] 1.2	[1] 1.3	1.3
2. Public Law 85-606 disaster health budgets [3] (millions of dollars)	1.5	1.5	1.4	0
(e) Federal employment (employees)	164	164	168	168
(f) Non-Federal employment:				
1. PHS consultants	8	4	6	20
2. State employment (employees)	[1] 282	[1] 387	[1] 410	410

[1] Data for previous calendar year; e.g., in fiscal year 1964 column, the figure is for calendar year 1963.
[2] Included in the funds shown on preceding line.
[3] Funds from other Federal agencies.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Cooperation and coordination

(a) Departmental policy requires the incorporation of disaster assistance and emergency preparedness functions into the ongoing programs of the Service. Working together as a team with the other Federal and State agencies involved and with a single point of disaster assistance control at headquarters and in each regional office, the Service is able to provide requested assistance promptly to the State and communities, subject only to limitations of personnel, funds, and delegated authority.

(*b*) By Executive order from the President and delegation from the Secretary of Health, Education, and Welfare, the Service is responsible for the direction and coordination of civilian emergency health services activities of the Federal Government and for initiating joint planning efforts with other agencies involved. Participating agencies within the Department of Health, Education, and Welfare are the Food and Drug Administration, Vocational Rehabilitation Administration, and the Children's Bureau.

(*c*) Cooperative working relationships have been established between the Service and all other Federal agencies having health and related responsibilities. Formal memorandums of understanding have been developed with Housing and Home Finance Agency, Veterans' Administration, Tennessee Valley Authority, Labor, and General Services Administration as well as with the quasi-Federal American National Red Cross. Other agencies with which the Service routinely works are Office of Emergency Planning, Department of Defense, Commerce, Treasury, and Agriculture.

(*d*) In accordance with traditional arrangements, the Service works closely with State health officers. A Federal disaster health program representative is assigned to almost every State health agency and—by means of its network of headquarters, regional, and State offices—the health mobilization organization is able to respond quickly and effectively to State and local disaster health needs. State agencies such as departments of education, water pollution control, and water resources also are involved in accomplishing specific disaster health programs.

(*e*) Federal disaster health program representatives at State health agencies work directly with local health officials and hospitals in developing preparedness measures and providing disaster assistance.

(*f*) The Service cooperates with foreign governments which request information or send representatives to study the U.S. disaster health program. A formal memorandum of understanding between the United States and Canada is being developed to establish mutual assistance policies and procedures regarding use of health manpower.

(*g*) Close liaison is maintained with health professional societies, several of which have disaster committees. Selected associations have participated under research contract or as consultants in the development of specific professional guidance materials. In cooperation with the military services and medical schools, Public Health Service sponsors disaster training for medical students. National professional, labor, civic, fraternal, and other organizations assist by endorsing and promoting the medical self-help training program.

8. Laws and regulations

Federal Civil Defense Act (50 U.S.C. App. 2251–2297).

Public Health Service Act (Public Law 85–410, sec. 214(b), 314, 322(d)).

Federal Disaster Act (Public Law 81–875, sec. 3).

Executive Order 11001 (27 F.R. 1534) (Feb. 16, 1962).

Executive Order 10958 (F.R. 7571) (Aug. 14, 1961).

Executive Order 10346 (17 F.R. 3477) (Apr. 17, 1952).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

By increasing individual and organizational capability to survive and recover from the effects of disaster, the program helps to maintain the labor force and the personal income of workers in disaster affected areas. In the period 1961 to date, medical stockpile procurement ($14,830,676) stimulated the medical supply and equipment and related industries.

10. Economic classification of program expenditures. (See table 2.)

Program: Disaster health program.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Public Health Service—Office of the Surgeon General.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In thousands of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	2,049
Other	10,582
Total Federal expenditures [1]	12,631

[1] This is on the basis of actual disbursements, and hence the $12,631,000 (shown here) differs from the $8,000,000 (of obligations incurred) shown for fiscal year 1965 in item 4 (table 1, above). The $12,631,000 shown here is entirely Federal funds, and is directly appropriated to this agency. The breakdown required in item 10 (this page) is unavailable for the State funds and other Federal agency funds shown in item 4, subitems d-1 and d-2.

Saint Elizabeths Hospital

CONTENTS

Mental Health Program—Patient Treatment and Care

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The primary purpose or activity of the mental health program at St. Elizabeths Hospital is the treatment and care of mentally ill patients and the rehabilitation and return to community life of as many such patients as possible. Closely related to the treatment program are extensive research and training activities.

2. Operation

The provision of patient treatment and care includes medical, nursing, and related services, along with the necessary administrative, maintenance, and dietary support. This program operates under an annual congressional appropriation for the operation and maintenance of the hospital, which is supplemented by reimbursements, primarily from the District of Columbia and certain Federal agencies, for patient services furnished their beneficiaries. Reimbursements also include, to a small extent, receipts from miscellaneous other sources such as cafeteria sales, sale of scrap, etc. The hospital operates under an indefinite appropriation, under which it receives, in appropriated funds, an amount equal to the difference between reimbursements actually received and the total program costs approved by the Congress. Charges to the District of Columbia for patient care are based upon a day rate comparable to per diem costs of mental hospitals in the upper 10 percent of the States. The difference between the rate charged and the actual daily cost of care is paid from the hospital's direct appropriation, and represents the cost differential between the provision of care by a quality State institution, as opposed to a national demonstration center. The direct Federal appropriation also finances the cost of care rendered certain Federal patients who are not beneficiaries of other agencies, 40 percent of the hospital's training program, and all of its research activities. Training and research will be discussed as separate programs.

3. History

St. Elizabeths Hospital was established by the act of March 3, 1855, Rev. Stat. paragraph 4838 (1875), 24 U.S.C. 161. At that time it was known as the Government Hospital for the Insane. It acquired its present title by the act of July 1, 1916, paragraph 1, 39 Stat. 309. In 1940, the functions of the hospital were transferred

from the Department of the Interior to the Federal Security Agency under Reorganization Plan No. IV, paragraph 11(a), 54 Stat. 1236. The functions of the Federal Security Administration, under which the hospital operated, were transferred to the Department of Health, Education, and Welfare under Reorganization Plan No. I of 1953, paragraph 5, 67 Stat. 631.

4. Level-of-operations.—(See table 1.)

The level of operations for patient treatment and care at St. Elizabeths Hospital for the period 1964 through 1967 is measured in terms of average daily patient load, appropriations, obligations, and patient movement statistics. This information is set forth in the following table.

Program: Mental health program—patient treatment and care.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; St. Elizabeths Hospital.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966, estimates	Fiscal year 1967, estimates
(*a*) Magnitude of program (patients residing in hospital) (average daily patient population)	6,412	6,148	5,936	5,722
(*b*) Participants (average daily patient population):				
(1) Federal Government:				
(*a*) Direct appropriation	751	738	722	701
(*b*) Reimbursable patients from other Federal agencies	436	407	352	293
(2) District of Columbia	5,225	5,003	4,862	4,728
Total participants	6,412	6,148	5,936	5,722
(*c*) Federal finances (exclusive of reimbursements from other Federal agencies):				
(1) Unobligated appropriation available	$7,312,202	$8,851,327	$9,440,200	$7,211,900
(2) Obligations incurred	7,289,738	8,867,546	9,440,200	7,211,900
(3) Allotments or commitments made				
(*d*) Matching or additional obligations for the program: [1]				
(1) Reimbursements from the District of Columbia	17,820,000	17,330,270	17,922,230	20,415,560
(2) Reimbursements from other Federal agencies	1,789,873	1,849,885	1,706,000	1,480,230
(3) Reimbursements from miscellaneous other sources	63,874	63,398	60,000	60,240
Total additional obligations	19,673,747	19,243,553	19,688,230	21,956,030
(*e*) Number of Federal government employees (civilian employment engaged in operation and maintenance of hospital) (man-years):				
(1) Permanent	3,661	3,594	3,573	3,573
(2) Other	21	10	15	30
Total Federal personnel	3,682	3,604	3,588	3,588
(*f*) Non-Federal personnel employed in the program				
(*g*) Other measures of level or magnitude of performance:				
(1) Patient movement data (actual):				
Admissions	1,692	1,965	(2)	(2)
Discharges	1,446	1,557	(2)	(2)
Deaths	444	423	(2)	(2)
(2) Patients on rolls (residing in hospital plus patients on visit) (average daily patient population)	7,672	7,585	(2)	(2)

[1] Reimbursements to the hospital are divided between two programs. It is not feasible to distribute items (*d*)(1) through (*d*)(3), except to prorate them on the basis of percentage of total reimbursements attributable to each program.
[2] Estimate not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The patient treatment and care program at St. Elizabeths Hospital maintains operational and financial relationships with other programs of the hospital, other agencies of the Department of Health, Education, and Welfare, other departments and agencies of the Federal Government, and with the District of Columbia. It is generally felt that the hospital avails itself of most of the opportunities for coordination and cooperation whenever they now exist. Examples of such coordinated activity are set forth in the following:

(*a*) *Coordination within the hospital.*—The hospital operates training and research programs in various medical and related disciplines, which are closely integrated with patient treatment activities. Under the training program, interns, residents, and affiliate student nurses are afforded unusual opportunities to observe and participate in the day-to-day treatment of the hospital's large and varied patient population. In recognition of the mutual benefits thus derived by both trainee and patient, some 60 percent of the annual operating cost of the training program is paid from reimbursements received for patient care. In addition, the 100 percent federally financed research program avails itself of the same patient population to provide much needed firsthand data required for the furtherance of numerous research projects. Conversely, this arrangement benefits the treatment program in terms of the new and improved medical and related techniques which are developed from such projects.

(*b*) *Coordination with other agencies of the Federal Government.*—The greatest single medium of coordination and cooperation by the hospital, with other agencies of the Federal Government, is found in the many arrangements by which the hospital provides psychiatric treatment and care for beneficiaries of the various Federal agencies, pursuant to the provisions of 24 U.S.C. 168a.

Typical of the agencies which obtain treatment services for certain of their beneficiaries are the Public Health Service, Veterans' Administration, U.S. Coast Guard, Department of State, and Department of Justice. At the present time, approximately 18 percent of the patient load at St. Elizabeths Hospital is comprised of various classes of Federal beneficiaries.

(*c*) *Coordination with the District of Columbia.*—In view of the physical location of St. Elizabeths Hospital within the District of Columbia, and in view of the fact that some 82 percent of the patient load at St. Elizabeths consists of District of Columbia residents, the relationships between the hospital and the community are numerous and varied. The hospital, for example, provides treatment and care for District of Columbia residents at a per diem rate comparable to that of mental hospitals in the upper 10 percent of the States. The difference between this rate and the actual per diem cost (a somewhat higher figure) is financed from direct Federal appropriations, and represents the cost of special or additional treatment services, which would not ordinarily be available in even the higher quality State mental hospitals. In recognition of the considerable impact which the treatment cost of some 5,000 District of Columbia patients has

upon the District budget, St. Elizabeths Hospital maintains a continuing, informal liaison with the District of Columbia government, keeping them informed of any major program changes which would materially affect their budget. This is particularly true with respect to the formulation of patient load estimates, reimbursement rates, and new construction.

8. Laws and regulations

There follows a list of citations and brief descriptions of the principal laws and statutes pertaining to the patient treatment and care program at St. Elizabeths Hospital.

CITATION	DESCRIPTION
24 U.S.C. 161–221	Original act of Mar. 3, 1855 (as amended) establishing St. Elizabeths Hospital, then known as the Government Hospital for the Insane.
Public Law 89–156	Department of Health, Education, and Welfare Appropriation Act for fiscal year 1966.
21 District of Columbia Code 353–356, (Public Law 88–597)	Provides for the protection of the constitutional rights of certain individuals who are mentally ill; provides for their care, treatment, and hospitalization, and for miscellaneous other purposes. Known as the "District of Columbia Hospitalization of the Mentally Ill Act." Includes necessary provisions for the civil commitment of District of Columbia patients.
22 District of Columbia Code 3508	Provides for commitment of District of Columbia sexual psychopaths.
24 District of Columbia Code 301–302	Criminal commitment of District of Columbia patients, including those adjudged not guilty by reason of insanity.
31 U.S.C. 686	The Economy Act of 1932. As applied to St. Elizabeths Hospital, it makes possible the admission of beneficiaries of other Federal departments and independent agencies, whenever such department or agency cannot provide psychiatric care, and provided that funds are available for such a purpose.
22 U.S.C. 1156	Admission of certain employees of the U.S. Foreign Service.
24 U.S.C. 194	Provides for admission of certain inmates of the Soldiers' Home.
24 U.S.C. 195a, and 42 U.S.C. 253a	Provides for admission of certain Public Health Service beneficiaries.
24 U.S.C. 196, 196b	Provides for hospitalization of American citizens adjudged insane in the Canal Zone and in the Virgin Islands.
24 U.S.C. 212	Provides for admission of Federal prisoners, as a result of criminal proceedings.
38 U.S.C. 616	Provides for admission of beneficiaries of the Veterans' Administration.
42 U.S.C. 222, 249c, 251 and 253a	Provides for admission of beneficiaries of the Bureau of Employees' Compensation, beneficiaries of the Immigration and Naturalization Service, and members of the U.S. Coast Guard.
24 U.S.C. 324a	Hospitalization of U.S. nationals becoming mentally ill while abroad.
32 U.S.C. 417	Admission of persons found ill on Federal reservations.

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The preceding citations exclude those legislative acts which, although having significance in the hospital's history, do not pertain directly to current programs. However, these citations are furnished as part of the historical summary which appears earlier.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The beneficial effects of operating a psychiatric hospital are not always equated in economic terms. Nevertheless, there are substantial benefits, both long term and immediate, to be derived from the operation of an institution devoted to the treatment and care of the mentally ill.

(*a*) *Background.*—In another section of the human resources survey, the National Institutes of Health, PHS, have cited statistics which emphasize the seriousness of mental illness, both in human and economic terms. By way of example, NIH points out that mental illness afflicts 1 out of 10 Americans, it fills nearly one-half of all hospital beds in the Nation, and costs some $3 billion annually. The total cost to the taxpayers is over $2.4 billion a year in direct public outlays for service, including $600 million for mental retardation. While the number of outpatient psychiatric clinics increased by 50 percent, from about 1,200 in 1954 to 1,800 in 1963, the number of patients under care in these clinics increased during the same period by 127 percent, or from 379,000 to 862,000. During 1964, there were 300,000 admissions to State and county mental hospitals, the largest number in history.[1] Later in its presentation, NIH discusses mental illness in terms of indirect (as well as direct) costs, and estimates a total national outlay of about $4 billion annually, including indirect costs.[2] It is evident from the statistics cited that any institution dedicated to the treatment of mental illness has a tangible contribution to make to the economy.

(*b*) *Long-term effects of patient treatment.*—Patient treatment and care programs at St. Elizabeths Hospital serve the Nation's mental health efforts in several ways. For example, the hospital develops and demonstrates new and improved techniques for treatment of the mentally ill. Furthermore, it applies these techniques to its own patients, thereby restoring increasing numbers of individuals to useful lives. As the result of the hospital's treatment and rehabilitative activities, a variety of talents is being restored to the community which would otherwise have been lost. By way of example, discharges from the hospital during 1965 were more than double the number effected 10 years ago. Although not every discharged patient successfully returns to a fully productive life, the trend is a valid index of an increasing return for dollars invested in mental health, in terms of individuals restored to a self-supporting, productive and taxpaying status.

[1] Statistics appear in the NIH response, at pp. 814-15.
[2] Ibid.

(c) *Direct benefits.*—A second and obvious economic effect of the hospital's treatment and care program is the employment it provides and the business activity it stimulates as a user of goods and services. This aspect is covered under item 10.

10. Economic classification of program expenditures. (See table 2.)

Program: Mental health program—patient treatment and care.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; St. Elizabeths Hospital.

TABLE 2.—*Economic classification of program expenditures* [1] *for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	8.8
Other	1.9
Total Federal [2]	10.7
Non-Federal obligations financed by:	
District of Columbia	17.3
Other sources	.1
Total expenditures for program	28.1

[1] Expenditures here refer to obligations.
[2] Of the $10.7 million, $8.9 million represent obligations from direct appropriation and $1.8 million are obligations from reimbursements received.

HEALTH PROFESSIONS EDUCATION

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The training and education program of St. Elizabeths Hospital provides multidisciplinary clinical training for professional and associated personnel engaged in or interested in mental health activities. The principal objective or program goal is to increase the number and improve the skills of persons serving in medical, nursing, and ancillary disciplines concerned with the treatment of mental patients.

2. Operation

Forty percent of the training and education program is financed from direct Federal appropriations, with the remaining 60 percent being funded from reimbursements. This program constitutes one of three activities under the operating budget for St. Elizabeths Hospital. The other two activities, Operation and Maintenance (patient treatment) and Research, are discussed separately as individual programs. The hospital provides training for interns and residents in various medical and allied disciplines, and for affiliate student nurses. Among the specialties offered in the medical and allied fields are psychiatry, nursing, psychology, surgery, neurology, pathology, dentistry, occupational and recreational therapy, chaplaincy, and psychodrama.

3. History

St. Elizabeths Hospital has provided health professions training, to a greater or lesser extent, throughout its 110-year history. The history of this program is an integral part of the history of the hospital, which is summarized in the preceding report on the mental health program.

4. Level of operations. (See table 1.)

Program: Health professions education.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; St. Elizabeths Hospital.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of program (Average number of individuals trained) (man-years)	131	114	147	147
(b) Participants:				
(1) Interns and residents (man-years)	108	91	124	124
(2) Affiliate student nurses (man-years)	23	23	23	23
Total participants (man-years)	131	114	147	147
(c) Federal finances:				
(1) Unobligated appropriations available	$255, 381	$337, 039	$429, 850	$432, 650
(2) Obligations incurred	$255, 381	$337, 039	$429, 850	$432, 650
(d) Matching or additional obligations for the program:[1]				
(1) Reimbursements from the District of Columbia	$346, 989	$455, 311	$586, 770	$603, 440
(2) Reimbursements from other Federal agencies	$34, 848	$48, 573	$56, 000	$43, 770
(3) Reimbursements from miscellaneous other sources	$1, 244	$1, 666	$2, 000	$1, 760
Total additional obligations	$383, 081	$505, 550	$644, 770	$648, 970
(e) Number of Federal Government employees (civilian employment engaged in health professions education; permanent employment; excludes trainees) (man-years)	28	37	31	31
(f) Non-Federal personnel employed in the program				

[1] Reimbursements to the hospital are divided between 2 programs. It is not feasible to distribute items (d)(1) through (d)(3), except to prorate them on the basis of the percentage of total reimbursements attributable to each program.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The training and education program at St. Elizabeths coordinates its activities with several area universities and hospitals by (1) providing training and experience for residents and student nurses from other institutions in fields of study not covered by their parent institutions, and (2) affiliating its own professional trainees with other hospitals and universities to train them in skills not available at St. Elizabeths.

8. Laws and regulations

Funds for operation of the training program during the current fiscal year were appropriated under Public Law 89–156. Stipends paid to interns and residents by St. Elizabeths Hospital are within maximum limitations prescribed by the Civil Service Commission, which are set forth in the Federal Personnel Manual, part 534, section 202.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The most obvious effect of a program which provides training in the health professions is the contribution of such a program to the Nation's resources of trained health personnel. There is an additional advantage to be gained in the mental health field, however. As the number of trained personnel and the quality of training increase, it becomes possible to actively rehabilitate, and return increasing numbers of psychiatric patients to community life and gainful employment. It is in this respect that both the economy and the individual are benefited.

10. Economic classification of program expenditures. (See table 2.)

Program: Health professions education.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; St. Elizabeths Hospital.

TABLE 2.—*Economic classification of program expenditures* [1] *for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services: wages and salaries	0.4
Total Federal	.4
Non-Federal expenditures financed by:	
District of Columbia	.4
Others	(2)
Total expenditures for program	.8

[1] Expenditures here refer to obligations.
[2] Less than one tenth of a million.

HEALTH AND MEDICAL RESEARCH

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The research activities of St. Elizabeths Hospital have as their goal the development of new knowledge and understanding concerning the causes of mental disorders, the factors bearing upon their manifestations, course and treatment of such disorders, and development of any possible means of their prevention.

2. Operation

Research activities are carried on under 100 percent financing by direct Federal appropriations. The hospital also develops programming which is consistent with the authorized eligibility of this institution for Public Health Service research grants.

3. History

To some extent, research has been carried on at St. Elizabeths Hospital throughout its entire history. However, it was in fiscal year 1961 that research activities were consolidated, increased in scope, and formally established as an identifiable program within the hospital's operating budget.

4. Level of operations. (See table 1.)

Program: Health and medical research.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; St. Elizabeths Hospital.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 estimates
(*a*) Magnitude of program:				
(1) Major subprogram areas within overall research program [1]	5	5	5	5
(2) Authorized personnel strength (positions)	38	38	38	38
(*b*) Participants (100 percent financed by Federal funds and staffed by Federal employees):				
Subprograms	5	5	5	5
Positions	38	38	38	38
(*c*) Federal finances: [2]				
(1) Unobligated appropriation available	$284,589	$391,531	$409,950	$433,450
(2) Obligations incurred	$284,589	$391,531	$409,950	$433,450
(3) Allotments or commitments made				
(*d*) Matching or additional expenditures for the program (obligations from funds received under PHS grants)	$9,405	$71,752	$172,037	$144,327
(*e*) Number of Federal Government employees (permanent civilian employment, paid from hospital research activity funds) (man-years)	25	35	36	36

[1] Several practical problems arise in attempting to apply work measurement or other quantitative standards to a research program. Among these problems are (*a*) the varying numbers of individual projects being carried on under the various subprograms, and (*b*) considerable variations in the length of time required for the completion of different projects. To assess the accomplishments and scope of research at St. Elizabeths, the following information is offered. The 5 major subprogram areas now operated at the hospital consist of (1) experimental psychiatry, (2) operant conditioning and psychophysics, (3) experimental communications behavior, (4) personality assessment, and (5) investigation of criminal behavior. Within these broad areas, 52 individual research projects have been completed since formalization of the research program in 1961. An additional 21 projects are currently either underway, or at an advanced planning stage.

[2] Certain research activities at the hospital are conducted jointly with the Clinical Neuropharmacological Research Center of the National Institute of Mental Health. Appropriations and obligations shown above are reported only insofar as these activities are financed from St. Elizabeths appropriated funds.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

References have been made in preceding material to certain working relationships with the Clinical Neuropharmacological Research Center of the National Institute of Mental Health, (CNRC). The presence of the CNRC research program at St. Elizabeths Hospital necessarily involves the participation of a number of the hospital's professional staff on the basis of an arrangement worked out with NIMH. This in turn served as a valuable stimulus in crystallizing a long-standing, though theretofore unstructured, interest in research among the hospital's clinical and teaching staff. Further, it became apparent early in the operation of the CNRC that its own rather specific objectives would be advanced, and that the functions of the hospital as a clinical treatment and professional training institution would be strengthened, through the development of a formal research activity within the hospital complementary to and carefully coordinated with the work of the CNRC. Following consultation with NIMH, therefore, Federal funds were requested and granted for fiscal year 1961 with the objective of establishing and developing a program of hospital research in the clinical and behavioral sciences. The broad mission of this hospital research program in collaboration with the CNRC was the investigation of appropriate problems concerning the causes, nature, course, treatment, and prevention of mental illness.

8. Laws and regulations

Funds for operation of the research program during the current fiscal year were appropriated under Public Law 89–156, as part of the overall appropriation for the operating budget of the hospital.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Advances and improvement made in the understanding and effective treatment of various forms of mental illness directly affect the ability of St. Elizabeths Hospital and other institutions, to treat successfully and return increasing numbers of patients to the community, and to gainful employment.

10. Economic classification of the program expenditures. (See table 2.)

Program: Health and medical research.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; St. Elizabeths Hospital.

TABLE 2.—*Economic classification of program expenditures* [1] *for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services:	
Wages and salaries	0.4
Other	(2)
Total Federal	.4

[1] Expenditures here refer to obligations.
[2] Less than one-tenth of a million.

HOSPITAL CONSTRUCTION AND MODERNIZATION

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The basic objectives of the construction and modernization program at St. Elizabeths Hospital are (1) the replacement of obsolete, worn out buildings with modern structures which are more suited to the purposes and practices of modern medicine, and (2) the improvement and renovation of existing facilities to make them more effective in serving their various purposes.

2. Operation

Construction and modernization at St. Elizabeths Hospital is financed by a direct Federal appropriation for buildings and facilities, under which funds remain available until expended.

3. History

The first of the hospital buildings (a portion of the complex known as center building) was constructed during the period 1855–60. The physical plant expanded steadily, having a particularly active period shortly after the turn of the century, when over a dozen structures were completed during the period 1900–02. At the present time, the hospital has over a hundred buildings, approximately half of which are devoted principally to patient care. The remaining structures are used for maintenance, administration, storage, industrial services, and special services to patients.

4. Level of operations. (See table 1.)

Program: Hospital construction and modernization.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; St. Elizabeths Hospital.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of program:				
(1) Construction (new approved)			[1] 1	[1] 1
(2) Improvements (projects)	9	10	12	10
(b) Participants (direct appropriation from Federal Government) (projects)	9	10	13	11
(c) Federal finances:				
(1) Unobligated appropriations available	$9,188,612	$10,450,433	$11,085,353	$10,010,011
(2) Obligations incurred	$770,179	$1,342,080	$3,213,342	$3,294,000
(d) Matching or additional expenditures for program				
(e) Number of Federal Government employees [2]				
(f) Non-Federal personnel employed in the program [2]				
(g) Other measures of level or magnitude of performance (new obligational authority)	$627,000	$2,032,000	$1,977,000	$2,138,000

[1] Program statement, plans, and specifications for a security facility.
[2] The bulk of hospital funds is allocated to the Public Buildings Service. The hospital is therefore unable to identify man-years attributable to these activities.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

Federal appropriations initially finance construction and improvement at St. Elizabeths Hospital. However, the District of Columbia, in accordance with Public Law 472, 83d Congress, ultimately pays a portion of these costs throughout the useful life of the various facilities. Repayment of a portion of the construction costs by the District to the Federal Government is based upon the percentage of District of Columbia patients within the total patient load of the hospital. When the District's pro rata share of the cost of each project has been thus developed, it is distributed throughout the estimated useful life of each project and assessed to the District on a patient-day basis. No interest costs are assessed, however. Representatives of the District of Columbia government are consulted and kept advised of construction plans of the hospital.

8. Laws and regulations

Funds for hospital construction and modernization at St. Elizabeths Hospital in 1966 were appropriated under Public Law 89–156, DHEW Appropriation Act of 1966.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The construction and modernization program complements the other programs of the hospital by providing new and improved facilities which make more effective the program of patient treatment and rehabilitation. As pointed out in connection with the other programs, the economy is ultimately benefited by increases in the number of individuals who are psychiatrically rehabilitated and gainfully employed, and corresponding decreases in the number of individuals who are either public charges or dependent upon others for their existence. There are also the obvious direct economic benefits, in the form of employment and patronage of private industry, which arise whenever a large-scale construction or improvement project is undertaken.

10. Economic classification of program expenditures. (See table 2.)

Program: Hospital construction and modernization.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; St. Elizabeths Hospital.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services [1]	0.7
Total Federal expenditures [2]	.7

[1] Consists primarily of transfers of funds to the General Services Administration and payments to private contractors. The hospital is unable to segregate the portion of such payments which is used ultimately for wages and salaries.
[2] For comparable figure for obligations see answer to question 4.

Social Security Administration

Old-Age, Survivors, Disability, and Health Insurance

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The Federal old-age, survivors, disability, and health insurance (OASDHI) program is intended to provide continuing income for individuals and their families as partial replacement of earnings lost through old age, total disability, or death of the family earner and, beginning July 1966, to provide protection against the cost of health care in old age.

During working years employees, employers, and self-employed people pay social security contributions, which go into special trust funds. When earnings stop or are reduced because the worker retires, dies, or becomes disabled, monthly cash benefits are paid from the funds to replace part of the earnings that are lost. Part of the contributions made during the working years are put in a special fund so that when workers or their dependents reach age 65 they will have basic hospital insurance to help pay their hospital bills. Virtually all persons now 65 and over are eligible for the hospital insurance benefits; presently, the costs for uninsured persons are paid from general revenues. Payments under the program serve as a base on which the individual may add savings, private insurance income, income from private pension plans, and other sources.

The social security program also includes a voluntary supplementary medical insurance plan, under which protection is provided to meet part of the costs of physicians' services and other medical services not covered by the basic hospital plan. The voluntary insurance plan is open to all people age 65 and over who choose to enroll and pay the required premiums. It is financed in equal shares by the older persons who elect to participate and by the Federal Government through general revenues.

2. Operation

The Social Security Administration, a component of the Department of Health, Education, and Welfare, administers the OASDHI program. All contributions go into Federal trust funds from which all benefits and administrative expenditures are paid. Administration of the cash benefits program is a direct Federal operation. Private organizations, however, as well as public agencies other than SSA, will be used in administering the health insurance plans.

The Social Security Administration is composed of the Office of the Commissioner and five staff offices, and seven bureaus. To the greatest extent possible, operations of the Social Security Administration are decentralized to provide services at the local level to per-

sons covered by the program, to beneficiaries and claimants, and to persons who appeal claims decisions. The Bureau of District Office Operation, through its regional representatives in the field, supervises the activities of over 600 district offices concerned with operations of the program. Eight regional assistant commissioners report directly to the Office of the Commissioner and have overall responsibility for all social security activities in a geographic area including the coordination of district office and payment center activities. Seven regional hearings representatives of the Bureau of Hearings and Appeals provide administrative direction to hearings examiners located in 60 cities throughout the country, who hold hearings and render decisions in connection with appeals of OASDHI determinations.

3. History

The severe depression of the 1930's dramatized the fact that new methods were needed to cope with the economic problems that faced the American people. In 1935, President Franklin D. Roosevelt proposed to the Congress economic security legislation, embodying the recommendations of a specially created Committee on Economic Security. The Congress adopted many of the recommendations of the Committee and passed the Social Security Act which was signed into law on August 14, 1935. This law established a Federal system of old-age benefits for retired workers who had been employed in industry and commerce, along with a Federal-State unemployment insurance system. Federal financial aid was also provided to the States to help them meet the costs of assistance to the needy and for public health and vocational rehabilitation services.

The old-age insurance program was not actually in full operation before significant changes were adopted. The Congress in 1939 made the old-age insurance system a family program rather than a program for retired workers only, by providing benefits to a worker's dependents and survivors. Also, the basis for computing benefits was changed from cumulative lifetime earnings after 1936 to average monthly earnings in covered work, making it possible to pay reasonably adequate benefits to many workers approaching retirement age and to their dependents. The amendments also made monthly benefits first payable in 1940, instead of 1942 as originally planned.

No major changes were made again in the program until 1950 when it was broadened to cover many jobs that had at the beginning been excluded, chiefly because experience was needed to work out ways to report earnings and collect contributions of certain occupational groups. Among the groups covered by the 1950 amendments were regularly employed farm and household employees and most persons—other than farmers and professional people—who work for themselves. Employees of State and local governments, if not protected by public employee retirement systems, and employees of nonprofit organizations were covered by special arrangements on a voluntary group basis.

During the 1950's coverage was extended to farm operators, most self-employed professional people, and the members of the Armed Forces; coverage was also made available to State and local employees

covered by retirement systems (except for policemen and firemen in some States) on a voluntary group basis. In 1965, self-employed doctors of medicine were covered.

All gainfully employed workers are now covered, with the exception of most Federal and some other government employees who have separate retirement protection, farm and domestic workers who are not regularly employed or who do not earn enough to be covered, and very low income self-employed people.

Over the years, changes have been made in the amount of work required to obtain an insured status. Under the 1939 amendments, a worker was generally eligible for benefits if he had worked in covered employment half the time (one out of every two calendar quarters) after 1936 and before the age 65 and had a minimum of six quarters. As coverage was extended, newly covered workers were also enabled to qualify after minimum amounts of time in covered employment. At the present time a person is insured if he has credit for covered work roughly equal to one-fourth of the time (one calendar quarter for each year) after 1950. The 1965 amendments eased the eligibility requirements for people 72 and over who were not eligible for social security benefits by introducing a transitional insured status under which a special benefit may be paid with less than six quarters of coverage.

The scope of the program was significantly broadened in 1956 through the addition of disability insurance. Benefits were provided for severely disabled workers aged 50–64 and for adult disabled children (if disabled before age 18) of deceased and retired workers. In 1958 the act was further amended to provide benefits for dependents of disabled workers similar to those already provided for dependents of workers retired because of old age. In 1960 the age 50 limitation for disability benefits was removed so that disability benefits could be payable at any age before 65. The 1965 amendments eliminated the requirement that disability be of long continued and indefinite duration and provided that a severely disabled person could qualify if his impairment could be expected to result in death or to last at least 12 months.

Significant changes have been made in the eligibility age for retirement benefits. The minimum age at which old-age benefits could be paid was lowered from 65 to 62 for women in 1956, and for men in 1961, and from age 62 to 60 for widows in 1965. Full benefits are paid widows, widowers, and dependent parents at age 62 but the benefits for working men and women, wives, and dependent husbands who claim them before age 65 and for widows who claim them before age 62 are reduced to take account of the longer period over which they will get their benefits.

In 1950, when the program was extended to cover several million additional jobs, the law also was amended to allow a worker's average monthly earnings to be figured on the basis of his earnings after 1950. Similar consideration was given to the groups newly covered by the program in 1954 and 1956 by allowing up to 5 years of lowest earnings to be dropped from the computation of average earnings. So that people already covered by the program would not be treated less favorably than the newly covered groups, these special provisions

were made available to all workers who worked in covered employment after 1950, regardless of when their jobs were first covered.

The benefit structure has been improved several times since 1950. In 1950, the Congress increased benefits of those on the rolls and raised future benefit levels by adopting a new benefit formula applicable to persons claiming benefits after August 1950. Contributing to the effectiveness of the new benefit formula was an increase in the maximum annual earnings that could be taxed and credited toward benefits, from $3,000 to $3,600.

Since 1950, benefits have been increased periodically by legislative action, not only to adjust to the changed value of the dollar, but also to reflect in part the rising level of living for the population as a whole. Benefits were increased for all groups of beneficiaries in 1952, 1954, and 1958, and in 1954 the earnings base was increased from $3,600 to $4,200 and in 1958 to $4,800. The 1965 amendments provided for a 7 percent across-the-board benefit increase retroactive to January 1965 and an increase in the earnings base to $6,600 beginning in January 1966.

As a result of the changes made by the Congress, benefits have done somewhat better than keep up with increases in prices that have occurred since benefits first became payable, although they have lagged in relation to rising wages.

By far the most important provision of the 1965 amendments concerned the establishment of a comprehensive health insurance program for the aged. The amendments set up a basic hospital insurance program financed through a separate payroll tax and trust fund which provides protection against costs of hospital and related care; and a voluntary supplementary medical insurance plan financed through small monthly premiums and a Federal Government contribution which covers part of the cost of physicians' services, and other related medical and health services.

Today, practically everyone in the United States is protected by the OASDHI program. More than 9 out of 10 people in covered employment and self-employment are covered or eligible for coverage. At the beginning of 1965, about 94 million people were insured for cash benefits. Fifty-eight million were permanently insured; that is, they had worked long enough under the program to qualify for retirement benefits even if they do no more covered work. About 92 percent of the people now becoming 65 are eligible for monthly cash benefits; nine-tenths of all children and their mothers can count on monthly survivors insurance benefits if the family breadwinner dies; and about 54 million people had worked long enough and recently enough so that they can get benefits in the event that they should become totally disabled this year. More than 20 million people are receiving monthly benefits at a rate of about $1.5 billion a month.

Under the new health insurance program, about 19 million persons aged 65 and over will be eligible for benefits beginning in July 1966.

4. Level of operations. (See table 1.)

Program: Old-age, survivors, disability, and health insurance.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Social Security Administration.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 estimates
(a) Magnitude of the program (calender year)—Covered employment	77,700,000	79,500,000	81,500,000	83,400,000
(b) Applicants or participants:				
State government agencies:				
Vocational rehabilitation agencies	49	49	49	49
Public assistance agencies	7	7	7	7
Public health agencies			53	53
Individuals or families:				
Accounts established	7,554,732	5,189,600	6,376,000	4,482,000
Inquiries	29,931,403	30,421,384	47,271,000	47,840,000
Claims or social security benefits	3,473,019	3,525,293	7,894,000	4,713,000
Beneficiaries in monthly payment status (end of year)	19,470,850	20,156,883	21,785,000	22,678,000
Aged eligible for hospital insurance				19,259,000
Aged eligible for medical insurance				15,571,000
Other: Intermediaries for health insurance program (private health plans; insurance companies)			175	175
(c) Federal finances: [1]				
Unobligated appropriations available (including contingency fund) [2]	$318,961,057	$338,226,230	$500,583,295	$618,486,935
Obligations incurred	307,415,115	325,668,051	478,784,360	579,081,935
Allotments or commitments made—Benefit payments	15,830,373,311	16,618,261,749	19,840,000,000	[3] 23,949,000,000
Federal contribution to the supplementary medical insurance program			[4] 342,000,000	550,000,000
(d) Matching or additional expenditures for the program				
(e) Number of Federal Government employees administering, operating, or supervising the activity (equivalent man-years)	35,448	35,345	47,594	47,509
(f) Non-Federal personnel employed in the program (equivalent man-years)	1,788	1,956	4,141	13,772
(g) Other measures of level or magnitude of performance:				
Employer reports	18,223,490	18,492,208	18,976,000	19,380,000
Earnings items reported by employers for posting to workers' accounts	272,508,786	282,240,015	290,028,000	305,046,000

[1] Expenditures for benefit payments and administrative expenses under the old-age, survivors, disability, and health insurance program are paid out of trust funds. All expenses incurred in carrying out the provisions of title II and title XVIII are charged to the trust funds. Under title XVIII, the trust funds are reimbursed by the Federal Government from general funds of the Treasury for costs of providing hospital insurance benefits to people who are not social security or railroad beneficiaries, and for the Federal Government's share of the cost of the supplementary medical insurance plan.

[2] Includes in 1966, $25,800,000 and in 1967, $12,947,000 from general funds for administrative expenses incurred in the payment of hospital insurance benefits to uninsured people.

[3] Includes $270,000,000 from general funds for payment of hospital insurance benefits to uninsured people.

[4] A contingency fund authorized under the Act but not expected to be obligated.

5. Estimated magnitude of program in 1970

It is estimated that, in calendar year 1970, the combined operations under the old-age and survivors insurance trust fund, the disability insurance trust fund, and the hospital insurance trust fund will result in contributions and benefits amounting to $32 billion and $27 billion, respectively. These estimates are based on the assumption that economic activity will expand throughout the period 1965–70, with employment and earnings increasing steadily through 1970. Government contributions from general revenues to the supplementary medical insurance trust fund might be in the neighborhood of $1.5 billion, although this estimate must remain very rough until there is some experience under the program.

6. Prospective changes in program orientation

(*a*) *Pending legislative proposals.*—In the immediate future, preparation for administering the health insurance proposals will be of first priority. The history of the social security programs would, however, indicate that the Congress will continue to make additions and improvements, and to fill gaps in coverage when they become apparent.

(*b*) *Proposed administrative and organizational changes.*—In July 1965, a reorganization of the Social Security Administration went into effect. The reorganization made certain basic improvements in organization structure which the passage of time and the growth of the social security programs, in size and complexity, made increasingly desirable, and also was sufficiently broad to fully accommodate the new responsibilities growing out of the 1965 amendments to the Social Security Act.

The primary objectives of the reorganization are:

(i) Accommodate within the overall structure of the Social Security Administration the important new units with special responsibility for the hospital and supplementary medical insurance programs.

(ii) Modify existing units to accommodate additional responsibilities because of these programs.

(iii) Provide for greater efficiency and economy and fuller utilization of scarce skills in the new technical area of electronic data processing and transmission by centering responsibility for this function in a single headquarters unit.

(iv) Strengthen the role of the management unit at the top level of the agency in order to better assure the most effective, efficient, and economical administration of both old and new program responsibilities.

(v) Increase the technical support for district offices, payment centers, and State agency operation by assigning responsibility for functional supervision of technical work to specialized bureaus and their representatives.

(vi) Strengthen the administration of the social security program in the field by placing responsibility for coordination and leadership of all social security activities in a given geographical area under a Regional Assistant Commissioner reporting directly to the Office of the Commissioner.

As reorganized, the Social Security Administration headquarters now consists of seven bureaus and five staff offices, with eight Regional Assistant Commissioners in the field having broad responsibility for all social security activities in a geographic area, reporting to the Commissioner of Social Security.

The seven bureaus, each headed by a Bureau Director reporting to the Commissioner, are: Bureau of Data Processing and Accounts, Bureau of Hearings and Appeals, Bureau of Federal Credit Unions, Bureau of Health Insurance, Bureau of Retirement and Survivors Insurance, Bureau of Disability Insurance, and Bureau of District Office Operations. Each of the latter four Bureaus has a regional representative in a given geographic area, and is responsible for the SSA-wide effectiveness of their respective programs in the headquarters and the field. The Regional Assistant Commissioners assure

program coordination of the regional representatives, although the latter receive functional direction from their parent Bureaus.

The headquarters staff offices are: Office of the Actuary, Office of Research and Statistics, Office of Information, Office of Program Evaluation and Planning, and the Office of Administration. The latter acts as the right hand of the Commissioner in giving leadership and unified direction to the SSA-wide administration of the social security programs.

(c) *Probable changes in the conditions under which the program will function in 1970.*—Social Security Administration projections as to the operation of the programs through 1970 assume a continuing rise in real per capita national income, and specifically per annum increases of 3 percent in average earnings in covered employment, of 1.8 percent in the labor force, of almost 2 percent in the total number of persons aged 65 and over, and of 5 percent in total beneficiaries.

The cost estimates for the program assume a rise in hospital care costs of about 6 percent per annum over the period. Some increase in total medical expenditures and an expansion in medical manpower and facilities, particularly skilled nursing home care, is assumed.

7. Coordination and cooperation

(a) *Within the Social Security Administration.*—The administration of the OASDHI program is a cooperative undertaking involving every major component of the Social Security Administration. The coordination of all activities is necessary for the fullest utilization of operational experience and appraisal, management consideration, and policy development and evaluation. This coordination is accomplished through the work-planning system and coordination of projects, intra-Administration clearance of policy and instructional matters, conferences, meetings and training programs, and joint studies and dissemination of results of these studies.

For example, in the administration of the old-age and survivors insurance program, procedures have been established under which the Bureau of Retirement and Survivors Insurance takes steps to insure the earmarking of social security accounts in the Bureau of Data Processing and Accounts that are currently entitled to monthly benefits. The BDPA then relays to BRSI all pertinent information it receives which may affect the individual's eligibility for benefits. Coordination is also required for the periodic investigation of the continuing eligibility of a statistical sample of beneficiaries in pay status, to provide the basis for annual reports assessing the integrity of the social security payment rolls and the administrative actions being taken to promote compliance.

To administer the disability program, the Bureau of Disability Insurance makes the following coordinations: With the Bureau of Retirement and Survivors Insurance, for the formulation of disability policies so that they will be consistent with the overall policies for taking, developing, and adjudicating claims under the provisions of the social security law (BRSI has final responsibility for the issuance of rulings and regulations and receives all disability proposals for coordination and publication); with the Bureau of District Office Operations for the clearance of instructions and policies affecting district offices to assure operational feasibility, effect on the public, etc.; with the Office of Information in the preparation of informational material

addressed to the public, to the medical profession, and others; with the Bureau of Hearings and Appeals, to clear and coordinate proposed policies affecting the judicial process, to confer on regulations and rulings, and to arrive at agency positions in specific court cases; and with the Office of Program Evaluation and Planning to discuss matters of disability program improvement through legislative changes, as well as to react to their proposals from the viewpoint of operational feasibility.

Similar intensive coordination and cooperation prevail at the policy, planning, administrative, and operational levels in the administration and implementation of the health insurance provisions of the Social Security Act.

Overall program research and a statistical program are carried on by the Office of Research and Statistics, involving the coordination with and cooperation of the other components, such as BDPA, which is responsible for all data-processing activities. Another unit of ORS conducts, in cooperation with BDOO, a statistical system that provides a means of measuring and evaluating the way in which program policies are carried out in the processing and payment of claims for benefits.

(*b*) *With other units of the Department.*—

(i) Office of the Secretary: Close cooperation and coordination are required with the Office of the Secretary in the formulation of policies and legislative programs, in the development and clearance of research projects, and in technical details such as clearance of general and statistical forms. SSA personnel also serve on interdepartmental committees and on task forces as Department representatives.

(ii) Office of the General Counsel: There is a day-to-day relationship with the OGC on legal matters. This coordination is necessary to clear policies and procedures requiring legal clearance, to assure their conformity with the law and with congressional intent. Extensive dealings are also had with OGC in court cases involving OASDHI, primarily to assist in formulating the Department's defense of determinations.

(iii) Public Health Service: In the disability program, contacts are made with the PHS to take up problems involving medical standards for the adjudication of disability, medical report forms designed for the use of doctors, information materials aimed at the medical profession, research projects having medical content and other problems related to the disability program. In the health insurance program there will be numerous points of administrative contact with PHS. The more important of these will be the mutual involvement of PHS and SSA with the State agencies in setting standards for provider certification and in setting overall policy for assuring continuous adherence to such standards.

Also SSA and PHS work closely together in developing and carrying out related research and survey programs. Under the new health insurance program the SSA is directed to plan, on a continuing basis, with the PHS and the Welfare Administration for statistical programs designed to meet the needs of constituents and interested voluntary agencies.

SSA also works extensively with the National Center for Health Statistics (PHS) to obtain reliable public records of births, deaths, marriages, divorces, etc., needed to administer the social security

program, and for purposes of achieving uniformity in recordkeeping within the 50 States and political subdivisions.

(iv) Welfare Administration: The health insurance program requires continuous close coordination with WA's Bureau of Family Services in effecting supplementary medical insurance coverage for elderly persons on State welfare rolls, and coordination with title XIX (medical assistance) programs.

(v) Vocational Rehabilitation Administration: To take up problems, policies, and procedures affecting the interrelationships of the disability determination process with the VR program. The law requires the prompt referral of all disability applicants to assure consideration for VR purposes.

(vi) Office of Education: The 1965 amendments to the Social Security Act provide for the payment of benefits to children 18 to 22 who are in full-time attendance at an educational institution. Informal contacts have been made with the Office of Education, and arrangements are being made to establish a formal liaison with this agency to get the benefit of their expertise in the field of education, which may be helpful in the administration of this provision of the law.

(*c*) *With other Federal Government departments and agencies.*—

(i) Internal Revenue Service: Coordination arises out of comparable provisions in the Internal Revenue Code and the Social Security Act and the need for a uniform government position and compatible procedures.

(ii) Railroad Retirement Board: Because of the close interrelationship between the railroad retirement program and the OASDHI, it is necessary for the proper administration of each program that a close coordination exist between them. This involves arrangements for the transfer of earnings record information, entitlement data, terminations information, and other related information vital to the administration of each program. In certain instances, the entitlement to or amount of payment under OASDHI may depend on entitlement or potential entitlement of the applicant to payment under the RRB program, and vice versa. In the disability program, it has been necessary to coordinate the disability determinations in specific claims because of the legal provision which grants a disability freeze and/or benefits under both programs for the same worker; and the health insurance program will require coordination with RRB in effecting coverage of their annuitants and further exchange of information to avoid dual coverage. Additional opportunities for coordination and cooperation between RRB and SSA exist because of the financial interchange between the OASDHI system and the RR system, as provided by Public Law 234, approved October 30, 1951.

(iii) Veterans' Administration: The Social Security Act provides, under certain circumstances, for the granting of a presumed insured status in cases where an honorably discharged serviceman dies within 3 years of discharge and no VA pension or compensation has been or is being paid. In addition, the respective laws provide that an application filed with VA for survivor benefits may be an application for social security benefits. Furthermore, under certain circumstances the VA can pay the equivalent of social security benefits where the deceased veteran does not have an insured status. To administer these provisions of law the SSA has extensive informal arrangements with VA, to disseminate the required information

within the two agencies. The SSA has, also, from the beginning of the disability program, sought cooperation for the exchange of medical evidence relating to individuals who have filed disability claims under both programs. Mutually satisfactory procedures have been formulated to permit SSA district offices to secure relevant medical information from the files of VA regional and other offices. From time to time SSA has also met with the VA headquarters office on matters of adjudicative policy and on legislative proposals affecting both programs.

Further coordination with the VA exists in the administration of the OASDHI program outside the United States. The VA functions for SSA outside the United States in relation to claims development and investigations needed to establish whether persons are entitled and/or eligible to receive social security payments.

SSA has an informal written arrangement with the VA Regional Office in Manila. It performs functions in the Philippine Islands similar to those performed by the district offices in the United States with the basic exception that it does not formally disallow or make an initial adjudication of the claim. It performs required investigations throughout the Philippine Islands. SSA completely finances the social security part of the operation and pays all costs of any functions related to the administration of social security.

(iv) U.S. Bureau of Employee Compensation: In the disability provisions of the Social Security Act a section was added requiring the reduction of the benefits where the claimant is receiving a payment under a Federal or State workmen's compensation statute. To administer this provision the need arises for working out arrangements with the Federal and State agencies having jurisdiction over the workmen's compensation laws to secure information as to whether a person is a workmen's compensation beneficiary.

(v) Department of Justice: Continuing negotiations and coordination exist with the Immigration and Naturalization Service. It assists in establishing a person's entitlement to benefits through furnishing documentation of age, marriage, and naturalization records. SSA also secures from the Service information on the citizenship of beneficiaries where that information is material or required by the claims process. Reimbursement is often made to the Service for data supplied for official use from its records. Also, in carrying out responsibilities under the health insurance program it is necessary to look further into ways and means for claimants to prove citizenship and lawful admission to the United States. Both elements are included among the requirements for entitlement to hospital and medical benefits. Consequently, liaison is being established with the Service for the purpose of ascertaining the most feasible method of obtaining proof of the above factors.

In the area of prosecutions for violating the criminal provisions of the Social Security Act and other related criminal statutes, the SSA cooperates with the Department of Justice (U.S. attorneys). SSA, through the Office of the General Counsel, refers situations to U.S. attorneys whenever it believes that it has convincing evidence that violations have occurred. The U.S. attorneys are charged with the responsibility of deciding if prosecutions are warranted and, if so, of representing the Government in such prosecutions. The SSA cooperates with the U.S. Secret Service and the Federal Bureau of Investi-

gation on alleged forgeries of benefit checks and other matters that are of concern to the SSA but are not violations of the Social Security Act.

(vi) Department of State: The Department of State, like the Veterans Administration, functions for SSA outside the United States. The Department performs duties around the world relating to the dissemination of information, the handling of inquiries by potential claimants, the handling of technical claims problems, and the investigation of such matters required by the SSA claims process. SSA finances different aspects of the program, depending upon the local needs of the various countries. Such financing is done under general informal written arrangements with the Department of State to the effect that SSA will reimburse and pay costs if the State Department feels it cannot supply the services without reimbursement or if the workload is too great. In the administration of the disability program, SSA has negotiated with the Department agreements and procedures for processing disability claims by residents of foreign countries. In this process, Department of State staff in foreign countries receive claims, communicate requirements to claimants, certify the qualifications of foreign physicians, and in other ways facilitate the processing of foreign claims.

Other examples of areas in which SSA cooperates with the Department of State are preparing consular reports on foreign social security systems; conducting seminars for foreign social security officials; and assisting in the training of labor attachés.

(vii) Department of Commerce, Bureau of Census: In many instances, the only early sources of proof of age for social security claimants are census records. Coordinated procedures have been established with the Census Bureau for claimants to secure such evidence. In some instances where it is necessary to verify that a claimant is of retirement age, the record is obtained from the Census Bureau, with the claimant's consent. This is a continuing coordinating process.

SSA cooperates with the Bureau of the Census in the preparation of the publication "County Business Patterns." In other areas SSA uses the Bureau in carrying out many of its surveys and for the tabulation of data from the surveys.

(viii) Treasury and Post Office Departments: Among the matters of common concern are problems of loss or theft of benefit checks, special sorting devices to enable expeditious processing by the Treasury and Post Office of the tremendous volume of social security checks, prompt settlement of claims of nonreceipt of checks, and issuance of regulations in accordance with section 205(n) of the Social Security Act, as amended, permitting negotiation of a combined husband-wife check that was not negotiated prior to the death of one of the beneficiaries.

(ix) Other Federal departments or agencies:

(*1*) The Social Security Act provides for the granting of gratuitous wage credits of $160 per month for military service during and after World War II service but before 1957 where no other Federal agency (other than VA) is paying or has paid a periodic benefit based on such service. The veteran must have had a certain minimum amount of service and must have been discharged under conditions other than dishonorable. This provision requires extensive coordination with military service departments

for purposes of ascertaining the type of discharge, the dates of active service, and whether any other benefits are payable based on such service. Coordination with other Federal benefit-paying organizations, such as the Civil Service Commission, becomes necessary in certain cases. In the administration of the health insurance program, coordination with the Civil Service Commission also is necessary to effect coverage of their annuitants.

(2) Continued emphasis is being placed by the Office of Research and Statistics on the development of ways for capitalizing on the potential wealth of SSA statistics as a resource for economic and social research. Information relating to individuals is not released except in specified circumstances as provided in the statute and regulations. Statistical data and other materials not involving disclosure are made available for research use to the maximum extent consistent with other administrative demands. As a consequence, opportunities for coordination and cooperation with other programs or agencies will undoubtedly increase.

(*d*) *With State governments and their instrumentalities.*—The implementation of the OASDHI program requires continuous close coordination and cooperation with designated agencies of the State governments.

There is a provision for coverage of State and local government employees by contract between the States and the Federal Government. To administer this provision, cooperation is achieved by providing a handbook for State administrators, making available individuals for technical discussions at the State level, and helping the State in disseminating information and assistance to its local reporting officials. SSA meets with, provides information to, and utilizes the cooperation of associations of State administrators.

In the administration of the disability program, the State agencies, under agreements with the Secretary of Health, Education, and Welfare, make determinations as to the existence of a disability as defined in the law. Payment is made to the States for the cost of this service. Agreements have been negotiated in all States involving 56 separate agencies; on several occasions since the disability program was enacted it has been necessary to modify agreements. Periodically, staff from SSA headquarters and regional offices visit State agencies to confer on adjudicative, administrative, and operation problems. Use is also made of a "States' Council Committee on SSA Relationships," made up of designated members of the "States' Council of VR Directors." At periodic meetings of this Committee proposed policies and procedures are presented to get reactions and to elicit ideas for improving the Federal-State partnership in the disability insurance program.

Also, the disability provisions of the Social Security Act include a section requiring the reduction of the benefits where the claimant is receiving a payment under a Federal or State workmen's compensation statute. To administer this provision the need arises for SSA to work out arrangements with the Federal and State agencies having jurisdiction over the workmen's compensation laws (State workmen's compensation bureaus and commissions) to secure information as to whether a person is a workmen's compensation beneficiary.

The amendments relating to hospital and medical insurance for the aged specifically require that the Secretary of Health, Education, and Welfare enter into agreements with those States able and willing to do so, under which an appropriate State agency will be utilized to certify provider institutions within the State for participation in the program. By agreement, the functions of the State agencies may be broadened to include the provision of consultative services to institutions seeking certification, and assistance to institutions in establishing utilization review procedures. Provision is made for the reimbursement of State agencies for the cost of rendering these services. Accordingly, implementation of the health insurance amendments will involve continuous close coordination and cooperation with designated agencies of the State governments.

In administering the health insurance program, the SSA will work closely with State welfare agencies as well as with the Bureau of Family Services of the Welfare Administration (see above) in effecting supplementary medical insurance coverage for aged persons on welfare rolls and in coordinating title XVIII and title XIX activities.

Coordination also exists between various State agencies and SSA for the purpose of furnishing information to assist the agencies in administering their laws, as follows:

(i) State agencies administering unemployment compensation laws: Any information needed for purposes of administering or evaluating unemployment compensation laws (except medical information) is furnished;

(ii) State agencies administering programs receiving Federal grants-in-aid under titles I, IV, V, X, and XIV of the Social Security Act: Information is furnished about entitlement to and social security benefits paid, date of birth, whether a period of disability has been established, the beginning and ending date of the period and the date of onset of disability, to enable the agency to determine eligibility for assistance or the amount of payments or services due the claimant. Also, to a State agency administering a program for aid and services to needy families with children, information concerning the whereabouts of a deserting parent of a child eligible for benefits under such assistance programs; and

(iii) State agencies administering a program receiving Federal aid under the VR Act: For purposes of administration, information is furnished about entitlement to or social security benefits paid, date of birth, medical information, and information concerning establishment of disability.

(*e*) *With local governments or communities.*—Although SSA is not directly involved in coordinations with local governments or communities, it looks to the community for welfare services needed by beneficiaries since these services are not provided within the social insurance system. Too often the needed services are not available in the community or are too restricted to be generally effective. In furtherance of the objective of having services available in the community that are needed by children, the disabled, and the aging, the SSA participates with national and voluntary agencies in overall planning to promote the development and extension of such services.

Within DHEW and the Federal Government, this planning is done through intradepartmental committees, interdepartmental committees, and collaborative public and private demonstration projects.

The kinds of organizations and agencies with which SSA plans for community services are: national councils; national forums; typical national associations of local health or welfare agencies; typical national organizations in health and welfare mainly concerned with personnel standards and programs of education and training; typical associations for professional personnel; typical organizations sponsored by public authorities; membership societies representing labor and special groups; typical health organizations; and semiprivate corporations and institutions involved in social research.

The nature of this collaborative work involves planning and development; membership in a government committee; assignment to a joint task force; participation in a voluntary organization committee; work to maintain information and to keep informed on all community development work on health and welfare; communication to health and welfare organizations, their lay and professional staff, of select technical and interpretative SSA materials and information; participation in special seminars and institutions.

The SSA also looks to the community for services in the selection of a representative payee for beneficiaries who are in need of a representative to receive and manage their benefits. These beneficiaries are children deprived of normal parental care and protection or are adults who are mentally incapable of self-direction. SSA looks to local public welfare agencies and voluntary agencies for social investigation and recommendation of the payee, as well as for the provision of needed supportive and protective health and welfare services.

(*f*) *With foreign governments or international organizations.*—The Social Security Administration participates in the activities and in policy planning related to at least four international organizations: the International Social Security Association, the International Labor Organization, the Inter-American Conference on Social Security, and the United Nations Social Commission. It also participates with other agencies in the work of such organizations as the Organization of American States. Examples of the types of activity and cooperation of the SSA in these organizations are: The Commissioner of SSA serves as a member of the Bureau of ISSA—the managing board of the organization, which meets at least once a year. The Commissioner also served as president of the 15th General Assembly of ISSA, which met in Washington in 1964. SSA is assisting ISSA in establishing a Social Security Abstracting Service that will publish in several languages abstracts of articles relating to social security appearing in foreign countries. Various officials of the SSA have served as reporters on ISSA committees, contributed articles to the Bulletin of ISSA, and have helped in carrying out technical studies. In ILO activities, SSA cooperation includes representation on U.S. delegations to meetings dealing with social security, participation in the formulation of U.S. policy papers with respect to ILO questions, collaboration in technical assistance activities, and contributions to research activities. Officials of the SSA have participated in the work of the United Nations Social Commission and frequently serve as advisers to the U.S. representatives in that body.

SSA furnished personnel to assist in the carrying out of the International Cooperation Year White House Conference.

SSA also provides to foreign countries technical information on and experience under the U.S. social security program through the training

of foreign social security officials and through technical assistance programs abroad. SSA officials have also participated in a number of advisory missions to other countries.

(*g*) *With nonprofit organizations or institutions.*—In the administration of the disability program, SSA has continuing liaison with the American Medical Association and with State and county medical societies to discuss the needs of the disability insurance program. In these contacts the primary concern is to improve the understanding of practicing physicians about the evidentiary requirements of the disability determination process as well as the philosophy and objectives of the disability program. Since the family physician is the primary source of medical evidence relating to the claimant's disability it is vital to the effective administration of the program that the attending physicians cooperate fully and that they understand what is needed for a disability determination. SSA staff has visited the AMA headquarters in Chicago to discuss these problems, and AMA officials have attended meetings sponsored by SSA. An information film directed at physicians was jointly produced with the AMA, and SSA articles have been published in the AMA Journal and in State journals. Since the beginning of the disability program a medical advisory committee made up of nongovernmental consultants in the medical and related fields has been helpful. The original medical adjudicative guides were cleared with and approved by this committee, and subsequent revisions have been discussed and cleared at other meetings of the same committee. The committee has been consulted on policies and procedural proposals affecting the medical profession. The membership of the committee has changed during the 10 years of its existence; the present arrangement is for a rotating membership. SSA also has liaison with the American Hospital Asociation in discussions of medical evidentiary needs for claimants who have been hospitalized.

The health insurance amendments authorize the Secretary of Health, Education, and Welfare to enter into agreements with such private organizations as are nominated by groups of providers under which the organization will determine (subject to review) the amount of reimbursement to be made to providers and will make the payments. By agreement, such organizations may perform numerous other administrative services for the Government in connection with the program. Also, in the supplementary medical insurance program, there is provision for contracting with organizations lawfully engaged in the health insurance business to administer the program.

Under the legislative language, such nonprofit organizations as Blue Cross, Blue Shield, and various other types of mutual group health insurance organizations might qualify for significant administrative roles in implementing the health insurance program.

The SSA collects a wealth of data which it makes available, on a very limited basis, for research uses by other organizations, private as well as public, under the regulations set up to maintain the confidentiality of information relating to individuals.

The SSA supports research by people outside Government through the cooperative research and demonstration grants program. The program provides for grants, contracts, or cooperative arrangements with universities and other nonprofit agencies, public and private, for the support of research or demonstration projects that relate to

the prevention or reduction of dependency, that aid in the coordination of planning between private and public welfare agencies, or that will help improve the administration and effectiveness of the SSA.

(*h*) *With business enterprises.*—Commercial insurance companies engaged in the health insurance business may qualify as intermediaries under the basic hospital insurance program under the supplementary medical insurance plan (as indicated in (*g*), above).

Hospitals, nursing homes, home health services, and medical laboratories are potentially eligible to participate as providers of services in the health insurance program even though operated as profitmaking private business enterprises.

The health insurance legislation creates the possibility of continuous development of cooperative and coordinative action between the public and private sectors in providing health insurance benefits to the elderly.

(*i*) *With others.*—The law provides for the periodic appointment of an Advisory Council on Social Security to review the status of the trust funds in relation to the long-term commitments and effectiveness of the program. The councils are made up of representatives of organizations of employers, employees, self-employed people, and the general public.

Specific provision is made in the health insurance amendments for the appointment by the Secretary of a Health Insurance Benefits Advisory Council and a National Medical Review Committee. The membership of the Health Insurance Benefits Advisory Council will include persons who are outstanding in fields related to hospital, medical, and other health activities. The Council will advise the Secretary on matters affecting the health insurance program. The membership of the National Medical Review Committee shall include individuals representative of organizations and associations of professional personnel in the field of medicine or related fields, and at least a majority of the members shall be physicians. The Committee will study the utilization of hospital and other medical care and services for which payment may be under the health insurance amendments and may make recommendations for changes in the administration of the program. Because of the nature of these functions it will be some time before this Committee is constituted.

In addition to the coordination specifically required by the law in establishing these two advisory groups, consultation with professional groups interested in the provision of medical care will proceed on a broad base through continuous contacts with professional groups and associations of groups, such as the American Medical Association, the American Hospital Association, the Life Insurance Association of America, the Blue Cross Association, the American Association of Hospital Accountants, and numerous others representative of physicians, nurses, hospitals, nursing homes, elderly persons, health insurance organizations, etc.

Continuous interchange of views between the SSA and these various interested groups creates the possibility of a vast, coordinated effort to achieve maximum results from the health insurance legislation on behalf of elderly citizens.

An Advisory Committee on Research Development, composed of outstanding social scientists, provides advice on the development of the research program and its relationship to the research activities

and objectives of academic and other groups. Such activities help to provide continuing coordination with the universities and stimulate scholarly interest in the study of social security.

An Advisory Committee on Health Insurance Benefits Research and Statistics has been established to advise the Office of Research and Statistics in the development of a comprehensive long-range research program. The committee is made up of people well known in the field of health insurance and public health.

8. Laws and regulations

(*a*) *Major social security (titles II and XVIII) legislation.*—

Public Law 271, 74th Congress, approved August 14, 1935 (49 Stat. 620). The Social Security Act of 1935.

Public Law 379, 76th Congress, approved August 10, 1939 (53 Stat. 1360). The Social Security Act Amendments of 1939.

Public Law 719, 79th Congress, approved August 10, 1946 (60 Stat. 978). The Social Security Act Amendments of 1946.

Public Law 379, 80th Congress, approved August 6, 1947 (61 Stat. 793). The Social Security Act Amendments of 1947.

Public Law 492, 80th Congress, passed over veto April 20, 1948 (62 Stat. 195). To exclude certain news vendors.

Public Law 642, 80th Congress, passed over veto June 14, 1948 (62 Stat. 438). To maintain status quo of employment and employment taxes.

Public Law 734, 81st Congress, approved August 28, 1950 (64 Stat. 477). The Social Security Act Amendments of 1950.

Public Law 590, 82d Congress, approved July 18, 1952 (66 Stat. 767). The Social Security Act Amendments of 1952.

Public Law 761, 83d Congress, approved September 1, 1954 (68 Stat. 1052). The Social Security Amendments of 1954.

Public Law 880, 84th Congress, approved August 1, 1956 (70 Stat. 807). The Social Security Amendments of 1956.

Public Law 85–840, approved August 28, 1958 (72 Stat. 1013). The Social Security Amendments of 1958.

Public Law 86–778, approved September 13, 1960 (74 Stat. 924). The Social Security Amendments of 1960.

Public Law 87–64, approved June 30, 1961 (75 Stat. 131). The Social Security Amendments of 1961.

Public Law 88–650, approved October 13, 1964 (78 Stat. 1075). Social security—Disability.

Public Law 89–97, approved July 30, 1965 (79 Stat. 286). The Social Security Amendments of 1965.

(*b*) *Regulations.*

1. Regulations No. 1: Disclosure of official records and information. Code of Federal Regulations, title 20, chapter III, part 401.

2. Regulations No. 4: Federal old-age, survivors, and disability insurance. Code of Federal Regulations, title 20, chapter III, part 404.

3. Regulations No. 22: Statements of procedure. Code of Federal Regulations, title 20, chapter III, part 422.

4. Regulations pertaining to the health insurance provisions of the Social Security Act are presently being drafted.

(*c*) *Appropriation authorizations.*—Authority for the total program rests in the Social Security Act, as amended. Authorization for the

payment of benefits and administrative costs for the old-age, retirement, and disability insurance programs from the trust funds is contained in title II, sections 201(g)(1) and 201(h) of the act. Authorization for the payment of benefit payments and administrative expenses for the health insurance program from the new trust funds is contained in title XVIII, section 1817(h) of the act.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

There can be little doubt that a program as comprehensive as OASDHI has a considerable impact on the American economy. It is the program most Americans look to as the major source of protection when work income is cut off or sharply reduced because of old age, death, or disability, or when health costs are high in old age. Thus the program contributes not only to individual economic security but to the overall economic stability of the Nation.

(*a*) *Effects on personal incomes of persons involved and on the distribution of personal income.*—Benefits under OASDHI in fiscal 1967 will amount to about $25 billion. For the retired, aged, or disabled workers and their families and for survivors, OASDHI benefits are the major source of continuing income. A nationwide survey of the aged made in 1963 showed, as had earlier surveys, that benefits under OASDHI are practically the only source of income for about a fourth of the beneficiaries—almost one-fifth of the aged couples and for more than one-third of the unmarried beneficiaries. While some 5 million aged beneficiaries had total incomes below the poverty level ($1,500 for a single person and $1,850 for a couple) in 1964, 5½ million were kept out of poverty by their social security benefits. Only about one-fourth of the beneficiaries had enough income from other sources to live above this level in the absence of social security benefits.

About three-fourths of those aged 65 and over are now receiving cash benefits under the OASDHI program, and an additional 10 percent can draw benefits when they or their husbands stop working. A large proportion of those not eligible for OASDHI are receiving public assistance. The new health insurance program together with the increased cash benefits under the 1965 amendments should somewhat decrease the need of aged persons for public assistance.

The health insurance protection for those 65 and over will not only assure better medical care for many older persons but will greatly ease the financial situation of younger families as well as of the aged persons themselves.

At the end of 1965, over a million workers aged 62 to 64 were drawing benefits under the early retirement provisions of the program; about a million disabled workers and their families and about 2½ million orphans and their widowed mothers were deriving support from the program. Surveys of disabled workers and of widows and children under OASDHI show a picture similar to that for the aged. Disabled workers have almost no earnings of their own and usually have little in other resources besides their OASDHI benefits. Fatherless families who receive OASDHI benefits are more financially secure than most other fatherless families because of the assured income the program provides. OASDHI benefits were the largest source of income for almost two-thirds of the survivor families in a 1963 survey.

There is practically universal agreement that the OASDHI program results in a redistribution of income. Income is transferred from those with current earnings to those with little or no earnings, from producing to nonproducing groups. With respect to an individual, income is transferred from periods when he is earning to periods when his earning capacity is eliminated or reduced. To the extent that these income transfers are offset by shifting of employer payroll taxes to consumers in the form of higher prices, the apparent redistribution is reduced, but such shifting is unlikely to eliminate income redistribution.

OASDHI benefits thus cannot be considered as entirely a net addition to the aggregate incomes of the beneficiaries, because of the possible shifting of payroll taxes forward to consumers and, in addition, because of the probability that beneficiaries would have other, however inadequate, sources of income in the absence of OASDHI. To the extent that relatives of beneficiaries do not need to support aged or otherwise dependent relatives because of OASDHI benefits, their standard of living is, of course, improved. Furthermore, no other source provides the kind of assured and continuing flow of income to beneficiary families, or the adjustments of benefit amounts to changing per capita income levels, that are characteristics of a broad social insurance program such as OASDHI.

The limit on taxable earnings under OASDHI does reduce the extent of the transfers from upper-income groups to other segments of the population. This limit and the absence of exemptions have the net effect, according to Margaret S. Gordon,[1] that OASDHI probably transfers income primarily from middle-income groups to lower- and lower-middle-income groups. One study which supports this generalization was made by Carroll.[2] Using 1958 data he arrives at an estimate that the OASDHI program resulted in a transfer of $4.5 billion from expenditure units with incomes of $3,000 or more to those with incomes of $3,000 or less. The largest shift, Carroll estimated, was from the $3,000 to $7,499 group to the $1,001 to $1,999 group, amounting to some $2.5 billion. There were, however, serious limitations on the methodology and assumptions underlying this study so that it should be regarded as suggestive rather than conclusive.

(*b*) *Effects on placement or productivity of workers, or both, and on their earnings.*—The effect of the OASDHI program has probably been to increase labor productivity, although there is no conclusive evidence that this is so. The knowledge by a worker that he will at least not face destitution in old age or if he becomes totally disabled, and that his family will not completely lack income if he should die, probably increases his sense of security and his efficiency. There is no evidence, at any rate, that the type of insecurity which the OASDHI program obviates contributes to higher productivity.

OASDHI may have contributed to improving productivity, according to Margaret S. Gordon,[3] through shifts in the structure of the labor force. In this interpretation, the decline in the labor-force participation rate of elderly men since 1940 is attributed, at least in part, to the availability of retirement benefits.

[1] Margaret S. Gordon, "The Economics of Welfare Policies," New York and London, Columbia University Press, 1963, p. 44.
[2] J. J. Carroll, "Alternative Methods of Financing Old-Age, Survivors, and Disability Insurance," Ann Arbor, Institute of Public Administration, University of Michigan, 1960. See table 22, p. 99.
[3] Op. cit., pp. 31-40.

However, instead of considering this withdrawal a depressant on real GNP, as some analysts have done, the viewpoint is taken that the withdrawal of elderly men from the labor force made possible a part of the accompanying increase in the employment of women and teenagers. In turn, the change in the composition of the labor force, which was probably due primarily to other factors—for example, the long-term growth of the service industries—had beneficial effects on productivity, largely because of the greater educational attainment of the younger workers. Related to this factor is the effect of OASDHI in enabling dependent beneficiaries to continue their schooling rather than being forced into the labor market.

To the extent that the OASDHI program is more likely to encourage labor mobility than private pension plans, it can be argued that the program increases productivity. That is, workers are, to some extent, more willing and able to change jobs or occupations because of the knowledge that their OASDHI benefit rights can go with them to a new job, unlike the majority of private employer benefit plans.

(*c*) *Effects on business or industrial organization and management.*—While it is difficult to discern any effect on general business structure or organization from the operation of the OASDHI, the program has stimulated demand for certain goods and services bought by elderly persons but correspondingly reduced demand for those things bought by taxpaying workers; the health insurance provisions of the 1965 act will surely increase the amount spent on medical care of elderly beneficiaries.

The movement of population to Florida and other areas with mild climates is one of the more conspicuous effects of OASDHI. The housing industry, in all areas, has benefited from the increased ability of many OASDHI recipients to maintain separate households instead of living with relatives, in rooming houses, or in institutions, as they would have been forced to do in the absence of OASDHI benefits. In what may be a partial offset, the new health insurance program seems likely to stimulate the establishment of nursing homes and other extended-care facilities.

No clear consensus has emerged as to the effect of the employer portion of the payroll tax. The tax constitutes a cost of doing business and therefore might be considered an encouragement to employers to introduce labor-saving machinery, particularly in labor-intensive industries. In practice, there is little evidence that the tax has had this effect. For one thing, it can be presumed that employers who are able to shift the tax either to their customers or employees will do so, and thus will not bear the real burden of the tax. Secondly, whether or not the tax is shifted, it amounts to such a small proportion of total labor costs that it is not likely to be a significant factor in employer decisions.

(*d*) *Effects on the stability, level, volume, or other aspects of employment, wages, costs, production, sales prices or other phases of economic activity.*—The Advisory Council on Social Security, which submitted its report to the Congress in January 1965, considered the economic impact of the program. The Council stated in its report:

> In important respects, the program supports consumer demand and helps to prevent deflation. Because of social security, 20 million retired people, disabled people, widows and orphans now have an assured regular income which, of course, continues undiminished even when other sectors of consumer income decline.

Moreover, the program operates automatically to compensate in part for the loss of income arising from the high rate of retirement that occurs when the general level of employment declines.

The OASDHI program operates to offset the effects of business cycles on the economy by the changes that take place in the relationship between benefits paid out and contributions received. In the downswing of the cycle, benefit payments increase because workers who are of retirement age or disabled are forced out of employment or into part-time employment. At the same time OASDHI taxes fall off because of the decline in employment and payrolls. Conversely, in an upswing persons eligible for retirement or disability benefits will be able to take advantage of increased employment opportunities and postpone retirement, while at the same time tax income will rise more rapidly than benefit payments because of expanding employment.

The operations of OASDHI may not be completely countercyclical, however, to the extent that the OASDHI trust funds have to liquidate their holdings of Government bonds in a downswing and increase their purchases of Government bonds in an upswing. The effect of selling bonds, for example, is to decrease the supply of loanable funds and raise interest rates; the reverse is true of buying bonds. These effects can be, and probably will be, offset by monetary policy, but they tend to make the task of monetary policy that much more difficult.

As the program becomes larger, its cyclical effect, both on aggregate demand and on the capital markets, will become more significant. However, the question of the cyclical impact of OASDHI has been rendered less topical by the ability of the economy to grow without cyclical fluctuations since the mild recession of 1960–61. Possibly a more important criterion by which to evaluate the program is its effect on consumption and savings patterns.

The weight of evidence indicates that the OASDHI program has a stimulating effect on aggregate consumption because of the redistribution of income toward low-income groups, and their tendency to spend larger proportions of current income than the population as a whole. This stimulating effect operates even when benefits and contributions are in balance; when benefits exceed contributions its effect is reinforced.

With respect to the concern expressed in earlier years about the alleged deflationary effect of trust fund accumulations, it should be noted that the OASDHI program showed an excess of benefits over contributions in 4 of the 7 years from 1958 through 1964—1958, 1959, 1961, and 1962 during which the economy experienced underemployment of resources and unemployment levels higher than desirable. This behavior was the reverse of that in the early 1950's, when the program was taking in more than it paid out, an action appropriate for that period. Estimates for 1965 also show a deficit, but a substantial surplus is expected in 1966 and succeeding years, under present assumptions. To the extent that inflationary tendencies do develop in these years, the operations of OASDHI itself will tend to offset them. The effect of the OASDHI program is only a small part of the total inflationary or deflationary effect of Federal Government operations on the economy, however.

(*e*) *Any benefits (not included above) resulting from the program.*—In addition to the direct benefits of the OASDHI program to the recipi-

ents and the economy at large, the program has also produced indirect benefits in the form of savings in other programs. The decline in the number of recipients of old-age assistance is a matter of record; from a peak of 2.8 million in 1950, the number of these recipients had fallen to about 2.2 million at the end of 1964, in spite of an increase in number of the aged. The number of recipients of most other public assistance programs has increased, except for general assistance, which has shown no trend during the postwar period, allowing for cyclical variations. The cost of public assistance programs has increased, even in the case of old-age assistance, but the cost of these programs, in the absence of OASDHI, would certainly have increased much more than they did in fact increase.

One of the groups in our society that may have benefited most directly from the program has been the aged Negro. As a result of certain provisions of the program the aged Negro, for the first time in his life, may find that his income more closely approximates that of his fellow white American than at any time during his working lifetime. OASDHI benefits are the primary source of support for the aged Negro, as well as for the aged white person.

Although the generally lower earnings of Negroes mean that they draw, on the average, less than white workers, the fact that the benefit formula is more generous to workers with low earnings results in the Negro beneficiary receiving more in terms of what he and his employer have paid into the system and as a proportion of the wages replaced.[4]

The existence of OASDHI has also resulted in relieving the burden on relatives of supporting the aged, the disabled, or dependent children, as mentioned in an earlier section. The new health insurance program will do much to relieve relatives of the burden of providing help for meeting the heavy costs of major illnesses that befall their aged relatives.

(*f*) *Pertinent geographical differentials.*—Apart from such conspicuous geographical impacts of OASDHI as the concentration of retirees in certain areas of the country, geographical differences in the impact of the OASDHI program are much more difficult to discern. Nevertheless, the program can be presumed to have some degree of differential impact on different areas of the country because of the income redistribution effects already mentioned and the fact that income levels and population characteristics do vary interregionally. That is, areas with lower-than-average income levels are probably benefited more than those with above-average incomes, and areas with a higher-than-average proportion of retirees derive more benefits, net, than areas with a smaller proportion of retirees and other dependent groups. A recent study indicated that the Southern States, compared with other regions, have a relatively greater proportion of disabled workers qualifying for disability insurance benefits than of workers insured for benefits.

One specific impact of the program has probably been to support the economies of those economically depressed areas which are characterized by higher-than-average proportions of dependents, and from which those in the productive age groups have emigrated.

(*g*) *The measurable contribution of the program to either the magnitude or the rate of growth of the gross national product.*—It has not been possi-

[4] Mollie Orshansky, "The Aged Negro and His Income," Social Security Bulletin, February 1964.

ble to measure in any exact way the contribution of the program to either the magnitude or the rate of growth of the GNP. To the extent that the OASDHI program has increased worker productivity, as described in section (*b*), it has contributed to the growth of the economy.

The effect of the OASDHI program on aggregate savings is even less determinable than its effect on productivity. In this connection, a recent study, supported in part by a Social Security Administration research grant, seems to indicate that contributors to private pension plans (essentially all of whom are also covered by OASDHI) save more at each income level than those who are not contributors.[5] To what extent OASDHI alone has a similar effect is not known. The experience of Western Europe, where the proportion of national income devoted to OASDHI-type programs is much higher than in the United States,[6] suggests that large spending on such programs is at least not inconsistent with rapid growth rates.

10. Economic classification of program expenditures. (See table 2.)

Program: Old-age, survivors, disability, and health insurance.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Social Security Administration.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government: [1]	
Purchases of goods and services:	
Wages and salaries	[2] 314
Other	68
Transfer payments to individuals (benefit payments)	16,618
Total Federal expenditures	17,000

[1] Amounts shown are for benefit payments and for administrative expenses for the Social Security Administration salaries and expenses and construction appropriations and administrative costs incurred by the Office of the Secretary, DHEW, and by the Treasury Department that are charged to the trust funds.
[2] Includes administrative costs for wages and salary and other amounting to $3 million incurred by the Office of the Secretary and $53 million incurred by the Treasury Department.

[5] George Katona, "Private Pensions and Individual Savings." Survey Research Center Institute for Social Research, the University of Michigan (Monograph 40), 1965, p. 90.
[6] "Economic Policies and Practices: European Social Security Systems" (Paper No. 7), Joint Economic Committee Print, 89th Cong., 1st sess., p. 11.

Welfare Administration

CONTENTS

Bureau of Family Services—Grants to States for Public Assistance

Part I. Description of the Program

1. Objectives

The purpose of Federal grants-in-aid for public assistance is to help the States establish and maintain statewide programs under which families and individuals may receive financial assistance to enable them to secure the necessities of life; and social services to help them to maintain and strengthen family life and to develop their maximum potential for self-support and self-care.

2. Operation

Grants to States are based on State plans submitted for each program, old-age assistance, medical assistance for the aged, aid to families with dependent children, aid to the blind, and aid to the permanently and totally disabled. These plans must be approved by the Welfare Administration as meeting the requirements of the Social Security Act. To be approved, the State plan must be in operation throughout the State. The State must share in the cost, and a single State agency must administer the plan or supervise administration by local units of government. The aid must be given in money directly to the needy person or to his judicially appointed legal representative, except that the State agency may pay doctors, hospitals, and other suppliers of medical care for medical services they provide to needy recipients. The State agency must provide, if requested, a fair hearing for any person whose application for aid is denied or whose payment is decreased or stopped. These requirements of the Federal law are intended to insure that Federal money is used equitably and for the purpose for which Congress appropriates it.

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3. History

Federal legislation and expenditures.—In 1935, the Social Security Act authorized Federal grants to States to pay part of the costs of aiding people who are old (title I) or blind (title X) and children who have been deprived of parental support or care (title IV). In 1950, Congress added Federal grants to States to help people who are permanently and totally disabled (title XIV).

Amendments adopted in 1960 authorized Federal grant-in-aid for medical assistance for the aged (MAA), which was established as an additional program under title I.

Under the public welfare amendments of 1962, the Congress adopted a series of amendments, including among others, one which placed greater emphasis than hitherto on the social service aspects of the assistance programs and provided a higher rate of Federal financial participation in State and local costs of providing social services that are prescribed by the Secretary to deal with some of the most serious social problems frequently associated with financial dependency.

In addition to the changes described above, the Congress has made 11 major changes in the formula for determining the Federal share of assistance payments. Each of these changes provided for a higher rate of Federal financial participation in assistance payments.

The rise in Federal expenditures that followed each of these changes in the Federal share is shown in Trend Report, "Graphic Presentation of Public Assistance and Related Data," published by the Welfare Administration, Bureau of Family Services, December 1964.

The factors underlying the increase in Federal expenditures that occurred between 1950 and 1964 are analyzed in appendix I. For year to year changes see the Trend Report.

Appendix II shows the annual amounts expended by source of funds, from 1936 through 1965.

State and local operations.—As of August 31, 1965, 54 jurisdictions including all the States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands were administering old-age assistance, aid to families with dependent children, and aid to the blind under approved plans; 53 were administering aid to the permanently and totally disabled; and 47 States had plans approved for medical assistance for the aged.

Under the provisions of the public assistance titles of the Social Security Act, the States determine the level at which the need for financial assistance and other services is to be met. This determination reflects both the fiscal ability and willingness of a State to provide the non-Federal share of the costs of the programs. The variations among States in the number of people who receive assistance and the amounts they receive, therefore, do not reflect actual differences in need as determined against a uniform standard either for assistance or for other eligibility requirements. In general, where need is greatest, fiscal ability is limited and assistance standards tend to be low.

Over the years some progress has been made in removing restrictive eligibility requirements and in raising assistance standards so that more needy people can receive assistance. In 1965, however, only a handful of States had assistance standards that would permit assistance recipients to live at the "economy level," which is roughly comparable to the amount required to move people above the poverty

level. Thus the majority of people who receive assistance are living below the poverty level, even after they receive assistance.

Appendix III describes national program trends. For year-to-year changes in numbers of recipients, see Trend Report, pp. 53 and 54.

Appendix IV is a chart showing State detail on recipient rates. For national trend data, see Trend Report, pp. 55 and 56.

Appendix V is a chart showing State detail on average monthly payments per recipient. For national trend data, see Trend Report, pp. 67 and 68.

Appendix VI is a chart showing State detail on expenditures per inhabitant for assistance payments.

Appendix VII is a chart showing State detail on State-local fiscal effort for the federally aided public assistance programs and for general assistance, which is financed entirely from State-local funds.

4. Level of operations. (See table 1.)

Program: Grants to States for public assistance.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Bureau of Family Services.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program	Average monthly number of recipients of assistance	6,986,800	7,336,200	7,635,900	7,808,800
(b) Applicants or participants: State government agencies	State agencies to which grants are made	[1] 58	[1] 58	[1] 58	[1] 58
(c) Federal finances: Unobligated appropriation available					
Allotments or commitments made (specify) (millions)	Federal share of total expenditures for the year for assistance payments and administration, services, and training.	$2,943.4	$3,179.5	$3,599.5	$3,769.4
(d) Matching or additional expenditures for the program (specify nature of entries) (millions).	Non-Federal share of total expenditures for assistance payments and administration, services, and training.	$2,007.1	$2,261.8	$2,507.6	$2,497.3
(e) Number of Federal Government employees administering, operating, or supervising the activity, total	Man-years	403	449	516	636
Program policies and standards	do	103	123	142	186
Review State plans and grants, evaluate State operations.	do	222	246	288	351
Research and statistics	do	43	46	50	53
Administration	do	35	34	36	41
(f) Non-Federal personnel employed in the progam	Estimated number in June	74,000	80,000	87,000	95,000

(g) Other measures of level or magnitude of performance:					
Total expenditures (sum of (c) and (d) above) as percent of GNP.	0.8	0.8	0.9	0.9
Recipients in June: [2]				
OAA:				
Number	2,182,000	2,149,200	2,144,500	2,131,500
Rate per 1,000 population 65 years and over	121	117	116	113
MAA:				
Number [2]	411,200	675,000	859,000	860,000
Rate per 1,000 population 65 years and over	23	37	46	46
AFDC:				
Number [3]	4,214,800	4,429,000	4,525,400	4,652,300
Rate per 1,000 population under 18 [3]	44	46	47	48
AB:				
Number	97,400	95,300	94,500	93,000
Rate per 100,000 population aged 18 and over	81	78	76	74
APTD:				
Number	501,400	555,500	581,500	632,000
Rate per 1,000 population aged 18 to 64	4.9	5.3	5.5	5.9

[1] 4 States have separate State agencies for the administration of aid to the blind.

[2] For programs other than MAA, recipients in June for fiscal years 1964 and 1965; for 1966 and 1967, average monthly number included in budget request. For MAA, estimated annual number of different recipients.

[3] Includes both adults and children; rate based on number of children.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

(*a*) *Pending legislative proposals.*—None.

(*b*) *Proposed administrative and organizational changes.*—None.

(*c*) *Probable changes in conditions under which the program will function in 1970.*—Not answered.

7. Coordination and cooperation

(*a*) *Within Bureau.*—The programs of the Bureau require continuous internal coordination so that the members of families served by its federally aided programs may be strengthened in their social functioning, and in their efforts toward self-support and self-care. In addition to the overall coordination and cooperation now existing among the divisions of the Bureau, the following opportunities for broader coordination are presented currently:

(1) Between medical care and maintenance programs, particularly since the advent of 1965 legislation which greatly broadened the scope of the medical care and services that can be made available to recipients of public welfare programs.

(2) Between social services and community planning programs. This is indicated if we are to achieve the greater utilization of community resources required of the States as they broaden their scope of services under the 1962 Public Welfare Amendments and other legislation.

(3) Between staff development and social services to enhance the effectiveness of personnel providing services.

(*b*) *With other units of the Department.*—As provided by law, there is longstanding collaboration, coordination, and cooperation between the Bureau of Family Services and other units of the Department of Health, Education, and Welfare. Some of the collaborative efforts, such as joint publications and agreements to prevent duplication and bring about greater utilization of services, are:

(1) With the Vocational Rehabilitation Administration around rehabilitation and self-support.

(2) With the Children's Bureau around health and social service.

(3) With the Public Health Service around physical and mental health.

(4) With the Social Security Administration around economic maintenance.

(5) With the Administration on Aging around program planning for the aging population.

(6) With the Office of Juvenile Delinquency and Youth Development around juvenile delinquency and youth development programs.

(7) With the Office of Education around such educational programs as vocational education, consumer education, home economics, and job training as related to title V of the Economic Opportunity Act administered by Bureau of Family Services.

(*c*) *With other Federal Government departments or agencies.*—The Bureau of Family Services coordinates its program with other Federal Government departments or agencies in all instances when it is appro-

priate to do so. The exchange of program data and information increases interagency awareness of each program. This in turn makes for program planning by each agency that is better coordinated with the broad range of programs which come under the cognizance of other Federal Government departments or agencies. Another means by which the Bureau of Family Services cooperates with other Federal Government departments is to have staff members serve on interdepartmental committees and task forces. This, too, facilitates program planning that is better coordinated with the programs of other Federal agencies. Examples of other Federal departments with which the Bureau of Family Services maintains close liaison are the following:

(1) Department of Agriculture, which conducts donated foods and food stamp programs of direct benefit to large numbers of public welfare recipients.

(2) Department of Housing and Urban Development, which has responsibility for public housing, urban renewal, and loans for home improvements, all of which affect public welfare recipients and other low-income groups.

(3) Department of State, with which the Bureau of Family Services cooperates in carrying out its repatriation program, and through representation in the International Office of the Welfare Administration.

(4) Department of Labor, which, through the Bureau of Labor Statistics, maintains up-to-date information on family living costs; and with which the Bureau of Family Services works in coordinating the work experience program under title V of the Economic Opportunity Act.

(5) Office of Economic Opportunity in relation to work experience programs and other programs under the Economic Opportunity Act.

(*d*) *With State governments or their instrumentalities.*—By law, the programs which the Bureau of Family Services administers can either be State administered or locally administered and State supervised. In either event, coordination and cooperation between the Bureau of Family Services and State governments or their instrumentalities is basic. Some of the methods used to bring about coordination between Federal and State efforts in the public assistance programs are:

(1) Consultation by Bureau of Family Services staff upon request from the States.

(2) Review of State programs by Bureau of Family Services staff.

(3) Conducting of joint institutes, workshops, and conferences with State staff.

(4) Representation of State staff on Federal committees and work groups.

(5) Written communication between State staff and Bureau of Family Services staff, both at the central and regional office levels.

(*e*) *With local governments or communities.*—The law puts the Bureau of Family Services into direct relationships with the States, which bear responsibility for administering or supervising statewide programs. Although the Bureau of Family Services has an indirect relationship to local welfare departments, and generally relates to

them only through the State level, coordination and cooperation with the local agencies may be brought about through any of the methods described in 7(*d*) above, but geared at the local level.

(*f*) *With nonprofit organizations or institutions.*—The Bureau of Family Services recognizes that a successful public welfare program involves collaboration with voluntary organizations. It maintains ongoing liaison with numerous national voluntary organizations for the purpose of mutual exchange of information about program developments. Some of the national voluntary agencies with which the Bureau of Family Services maintains active liaison are the following:

(1) Family Service Association of America.
(2) Child Welfare League of America.
(3) American Public Welfare Association.
(4) American Home Economics Association.
(5) Council on Social Work Education.
(6) National Study Group on Coordination of Social Service Statistics.
(7) National Association of Housing and Redevelopment Officials.
(8) National Association of Services to Unmarried Parents.
(9) National Association of Social Workers.
(10) National Conference on Social Welfare.
(11) National Council on Aging.
(12) National Social Welfare Assembly.

(*g*) *With business enterprises.*—The nature of the main thrust of the Bureau of Family Services is public assistance under the Social Security Act. This does not require a direct relationship between the Bureau of Family Services on the Federal level and business enterprises as such.

8. Laws and regulations

(1) Old-age assistance and medical assistance for the aged: Social Security Act (Public Law 271), 74th Congress, August 14, 1935, titles I and XI, as amended (42 U.S.C. 301 et seq. and 1301 et seq.); Public Law 474, 81st Congress, section 9 (relating to Navajo and Hopi Indians) (25 U.S.C. 639).

(2) Aid and services to needy families with children: Social Security Act (Public Law 271), 74th Congress, August 14, 1935, titles IV and XI, as amended (42 U.S.C. 601 et seq. and 1301 et seq.); Public Law 474, 81st Congress, section 9 (relating to Navajo and Hopi Indians) (25 U.S.C. 639).

(3) Aid to the blind: Social Security Act (Public Law 271), 74th Congress, August 14, 1935, titles X and XI, as amended (42 U.S.C. 1201 et seq. and 1301 et seq.); Public Law 474, 81st Congress, section 9 (relating to Navajo and Hopi Indians) (25 U.S.C. 639).

(4) Aid to the permanently and totally disabled: Social Security Act (Public Law 271), 74th Congress, August 14, 1935, title XIV as added August 28, 1950, Public Law 734, 81st Congress, and title XI, as amended (42 U.S.C. 1351 et seq. and 1301 et seq.).

(5) Aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged: Social Security Act (Public Law 271), 74th Congress, August 14, 1935, title XVI as added July 25, 1962, Public Law 87–543, and title XI, as amended (42 U.S.C. 1381 et seq. and 1301 et seq.).

(6) Medical assistance programs: Social Security Act (Public Law 271), 74th Congress, August 14, 1935, title XIX as added July 30, 1965, Public Law 89–97 (42 U.S.C. 1396–1396d), and title XI, as amended (42 U.S.C. 1301 et seq.).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) *Effects on personal incomes of persons served or involved and on the distribution of personal income:*—The incomes of public assistance recipients tend to place these individuals in the lowest income strata Income resources outside of the public assistance payments themselves are meager. The situation is summarized from the recent national surveys of the four programs:

(1) The 1960 study of old-age assistance recipients revealed that the average income from all sources for OAA recipients was $974 a year, of which 77 percent came from the OAA payment, 16 percent from OASDI benefits, less than 1 percent from earnings of recipients, and 6 percent from other sources.

(2) Aid to the blind recipients, according to the 1962 survey in that program, averaged $1,109 a year in income from all sources—79 percent from AB payments, 11 percent from OASDI, 5 percent from earnings (including those earnings which, under the law, are disregarded in determining the assistance payment), and 5 percent from other sources.

(3) Recipients of aid to the permanently and totally disabled, according to the 1962 survey, averaged $913 in total income—85 percent from APTD payments, 9 percent from OASDI, and 6 percent from other sources.

(4) From the 1961 survey of families receiving aid to families with dependent children (these families including, on the average, one parent and three children) it is known that the average annual family income was $1,677, of which 81 percent came from AFDC payments, 7 percent from earnings of recipients, 3 percent from OASDI benefits, and 9 percent from all other sources.

(*b*) *Effects on the placement or productivity of workers, or both, and on their earnings.*—Self-support has been identified as one of the significant social purposes of the 1962 service amendments to the public assistance titles of the Social Security Act. The Bureau of Family Services has worked with individual States to implement this goal. Since States generally have not yet reached the full scope of service toward which they are working for July 1, 1967, or thereabouts, it is not yet possible to fully assess the effects of the social service amendments on productivity and earnings.

A preliminary report from 78 counties showed the following highlights concerning services that were provided monthly to approximately 48,000 AFDC families and 12,700 aged, blind, or disabled persons, making a total of 60,700 cases.

(1) Services for self-support and to strengthen family functioning were predominant.

(2) Tabulations based upon 70 of the reports with comparable data showed:

4,700 adult and AFDC cases with improved potential for self-support, with 190 individual children directly benefiting from services.

2,750 adult and AFDC cases in which clients secured employment, with 1,360 individual children directly benefiting from services.

1,500 adult and AFDC cases secured vocational preparation, with 158 individual children directly benefiting from services.

As indicated, the majority of the reports concerned services for self-support with considerable emphasis on training for employment. This emphasis appears largely responsible for the reported total monthly reduction in assistance payments of approximately $700,000 due to terminations and reductions of assistance for cases served.

(*f*) *Pertinent geographic differentials.*—Nationwide [1] 13 percent of the aged population (persons 65 years of age and over) are recipients of public assistance—old-age assistance or medical assistance for the aged. (June 1965 data.) However, the several regions of the Nation vary widely in the extensiveness of this aid. In the Middle Atlantic States (New York, Pennsylvania, and New Jersey) fewer than 5 percent of the aged receive assistance; in the East North Central States only 7 percent, and in New England only 11 percent received aid. By contrast, high proportions of the aged population in the Deep South States receive assistance—32 percent in the East South Central and 28 percent in the West South Central States. Other areas have medium rates: In the Mountain States 18 percent of the aged population receives aid; in the Pacific States, 17 percent; and in the West North Central and South Atlantic areas, 13 percent.

In AFDC, too, there are large regional variations, but the pattern is quite different from that of the programs for the aged. Whereas in the Nation as a whole 4.6 percent of all children under 18 receive AFDC (June 1965 data), the rate ranges from 3.3 percent in the West South Central census division to 3.7 percent in the West North Central States, 3.8 percent in the East North Central States, 4 percent in New England and in the mountain area, 4.3 percent in the South Atlantic States, 5 percent in the East South Central States, 5.6 percent in the Middle Atlantic States, and a high of 5.8 percent in the Pacific census division.

There is a marked contrast between the types of places in which AFDC recipients are most typically found and those in which adult assistance recipients are mostly concentrated. The 1961 AFDC survey showed that 6.3 percent of all children living in the central cities of standard metropolitan statistical areas were recipients of AFDC. In the nonmetropolitan counties rates were much lower—3.9 percent in the cities and towns, 4.1 percent in rural nonfarm places, and 2.7 percent among children living on rural farms. The lowest rate of all was in the suburban metropolitan areas—1.7 percent. For old-age assistance the highest rates, according to the 1960 study of that program, were in nonmetropolitan counties. Of all persons aged 65 and over, 19 percent of those in the cities and towns of nonmetropolitan counties were receiving OAA, as were 21 percent of those in rural nonfarm areas and 18 percent of those living on farms. As for the aged population of the standard metropolitan areas, only 13 percent of those living in the central cities were receiving OAA

[1] Rate per 1,000 for MAA included in this total includes only those on whose behalf payments were made in June 1965. Rate shown for MAA in table 1, above, is based on annual number of different individuals aided.

and only 6 percent of those living in suburban areas received it. The patterns of recipient rates by type of place of residence for aid to the blind and aid to the permanently and totally disabled were found, in the 1962 studies of those two programs, to be very similar to the pattern for OAA.

10. Economic classification of program expenditures. (See table 2.)

Program: Grants to States for public assistance.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Bureau of Family Services.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government: Grants to State and local governments	3,179.5
Total Federal expenditures	[1] 3,179.5
Non-Federal expenditures financed by: State and local governments	2,261.8
Total expenditures for program	5,441.3

[1] Represents expenditures for the fiscal year 1965. Federal expenditures in the fiscal year 1965 were $3,059.5 million. See "Appendix to the Budget for Fiscal Year 1967," pp. 507 and 508.

(Appendixes I–VII on grants to States for public assistance follow.)

APPENDIX I

PUBLIC ASSISTANCE: FACTORS UNDERLYING NET INCREASE IN FEDERAL FUNDS BETWEEN FISCAL YEARS 1950 AND 1964

In 1964 the Federal share of public assistance costs amounted to more than $2.9 billion ($2,941,656,000) or 59.7 percent of the total expended for the federally aided categories. Fourteen years earlier, the Federal Government contributed only $1.1 billion or 51.6 percent of the total costs of such programs. Thus both the total amount and the rate of Federal financial participation have gone up substantially within the 14-year period.

Of the increase of $1.8 billion ($1,845,869,000) in the Federal amount, all but about $105 million can be attributed to Federal legislation that established new programs and services or changed the formulas for computing the Federal share of assistance.

Of the total increase of $1.8 billion, more than five-eighths (64 percent) was for programs or services that have been established under successive amendments to the Social Security Act. The costs for these new services and programs were $1,174 million in 1964 (line 2, col. 1 of table below).

The rest of the increase—$671.9 million (line 3)—represents the rise over the 14-year period in the costs of programs and services that were in operation in both 1950 and 1964. During this period, the number of old-age assistance recipients declined because most older people now receive insurance benefits; and the number of children assisted rose primarily because of the increase in the child population. The net effect of fewer old-age assistance recipients and more child recipients was a decline of $26.1 million (line 3A) in total costs due to changes in the number of recipients. This decline of $26.1 million offset in part the increase of $698 million (line 3B) that was required to finance higher average payments per recipient in 1964.

All but an estimated $135 million of the increase of $698 million for the rise in average payments was the result of congressional liberalizations in the formula for computing the Federal share of assistance payments. Of the total increase of $698 million (line 3B), about $326.1 million (line 3B1) was needed to keep up with the rise in cost of living. The balance of $371.9 million (line 3B2) represented amounts available for actual increases in allowances for food, clothing, and shelter.

A brief explanation of the factors underlying changes in Federal funds for assistance payments for the programs of old-age assistance, aid to families with dependent children, and aid to the blind and in the Federal share of State and local administration for all programs combined follows.

Old-age assistance.—The increase of almost $261 million (line 1, col. 5) in expenditures from Federal funds for assistance payments represents the net effect of a rise of $449 million (line 3B) because of an increase in the Federal amount per recipient and a decrease of $188 million (line 3A) as a result of a drop in the number of recipients. The change in the Federal amount per recipient was due almost entirely to congressional changes in the formula for computing the Federal share of assistance payments. The decrease due to a decline in the number of recipients reflects primarily a sharp drop in the proportion of the aged population receiving assistance as a result of the expansion of the number of persons getting OASI benefits.

In order to estimate the separate effects on the old-age assistance program of (1) growth in the population and (2) change in recipient rate (number of recipients per 1,000 aged persons in the population), it is necessary to examine: (*a*) What would have happened to Federal expenditures if only the increase in population had occurred and there had been no change in the recipient rate between 1950 and 1964; and (*b*) what would have happened to Federal expenditures if only the recipient rate had changed and there had been no change in the population between 1950 and 1964.

Our calculations show that given the circumstances under (1) above, costs would have risen by $377 million (line 3A1), and under (2) above they would have gone down by $565 million (line 3A2). The net effect of the $565 million decrease due to a drop in recipient rate and the $377 million increase as a result of the growth in the aged population was a decrease in costs of $188 million (line 3A).

The increase in the Federal amount per recipient between 1950 and 1964 resulted in an increase of $449 million (line 3B). Part of this increase helped the States to meet the rise in the cost of living (line 3B1), and the rest enabled them to improve their assistance standards (line 3B2).

Aid to families with dependent children.—Between 1950 and 1964 Federal funds for assistance payments for the same program coverage and services as in 1950 went up $330 million (line 1, col. 6). Included in this amount are increases of $162 million (line 3A) for a rise in the number of children receiving assistance and $168 million for a higher Federal amount per recipient.

An examination of the effect of the growth of the child population and the increase in recipient rate is given below.

1. If only the child population had gone up between 1950 and 1964 and there had been no change in the recipient rate between the 2 years, Federal costs would have risen by $106 million (line 3A1).

2. If only the recipient rate had gone up and there had been no change in the child population between 1950 and 1964, Federal funds would have gone up by $56 million (line 3A2). As a result of the combined effect of the rise in the recipient rate and the increase in the child population, the cost due to change in recipients went up by $162 million (line 3A).

The increase in the Federal share of the average monthly payment amounted to $168 million. Of this total, $117 million (line 3B1)—about seven-tenths—was needed to keep up with the rise in the cost of living; and $51 million was available to raise assistance standards.

Aid to the blind.—The rise of almost $14.5 million (line 1, col. 7) in expenditures from Federal funds reflects a decrease of about $0.6 million (line 3A) as a result of the change in number of recipients and $15.1 million (line 3B) in the Federal amount per recipient.

The effect of an increase in the population 18 or more years of age and a decline in the proportion of that population that received assistance can be analyzed separately. It is necessary to examine (1) what would have happened to Federal funds if only the population 18 or more years old had risen and there had been no change in the recipient rate between 1950 and 1964; and (2) what would have happened to Federal expenditures if only the recipient rate had gone up and there had been no change in the population between 1950 and 1964.

Our calculations show that given the circumstances under (1) above, Federal funds would have gone up by $4.5 million (line 3A1), and under (2) above they would have gone down by $5.1 million (line 3A2). The decrease in cost because of the decline in recipient rate was more than sufficient to offset the increase due to population growth, and there was a net decrease of $0.6 million.

The rise in the Federal share of assistance payments amounted to $15.1 million (line 3B). About two-fifths of this increase—$6.5 million (line 3B1)—was needed to keep up with the rise in the cost of living. The remainder of $8.5 million (line 3B2) represented real increases in the amounts for items included in the budget for recipients.

Cost of State and local administration.—The Federal share of the costs of operating the State and local welfare agencies for the same program coverage and services as in 1950 went up by $66.3 million (line 1, col. 9) between 1950 and 1964. This amount reflects an insignificant decline because of an overall net reduction in the number of recipients and a rise in the Federal share of the administrative cost per case per month.

In order to estimate the separate effects on administrative costs of (1) changes in the number of cases and (2) the change in the cost of administration per case per month, it is necessary to examine:

1. What would have happened to Federal funds if only the number of cases changed and there had been no change in the cost of administration per case per month between 1950 and 1964; and

2. What would have happened to Federal expenditures if only the Federal cost per case-month had gone up and there had been no change in the number of cases between 1950 and 1964.

Using the assumptions outlined under (1) above, costs would have gone down insignificantly ($30,000) because the reduction of $8.2 million in old-age assistance and an insignificant reduction in aid to the blind due to a decline in the number of cases slightly more than offset a rise in costs for aid to families with dependent children ($8.2 million) that occurred because of larger caseloads in that program.

(2) Under the assumptions outlined under (2) above, the cost would have risen by $66.3 million (line 3B) for all three programs. That the increase in the cost of administration per AFDC case per month was the largest is to be expected because of the greater complexity of establishing eligibility for this program, particularly when eligibility is based on the absence of the father from the home. Of the total increase of $66.3 million, because of the rise in the cost of administration per casemonth, $17.4 million (line 3B1) was needed to keep up with rising prices. The balance of $49 million (line 3B2) was used for two purposes: (1) to raise the comparatively low salaries of employees of State and local agencies in an attempt to compete with other employers in the community; and (2) to reduce work loads of caseworkers and supervisors so that more time per case would be available to determine initial and continuing eligibility for assistance.

Public assistance: Factors underlying net increase in Federal funds between fiscal years 1950 and 1964

[Amounts in thousands]

Program	Total increase in Federal funds for assistance and administration		Change in Federal share of assistance payments					Increase in Federal share of State and local administration	
	Amount (sum of cols. 3, 4, 8, and 9)	Percentage distribution	New programs included in 1964 but not in 1950	Additional 1964 costs associated with 1950 program coverage and services				New programs included in 1964 but not in 1950	Total additional 1964 costs associated with 1950 programs
				Total (sum of cols. 5, 6, and 7)	OAA	AFDC	AB		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1. Total [1]	$1,845,869	100.0	+$1,058,411	+$605,592	+$260,934	+$330,184	+$14,474	+$115,571	+$66,295
2. New programs or services included in 1964, as a result of new Federal legislation, but not in 1950, total	1,173,982	63.6	+1,058,411					+115,571	
A. APTD	276,342	15.0	+252,880					+23,462	
B. MAA	208,361	11.3	+195,955					+12,406	
C. A needy AFDC adult excluding UP	164,482	8.9	+164,482						
D. Additional State plans [2]	5,377	.3	+5,114					+263	
E. Guam, Puerto Rico and Virgin Islands	10,174	.5	+8,235					+1,939	
F. Vendor medical payments [3]	359,498	19.5	+340,622					+18,876	
G. AFDC-UP excluding 2d parent	71,259	3.9	+66,069					+5,190	
H. 2d AFDC parent including UP	25,054	1.3	+25,054						
I. 75 percent participation in social services and training	53,435	2.9						+53,435	

3. Program coverage and services as in 1950, total	671,887	36.4		+605,592	+260,934	+330,184	+14,474		+66,295
A. Change in number of recipients, total	−26,129			−26,099	−187,599	+162,083	−583		−30
(1) Due to population growth				+487,656	+377,379	+105,764	+4,513		
(2) Due to change in rate per 1,000 population				−513,755	−564,978	+56,319	−5,096		
B. Change in amount per recipient, total	[4] 698,016			[4] +631,691	+448,533	+168,101	+15,057		+66,325
(1) Amount needed to give effect to changes in price levels	326,114			+308,754	+185,467	+116,754	+6,533		+17,360
(2) Other	371,902			+322,937	+263,066	+51,347	+8,524		+48,965

[1] Represents difference between actual expenditures of $2,941,656,000 in 1964 and $1,095,787,000 in 1950.
[2] Extension of Federal participation to aid to the blind programs in Pennsylvania and Missouri.
[3] In programs of OAA, AFDC, and AB.
[4] Primarily due to liberalizations in Federal matching formula. All but about $135,000,000 is the result of changes in the formula for computing the Federal share of assistance payments.

Source: Department of Health, Education, and Welfare: Welfare Administration; Bureau of Family Services; Division of Program Statistics and Analysis, Feb. 16, 1965.

APPENDIX II

ASSISTANCE AND ADMINISTRATION BY SOURCE OF FUNDS, FISCAL YEARS 1936 TO DATE

Public assistance: Expenditures for assistance payments and administrative costs, by source of funds, fiscal years 1936–64

[All States. Beginning 1951, includes vendor payments for medical care. Dollar amounts in thousands.]

Fiscal year	Total				Assistance					Administration [1]			
	All funds	Federal funds	State funds	Local funds	All funds	Federal funds		State funds	Local funds	All funds	Federal funds	State funds	Local funds
						Amount	Percent						
1936 [2]	$349,892	$20,202	$314,773	$14,971	$320,883	$19,178	6.0	[3] $286,788	[3] $14,917	[4] $29,009	$1,024	[4] $27,985	(4)
1937	779,213	142,568	593,666	42,979	717,664	135,313	18.9	[3] 539,372	[3] 42,979	[4] 61,549	7,255	[4] 54,291	(4)
1938	990,496	212,484	719,054	58,958	913,880	201,400	22.0	[3] 653,522	[3] 58,958	[4] 76,616	11,084	[4] 65,532	(4)
1939	1,101,605	244,294	785,650	71,662	1,017,824	231,359	22.7	[3] 714,804	[3] 71,662	[4] 83,781	12,935	[4] 70,846	(4)
1940	[5] 1,123,660	279,404	551,968	291,262	1,038,991	266,667	25.7	510,647	261,676	[5] 84,669	12,736	41,321	$29,586
1941	[5] 1,107,405	333,474	505,559	268,370	1,011,185	315,293	31.2	463,552	232,341	[5] 96,221	18,183	42,007	36,029
1942	[5] 1,060,589	373,520	457,805	229,263	969,299	352,520	36.4	421,388	195,391	[5] 91,290	21,000	36,417	33,872
1943	1,010,544	394,976	435,641	179,925	928,940	372,095	40.0	403,827	153,016	81,605	22,880	31,814	26,909
1944	1,013,614	409,576	454,892	149,148	935,826	385,840	41.2	425,377	124,609	77,788	23,734	29,515	24,539
1945	1,028,000	417,570	467,687	142,745	951,229	393,323	41.3	438,755	119,152	76,771	24,247	28,932	23,592
1946	1,147,502	446,048	550,817	150,635	1,064,191	419,510	39.4	517,267	127,412	83,312	26,539	33,550	23,223
1947	1,440,584	615,923	654,938	169,722	1,342,202	580,766	43.3	615,617	145,819	98,381	35,158	39,321	23,904
1948	1,700,462	722,527	778,189	199,746	1,584,824	679,916	42.9	732,554	172,354	115,638	42,611	45,635	27,392
1949	2,087,137	939,509	925,380	222,250	1,950,633	889,047	45.6	869,822	191,764	136,504	50,462	55,558	30,485
1950	2,488,831	1,095,788	1,127,714	265,329	2,328,671	1,038,507	44.6	1,059,780	230,384	160,160	57,281	67,934	34,945
1951	2,583,430	1,188,179	1,090,097	305,153	2,409,319	1,122,383	46.6	1,024,226	262,711	174,111	65,798	65,870	42,443
1952	2,582,483	1,209,076	1,066,712	306,695	2,392,643	1,133,543	47.4	997,054	262,046	189,840	75,533	69,658	44,649
1953	2,725,927	1,358,827	1,059,338	307,761	2,523,904	1,277,180	50.6	986,205	260,519	202,023	81,647	73,134	47,242
1954	2,774,807	1,406,076	1,035,051	333,680	2,563,335	1,320,063	51.5	960,516	282,751	211,472	86,008	74,535	50,929
1955	2,939,570	1,440,771	1,109,844	388,956	2,713,459	1,350,294	49.8	1,030,883	332,282	226,112	90,477	78,961	56,674
1956	3,022,101	1,462,791	1,160,133	399,177	2,781,698	1,365,411	49.1	1,077,238	339,049	240,403	97,330	82,894	60,129
1957	3,228,870	1,610,338	1,207,765	410,766	2,970,006	1,505,031	50.7	1,118,212	346,764	258,863	105,307	89,553	64,003
1958	3,537,538	1,757,078	1,309,392	471,068	3,251,007	1,641,572	50.5	1,210,459	398,976	286,531	115,506	98,933	72,092
1959	3,888,750	1,972,980	1,388,684	527,087	3,574,386	1,847,971	51.7	1,281,187	445,229	314,364	125,009	107,497	81,858
1960	4,039,433	2,055,228	1,458,897	525,311	3,705,216	1,921,605	51.9	1,343,703	439,908	334,217	133,621	115,194	85,402
1961	4,298,276	2,191,228	1,538,895	568,156	3,938,653	2,048,829	52.0	1,412,758	477,066	359,623	142,397	126,136	91,090
1962	4,671,791	2,467,715	1,622,564	581,515	4,268,996	2,303,515	54.0	1,482,175	483,306	402,795	164,197	140,389	98,209
1963	5,025,156	2,728,587	1,671,431	625,139	4,583,000	2,535,390	55.3	1,527,115	520,494	442,157	193,197	144,315	104,644
1964	5,376,532	2,941,656	1,756,554	678,322	4,867,011	2,702,506	55.5	1,596,401	568,103	509,521	239,150	160,153	110,218

[1] See footnote 1 on aid to the blind and general assistance tables.

[2] Represents data for February–June for special types of public assistance and for January–June for general assistance.

[3] Local funds for general assistance are included in State funds.

[4] Data on administration for 1936–39 are estimated; local funds for these years are included in State funds.

[5] Federal Emergency Relief Administration funds included as follows: 1940, $40,909; 1941, $1,645; 1942, $2,002. Fiscal year 1940 includes also $984,990 administrative costs for which distribution by source of funds not available.

Special types of public assistance: Expenditures for assistance payments and administrative costs, by source of funds, fiscal years 1936–64

[All States. Beginning 1951, includes vendor payments for medical care. Dollar amounts in thousands]

Fiscal year	Total				Assistance					Administration [1]			
	All funds	Federal funds	State funds	Local funds	All funds	Federal funds		State funds	Local funds	All funds	Federal funds	State funds	Local funds
						Amount	Percent						
1936 [2]	$83,882	$20,202	[3] $48,763	[3] $14,917	$81,493	$19,178	23.5	$47,398	$14,917	$2,389	$1,024	[3] $1,365	([4])
1937	333,144	142,568	[3] 147,597	[3] 42,979	316,234	135,313	42.8	137,942	42,979	16,910	7,255	[3] 9,655	([4])
1938	488,889	212,484	[3] 217,447	[3] 58,958	462,470	201,400	43.5	202,112	58,958	26,419	11,084	[3] 15,335	([4])
1939	576,720	244,294	[3] 260,765	[3] 71,662	545,465	231,359	42.4	242,445	71,662	31,255	12,935	[3] 18,320	([4])
1940	[5] 629,764	279,404	263,301	86,579	594,541	266,667	44.9	247,679	80,195	[5] 35,223	12,736	15,622	$6,384
1941	716,567	333,474	289,869	93,224	673,337	315,293	46.8	273,754	84,291	43,231	18,183	16,115	8,933
1942	798,415	378,520	330,613	94,282	749,800	352,520	47.0	312,644	84,636	48,615	21,000	17,969	9,646
1943	843,552	394,976	356,146	92,430	791,411	372,095	47.0	337,174	82,141	52,142	22,880	18,972	10,289
1944	896,737	409,576	401,166	85,996	840,441	385,840	45.9	380,577	74,023	56,296	23,734	20,589	11,973
1945	923,376	417,570	418,315	87,492	865,823	393,323	45.4	397,443	75,058	57,553	24,247	20,872	12,433
1946	1,026,441	446,048	487,538	92,854	963,231	419,510	43.6	463,322	80,398	63,211	26,539	24,216	12,456
1947	1,272,399	615,923	556,570	99,905	1,198,354	580,766	48.5	529,768	87,820	74,044	35,158	26,802	12,086
1948	1,487,942	722,527	651,100	114,315	1,401,810	679,916	48.5	621,053	100,841	86,132	42,611	30,047	13,474
1949	1,820,494	939,509	762,781	118,204	1,718,370	889,047	51.7	725,133	104,189	102,124	50,462	37,648	14,014
1950	2,125,574	1,095,788	900,302	129,484	2,009,327	1,038,507	51.7	856,073	114,747	116,247	57,281	44,229	14,737
1951	2,259,646	1,188,179	898,336	173,130	2,127,106	1,122,383	52.8	854,142	150,582	132,540	65,798	44,193	22,549
1952	2,320,338	1,209,076	929,701	181,561	2,168,149	1,133,543	52.3	878,282	156,324	152,189	75,533	51,419	25,237
1953	2,476,591	1,358,827	932,243	185,520	2,311,808	1,277,180	55.2	877,052	157,576	164,783	81,647	55,191	27,944
1954	2,517,268	1,406,076	910,806	200,415	2,343,468	1,320,068	56.3	853,073	170,327	173,830	86,008	57,733	30,089
1955	2,609,698	1,440,771	941,923	227,005	2,426,790	1,350,294	55.6	882,485	194,011	182,909	90,477	59,438	32,994
1956	2,708,072	1,462,791	1,004,106	241,174	2,511,256	1,365,411	54.4	940,768	205,077	196,816	97,380	63,338	36,097
1957	2,907,132	1,610,338	1,048,513	248,280	2,694,012	1,505,031	55.9	979,564	209,417	213,120	105,307	68,950	38,863
1958	3,144,454	1,757,078	1,118,826	268,550	2,911,176	1,641,572	56.4	1,043,742	225,862	233,278	115,506	75,084	42,688
1959	3,399,803	1,972,980	1,136,030	290,793	3,148,114	1,847,971	58.7	1,056,436	243,707	251,689	125,009	79,594	47,086
1960	3,548,378	2,055,226	1,191,271	301,881	3,279,254	1,921,605	58.6	1,106,335	251,314	269,124	133,621	84,936	50,568
1961	3,759,372	2,191,225	1,248,073	320,073	3,472,188	2,048,829	59.0	1,155,978	267,381	287,184	142,397	92,095	52,692
1962	4,192,255	2,467,713	1,367,943	356,599	3,861,116	2,303,515	59.7	1,260,674	296,927	331,138	164,197	107,269	59,672
1963	4,573,347	2,728,587	1,445,170	399,590	4,200,497	2,535,390	60.4	1,331,377	333,729	372,850	193,197	113,792	65,861
1964	4,930,753	2,941,656	1,539,337	449,760	4,491,783	2,702,506	60.2	1,410,025	379,252	438,970	239,150	129,312	70,508

[1] Represents data for approved plans only; administration for programs administered without Federal participation not available. See also footnote on aid to the blind table.

[2] Represents data for February–June.

[3] Data on administration for 1936–39 are estimated; local funds for these years are included in State funds.

[4] Includes $481,159 administrative costs for which distribution by source of funds not available.

NOTE: "Special types of public assistance" comprises the Federally aided categories—old-age assistance, medical assistance for the aged, aid to families with dependent children, aid to the blind, and aid to the permanently and totally disabled. It does not include general assistance.

Old-age assistance: Expenditures for assistance payments and administrative costs, by source of funds, fiscal years 1936–64

[All States. Beginning 1951, includes vendor payments for medical care. Dollar amounts in thousands]

Fiscal year	Total				Assistance				Administration [1]			
	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds
1936 [2]	$54,716	$17,432	[3] $30,840	[3] $6,444	$52,907	$16,602	$29,861	$6,444	$1,809	$830	[3] $979	([3])
1937	257,214	125,050	[3] 108,355	[3] 23,809	244,201	119,095	101,297	23,809	13,013	5,955	[3] 7,058	([3])
1938	379,522	182,789	[3] 161,688	[3] 35,045	360,249	174,085	151,119	35,045	19,273	8,704	[3] 10,569	([3])
1939	440,552	208,577	[3] 190,062	[3] 41,914	418,309	198,645	177,751	41,914	22,243	9,932	[3] 12,311	([3])
1940	[4] 474,400	229,016	196,154	48,882	449,969	220,415	184,845	44,709	[4] 24,431	8,600	11,309	$4,173
1941	535,654	263,343	217,010	55,301	505,063	251,271	205,019	48,773	30,591	12,073	11,991	6,527
1942	602,262	296,364	248,037	57,862	568,631	282,649	235,188	50,794	33,631	13,715	12,849	7,067
1943	653,209	321,017	271,997	60,196	616,569	305,748	258,430	52,391	36,640	15,269	13,566	7,805
1944	720,305	343,061	320,261	56,983	679,329	326,845	304,970	47,514	40,976	16,215	15,291	9,469
1945	743,984	352,108	333,868	58,007	701,951	335,453	318,224	48,274	42,032	16,655	15,644	9,733
1946	806,472	372,540	373,469	60,462	761,587	354,983	355,840	50,764	44,885	17,558	17,629	9,698
1947	960,363	495,337	402,275	62,751	910,330	471,995	384,471	53,864	50,033	23,342	17,804	8,887
1948	1,093,984	567,168	459,010	67,806	1,037,554	539,131	439,881	58,542	56,430	28,037	19,129	9,264
1949	1,325,920	726,672	534,364	64,884	1,259,381	693,690	509,545	56,146	66,539	32,982	24,819	8,738
1950	1,510,933	825,351	622,540	63,042	1,437,982	789,362	593,490	55,129	72,951	35,988	29,049	7,913
1951	1,549,196	832,126	620,772	96,297	1,472,544	794,004	595,040	83,499	76,652	38,122	25,732	12,798
1952	1,572,790	826,101	645,104	101,585	1,487,605	783,758	616,508	87,339	85,185	42,343	28,596	14,246
1953	1,671,805	920,063	647,970	103,772	1,581,052	874,998	617,396	88,658	90,753	45,065	30,574	15,114
1954	1,684,614	943,664	631,377	109,573	1,589,618	896,540	599,798	93,281	94,996	47,125	31,580	16,292
1955	1,686,441	933,970	635,006	117,464	1,589,811	886,034	603,317	100,461	96,629	47,937	31,690	17,003
1956	1,735,436	936,778	675,677	122,980	1,633,533	886,234	642,503	104,796	101,903	50,544	33,174	18,184
1957	1,832,190	1,009,966	696,768	125,456	1,724,289	956,462	661,896	105,932	107,901	53,505	34,872	19,524
1958	1,911,217	1,058,651	720,223	132,343	1,798,374	1,002,652	684,071	111,651	112,843	55,999	36,152	20,692
1959	1,973,089	1,149,550	691,728	131,811	1,858,004	1,092,347	655,375	110,282	115,085	57,203	36,353	21,529
1960	2,014,736	1,171,485	707,249	136,001	1,894,639	1,111,814	669,152	113,674	120,096	59,672	38,098	22,327
1961	2,035,554	1,219,807	689,608	126,139	1,914,946	1,159,941	649,820	105,185	120,608	59,866	39,788	20,954
1962	2,020,168	1,267,845	649,175	103,148	1,899,039	1,207,745	608,525	82,769	121,130	60,100	40,650	20,380
1963	2,128,252	1,361,677	658,346	108,229	2,003,338	1,297,769	618,174	87,396	124,913	63,908	40,172	20,833
1964	2,162,393	1,390,536	662,815	109,043	2,030,945	1,321,202	620,373	89,370	131,448	69,333	42,442	19,673

[1] Represents administration for approved plans only; administration for programs administered without Federal participation not available.

[2] Represents data for February to June.

[3] Data on administration for 1936–39 estimated; local funds for these years included in State funds.

[4] Includes $348,809 administrative costs for which distribution by source of funds not available.

Medical assistance for the aged: Expenditures for assistance payments and administrative costs, by source of funds, fiscal years 1961–64

[Dollar amounts in thousands]

Fiscal year	Total				Assistance				Administration			
	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds
1961 [1]	$45,899	$22,851	$15,341	$7,707	$42,899	$21,355	$14,377	$7,167	$3,000	$1,496	$964	$539
1962	208,752	105,785	61,447	41,520	196,127	99,482	57,847	38,798	12,625	6,303	3,600	2,722
1963	308,002	157,008	92,594	58,400	289,175	147,477	87,570	54,129	18,827	9,531	5,024	4,272
1964	411,007	210,634	123,880	76,493	383,648	196,461	116,775	70,412	27,359	14,173	7,105	6,081

[1] Represents data for November–June; program approved for Federal participation effective Oct. 1, 1960.

Aid to families with dependent children: Expenditures for assistance payments and administrative costs, by source of funds, fiscal years 1936–64

[All States. Beginning 1951, includes vendor payments for medical care. Dollar amounts in thousands]

Fiscal year	Total				Assistance				Administration [1]			
	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds
1936 [2]	$23,296	$1,841	[3] $13,558	[3] $7,896	$22,853	$1,691	$13,265	$7,896	$443	$150	[3] $293	([3])
1937	61,719	13,094	[3] 31,784	[3] 16,839	58,501	12,005	29,656	16,839	3,217	1,089	[3] 2,128	([3])
1938	90,793	24,397	[3] 44,467	[3] 21,928	84,505	22,269	40,307	21,928	6,288	2,128	[3] 4,160	([3])
1939	115,166	30,289	[3] 57,521	[3] 27,356	107,055	27,544	52,155	27,356	8,111	2,745	[3] 5,366	([3])
1940	[4] 132,867	44,218	54,982	33,554	123,366	40,447	51,326	31,593	[4] 9,501	3,771	3,656	$1,961
1941	157,134	63,018	60,422	33,694	146,003	57,533	56,859	31,611	11,131	5,485	3,563	2,083
1942	170,653	69,330	69,214	32,110	157,405	62,774	64,737	29,894	13,248	6,556	4,477	2,216
1943	163,549	65,402	70,206	27,941	149,962	58,627	65,495	25,840	13,587	6,774	4,711	2,102
1944	148,811	56,714	66,573	25,524	135,896	50,266	62,180	23,450	12,914	6,448	4,394	2,073
1945	151,847	55,157	70,095	26,595	138,533	48,520	65,726	24,287	13,314	6,637	4,369	2,308
1946	189,014	62,796	97,046	29,171	173,107	54,869	91,433	26,805	15,906	7,927	5,613	2,366
1947	275,836	106,500	135,411	33,924	254,547	95,875	127,529	31,143	21,289	10,626	7,882	2,781
1948	352,315	138,901	170,030	43,384	325,716	125,695	160,371	39,650	26,599	13,206	9,659	3,734
1949	446,249	192,322	203,309	50,619	414,139	176,363	191,961	45,815	32,110	15,959	11,348	4,804
1950	559,924	246,865	249,005	64,053	520,330	227,216	235,465	57,649	39,594	19,650	13,539	6,404
1951	613,937	311,802	234,208	67,927	567,683	288,769	219,405	59,509	46,254	23,033	14,803	8,418
1952	598,658	311,098	221,982	65,578	547,268	285,512	205,229	56,527	51,390	25,586	16,753	9,051
1953	618,307	345,195	209,939	63,173	562,039	317,241	192,005	52,793	56,268	27,954	17,934	10,380
1954	619,136	354,237	197,708	67,190	561,111	325,440	179,272	56,399	58,025	28,797	18,437	10,791
1955	683,907	387,395	216,420	80,092	620,561	355,981	196,941	67,639	63,346	31,414	19,478	12,453
1956	708,289	396,726	226,360	85,203	639,476	362,563	205,550	71,363	68,813	34,163	20,810	13,840
1957	776,479	450,475	237,698	88,306	700,269	412,701	214,362	73,207	76,209	37,774	23,336	15,099
1958	902,651	529,560	273,718	99,373	815,196	486,113	246,852	82,231	87,455	43,447	26,866	17,142
1959	1,056,620	624,331	313,117	119,172	956,380	574,351	282,690	99,338	100,240	49,980	30,427	19,834
1960	1,130,515	665,700	340,530	124,284	1,021,097	611,177	307,732	102,188	109,418	54,523	32,798	22,096
1961	1,240,092	716,164	384,625	139,304	1,118,991	655,872	348,465	114,654	121,101	60,292	36,160	24,649
1962	1,488,491	844,827	480,599	163,065	1,338,603	770,245	434,369	133,989	149,888	74,582	46,231	29,076
1963	1,600,338	918,862	502,289	179,187	1,425,874	826,750	451,810	147,314	174,464	92,112	50,479	31,873
1964	1,755,542	1,007,194	544,725	203,623	1,537,888	884,105	484,654	169,129	217,654	123,089	60,071	34,494

[1] Represents administration for approved plans only; administration for programs administered without Federal participation not available.

[2] Represents data for February–June.

[3] Data on administration for 1936–39 estimated; local funds for these years included in State funds.

[4] Includes $113,861 administrative costs for which distribution by source of funds not available.

Aid to the blind: Expenditures for assistance payments and administrative costs, by source of funds, fiscal years 1936–64

[All States. Beginning 1951, includes vendor payments for medical care. Dollar amounts in thousands]

Fiscal year	Total				Assistance				Administration [1]			
	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds
1936 [2]	$5,870	$929	[3] $4,365	[3] $577	$5,733	$885	$4,272	$577	$137	$44	[3] $93	([3])
1937	14,213	4,424	[3] 7,458	[3] 2,331	13,533	4,213	6,989	2,331	680	211	[3] 469	([3])
1938	18,574	5,298	[3] 11,292	[3] 1,985	17,716	5,046	10,686	1,985	858	252	[3] 606	([3])
1939	21,002	5,428	[3] 13,182	[3] 2,392	20,101	5,170	12,539	2,392	901	258	[3] 643	([3])
1940	[4] 22,497	6,170	12,165	4,143	21,206	5,805	11,508	3,893	[4] 1,290	365	657	$250
1941	23,780	7,113	12,438	4,228	22,270	6,489	11,876	3,906	1,509	625	562	323
1942	25,500	7,826	13,362	4,311	23,764	7,097	12,719	3,948	1,736	729	643	363
1943	26,794	8,557	13,944	4,293	24,880	7,720	13,249	3,911	1,915	837	695	383
1944	27,621	9,801	14,331	3,489	25,215	8,729	13,428	3,058	2,406	1,071	904	431
1945	27,545	10,305	14,351	2,889	25,339	9,350	13,493	2,497	2,206	955	858	392
1946	30,956	10,712	17,023	3,221	28,536	9,658	16,049	2,829	2,420	1,054	974	392
1947	36,200	14,086	18,884	3,230	33,477	12,896	17,768	2,813	2,723	1,190	1,115	418
1948	41,643	16,458	22,060	3,125	38,540	15,090	20,801	2,649	3,103	1,368	1,259	476
1949	48,325	20,515	25,108	2,701	44,850	18,994	23,627	2,229	3,475	1,521	1,481	472
1950	54,718	23,572	28,757	2,388	51,016	21,929	27,117	1,969	3,702	1,643	1,640	419
1951	58,499	26,357	27,471	4,671	54,367	24,453	25,893	4,021	4,132	1,905	1,578	650
1952	62,967	29,570	28,504	4,894	58,209	27,316	26,741	4,152	4,758	2,254	1,763	741
1953	69,508	33,904	30,414	5,189	64,325	31,507	28,458	4,360	5,183	2,397	1,956	829
1954	72,122	35,735	30,796	5,591	66,763	33,287	28,771	4,705	5,359	2,448	2,025	886
1955	75,009	36,785	32,062	6,162	69,322	34,182	29,983	5,157	5,687	2,604	2,079	1,005
1956	79,110	37,823	34,329	6,958	73,064	35,072	32,145	5,847	6,045	2,751	2,183	1,111
1957	87,293	41,561	38,492	7,239	80,610	38,563	36,020	6,027	6,683	2,998	2,472	1,213
1958	92,549	44,276	40,590	7,683	85,397	41,035	37,989	6,373	7,153	3,242	2,601	1,310
1959	96,806	48,054	40,611	8,140	89,066	44,515	37,971	6,579	7,740	3,539	2,640	1,561
1960	100,202	48,961	42,863	8,379	92,309	45,354	40,191	6,764	7,893	3,607	2,672	1,615
1961	102,212	48,663	45,163	8,385	93,991	44,992	42,195	6,804	8,221	3,671	2,968	1,581
1962	101,493	47,572	45,935	7,986	92,819	43,698	42,790	6,331	8,674	3,875	3,144	1,655
1963	103,935	49,459	46,321	8,156	95,001	45,401	43,129	6,471	8,935	4,058	3,192	1,685
1964	106,306	51,361	46,930	8,016	96,665	46,762	43,569	6,334	9,642	4,599	3,361	1,682

[1] Represents administration for approved plans only except for Pennsylvania beginning 1940 and Missouri beginning 1948. In 1953 these plans were approved for Federal participation.

[2] Represents data for February–June.

[3] Data on administration for 1936–39 estimated; local funds for these years included in State funds.

[4] Includes $18,489 administrative costs for which distribution by source of funds not available.

Aid to the permanently and totally disabled: Expenditures for assistance payments and administration, fiscal years 1951–64

[All States. Includes vendor payments for medical care. Dollar amounts in thousands.]

Fiscal year	Total				Assistance				Administration			
	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds	All funds	Federal funds	State funds	Local funds
1951 [1]	$38,01	$17,894	$15,885	$4,235	$32,512	$15,157	$13,803	$3,552	$5,502	$2,738	$2,081	$683
1952	85,92	42,307	34,111	9,504	75,067	36,957	29,804	8,306	10,855	5,350	4,307	1,198
1953	116,97	59,664	43,921	13,386	104,392	53,433	39,194	11,766	12,579	6,231	4,727	1,621
1954	141,42	72,440	50,925	18,061	125,976	64,802	45,233	15,942	15,449	7,638	5,692	2,119
1955	164,34	82,620	58,435	23,286	147,095	74,098	52,244	20,753	17,247	8,523	6,191	2,533
1956	185,23	91,463	67,740	26,034	165,183	81,542	60,570	23,071	20,054	9,921	7,170	2,963
1957	211,17	108,336	75,556	27,279	188,844	97,305	67,286	24,253	22,327	11,031	8,270	3,026
1958	238,03	124,591	84,296	29,150	212,209	111,773	74,830	25,607	25,828	12,818	9,466	3,543
1959	273,28	151,045	90,574	31,669	244,664	136,758	80,399	27,507	28,624	14,287	10,175	4,162
1960	302,92	169,080	100,628	33,216	271,208	153,260	89,261	28,687	31,717	15,820	11,368	4,530
1961	335,61	183,740	113,336	38,539	301,361	166,669	101,121	33,570	34,254	17,071	12,215	4,969
1962	373,35	201,684	130,786	40,880	334,528	182,346	117,143	35,039	38,822	19,338	13,643	5,840
1963	432,82	241,581	145,620	45,619	387,109	217,993	130,696	38,420	45,711	23,588	14,924	7,199
1964	495,50	281,931	160,988	52,585	442,637	253,975	144,655	44,007	52,867	27,955	16,334	8,579

[1] Represents data for October–June; program approved for Federal participation effective Oct. 1, 1950.

General assistance: Expenditures for assistance payments and administration, by source of funds, fiscal years 1936–64

[Beginning 1951, includes vendor payments for medical care. Dollar amounts in thousands]

Fiscal year	Total			Assistance			Administration [1]		
	All funds	State funds	Local funds	All funds	State funds	Local funds	All funds	State funds	Local funds
1936 [2]	$266,010	[3] $266,010	([3])	$239,390	$239,390	([3])	$26,620	[3] $26,620	([3])
1937	446,069	[3] 446,069	([3])	401,430	401,430	([3])	44,639	[3] 44,639	([3])
1938	501,607	[3] 501,607	([3])	451,410	451,410	([3])	50,197	[3] 50,197	([3])
1939	524,885	[3] 524,885	([3])	472,359	472,359	([3])	52,526	[3] 52,526	([3])
1940	[4] 493,896	288,667	$204,683	444,450	262,968	$181,481	[4] 49,446	25,699	$23,202
1941	[4] 390,838	215,690	175,146	337,848	189,798	148,050	[4] 52,990	25,892	27,096
1942	[4] 262,174	127,192	134,981	219,499	108,744	110,755	[4] 42,675	18,448	24,226
1943	166,992	79,495	87,495	137,529	66,653	70,875	29,463	12,842	16,620
1944	116,877	53,726	63,152	95,385	44,800	50,586	21,492	8,926	12,566
1945	104,624	49,372	55,253	85,406	41,312	44,094	19,218	8,060	11,159
1946	121,061	63,279	57,781	100,960	53,945	47,014	20,101	9,334	10,767
1947	168,185	98,368	69,817	143,848	85,849	57,999	24,337	12,519	11,818
1948	212,520	127,089	85,431	183,014	111,501	71,513	29,506	15,588	13,918
1949	266,643	162,599	104,046	232,263	144,689	87,575	34,380	17,910	16,471
1950	363,257	227,412	135,845	319,344	203,707	115,637	43,913	23,705	20,208
1951	323,784	191,761	132,023	282,213	170,084	112,129	41,571	21,677	19,894
1952	262,145	137,011	125,134	224,494	118,772	105,722	37,651	18,239	19,412
1953	249,336	127,095	122,241	212,096	109,153	102,943	37,240	17,942	19,298
1954	257,510	124,245	133,265	219,867	107,443	112,424	37,643	16,802	20,841
1955	329,872	167,921	161,951	286,669	148,398	138,271	43,203	19,523	23,680
1956	314,029	156,026	158,003	270,442	136,470	133,971	43,587	19,556	24,031
1957	321,738	159,252	162,486	275,994	138,648	137,346	45,743	20,604	25,140
1958	393,084	190,566	202,518	339,831	166,717	173,114	53,253	23,849	29,405
1959	488,947	252,653	236,294	426,273	224,751	201,522	62,675	27,903	34,772
1960	491,055	267,626	223,429	425,963	237,368	188,595	65,093	30,258	34,835
1961	538,904	290,822	248,082	466,465	256,780	209,685	72,439	34,042	38,398
1962	479,537	254,621	224,916	407,880	221,501	186,379	71,657	33,120	38,537
1963	451,809	226,261	225,548	382,503	195,738	186,765	69,307	30,523	38,783
1964	445,779	217,217	228,562	375,228	186,376	188,852	70,551	30,840	39,711

[1] Data incomplete.
[2] Represents data for January–June.
[3] Local funds included in State funds.
[4] Federal Emergency Relief Administration funds included as follows: 1940, $40,909; 1941, $1,645; 1942, $2,002. Fiscal year 1940 includes also $503,831 administrative costs for which distribution by source of funds not available.

APPENDIX III

SPECIAL TYPES OF PUBLIC ASSISTANCE: PROGRAM FACTS

Purpose of programs

The purpose of the special types of public assistance is to provide needy persons—dependent children who are deprived of parental support or care, and the needy aged, the medically indigent aged, the blind, and the permanently and totally disabled—with income to supplement their own resources and thus enable them to secure the necessities of life, and with social services to help them achieve as much economic and personal independence as possible. Individuals are considered needy if all the income they have or can obtain from other sources is less than the cost of the minimum living standard set by their State. The assistance payment is intended to make up the difference. The special types of public assistance are a joint undertaking of State, local, and Federal Governments. Federal grants are made to States under the public assistance titles of the Social Security Act.

Trends in number of recipients

The number of persons receiving old-age assistance has declined consistently since 1950, despite the increase in the aged population, because of the continuing growth in the number who receive social insurance benefits. In aid to families with dependent children, the upward trend since 1953 has resulted primarily from an increase in the number of children in the population and in the total number of families, coupled with a comparable rise in the number of families broken by divorce, separation, or desertion, or headed by an unmarried mother. In recent years such families have had a smaller rise in income than normal families, with the result that more of them need assistance. The extension of the program for aid to families with dependent children to cover children of unemployed parents, effective May 1961 and by now adopted by 18 States, has recently contributed to the rise in the number of recipients. Part of the steady growth in the program of aid to the permanently and totally disabled, which was not established until 1950, is the result of the initiation of new State programs. In aid to the blind there was an upward trend to the end of 1958; since then there has been a downward movement in the caseload. The first payments under the program of medical assistance for the aged were made in November 1960.

Public assistance programs are intended to play a role secondary to the social insurance program in providing income maintenance. Old-age, survivors, and disability insurance benefits have reduced very substantially the need for public assistance among the aged and among children whose fathers are dead and, to a lesser degree, among children whose fathers are disabled. In the future, disability insurance payments will increasingly have the effect of limiting the number of disabled individuals and their dependents who receive public assistance.

No resource comparable with the social insurance program is available for children who need assistance because their parents are divorced, separated, or unmarried. Such children now represent the majority of those cared for under the program for aid to families with dependent children. For these children, assistance is the only resource when family income is lacking. If the child population continues to increase as it has in recent years, if the rate of family disruption does not decline, and if the income position of families headed by women does not improve, the number of persons—children and adults—receiving help under the aid to families with dependent children program will inevitably continue to increase. Beginning with December 1957 the number of persons receiving aid to families with dependent children has exceeded the number receiving old-age assistance, and the margin between the two programs widens as the number receiving aid to families with dependent children advances and the number of old-age assistance recipients continues to decline.

AID TO THE BLIND

1. Number of recipients, December 1964: 96,000.
2. Number aided per 100,000 population aged 18 and over: 79.
3. Caseload trend: Except for a period of decline during World War II, the number of recipients of aid to the blind increased slowly but rather steadily from the initiation of the program to the end of 1958. Since then there has been a gradual downward movement in the caseload.

In calendar year 1963 assistance to 17,000 recipients was discontinued. This figure indicates an annual turnover rate of about 17 percent. The most common

reason for the closing of an AB case was the death of the recipient, accounting for about a third of all closings. Other important reasons for closing were: recipient no longer eligible with respect to need—25 percent (10 percent because of receipt of or increase in OASDI benefit); and recipient's transfer to another assistance program (usually OAA)—22 percent.

4. Average assistance payment, including vendor payments for medical care, December 1964: $85.80.

5. Total assistance payments, including vendor payments for medical care, fiscal year 1964: $97 million.

From Federal funds, 48.4 percent.

From State and local funds, 51.6 percent.

6. Recipients also receiving OASDI benefits: Number of recipient-beneficiaries, late 1962 (excludes most cases receiving assistance or State pension payments without Federal participation), 15,800.

Proportion of total AB caseload, 18.5 percent.

Well over half—56 percent—of recipient-beneficiaries are 65 or over and are receiving retirement benefits based on their own wage records or are receiving benefits as dependents of retired or deceased workers. Thirty percent of the recipient-beneficiaries are 50 to 64 years of age, and 15 percent are under 50. Most of these persons under 65 years of age are assumed to receive benefits based on their own wage records, but a small proportion consists of persons who were disabled prior to their 18th birthday and are eligible for benefits as adult disabled children of retired, disabled, or deceased beneficiaries.

Average OASDI benefit: Average benefit to beneficiaries on AB rolls is about 30 percent lower than average benefit to all aged beneficiaries.

Average AB payment: About 22 percent lower than average payment to recipients who do not receive OASDI benefits. But the average income from AB and OASDI combined, for recipients with both types of income, is 61.5 percent higher than the average income of nonbeneficiaries from AB alone.

7. Recipient characteristics (based on study in late 1962 of the more than 85,000 recipients of payments with Federal participation): To be eligible under Federal policy a recipient must have vision of 20/200 or poorer, or must have peripheral field limitation of 20° or less. Eighteen percent were found to be totally blind; 44 percent had slight vision but poorer than 5/200.

Most frequent eye affections reported were cataract (15 percent of all recipients), optic nerve atrophy (13 percent), glaucoma (12 percent), and retinal degeneration (9 percent).

Cause of blindness was not determined or not reported for 29 percent of all recipients and reported as unknown to science for 19 percent. Causes most frequently given were senile degeneration—9 percent of all recipients, congenital origin other than hereditary—8 percent, trauma and poisoning—7 percent, hereditary origin—5 percent, syphilis—5 percent, and other infectious diseases—7 percent.

Median age at loss of sight for the AB recipients was 39 years. Of all recipients for whom age at loss of sight was reported, 16 percent were blind at birth, and 7 percent lost their sight during the first 6 years of life. Fifty-five percent lost their sight at some time after their 35th birthday, including 17 percent who were 65 or over when they lost it.

Sixteen percent of all AB recipients were confined to the home at the time of the study because of their physical or mental condition. At the other extreme, 36 percent were not only not confined to the home, but they could get around outside of the home without assistance.

At least one chronic physical or mental condition was reported as known to the agency for 45 percent of the recipients. Most common conditions: heart or artery disease—13 percent of all recipients; diabetes—6 percent; arthritis or rheumatism—6 percent; mental deficiency or retardation—5 percent.

In addition to blindness, 9 percent of the recipients were reported to be deaf or have a serious hearing impairment, 1 percent had a serious speech defect, and 8 percent had a defect or deformity of limbs, back, spine, or trunk.

The median age of all recipients was 61.3 years. Forty percent were 65 or over, and only 14 percent were under 40 years of age.

Recipients are almost equally divided between males and females.

The racial breakdown of recipients was reported as follows: 69 percent white, 28 percent Negro, 2 percent other races, and 2 percent unknown.

The average (median) recipient had completed only 5.8 years of school. Only 10 percent of all recipients with schooling reported had graduated from high school; nearly two-thirds of the recipients had failed to complete as many as 8 grades of school, and 44 percent had fewer than 5 years of schooling.

Eight percent of all recipients are currently employed—12 percent of the male recipients and 3 percent of the female recipients. About one-third of the employed recipients are working full time.

While about 63 percent of the general population live in standard metropolitan statistical areas, only 50 percent of AB recipients do so. In consequence, the recipient rate is much higher in nonmetropolitan areas, where about 10 of every 10,000 persons receive AB, as compared to about 6 in every 10,000 in the metropolitan areas. In the central cities of metropolitan areas the rate is 7 per 10,000, as compared with 4 per 10,000 in the suburban parts of these areas.

Sixty-two percent of all AB recipients were born in the State in which they are now living and receiving assistance; 23 percent moved into the State 10 years or more before first receiving public assistance; 7 percent had lived in the State 5 or more, but less than 10 years; 4 percent had lived in the State less than 5 years; for 4 percent the length of time was unknown.

The median length of time for AB recipients since the most recent opening of the case is 6.1 years. Thirty-two percent of all recipients have received assistance continuously for 10 years or more.

Thirty-four percent of all recipients of AB had received federally aided public assistance at some time prior to the most recent opening of AB; 65 percent had not.

Of the male recipients, 31 percent have never been married, 41 percent are married, 8 percent are separated, 6 percent are divorced, and 14 percent are widowed. Of the female recipients, 22 percent have never been married, 20 percent are married, 9 percent are separated, 7 percent are divorced, and 41 percent are widowed. Four percent of all recipients are married to a blind spouse.

Seventeen percent of the male recipients and 9 percent of the female recipients have one or more children under 18 years of age.

Nearly three-fifths of all recipients maintain their own homes; 17 percent live in the home of a son, daughter, or parent; 9 percent live with other relatives; 4 percent live with other persons; 7 percent live in institutions; and 4 percent live elsewhere.

One-fourth of the AB recipients live in families with one or more other persons receiving public assistance. In 5 percent of the cases there is someone else in the home eligible for aid to the blind by reason of their own need and visual handicap. In more than 9 percent of all AB cases there is a recipient of OAA living in the same home, and in at least 8 percent there are recipients of AFDC.

8. Financial circumstances (based on 1962 study):

Budgeted requirements: Each State establishes its own income and property levels to be used in determining the eligibility of individuals for AB. The income level is defined in terms of money amounts considered necessary to purchase recognized items of need such as food, clothing, shelter, and household supplies. The State usually allows variations in these amounts to take account of the particular living circumstances of the recipient and the existence of special needs.

At the time of the 1962 study, monthly requirements averaged $94 per recipient. Requirements for AB recipients who receive OASDI benefits averaged $119; for nonbeneficiary recipients the average was $88.

Income other than assistance: The Social Security Act, as amended in 1962, provides that "the State agency shall, in determining need, take into consideration any other income and resources of the individual claiming aid to the blind, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, the State shall disregard (A) the first $85 per month of earned income, plus one-half of earned income in excess of $85 per month, and (B) for a period not in excess of 12 months, such additional amounts of other income and resources, in the case of an individual who has a plan for achieving self-support approved by the State agency, as may be necessary for the fulfillment of such plan." (Sec. 1002(8)). Of all AB recipients in 1962, 6.7 percent had some disregarded earned income, averaging $57 per month for recipients with such income.

In late 1962 AB recipients over the Nation had an average of $15, in monthly income from sources other than public assistance, to apply against budgeted requirements.

Thirty-six percent of all AB recipients had some income (including income in kind with a money value assigned) from sources other than assistance, to be applied to the assistance budget. Applied income averaged $42 per month for recipients with any such income.

Two percent of all recipients had included in their assistance budgets an average monthly income of $27 from their own earnings (amounts in excess of the disregarded earned income).

Eighteen percent of all recipients had an average of $53 per month in income from OASDI benefits.

Three percent of recipients had an average of $51 monthly income from other benefits or pensions.

Seven percent of recipients had an average of $23 monthly personal income from other sources.

For 3 percent of all recipients, cash income of other persons, averaging $39 per month, was shown as an item of income in the assistance budget.

Nine percent of all recipients had income in kind with a money value assigned. The average monthly value of such income for these recipients was $9.

Assistance payments: In addition to establishing its own standards of financial eligibility, each State also determines whether all or a percentage of the needs of recipients as determined under those standards are to be met through AB payments, with or without supplementary general assistance, and whether the AB payments are limited by arbitrary maximums.

At the time of the 1962 study, AB money payments to recipients and payments to institutions for institutional care averaged $72.93 a month per recipient. (Excluded from this average are payments made directly to suppliers for other medical care of AB recipients. In October 1962 total AB assistance payments averaged $79.21 per recipient; money payments to recipients averaged $70.52, and total payments to suppliers of medical care averaged $8.68 per recipient in the total national caseload.)

AB payments to recipients who received OASDI benefits averaged $59 per month; payments for nonbeneficiaries averaged $76.

For the country as a whole, the average amount of supplementary money payments from general assistance programs was only 29 cents per person receiving AB.

Unmet financial need: Well over half of the States fail to make all AB payments adequate to meet their own income tests of financial need. In these States some or all payments are subject to limitation, either through the imposition of maximum amounts on payments or through the reduction of the payment to a percentage of the computed need.

The existence of "unmet need," however, is not of itself a complete measure of the adequacy of assistance payments in a given State. Some States only recognize low levels of financial need; such a State, paying 100 percent of recognized need, may be actually paying less adequate assistance than some other States which recognize greater needs but apply a limitation to the individual payment.

Over one-fourth (26.5 percent) of all AB recipients had some unmet need; the average monthly amount of unmet need for such cases was $20. The total amount of unmet need equaled 4 percent of total budgeted requirements of all AB recipients.

AID TO FAMILIES WITH DEPENDENT CHILDREN [1]

1. Estimated population under age 18, January 1, 1965, 71,498,800.

During the past two decades the population of the U.S. under 18 years of age has increased rapidly. In January 1965 there were 71.5 million children under age 18, compared with 49.1 million in 1950 and 42.4 million in 1940.

2. Number aided in December 1964:

Families	1,030,000
Children	3,218,000
Recipients	4,289,000
Unemployed-parent cases:	
Families	67,000
Children	260,000
Recipients	388,000
Cases other than unemployed-parent cases:	
Families	963,000
Children	2,958,000
Recipients	3,901,000

3. Number of children aided per 1,000 population under age 18, December 1964:

Including children in unemployed-parent cases	45
Excluding children in unemployed-parent cases	41

[1] Formerly "Aid to Dependent Children."

4. Trend in number of recipients: Following a decline during World War II, the number of recipients of aid to families with dependent children rose in the postwar period to a peak of 2,246,000 in October 1950 when, under amendments to the Social Security Act, the program was broadened to include a needy relative with whom a dependent child is living, and program coverage was extended to Puerto Rico and the Virgin Islands. After October 1950 the recipient load decreased, reaching a low of 1,918,000 in November 1953. The trend in the number of recipients was generally upward, with seasonal variations, from the end of 1953 to the beginning of the 1957–58 recession, then rose sharply during that recession. Through 1959 and most of 1960 the number of recipients continued to increase but at a very low rate.

Beginning late in 1960 and extending through the first quarter of 1962, the caseload again increased at a rapid rate. Several interrelated factors influenced this rapid growth. Another recession accompanied by a high unemployment rate resulted in the usual increase in the AFDC caseload during such economic periods. The high rate of unemployment also spurred new Federal legislation, effective in May 1961, extending the AFDC program to include families with children of unemployed parents (AFDC–UP). Originally considered a stopgap measure with coverage authorized only through June 1962, this program was extended through June 1967 as part of the Public Welfare Amendments of 1962. While only 18 States were participating in the program in December 1964, the unemployed-parent segment has added significant numbers to the total caseload (450,000 persons during the peak month of April 1964).

During 1962 and 1963 the number of AFDC recipients increased only gradually—at about the same rate as the total child population—and the number of child recipients continued to represent about 4.2 percent of the Nation's children under 18 years of age. But in 1964 the number of recipients rose more rapidly, and by December the AFDC child recipients represented 4.5 percent of all children under 18.

The primary factors contributing to the general increase in the number of recipients since November 1953 are: (1) continued rapid growth in the child population; (2) a substantial increase in the total number of families in the population; (3) a comparable increase in the number of families headed by women and the persistence of an average income level for such families well below that for families headed by men: (4) the economic decline in 1954, in 1957–58, and again in 1960–61; (5) higher assistance standards, given impetus by the increase in living costs and facilitated by additional Federal funds available, under the 1956, 1958, and 1962 amendments to the public assistance titles of the Social Security Act.

The OASDI program has reduced very substantially the need for assistance among children whose fathers are dead. The insurance program has been less effective, however, in reducing the need for assistance among children whose parents are physically or mentally handicapped, because eligibility requirements for disability benefits are relatively stringent, and dependents' benefits have been payable only since September 1958.

Even more important for the trend in aid to families with dependent children, the OASDI program is not applicable to children in need because their parents are divorced or separated or because the father has deserted, is not married to the mother, or is absent for other reasons. Such children represent an increasingly large majority of those receiving help under the aid to families with dependent children program.

In the calendar year 1964, State agencies closed 475,000 cases, the equivalent of 49 percent of the cases open at the beginning of the year. Most families leave the rolls because of the employment of a person in the home, remarriage of the mother, or for other reasons which reflect changes in economic circumstances.

5. Average assistance payment, including vendor payments for medical care, December 1964:

Per family	$140.96
Per recipient	33.85
Unemployed-parent cases:	
Per family	190.97
Per recipient	32.97
Cases other than unemployed-parent cases:	
Per family	137.50
Per recipient	33.94

6. Total assistance payments, including vendor payments for medical care, fiscal year 1964, $1,538 million.

From Federal funds, 57.5 percent.

From State and local funds, 42.5 percent.

7. AFDC families also receiving OASDI benefits: Number of beneficiary families, late 1961, 50,200; proportion of total AFDC caseload, 5.7 percent.

Average OASDI benefit per family: Slightly less than half that received by all beneficiary families consisting of widows and children.

Average AFDC payment per family: 28 percent lower than average payment to AFDC families who do not receive OASDI benefits. However, the total income from AFDC and OASDI combined, for families with both types of income, is, on the average, about 38.6 percent higher than the average income from AFDC alone of families without OASDI benefits.

8. Family characteristics (based on 1961 study): The eligibility of almost all AFDC families is based on the status of the father rather than that of the mother. In 8 percent of the families the father is dead. In 67 percent of the families the father is absent because of divorce, separation, desertion, unmarried parenthood, imprisonment, or other reasons; in 18 percent of the families the father is incapacitated; and in 5 percent of the families the father is unemployed. For 2 percent of the families, the father's status is "other" than as described above.

More than two-thirds of all families live in places of 2,500 or more population; more than two-fifths live in cities of 50,000 or more population.

The mother is in the home in 9 out of 10 families. Both parents are in the home and the father either incapacitated or unemployed in about one-fifth of the families.

The median length of time since the most recent opening for AFDC is 2.1 years.

The median age of the children is 8.6 years. Three-fourths of the children are under 13 years of age.

9. Financial circumstances (based on 1961 study):

Budgeted requirements: Each State establishes the level of living to be used in that State in determining eligibility of families for AFDC. This level is defined in terms of money amounts considered necessary for specified consumption items or requirements. Such amounts are varied according to size and composition of the family, particular living circumstances, and the existence of special needs that are recognized by the State. As of January 1963, half of the States allowed only $203 or less for total basic needs to be included in the monthly budget for a "typical" AFDC family, consisting of a mother and three children. ("Total basic needs" represented the sum of maximum allowances for rent and utilities and fixed amounts for food, clothing, and other necessities.)

For the Nation as a whole the average AFDC family included 3.9 persons in late 1961. At that time the average of actual budgeted requirements for all families was $158 per month—$1.35 per person per day—including all consumption items except medical care paid for by agency payments to suppliers of such care.

Income other than assistance: Late in 1961 AFDC families over the Nation had an average of $27 in monthly income from sources other than public assistance to apply against budgeted needs:

Forty-five percent of all AFDC families had some nonassistance income. Such income averaged $60 per month for these families.

Thirteen percent of the families had an average of $54 per month in earnings of the mother.

Between 6 and 7 percent of the families had an average of about $40 per month in income from earnings of the father, children, or other person or persons in the assistance unit.

Thirteen percent of the families received, on the average, $56 per month from the father not in the home.

Six percent of the families received an average of $74 per month in OASDI benefits.

Ten percent of the families received, on the average, $47 per month in cash from other sources.

Eight percent of the families received income in kind valued, on the average, at $15 per month.

Assistance payments: AFDC money payments at the time of the 1961 study averaged $112 per month per family or $29 per person. (These figures do not include payments made directly to suppliers of medical care to AFDC recipients. Such payments were made by 39 States in December 1961; they averaged $7.74 per family, or $1.99 per person, for the national caseload in that month.)

Twenty-four States reported supplementation of some AFDC payments through general assistance at the time of the 1961 study. On a national basis, supplementary payments through general assistance averaged 69 cents per family in the study month.

Unmet financial need: Many of the States fail to make AFDC payments adequate to meet their own standards for family financial requirments. In these

States some or all monthly payments are subject to specific maximums or are otherwise limited, below the amount determined as needed under State standards. There were 38 States that reported some cases with unmet need in the 1961 study; in 27 of these States half or more of the AFDC families had unmet need. Twelve percent of the total financial need of the Nation's AFDC families as recognized in State standards was not being met from any source. Unmet need was reported for 46 percent of all AFDC families; the average amount of unmet need for these families was nearly $40. Unmet need amounted to $50 or more per month for 112,000 families.

On the other hand, some of the States that reported no families with unmet need in the 1961 study have relatively low assistance standards. In such States the average level of living actually provided to AFDC families may be lower than in some States which recognize a higher level of need but do not fully meet that need through assistance.

MEDICAL ASSISTANCE FOR THE AGED

1. Number of recipients, December 1964: 227,000.
2. Total assistance payments, December 1964: $44.1 million.
3. Average payment per recipient, December 1964: $194.69.
4. The program of medical assistance for the aged: Federal legislation establishing the program of medical assistance for the aged became effective October 1, 1960. The purpose of the legislation is to encourage States to establish programs for providing medical care for persons aged 65 or over who, in general, have sufficient resources to meet their needs except for medical care.

In establishing a program of medical assistance for the aged, a State has considerable latitude in deciding the scope of the program with respect to both the definitions of persons eligible and the kind and extent of medical services to be provided. Such services, however, must include both institutional and noninstitutional types of care. An age requirement higher than 65 may not be imposed, and no resident of the State and no citizen of the United States may be excluded. Legislation establishing the program of medical assistance for the aged provides that the Federal Government's share in the total amounts expended by States for such medical assistance will range from 50 to 80 percent, under a formula based primarily on State per capita income.

In fiscal year 1964, vendor payments for medical care in the MAA program totaled $381.7 million. Of the 37 States and other areas with programs in operation, all provided inpatient hospital care and 24 provided nursing home care. Payments for these two types of medical services were roughly the same, and together they accounted for 90 percent of all medical payments under the program.

OLD-AGE ASSISTANCE

1. Estimated population aged 65 and over, January 1, 1965: 18,176,000.

The population of the United States aged 65 and over has been increasing at a rapid rate. As of January 1, 1965, there were 18.2 million persons aged 65 and over compared with 16.6 million in 1960, 12.4 million in 1950, and 9 million in 1940.

2. Number of recipients, December 1964: 2,159,000.
3. Number aided per 1,000 population aged 65 and over, December 1964: 119. Rates are highest in the Southeast and Southwest, lowest in the Northeast.
4. Caseload trend: During World War II the caseload declined, reaching a low of 2,033,000 in mid-1945. Thereafter, the number aided increased until an alltime high was reached in the latter part of 1950, when 2,810,000 aged persons received assistance. Despite the steady increase in the aged population, the number of recipients has declined gradually since 1950. The proportion of the population aged 65 and over receiving old-age assistance decreased from 224 per 1,000 aged persons in June 1950 to 119 per 1,000 in December 1964. The decline in caseload since 1950 is attributable mainly to the extension of coverage and rapid growth in the number of beneficiaries under the program for old-age, survivors, and disability insurance. Among OASDI beneficiaries aged 65 and over only 68 per 1,000 received old-age assistance in June 1964, compared with an OAA rate of 269 per 1,000 aged persons not receiving OASDI.

About two-thirds of the cases closed in calendar year 1964 were closed because of death.

5. Average assistance payment per recipient, including vendor payments for medical care, December 1964: $78.90.

6. Total assistance payments, including vendor payments for medical care, fiscal year 1964: $2,031 million.

From Federal funds, 65.1 percent.

From State and local funds, 34.9 percent.

7. Recipients also receiving OASDI benefits: number of recipient-beneficiaries, February 1964, 881,400; proportion of total OAA caseload, 40.7 percent.

Some OASDI beneficiaries also need OAA, either because their benefit payments are not large enough to meet their recurring basic needs or because of special needs such as hospitalization, care in a nursing home, or other medical care.

Trend: The number of persons receiving both OAA payments and OASDI cash benefits has increased steadily and is likely to increase further because of almost universal coverage of the working population under OASDI.

Average OASDI benefit: The average benefit to beneficiaries on OAA rolls is about 32 percent lower than the average benefit to all aged beneficiaries.

Average OAA payment: The average OAA payment to beneficiary-recipients is about 26 percent lower than the average payment to recipients who do not receive OASDI benefits. The combined income from OAA and OASDI of beneficiary recipients is, however, 30.5 percent higher, on the average, than the average income of nonbeneficiaries from OAA alone.

8. Characteristics of OAA recipients (based on 1960 study [1]): Their median age is 76.4 years—4.3 years higher than the median for the total population aged 65 and over.

Women comprise two-thirds of the persons receiving OAA.

Marital status of the male recipients: 46 percent are married; 30 percent are widowed; 11 percent are divorced or separated; and 13 percent were never married.

Marital status of the female recipients: 18 percent are married; 67 percent are widowed; 8 percent are divorced or separated; and 7 percent were never married.

Because of physical or mental conditions, 20 percent of all recipients are confined to their homes, and 8 percent are bedfast or chairfast; half of the latter group live in institutions. Of recipients not confined to their homes, one in nine needs help to get around outside the home.

Almost two-thirds of the recipients live in quarters maintained as their own households, 16 percent live in the homes of sons or daughters, and 9 percent are in institutions; the remainder have other living arrangements.

A majority—57 percent—of all recipients live in nonmetropolitan counties.

The median time since most recent opening for OAA is 6.1 years. For those who receive OASDI benefits the median is 3.9 years; for those not receiving such benefits it is 7.2 years.

Of all recipients having nondependent children, almost a fourth receive contributions from the children.

OASDI benefits are received by about 3 out of 10 recipients: 38 percent of the men and 25 percent of the women.

9. Financial circumstances (based on 1960 study):

Budgeted requirements: Each State establishes its own income and property levels to be used in determining the eligibility of individuals for OAA. The income level is defined in terms of money amounts considered necessary to purchase specified consumption items such as food, clothing, shelter, and household supplies. These amounts are usually varied by the State to take account of particular living circumstances and special needs of the individual recipient.

At the time of the 1960 study, monthly requirements averaged $85 per recipient. The average of requirements for recipients confined to the home because of physical or mental conditions was $111, compared with $78 for recipients not so confined. For recipients living in institutions the average amount of monthly requirements was $162, for those living alone in their own homes this amount was $85, and for those living in the homes of a son or daughter it was $65. Requirements for OAA recipients who receive OASDI benefits averaged $98; for nonbeneficiary recipients the average was $79.

Income other than assistance: In 1960, OAA recipients over the Nation had an average of $18 in monthly income from sources other than public assistance to apply against budgeted requirements.

Sixty percent of all OAA recipients had some income (including income in kind with no money value assigned) from sources other than assistance. The total of all types of income other than assistance averaged $37 per month for recipients having some income.

[1] For more detailed information, see Public Assistance Rept. No. 48.

Thirty percent of all recipients had an average of $44 per month in income from OASDI benefits.

Four percent of all recipients had an average monthly income of $14 from their own earnings.

Six percent of all recipients (24 percent of those having nondependent children) received contributions from their children. These contributions averaged $23 per month.

Three percent of all recipients received benefits or pensions other than OASDI. Such income averaged about $53 per recipient.

Seven percent of all recipients had cash income from other sources which averaged $15 per month.

Ten percent of all recipients had income in kind with a money value assigned. The average monthly value of such income for these recipients was $8.

Assistance payments: In addition to establishing its own standards of financial eligibility, each State also determines whether all or a percentage of the needs of recipients as determined under those standards are to be met through OAA payments, with or without supplementary general assistance, and whether the OAA payments are limited by arbitrary maximums.

At the time of the 1960 study, OAA money payments to recipients and payments in their behalf to institutions for institutional care averaged $62.74 a month per recipient. (This average is based on data excluding payments made directly to suppliers for other medical care of OAA recipients. Payments to suppliers of medical care were made by 44 States in September 1960; total payments of this type averaged $10.75 per recipient for the national caseload in that month.)

OAA payments to recipients who received OASDI benefits averaged $50 per month; for nonbeneficiaries, the average OAA payment was $68.

For the country as a whole, the average amount of supplementary money payments from general assistance programs was only 16 cents per person receiving OAA.

Unmet financial need: Considerably more than half the States fail to make OAA payments adequate to meet their own income tests of financial need. In these States some or all payments are subject to limitation, irrespective of the amount of assistance needed as determined under the State's test.

Some States having relatively low amounts as the test for income needed may show little or no unmet financial need for their OAA recipients. In such States the average level of living actually provided persons receiving OAA may be lower than in some States which recognize a higher level as an income test of "need" but do not pay the full amount of such need.

For the country as a whole, unmet financial need averaged $4 a month per person receiving OAA. The total amount of unmet need represented 5 percent of the total amount budgeted for requirements.

AID TO THE PERMANENTLY AND TOTALLY DISABLED

1. Number of recipients, December 1964: 528,000.
2. Number aided per 1,000 population aged 18 to 64: 5.1.
3. Caseload trend: Since the inception of this public assistance category in October 1950 the trend in number of recipients has been steadily upward, partly as the result of the addition of new State programs, but largely the result of caseload increases in existing programs. By December 1964 all States but one (Nevada) were providing assistance of this type with Federal participation.

The number of cases closed—over 125,000 in calendar year 1963—indicates a fairly substantial turnover in the caseload. However, only an estimated three-tenths of the cases were closed because the recipient was no longer eligible in terms of need; the largest group of these, representing about 12 percent of the total, were closed because of the receipt of or increase in OASDI benefits. A fifth of the closings resulted from the death of the recipient; another fifth was due to the transfer of the recipient to another assistance program, in most instances OAA; and about 1 in every 13 closings resulted from the admittance of the recipient to an institution.

4. Average assistance payment, December 1964: $80.61.
5. Total assistance payments, fiscal year 1964: $442,637,000.

From Federal funds, 57.4 percent.

From State and local funds, 42.6 percent.

6. Recipients also receiving OASDI benefits:

Number of recipient-beneficiaries, late 1962, 57,500.

Proportion of total APTD caseload, 13.7 percent.

The likelihood of being a beneficiary of OASDI increases with the age of the APTD recipient: In 1962, 10.5 percent of the recipients under 50 years of age were beneficiaries, as compared with 15 percent of the recipients 50–64 years of age and 23.6 percent of those aged 65 and over.

Average OASDI benefit: Average benefit to beneficiaries on APTD rolls is 44 percent below the average benefit to all disability insurance beneficiaries.

Average APTD payment: The average APTD payment to recipient-beneficiaries is about 28 percent lower than the average payment to recipients who do not receive OASDI benefits. The average income from APTD and OASDI, for persons with both forms of income, is 62 percent higher than the average income from APTD alone of recipients without OASDI benefits.

7. Recipient characteristics (based on 1962 study): For 26 percent of the recipients the primary disability was a mental, psychoneurotic, or personality disorder, including 15 percent who were reported to be mentally deficient. Other important primary impairments were: diseases of the circulatory system, 21 percent of all recipients (four-fifths of these suffered from a heart disease); diseases of the nervous system and sense organs, 18 percent (one-third of these having vascular lesions of the central nervous system); diseases of the bones and organs of movement, 11 percent (mostly arthritis cases); and infective and parasitic diseases, 7 percent. All other conditions accounted for the primary diagnoses of the remaining 18 percent of the recipients.

Considering both primary and secondary diagnoses, at least 18 percent of the recipients were reported to be mentally deficient, and at least 13 percent to have arthritis.

In 19 percent of the cases the origin of the primary impairment was a congenital malformation or disease, or birth injury. Employment injury or disease accounted for less than 2 percent. Other diseases accounted for 56 percent, and other injuries for 6 percent, of the recipients' primary impairments. For 18 percent the cause was unknown.

APTD recipients had had their primary impairments for an average (median) of 13.3 years. Over one-third of the recipients had been impaired for 20 years or more, and over three-fourths had been disabled for 5 years or more.

Eleven percent of the recipients were bedfast or chairfast; 19 percent were not immobilized but were confined to the home because of the physical or mental condition. Another 19 percent were not confined to the home but needed personal help from others either in the home or to get around outside the home.

The median age of recipients was 55.1 years. Nearly half were 55 to 64 years of age. Only a fourth were under 45.

Just over one-half (51 percent) of the recipients were women.

Three-tenths of the recipients were Negro.

Only 7 percent of the recipients had graduated from high school. Over two-thirds had completed less than eight grades of school. The median amount of schooling completed was 5.7 years.

One-fifth of the male recipients had never been gainfully employed. Of those that had been employed, over one-fourth had not been employed for 10 or more years, and over half had not been employed for 5 years or more.

Of the female recipients, one-fifth had previously been occupied as homemakers, and another fifth had neither been gainfully employed nor occupied as homemakers. Of the remainder, nearly two-thirds had not been employed for 5 years or more.

In the standard metropolitan statistical areas of the Nation, 3.1 of every 1,000 persons 18 through 64 years of age were recipients of APTD; the rate was 4.4 per 1,000 for persons living in the central cities, as compared with 1.6 per 1,000 in the surrounding suburban area. In nonmetropolitan areas, 5.4 of every 1,000 persons 18 through 64 were receiving APTD.

Nearly two-thirds (64 percent) of the APTD recipients were receiving assistance from the State in which they were born. Another 20 percent were born in another State but lived in the present State for 10 years or more before beginning to receive federally aided public assistance. Fewer than 3 percent had moved in from another State and begun receiving assistance within 2 years after moving in.

Nearly three-fourths of the recipients had never received federally aided public assistance prior to the most recent opening for APTD.

The median case had been receiving APTD for 2.6 years since the most recent opening.

Nearly one-third (33 percent) of the male recipients were married, 10 percent were separated, 8 percent were divorced, 6 percent widowed, and 43 percent had never been married. Of the female recipients only 12 percent were married, while 16 percent were separated, 10 percent were divorced, 29 percent were widowed, and 32 percent had never been married.

About 18 percent of the male recipients, but only 8 percent of the female recipients, had one or more children under 18. Only one-ninth of the female recipients who had ever been married had children under 18; one-third of the male recipients who had been married had children under 18.

Slightly over half (54 percent) of the recipients resided in their own home; 18 percent lived in the home of a son, daughter, or parent; 10 percent lived with other relatives, and 4 percent with other persons. Nine percent lived in institutions (mainly nursing and convalescent homes), while 5 percent lived in hotels, rooming or boardinghouses, or similar places.

Nearly one-fourth (24 percent) of the recipients lived alone.

8. Financial circumstances (based on 1962 study):

Budgeted requirements: Each State establishes its own income and property levels to be used in determining the eligibility of individuals for APTD. The income level is defined in terms of money amounts considered necessary to purchase recognized items of need such as food, clothing, shelter, and household supplies. The State usually allows variations in these amounts in special circumstances to take account of the recipient's particular living situation and the existence of special needs.

Monthly requirements averaged $81 per recipient at the time of the 1962 study. The average requirements for recipients who receive OASDI benefits amounted to $105, as compared with an average of $77 for nonbeneficiary recipients.

Income other than assistance: The Social Security Act provides that in determining the need of an individual for APTD, the State must take into consideration any other income or resources he has. In late 1962 all APTD recipients had an average of $11 monthly in income from sources other than public assistance.

Thirty percent of all APTD recipients had some income (including income in kind with a money value assigned) from sources other than assistance; such income averaged $38 per month for these recipients.

Fourteen percent of all recipients had an average of $51 per month in OASDI benefits.

Two percent of all recipients averaged $47 per month in income from other benefits or pensions.

Eight percent of recipients had an average of $20 per month in income from other sources.

For 2 percent of all recipients, cash income of other persons included in the assistance unit, averaging $43 per month, was shown as an item of income in the assistance budget.

Seven percent of all recipients had income in kind with a money value assigned. The average monthly value of such income for these recipients was $9.

Assistance payments: In addition to establishing its own standards of financial eligibility, each State also determines whether all or a percentage of the needs of recipients as determined under those standards are to be met through APTD payments, with or without supplementary general assistance, and whether the APTD payments are limited by arbitrary maximums.

When the 1962 study was done, APTD payments to recipients and payments to institutions for institutional care averaged $64.35 a month per recipient. (This average does not include payments made directly to suppliers of other types of medical care for APTD recipients. In October 1962 total APTD assistance payments averaged $74.10, per recipient; money payments to recipients averaged $57.06, and total payments to suppliers of medical care averaged $17.04 per recipient in the total national caseload.)

APTD payments to recipients who received OASDI benefits averaged $48 per month; payments for nonbeneficiaries averaged $67.

Only 1 percent of the APTD recipients received supplementary money payments from State and local general assistance programs; such payments averaged only 56 cents per person in the total APTD caseload.

Unmet financial need: Well over half of the States fail to make all APTD payments adequate to meet their own income tests of financial need. In these States some or all payments are subject to limitation, either through the imposition of

maximum amounts on payments or through the reduction of the payment to a percentage of the computed need.

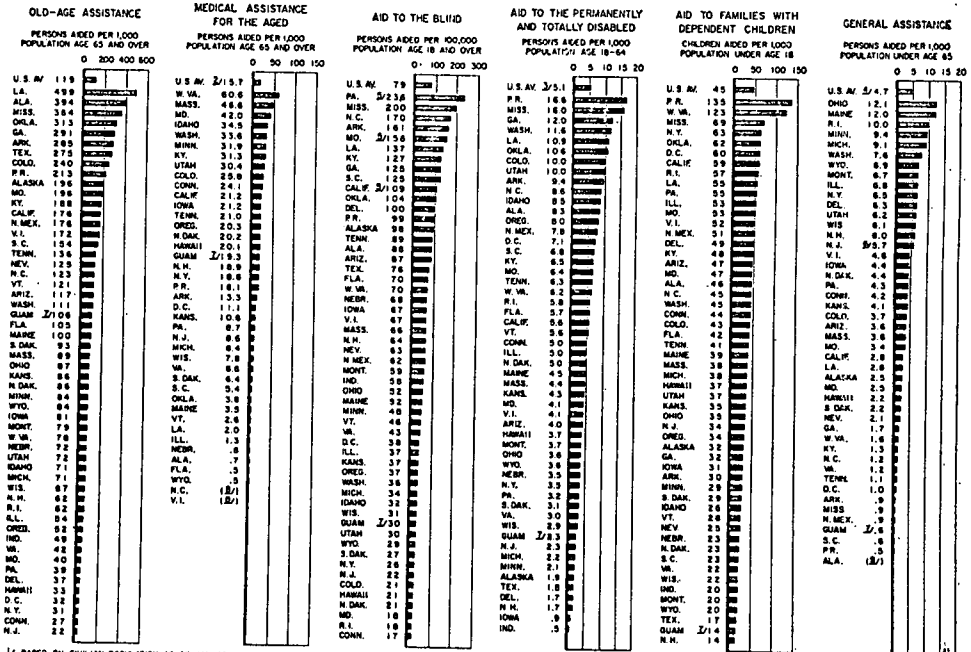
The existence of "unmet need," however, is not of itself a complete measure of the adequacy of assistance payments in a given State. Some States have set relatively low standards of financial need for recipients; such a State, paying 100 percent of recognized need, may be actually paying less adequate assistance than some other States which have higher standards but apply a limitation to the individual payment.

Over one-fourth (26.5 percent) of all APTD recipients had some unmet need; the average monthly amount of unmet need for such cases was $18. The total amount of unmet need equaled 6 percent of total budgeted requirements of all APTD recipients.

APPENDIX IV

PROPORTION OF POPULATION RECEIVING PUBLIC ASSISTANCE (RECIPIENT RATES) IN THE UNITED STATES, DECEMBER 1964 1/

(EXCEPT FOR GENERAL ASSISTANCE, INCLUDES RECIPIENTS RECEIVING ONLY VENDOR PAYMENTS FOR MEDICAL CARE.
CAUTION SHOULD BE USED IN MAKING COMPARISONS WITH EARLIER RATES BECAUSE OF REVISIONS IN POPULATION ESTIMATES ON WHICH RATES ARE BASED)

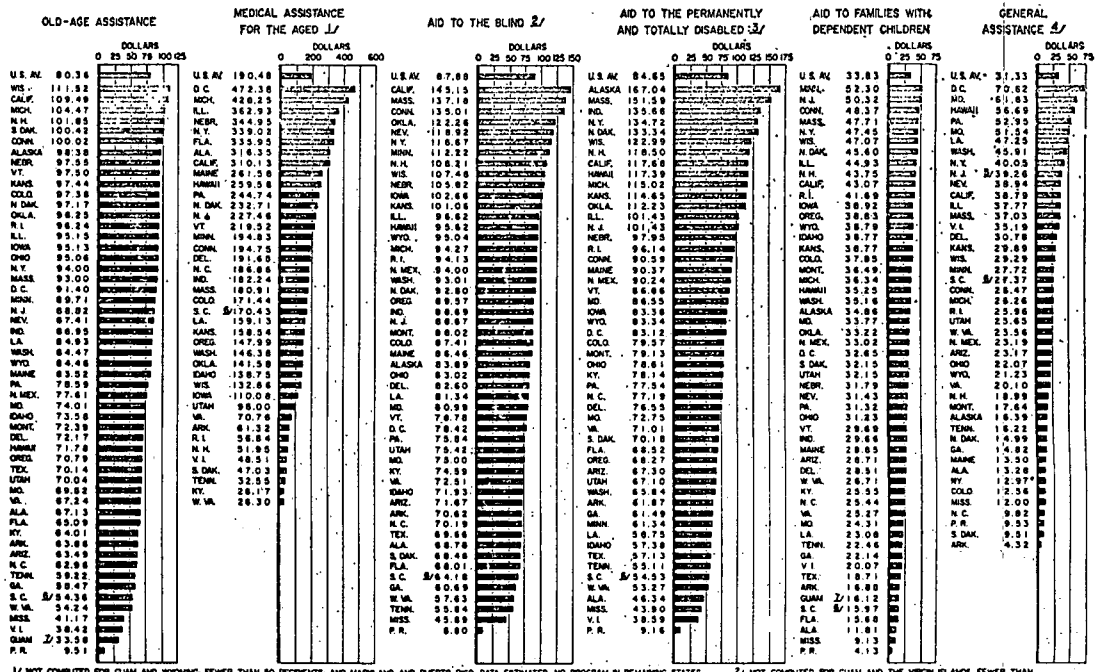


1/ BASED ON CIVILIAN POPULATION AS OF JANUARY 1, 1965 ESTIMATED BY THE BUREAU OF THE CENSUS. 2/ BASED ON DATA FOR 41 STATES LISTED WITH PROGRAMS IN OPERATION. RATE INCLUDING STATES NOT HAVING PROGRAMS IN OPERATION IS 12.3 PER 1,000 AGED PERSONS. 3/ NO PROGRAM IN NEVADA. 4/ BASED ON DATA FOR 46 STATES. NUMBER AIDED NOT AVAILABLE FOR FLORIDA, IDAHO, INDIANA, NEBRASKA, OKLAHOMA, OREGON, TEXAS AND VERMONT. 5/ INCLUDES RECIPIENTS OF PAYMENTS MADE WITHOUT FEDERAL PARTICIPATION. RECIPIENT RATES EXCLUDING THESE RECIPIENTS ARE AS FOLLOWS: CALIFORNIA, 108; MISSOURI, 132; AND PENNSYLVANIA, 65. 6/ INCLUDES UNKNOWN NUMBER OF PERSONS RECEIVING MEDICAL CARE, HOSPITALIZATION, AND BURIAL ONLY. 7/ DATA FOR SEPTEMBER; LATER DATA NOT AVAILABLE.
8/ PROGRAM IN OPERATION, BUT NO PAYMENTS WERE MADE IN DECEMBER 1964. 9/ LESS THAN 0.05.

APPENDIX V

AVERAGE MONTHLY PUBLIC ASSISTANCE PAYMENT PER RECIPIENT, JUNE 1965

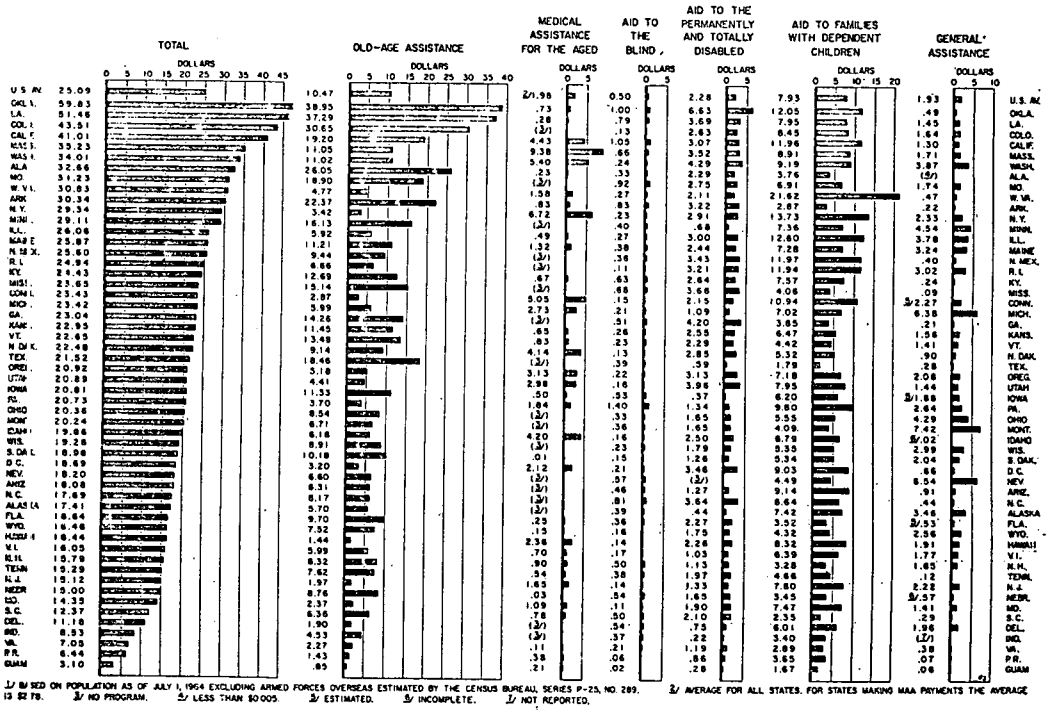
(EXCEPT FOR GENERAL ASSISTANCE, INCLUDES VENDOR PAYMENTS FOR MEDICAL CARE)



1/ NOT COMPUTED FOR GUAM AND WYOMING; FEWER THAN 50 RECIPIENTS; AND MARYLAND AND PUERTO RICO, DATA ESTIMATED. 2/ NO PROGRAM IN REMAINING STATES. 3/ NOT COMPUTED FOR GUAM AND THE VIRGIN ISLANDS, FEWER THAN 50 RECIPIENTS. 4/ NO PROGRAM FOR NEVADA. NOT COMPUTED FOR GUAM, FEWER THAN 50 RECIPIENTS. 5/ NOT COMPUTED FOR GUAM, FEWER THAN 50 RECIPIENTS; AND FLORIDA, IDAHO, INDIANA, IOWA, NEBRASKA, OKLAHOMA, OREGON, TEXAS, AND VERMONT, DATA NOT AVAILABLE. 6/ BASED ON DATA INCLUDING AN UNKNOWN NUMBER OF CASES RECEIVING MEDICAL CARE, HOSPITALIZATION, AND BURIAL ONLY, AND TOTAL PAYMENTS FOR THESE SERVICES. 7/ MAY DATA; JUNE DATA NOT RECEIVED. 8/ MARCH DATA; LATER DATA NOT AVAILABLE.

APPENDIX VI

AMOUNT EXPENDED PER INHABITANT 1/ FOR PUBLIC ASSISTANCE PAYMENTS
INCLUDING MEDICAL CARE VENDOR PAYMENTS,
FISCAL YEAR ENDED JUNE 30, 1964

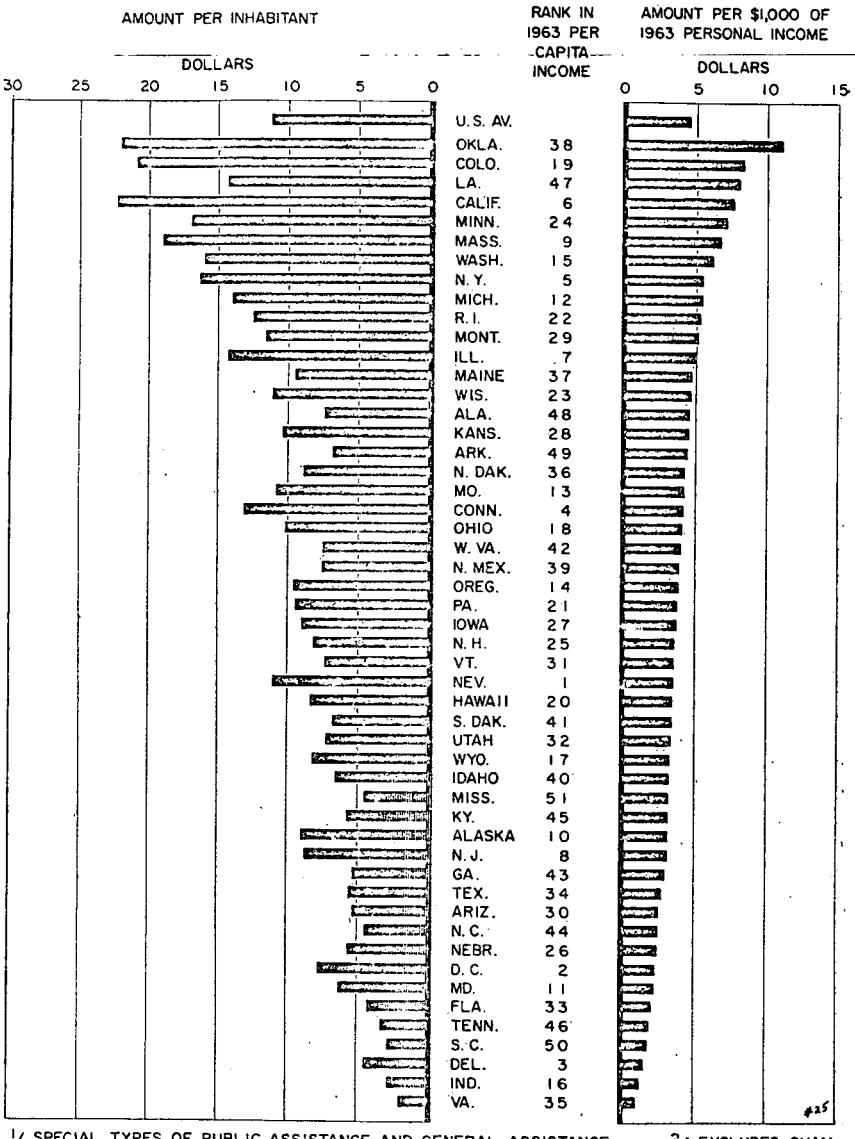


1/ BASED ON POPULATION AS OF JULY 1, 1964 EXCLUDING ARMED FORCES OVERSEAS ESTIMATED BY THE CENSUS BUREAU, SERIES P-25, NO. 289, 13 82 78. 2/ NO PROGRAM. 3/ LESS THAN $0.005. 4/ ESTIMATED. 5/ INCOMPLETE. 6/ NOT REPORTED.

7/ AVERAGE FOR ALL STATES. FOR STATES MAKING MAA PAYMENTS THE AVERAGE

APPENDIX VII

EXPENDITURES FOR PUBLIC ASSISTANCE 1/ FROM STATE AND LOCAL FUNDS, FISCAL YEAR 1964 2/



1/ SPECIAL TYPES OF PUBLIC ASSISTANCE AND GENERAL ASSISTANCE. 2/ EXCLUDES GUAM, PUERTO RICO, AND VIRGIN ISLANDS; INCOME DATA NOT AVAILABLE.

REVISED

CHILDREN'S BUREAU—MATERNAL AND CHILD HEALTH SERVICES

(Title V, pt. 1, of the Social Security Act)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To encourage and assist in the extension and improvement of health services for mothers and children, especially in rural areas and in areas suffering from severe economic distress.

2. Operation

Grants-in-aid to State health agencies. The States must provide matching funds for one-half of the amount appropriated; the remainder is not matched and is distributed to the States on the basis of the financial need of each State for assistance in carrying out its plan. State plans for the use of maternal and child health funds are made by State health agencies. The services are largely provided by local health departments.

States use the funds to pay the costs of conducting prenatal clinics where mothers are examined by physicians and get medical advice; for visits by public health nurses to homes before and after babies are born to help mothers care for their babies; for well-child clinics where mothers can bring their babies and young children for examination and immunizations, where they can get competent advice on how to prevent illnesses, and where their many questions about care of babies can be answered. Such measures have been instrumental in the reduction of maternal and infant mortality. The funds are also used to make available doctors, dentists, and nurses to the schools for health examinations and immunizations of schoolchildren and advice to parents on where to get needed medical or dental care. Some States also provide for the medical and hospital care of premature babies in special hospital centers that meet certain standards and for mothers with complications of pregnancy.

Practically all States use some of the funds for improving the quality of services to mothers and children by providing special training opportunities to physicians, nurses, nutritionists, medical social workers and other professional personnel. In addition, States have demonstration programs of various kinds, the most prominent of which are the mental retardation programs.

3. History

The basic purposes of the grant have remained unchanged since its inception. However the amount authorized for annual appropriation was increased in 1939, 1946, 1950, 1958, 1960, 1963, and 1965. In 1943, there was established under the general purposes of part 1 of title V, through congressional appropriations, the emergency maternity and infant care program. Under this program, the Children's Bureau made grants to State health departments to provide maternity care for wives of enlisted men in the four lowest pay grades of the Armed Forces and of aviation cadets, and to provide medical, nursing, and hospital care for their infants during the first year of life. This was a medical care program of major proportions, in which about 1.5 million mothers and children received care at an expenditure of more

than $125 million in Federal funds from the program's inception through its liquidation in 1949.

The 1960 amendments to the Social Security Act provided that special project grants (up to 25 percent of the amount available for distribution under section 502(b)) may be made to State health agencies (as was previously done), and also directly to public or other nonprofit institutions of higher learning for special projects of regional or national significance which may contribute to the advancement of maternal and child health. Section 502(b) was also amended to make clear that the Secretary may make allotments "from time to time," thereby permitting him to allot the funds at such times as will enable him most effectively to consider the financial needs of each State.

The 1963 amendments provided authority for research projects relating to maternal and child health and crippled children's services which show promise of substantial contribution to the advancement of these programs. These grants are to help improve the operation, functioning, and effectiveness of services by supporting studies that contribute to the advancement of health services for mothers and children. Appropriations under this authorization have been as follows:

Fiscal year 1964	$1, 500, 000
Fiscal year 1965	3, 000, 000
Fiscal year 1966	4, 000, 000

The 1965 amendments require a satisfactory showing of progressive extension of maternal and child health services with a view to making these services available to children in all parts of the State by July 1, 1975, and payment of the reasonable cost of inpatient hospital services in accordance with standards approved by the Secretary of Health, Education, and Welfare.

From fiscal year 1957 through fiscal year 1963, $1 million of maternal and child health funds were earmarked annually in the appropriation acts to be used only for special projects for mentally retarded children. Since the passage of the 1963 amendments to title V with their increased authorizations for maternal and child health, the following amounts have been earmarked in the annual appropriations for special projects for mentally retarded children:

Fiscal year 1964	$2, 250, 000
Fiscal year 1965	3, 500, 000
Fiscal year 1966	4, 750, 000

4. Level of operations. (See table 1.)

Program: Maternal and child health services (title V, pt. 1 of the Social Security Act).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Children's Bureau.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 estimates
(*a*) Magnitude of the program (children):				
Medical well-child conferences	1,485,000	1,643,000	1,800,000	1,950,000
Public health nursing visits to children	2,671,000	3,041,000	3,410,000	3,750,000
School health examinations by physicians	2,434,000	2,622,000	2,810,000	3,000,000
(*b*) Applicants: State health agencies	54	54	54	54
(*c*) Federal finances: Obligations incurred	$28,552,895	$34,468,680	$45,000,000	$50,000,000
(*d*) Matching or additional expenditures for the program by State and local governments	$92,155,889	$101,000,000	$120,000,000	$140,000,000
(*e*) Number of Federal Government employees administering the activity (man-years)	[1] 102	[1] 120	[1] 135	[1] 142
(*f*) Non-Federal personnel employed	[2]	[2]	[2]	[2]

[1] These estimates include staff in the Children's Bureau engaged in the administration of all health programs of the Bureau including maternal and child health and crippled children's services, maternity and infant care projects, projects for health services for school and preschool children and for training of professional personnel for the care of crippled children.
[2] Not available.

5. Estimated magnitude of program in 1970

The authorization for appropriations for the fiscal year 1970 is $60 million. Amounts available will be determined by appropriation.

6. Prospective changes in program orientation

The 1965 amendments require program expansion in order to make services available to children in all parts of the State by July 1, 1975. States will need to begin expansion of services immediately in order to meet this legislative goal.

7. Coordination and cooperation

The Division of Health Services is the administrative unit for all health programs relating to mothers and children, i.e., maternal and child health, crippled children, maternity and infant care, and health of school age and preschool children. Research relating to these programs, administered by the Division of Research, is coordinated with them by the responsible Division Directors and the Chief and Deputy Chief of the Bureau. The Children's Bureau and the Public Health Service work jointly with State health departments around areas of mutual concern, use a joint grants manual and meet jointly with State and territorial health officers annually.

Coordination with the Welfare Administration and the programs of other bureaus within the Welfare Administration and the Department is carried on through the Office of the Chief of the Bureau and the Office of the Commissioner of Welfare.

A memorandum of agreement between the Children's Bureau and the National Institute of Child Health and Human Development prevents duplication of research effort and the Bureau's membership on the advisory council for the Institute advances coordination of research effort.

Program coordination is also achieved at the regional level through the efforts of the various agency representatives and the regional directors.

The policies and procedures for maternity and infant care projects require that such projects be coordinated with the maternal and child health and crippled children's programs and with the child welfare

and other programs of public welfare agencies. In the case of project grants for school age and preschool children, the legislation requires coordination of services provided under the program with the State or local education, health and welfare programs for children.

8. Laws and regulations

Basic act of 1912 (42 U.S.C., ch. 6); Social Security Act, title V (42 U.S.C., ch. 7, subch. V); Reorganization Plan No. 2 of 1946 (60 Stat. 1095); Public Law 89–97 (79 Stat. 286).

Appropriations: Public Law 89–156 (79 Stat. 589).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic effects of all personal and community health programs are discussed in the statement covering those administered by Public Health Service and other operating agencies of the Department of Health, Education, and Welfare.

10. Economic classification of program expenditures. (See table 2.)

Program: Maternal and child health services (title V, pt. 1 of the Social Security Act).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Children's Bureau.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services: Wages and salaries	[1] 1.7
Transfer payments to individuals and nonprofit organizations	2.9
Grants to State and local governments	31.9
Total Federal expenditures	[1] 36.5
Non-Federal expenditures financed by:	
State and local governments	101.0
Individuals and nonprofit organizations	.3
Total, non-Federal expenditures	101.3
Total expenditures for program	137.8

[1] This estimate includes expenditures for staff of the Children's Bureau engaged in the administration of all health programs of the Bureau including maternal and child health and crippled children's services, maternity and infant care projects and research projects relating to maternal and child health and crippled children's services. This item is repeated for each of the health program since it is impossible to break out.

SERVICES FOR CRIPPLED CHILDREN

(Title V, part 2 of the Social Security Act)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

To encourage and assist in the extension and improvement, especially in rural areas and in areas suffering from severe economic distress, of services for locating crippled children and for providing medical, surgical, corrective and other services and care and facilities for diagnosis, hospitalization, and aftercare for children who are crippled or who are suffering from conditions which lead to crippling.

2. Operation

Grants-in-aid to State crippled children's agencies. The States must provide matching funds for one-half of the amount appropriated;

the remainder is not matched and is distributed to the States on the basis of the financial need of each State for assistance in carrying out its plan. State plans for the use of crippled children's funds are made by State crippled children's agencies. Each State law providing for the program either defines the crippling conditions to be included or directs the crippled children's agency to define them.

All States include children who are under 21 years of age and who have some kind of handicap that needs orthopedic or plastic treatment. This means children with cleft lips, cleft palates, or club feet; children with deformed bones; children who have been seriously burned or have been badly hurt in an accident; children with poliomyelitis or bone-and-joint tuberculosis.

All the States include in their crippled children's programs children with cerebral palsy and those with congenital heart disease. Nearly all include children with epilepsy, cystic fibrosis, and serious eye and ear problems.

In the past, crippled children's agencies have done a great deal more for children with handicaps needing orthopedic or plastic treatment than for children with other kinds of crippling conditions. The States are increasingly broadening their programs to include children with any kind of handicapping conditions or long-term illness, including crippled children who are also mentally retarded.

In 1963, 369,000 children received medical services in this program.

3. History

The basic purpose of this grant has remained unchanged since its inception. However, the amount authorized for annual appropriation was increased in 1939, 1946, 1950, 1958, 1960, 1963, and 1965. The increase authorized in 1939 also made available, for the first time in this program, a fund for services for crippled children, commonly referred to as the "B Fund," to be paid to the States without a matching requirement. This provision was the same as had been included from the beginning for the maternal and child health program.

The 1960 amendments to the Social Security Act provided that special project grants (up to 25 percent of the amount available for distribution under section 512(b)) may be made to State agencies (as was previously done), and also directly to public or other nonprofit institutions of higher learning for special projects of regional or national significance which may contribute to the advancement of services for crippled children. Section 512(b) was also amended to make clear that the Secretary may make allotments "from time to time," thereby permitting him to allot the funds at such times as will enable him most effectively to consider the financial need of each State.

The 1963 amendments provided authority for research projects relating to maternal and child health and crippled children's services which show promise of substantial contribution to the advancement of these programs. These grants are to help improve the operation, functioning and effectiveness of services by supporting studies that contribute to the advancement of health services for mothers and children. Appropriations have been as follows:

Fiscal year 1964	$1, 500, 000
Fiscal year 1965	3, 000, 000
Fiscal year 1966	4, 000, 000

The 1965 amendments require a satisfactory showing of progressive extension of services for crippled children with a view to making these services available to children in all parts of the State by July 1, 1975, and payment of the reasonable cost of inpatient hospital services in accordance with standards approved by the Secretary of Health, Education, and Welfare.

These amendments also provide a new authorization for grants to institutions of higher learning for training of professional personnel such as physicians, psychologists, nurses, dentists, and social workers for health and related care of crippled children, particularly mentally retarded children and those with multiple handicaps.

Since the passage of the 1963 amendments to title V with their increased authorizations for services for crippled children, the following amounts have been earmarked in annual appropriations for special projects for mentally retarded children:

Fiscal year 1964	$1,250,000
Fiscal year 1965	2,500,000
Fiscal year 1966	3,750,000

4. Level of operations. (See table 1.)

Program: Services for crippled children (title V, pt. 2, of the Social Security Act).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Children's Bureau.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 estimates
(*a*) Magnitude of the program: Estimated number of children receiving services	410,000	450,000	495,000	525,000
(*b*) Applicants: State crippled children's agencies	[1] 53	[1] 53	[1] 53	[1] 53
(*c*) Federal finances: Obligations incurred	$29,110,928	$34,545,543	$45,000,000	$50,000,000
(*d*) Matching or additional expenditures for the program by State and local governments	$59,812,770	$62,000,000	$75,000,000	$90,000,000
(*e*) Number of Federal Government employees administering the activity (man-years)	[2] 102	[2] 120	[2] 135	[2] 142
(*f*) Non-Federal personnel employed	[3]	[3]	[3]	[3]

[1] Arizona did not participate in the crippled children's program in 1964 and 1965 and may not participate in 1966 and 1967.

[2] These estimates include staff in the Children's Bureau engaged in the administration of all health programs of the Bureau including maternal and child health and crippled children's services, maternity and infant care projects, projects for health services for school and preschool children, and for training of professional personnel for the care of crippled children.

[3] Not available.

5. Estimated magnitude of program in 1970

The authorization for appropriations for the fiscal year 1970 is $60 million for grants for services for crippled children; it is $17.5 million for training of personnel to work with crippled children, particularly mentally retarded children and those with multiple handicaps. Amounts available will be determined by appropriation.

6. Prospective changes in program orientation

The 1965 amendments require program expansion in order to make services available to children in all parts of the State by July 1, 1975. States will need to begin expansion of services immediately in order to meet this legislative goal. They will continue to broaden their definitions of crippling in order to care for children with all kinds of

handicapping conditions and will work increasingly with mentally retarded children, particularly those in institutions and those with multiple handicaps. Agencies are increasingly requesting grants for chromosome diagnosis and genetic counseling services. New and technically complex diagnostic and treatment methods will be developed and utilized in the crippled children's program in ensuing years as research makes available new knowledge to help children who could not be helped formerly.

7. Coordination and cooperation. (See item 7 under Maternal and Child Health Services.)

8. Laws and regulations. (See item 8 under Maternal and Child Health Services).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic effects of all personal and community health programs are discussed in the statement covering those administered by Public Health Service and other operating agencies of the Department of Health, Education, and Welfare.

10. Economic classification of program expenditures. (See table 2.)

Program: Services for crippled children (title V, pt. 2, of the Social Security Act).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Children's Bureau.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services: Wages and salaries	[1] $1.7
Transfer payments to individuals and nonprofit organizations	1.5
Grants to State and local governments	31.7
Total Federal expenditures	[1] 34.9
Non-Federal expenditures financed by:	
State and local governments	62.0
Individuals and nonprofit organizations	.2
Total expenditures for program	97.1

[1] This estimate includes expenditures for staff in the Children's Bureau engaged in the administration of all health programs of the Bureau including maternal and child health and crippled children's services, maternity and infant care projects and research projects relating to maternal and child health and crippled children's services. This item is repeated for each of the health programs since it is impossible to break out.

CHILD WELFARE SERVICES

(Title V, Part 3, of the Social Security Act)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The child welfare services grant is to enable the Federal Government to assist State public welfare agencies in establishing, extending, and strengthening child welfare services. The funds are for local child welfare services and for developing State services for the encouragement and assistance of adequate methods of community child welfare organization.

2. Operation

Grants-in-aid to State public welfare agencies. Each State receives a uniform grant of $70,000 and an additional grant which varies directly with the child population under 21 and inversely with the average per capita income. Each State's allotment of funds earmarked for day care services (fiscal years 1963–66) varied directly with child population under 21 and inversely with per capita income, except that there was a minimum State allotment of $10,000.

The act specifies matching requirements by defining the "Federal share." For any State this is 100 percent less that percentage which bears the same ratio to 50 percent as the per capita income of the State bears to the per capita income of the United States except that the Federal share shall not be less than 33⅓ percent nor more than 66⅔ percent. The Federal share is defined as 66⅔ percent for Puerto Rico, the Virgin Islands, and Guam.

State plans for child welfare services are developed jointly by the State agency and the Children's Bureau. Child welfare services are a wide range of preventive, protective and ameliorative services including: casework services to children and their parents in relation to behavior problems, parent-child relationships, physical or mental handicaps, emotional and social adjustment; services to children who have been neglected, abused, abandoned, or exploited; social services to mentally retarded children and their parents; services to unmarried mothers and their babies; homemaker services to keep the child in his own home when a parent is overwhelmed with responsibilities, incapacitated, or absent; foster care in foster family homes or institutions when a child must be removed from his home for a variety of reasons; adoption services to provide a new permanent home for a child when he has lost his own forever; and day care services to care for and protect the child while his mother works or for other reasons, such as illness of the parent or handicap of the child.

States use almost all of their Federal child welfare services funds to pay the salaries of child welfare personnel and to provide educational leave for promising staff.

3. History

The basic purpose of this grant has remained generally unchanged since its inception. However, the amount authorized for annual appropriation was increased in 1939, 1946, 1950, 1956, 1958, 1960, 1962, and 1965.

The 1958 Social Security Amendments eliminated the reference to rural areas and other areas of special need which had been in the original act, thus making Federal funds available for urban children on the same basis as for rural children. The formula for allotment of funds was changed to make it consistent with the removal of the rural emphasis. Matching requirements and reallotment provisions were added. The provision with respect to return of runaway children was changed to include children up to 18 years of age and to provide for maintaining the child up to 15 days pending his return to his home community.

The 1960 amendments to the Social Security Act added a separate authorization for grants for special research or demonstration projects in the field of child welfare.

The Public Welfare Amendments of 1962 made major changes in the child welfare provisions by increasing the authorization for annual appropriation gradually from $25 to $50 million by the fiscal year 1969; earmarking for day-care services up to $10 million of this appropriation; adding specific conditions of State child welfare plan approval with respect to day-care services provided under the plan; adding, as a requirement of State child welfare plan approval, that the State make a satisfactory showing that it is extending child welfare services with a view to making available by July 1, 1975, in all political subdivisions of the State, for all children in need thereof, child welfare services provided, to the extent feasible, by trained child welfare personnel; clarifying and somewhat broadening the definition of child welfare services; and adding, to the provisions for grants for research or demonstration projects, authorization for grants to public or other nonprofit institutions of higher learning for special projects for training personnel for work in the field of child welfare. Appropriations under this authorization for research, training, and demonstration projects in child welfare have been as follows:

Fiscal year 1962	$350, 000
Fiscal year 1963	795, 000
Fiscal year 1964	3, 943, 000
Fiscal year 1965	5, 830, 000
Fiscal year 1966	8, 000, 000

The 1965 amendments further increased the authorization for annual appropriations to make them equivalent to the new authorizations for maternal and child health and crippled children's services; thus the authorization for fiscal year 1966 was raised to $45 million, increasing to $60 million for the fiscal year 1970. In addition, the provision earmarking child welfare services funds for day-care services and the provision for allotment of day-care funds were deleted and a requirement added that day care provided under the plan be provided only in facilities licensed by the State or approved by the State agency responsible for licensing such facilities.

4. Level of operations. (See table 1.)

Program: Child welfare services (title V, pt. 3, of the Social Security Act).
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Children's Bureau.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program: Estimated number receiving services from public child welfare agencies (children)	487, 500	532, 000	575, 000	625, 000
(b) Applicants (State welfare departments)	54	54	54	54
(c) Federal finances: Obligations incurred	$28, 975, 607	$33, 858, 944	$40, 000, 000	$46, 000, 000
(d) Matching or additional expenditures for the program by State and local governments	$284, 200, 000	$311, 500, 000	$341, 400, 000	$375, 000, 000
(e) Number of Federal Government employees administering the activity (man-years)	55	60	65	70
(f) Non-Federal personnel employed (State and local government personnel)	13, 400	14, 500	15, 700	17, 000

5. Estimated magnitude of program in 1970

The authorization for appropriations for the fiscal year 1970 is $60 million. It is estimated that about 781,500 children will be receiving child welfare services by that date, and that there will be about 16,585 professional child welfare staff by that date.

6. Prospective changes in program orientation

States are continuing to broaden geographic coverage, are making existing services more available, and are expanding their range of services. They are increasing staff skills by the regular use of educational leave and by in-service training activities. Services for the severely abused child, initiated only recently by some States, are expanding as are services for mentally retarded children with emphasis on keeping the retarded child in his own home wherever possible. Program innovations are mounting as State agencies move to incorporate into programs some of the results of research in child welfare.

7. Coordination and cooperation

The Division of Social Services is the administrative unit for the child welfare program and for the training grants for child welfare personnel. Research and demonstrations relating to child welfare, administered by the Division of Research, is coordinated by the responsible Division Directors and the Chief of the Bureau.

The Children's Bureau and the Bureau of Family Services which administers a number of other grants to State welfare agencies work jointly around areas of mutual concern and meet jointly annually with State public welfare administrators and State child welfare directors. The same regional staff works with State agencies in specific areas of common concern, for example, staff development and foster care of children. Handbook or manual materials are joint in some instances—for example, policies and procedures for implementation of title VI of the Civil Rights Act.

Program coordination at the regional level is achieved through the efforts of the various agency representatives and the regional director.

The child welfare plan must provide for coordination between the services provided under it and the services provided for dependent children under the State plan approved under title IV, and with respect to day care services for cooperative arrangements with the State health authority and the State agency primarily responsible for State supervision of public schools to assure maximum utilization of such agencies in the provision of necessary health services and education for children receiving day care.

Coordination with the Welfare Administration and with programs of other bureaus and offices within the Welfare Administration and the Department is carried on through the Office of the Chief and the Office of the Commissioner of Welfare.

8. Laws and regulations

Basic act of 1912 (42 U.S.C., ch. 6); Social Security Act, title V (42 U.S.C., ch. 7, subch. V); Reorganization Plan No. 2 of 1946 (60 Stat. 1095); Public Law 89–97 (79 Stat. 286).

Appropriations: Public Law 89–156 (79 Stat. 589).

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PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The aspects of the economic effects of the program delineated in item 9 of the questionnaire are not applicable in the child welfare services programs as such.

10. Economic classification of program expenditures. (See table 2.)

Program: Grants for child welfare services.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Children's Bureau.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services: Wages and salaries	[1] $1.0
Transfer payments to individuals and nonprofit organizations	3.8
Grants to State and local governments	33.9
Total, Federal expenditures	[1] 38.7
Non-Federal expenditures financed by:	
State and local governments	311.5
Individuals and nonprofit organizations	.4
Total expenditures for program	350.6

[1] These estimates include staff in the Children's Bureau engaged in the administration of all child welfare programs of the Bureau including child welfare services and grants for research, training or demonstration projects in child welfare.

SPECIAL PROJECT GRANTS FOR MATERNITY AND INFANT CARE

(Title V, Part 4, of the Social Security Act)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

In order to help reduce the incidence of mental retardation caused by complications associated with childbearing, grants are authorized to pay up to 75 percent of the cost of projects to provide necessary health care to prospective mothers who have or are likely to have conditions associated with childbearing which increase the hazards to the health of the mothers or their infants and who, the health department determines, will not receive necessary health care because they are from low-income families or for other reasons beyond their control.

2. Operation

Project grants to pay up to 75 percent of the cost of the project are made to the State health agency or with the consent of the State health agency to the health agency of a political subdivision of the State. Applications for grants must include written plan material giving a description of the project, including the geographical area covered, its objectives, eligibility for service, a description of services provided, personnel, and evaluation.

While projects differ somewhat, they enable health departments to provide comprehensive maternity care to selected high-risk patients and to improve greatly the quality of care by paying for it in hospitals staffed and equipped to provide high-quality services. The projects

also bring prenatal clinics closer to the mothers to be served and reduce the dangerous overcrowding in large public hospitals. All projects accept for hospital care high-risk infants of non-high-risk mothers in the project area. Many projects have special infant clinics where all project infants are followed periodically during the first year.

3. History

This is a new program authorized by the Maternal and Child Health and Mental Retardation Planning Amendments of 1963 (Public Law 88–156). Its enactment was a major recommendation of the President's Panel on Mental Retardation. The first appropriation, enacted in a supplemental appropriation for the fiscal year 1964, was $5 million; the 1965 appropriation was $15 million and that for 1966, $30 million.

By the end of the fiscal year 1965, 25 maternity and infant care projects had been approved. Projects had been approved in eight of the Nation's largest cities, and in eight other cities. Two projects serve metropolitan counties and six States and Puerto Rico have projects which serve predominantly rural areas.

4. Level of operations. (See table 1.)

Program: Special project grants for maternity and infant care (title V, pt. 4, of the Social Security Act).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Children's Bureau.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude of the program (services provided)	[1]	[1]	[1]	[1]
(b) Applicants:				
State health departments	4	15	34	34
Local health departments	3	10	16	16
(c) Federal finances: Obligations incurred	$4,682,686	$9,527,518	$30,000,000	$30,000,000
(d) Matching or additional expenditures for the program by State and local governments	$2,941,371	$3,667,547	$11,350,000	$11,350,000
(e) Number of Federal Government employees administering the activity (man-years)	[2] 102	[2] 120	[2] 135	[2] 1
(f) Non-Federal personnel employed	[1]	[1]	[1]	[1]

[1] Not available.

[2] These estimates include staff in the Children's Bureau engaged in the administration of all health programs of the Bureau including maternal and child health and crippled children's services, maternity and infant care projects, projects for health services for school and preschool children, and for training of professional personnel for the care of crippled children.

5. Estimated magnitude of program in 1970

Present legislation authorizes appropriations through fiscal year 1968 of $30 million a year from 1966 through 1968.

6. Prospective changes in program orientation

It is estimated that 25 new projects costing about $18 million will be approved in fiscal year 1966 making a total of 50 approved projects, the maximum that can be financed with the 1967 authorization.

7. Coordination and cooperation

See item 7 under Maternal and Child Health Services.

8. Laws and regulations

(42 U.S.C., ch. 7, subch. V.)

Appropriations: Public Law 89–156 (79 Stat. 589).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic effects of all personal and community health programs are discussed in the statement covering those administered by Public Health Service and other operating agencies of the Department of Health, Education, and Welfare.

10. Economic classification of program expenditures. (See table 2.)

Program: Special project grants for maternity and infant care (title V, pt. 4, of the Social Security Act).

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Children's Bureau.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government:	
Purchases of goods and services: Wages and salaries	[1] $1.7
Grants to State and local governments	4.1
Total Federal expenditures	[1] 5.8
Non-Federal expenditures financed by State and local governments	1.4
Total expenditures for program	7.2

[1] This estimate includes expenditures for staff in the Children's Bureau engaged in the administration of all health programs of the Bureau including maternal and child health and crippled children's services, maternity and infant care projects and research projects relating to maternal and child health and crippled children's services. This item is repeated for each of the health programs since it is impossible to break out.

SPECIAL PROJECT GRANTS FOR HEALTH OF SCHOOL AND PRESCHOOL CHILDREN

(Title V, pt. 4, of the Social Security Act)

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

In order to bring health care to the group of children who need it most by broadening the availability of community health resources and achieving better utilization of existing resources, a 5-year program of project grants to provide comprehensive health care and services for children of school age, and for preschool children, particularly in areas with concentrations of low-income families was authorized by Public Law 89–97.

2. Operation

Project grants to pay up to 75 percent of the cost of the project will be made to the State health agency, or with its consent to the health agency of any political subdivision of the State, to the State crippled children's agency, to schools of medicine and to teaching hospitals to enable them to provide comprehensive health care to children in need of such care in areas where low-income families are concentrated in order to help reduce the numbers of children of preschool and school age who are hampered by remediable handicaps, and to provide necessary health care for children from low-income families who would not otherwise receive it. Although all children in a project area may receive screening, diagnostic and preventive services, treatment (both medical and dental), correction of defects, and aftercare will be pro-

vided through the project only for children who would not otherwise receive it because of low income or for other reasons beyond their control.

3. History

This is a new program authorized by Public Law 89–97, the Social Security Amendments of 1965. It is responsive to the President's health message of January 7, 1965, and is recognition of the fact that while acute and chronic illness strikes all children, the burden and the need for medical services is greatest among the poor. About one-third of our children live in low-income families—these families tend to be concentrated in crowded urban centers or in depressed rural areas. They strain the medical resources available to them in the communities in which they live, the quality of care deteriorates and an increasing number do not receive the services they need.

A supplemental appropriation of $15 million for grants, the amount authorized for the fiscal year ending June 30, 1966, was signed by the President on October 31, 1965.

4. Level of operations

The appropriation and estimated obligations for 1966 are $15 million, and for 1967 are $35 million.

5. Estimated magnitude of program in 1970

The authorization for appropriation for project grants for fiscal year 1970 is $50 million. It increases to this in steps of $5 million from a $35 million authorization in fiscal year 1967.

6. Prospective changes in program orientation

Because of the need for medical services for school age and preschool children in low-income families it is anticipated that the program once funded will develop rapidly and that the full authorization will be needed. The legislation calls for evaluation and recommendation as to continuation and modification at the end of 5 years.

7. Coordination and cooperation

See item 7 under Maternal and Child Health Services.

8. Laws and regulations

Public Law 89–97 (79 Stat. 286).

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

The economic effects of all personal and community health programs are discussed in the statement covering those administered by Public Health Service and other operating agencies of the Department of Health, Education, and Welfare.

10. Economic classification of program expenditures

Program not in operation in fiscal 1965.

Office of Juvenile Delinquency and Youth Development—Juvenile Delinquency and Youth Offenses

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The program is designed to provide Federal financial assistance and technical consultation to public and private agencies and institutions for the development of new approaches and techniques for the prevention and control of juvenile deliquency. Funds are awarded for demonstration and training programs which are deemed innovative and possess potential for adaptation by other communities, agencies, and institutions.

2. Operation

The Office of Juvenile Deliquency and Youth Development has no regional or field offices. It provides grants and contracts directly to State, local, or other public or nonprofit agency, organization, or institution for demonstration and training programs, as well as technical assistance to help grantees design and carry out their programs.

3. History

The President's Committee on Juvenile Deliquency and Youth Crime was created by Executive order on May 11, 1961, as a means of providing a new federally coordinated approach to the prevention and control of juvenile deliquency. It involved the cooperation of three Cabinet officers and their departments. The Attorney General was designated Chairman, and the Secretaries of Labor and Health, Education, and Welfare were appointed as members.

The Committee was charged with coordinating and recommending expansion of activities of the Federal Government relating to juvenile delinquency, as well as new programs in the field of youth and crime.

In September 1961, the Congress—responding to a request from the White House—enacted the Juvenile Delinquency and Youth Offenses Control Act, making possible a joint Federal-local program designed to provide new answers to an old and perplexing question. The act authorized $10 million a year for 3 years to be used for demonstration and training grants, and also authorized technical assistance and information services for the general public or agencies involved with troubled youth. The Office of Juvenile Delinquency and Youth Development was created to administer the act within the Department of Health, Education, and Welfare—in cooperation with the President's Committee on Juvenile Delinquency and Youth Crime.

In July 1964, the 88th Congress passed a 2-year extension of the act, including amendments providing for a study of the relationship between compulsory school attendance laws, the laws and regulations governing the employment of minors, and the effects of such laws on juvenile delinquency and youth crime. It also authorized a special project to be conducted in the Washington Metropolitan area to demonstrate to the Nation the effectiveness of a large-scale, well-rounded program for the prevention and control of juvenile delinquency. It authorized $10 million for fiscal 1965, and $5 million for the Washington, D.C. project (to remain available until expended).

On July 8, 1965, the Congress again voted a 2-year extension of the act, authorizing a total of $16,500,000 through June 30, 1967.

To date, the program has funded 74 demonstration and 215 training projects.

4. Level of operation. (See table 1.)

Program: Juvenile delinquency and youth offenses.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Office of Juvenile Delinquency and Youth Development.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Grants awarded by this Office	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 estimates
Number of grants awarded	58	73	71	98
Applicants:				
Private nonprofit agencies	24	41	[1] 36	[1] 49
Educational institutions	27	24	[1] 28	[1] 41
State or local governments	6	8	[1] 7	[1] 8
Federal agencies	1	0	[1] 0	[1] 0
Unobligated appropriations available	0	[2] $7,000	0	0
Obligations	$6,852,000	$11,475,000	$6,750,000	$8,207,000
Matching funds	([3])	([3])	([3])	([3])
Number of Federal Government employees administering, operating, or supervising the activity [4] (man-years)	18	32	35	36
Non-Federal personnel employed in the program (man-years)	6	7	5	5

[1] Estimated on basis of 1964–65 expenses.
[2] Returned to the Treasury.
[3] Grants are now awarded on a matching basis. Most projects have contributed some of their own funds and many projects also are supported by other Federal agencies and/or private groups. Tabulations on the amounts of these funds are not readily available.
[4] The Office is staffed by the Director and his Deputy, the Chief of Training and Demonstration Programs, 8 social science analysts and 2 program analysts, 4 research analysts, 2 information specialists, and 4 administrators. In addition, there are 10 secretaries in support of the Office. The primary responsibilities of the demonstration and training staffs are as follows:

The Demonstration Section has the responsibility for the encouragement of programs that demonstrate the effectiveness of community efforts for the prevention and control of juvenile delinquency. It provides constant consultation and other technical assistance to the projects. It also gives assistance to communities planning programs to combat juvenile delinquency when these communities request assistance, even in the absence of the possibility of Federal financial support.

The Training Section has the responsibility of operating the training grant programs. It encourages the development of training centers for the training of personnel in fields relating to juvenile delinquency prevention and control. The Training Section is responsible for consultation to any of the training activities supported by the program and to others upon request. It reviews data regarding juvenile delinquency and develops generalizations that are useful for the entire country.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) and (*b*) Within the Welfare Administration, the Office of Juvenile Delinquency and Youth Development actively coordinates its programs with other units—specifically, the Children's Bureau, the Bureau of Family Services, and the research unit of the Commissioner's office. In addition, the Office maintains ongoing relationships with other units of the Department—such as the National Institute of Mental Health, Office of Education, and Vocational Rehabilitation Administration; and participates in such intradepartmental activities as the Department of Health, Education, and Welfare task force on social work education and manpower.

(*c*) The Office of Juvenile Delinquency and Youth Development maintains close contacts with the Office of Economic Opportunity, the Department of Justice, the Department of Labor, and other

Federal agencies and departments through the instrumentality of the President's Committee on Juvenile Delinquency and Youth Crime.

(*d*) and (*e*) Consultants maintain relationships at the appropriate levels of State and local governments where such State and local governments or their instrumentalities are involved in projects funded by the Office of Juvenile Delinquency and Youth Development.

(*f*) No formal relationships with foreign governments or international organizations are maintained.

(*g*) Same as (*d*) and (*e*), in addition to such public and private nonprofit institutions as colleges and universities, youth organizations, et cetera.

(*h*) Consultation provided and contact maintained as requested (i.e., discussions continuing with Inland Steel Corp. relative to a program involving job training for delinquent youth).

8. Laws and regulations

Public Law 87-274, 87th Congress, S. 279, September 22, 1961—Juvenile Delinquency and Youth Offenses Control Act of 1961; authorized $10 million for the fiscal year ending June 30, 1962, and a similar sum for each of the two succeeding fiscal years.

Public Law 88-368, 88th Congress, H.R. 9876, July 9, 1964—extending the 1961 act for an additional 2 years with the amendments referred to in question 3.

Public Law 89-69, 89th Congress, H.R. 8131, July 8, 1965—extending the original act through June 30, 1967.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

All of the comprehensive demonstration projects had, as their target population, youth and their families in low-income areas which are also high in delinquency. These projects were designed to provide a total-community attack on conditions giving rise to delinquency. The program was based on the belief that delinquency is not just a personal deficiency on the part of the individual, but is also the result of social conditions which include discrimination, inadequate opportunities, poor housing, et cetera.

To attack these conditions, it appeared necessary to mobilize broad community support so that all agencies—public and private—could work together with new techniques, new attitudes, and new combinations of services. Basic to these projects were job training and placement. An essential ingredient has been community organization aimed at providing low-income groups with the opportunity to develop skills and the desire to improve their own situation.

Training projects reaching teachers, social workers, police and judges, employment counselors, etc., have upgraded the skills of such personnel and increased the understanding of the "culture of poverty," thereby providing wider opportunities to inner-city youth. The poor themselves have been trained as homemakers, homework helpers, and as various "human service" aids—in recreation, day care, et cetera.

10. Economic classification of program expenditures. (See table 2.)

Program: Juvenile delinquency and youth offenses.
Department or agency, and office or bureau: Department of Health, Education, and Welfare; Welfare Administration; Office of Juvenile Delinquency and Youth Development.

TABLE 2.—*Economic classification of program expenditures for fiscal year 1965*

[In millions of dollars]

Federal Government: [1]	
Purchases of goods and services:	
Wages and salaries	$0.4
Other	.5
Grants to State and local governments	1.4
Transfer payments to individuals and nonprofit organizations	9.1
Total Federal expenditures	11.5
Non-Federal expenditures data not available	

[1] Expenditures here refer to obligations. Actual Federal expenditures for the program were $9.9 million as compared with $11.5 million for obligations.

Administration on Aging

COMMUNITY PLANNING, SERVICES, AND TRAINING

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The Older Americans Act (Public Law 89–73) provided for the creation of an Administration on Aging within the Department of Health, Education, and Welfare, for a program of grants to the States to provide assistance in the development of new or improved programs to help older persons through community planning, services, and training, and for direct grants to public and nonprofit agencies for research, development of programs and services, and training specialized personnel. The Administration on Aging is headed by a Commissioner on Aging appointed by the President with Senate confirmation.

The Administration on Aging provides a focal point for matters concerning the efforts of the Federal Government to meet the needs of older people and to create conditions and opportunities which will enable them to continue to serve the Nation. In addition to administering the three grant programs (described below), the Administration on Aging is charged with: Serving as a national clearinghouse of information on aging; assisting the Secretary on matters related to aging; developing plans for, conducting, and arranging for research and demonstration programs; providing technical assistance and consultation to State agencies and political subdivisions; preparing, publishing, and disseminating educational materials; gathering statistics; and stimulating more effective use of existing resources and services.

The declaration of objectives of the Older Americans Act states that it is "the joint and several duty and responsibility of the governments of the United States and of the several States and their political subdivisions to assist our older people to secure equal opportunity to the full and free enjoyment of the following objectives: (1) An adequate income in retirement in accordance with the American standard of living. (2) The best possible physical and mental health which science can make available and without regard to economic status. (3) Suitable housing, independently selected, designed, and located with reference to special needs and available at costs which older citizens can afford. (4) Full restorative services for those who require institutional care. (5) Opportunity for employment with no dis-

criminatory personnel practices because of age. (6) Retirement in health, honor, dignity—after years of contribution to the economy. (7) Pursuit of meaningful activity within the widest range of civic, cultural, and recreational opportunities. (8) Efficient community services which provide social assistance in a coordinated manner and which are readily available when needed. (9) Immediate benefit from proven research knowledge which can sustain and improve health and happiness. (10) Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives."

2. Operation

The Administration on Aging, as one of the operating agencies of the Department of Health, Education, and Welfare carries on functions both individually and jointly with its other operating agencies. Coordination is effected by the Office of the Secretary, by means of a departmental committee on aging, and through direct rapprochements with other agencies.

Coordination with programs of other departments is effected through joint program consultation on operations and through the President's Council on Aging, established by Executive Order 11022 in 1962. The Secretary serves as chairman and the Commissioner on Aging as deputy chairman of the council which includes the Departments of Health, Education, and Welfare; Agriculture; Commerce; Housing and Urban Development; Labor; Treasury; and the Civil Service Commission and the Veterans' Administration.

A significant cooperative activity of the Administration on Aging with the Office of Economic Opportunity is the program for employing impoverished older people in community services (foster grandparents program). This program is described separately in the final section of this report.

The Administration on Aging initiates and maintains liaison and cooperative activities with national organizations of older people and with professional and voluntary organizations in the field.

Administration of the program of grants to the States and provision of consultation to States and communities is handled by central office staff with the assistance of regional representatives on aging in the nine regional offices of the department.

In carrying out the purposes of the Older Americans Act, the Secretary is assisted by a 15-member Advisory Committee on Older Americans under the chairmanship of the Commissioner on Aging. Technical advisory committees are established as needed.

3. History

The Older Americans Act (Public Law 89–73) was signed into law by President Lyndon B. Johnson on July 14, 1965. The Administration on Aging, established by the act, became operational on October 1, 1965, when a supplemental appropriation for the Department was made. At the same time, the President named a Commissioner for the Administration, who was then confirmed by the Senate.

The law represents the fulfillment of a longtime objective of congressional leaders to designate a high-level agency of Government to be concerned with all the manifold needs of older people and to serve as a clearinghouse and coordinating mechanism for the activities of Government agencies which affect the aging.

Many steps, stretching over nearly two decades, led to passage of the Older Americans Act. Perhaps most significant was the White House Conference on Aging in 1961. One of the recommendations of the Conference was that the Federal coordinating agency in the field of aging should be given a statutory basis and more independent leadership. Provisions of the act, including functions assigned to the Administration on Aging, are directed toward accomplishing this and other recommendations of the White House Conference. Some of these functions had been performed, on a restricted basis, by the former Office of Aging in the Department of Health, Education, and Welfare since 1950.

4. Level of operations. (See table 1.)

Program: Community planning, services, and training.
Department and agency, and office or bureau: Department of Health, Education, and Welfare; Administration on Aging.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure and unit	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimates	Fiscal year 1967 estimates
(a) Magnitude of the program—Appropriation	(1)	(1)	$5,000,000	$6,000,000
(b) Applicants or participants: States	(1)	(1)	37	55
(c) Federal finances:				
Unobligated appropriations available	(1)	(1)	$1,104,000	0
Obligations incurred	(1)	(1)	$3,896,000	$7,104,000
Allotments made	(1)	(1)	$5,000,000	$6,000,000
(d) Matching expenditures from States and other agencies	(1)	(1)	$1,692,000	$2,486,000
(e) Number of Federal employees administering, operating, or supervising the activity	(1)	(1)	41	41
(f) Non-Federal personnel employed in the program	(1)	(1)	(2)	(2)

[1] Not applicable; program not in operation.
[2] Not available.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The Administration on Aging works closely with the States in the development of State plans (required by the act) for carrying out the activities authorized by the act. It also provides consultation to States, communities, and agencies in determining needs of older people, establishing program and service priorities, development of methods and procedures, and making use of other Federal program resources.

Information regarding program goals, priorities, joint agency approaches, and other matters, developed by the Administration on Aging in cooperation with other Federal agencies, is transmitted to the States.

8. Laws and regulations

See title III of Public Law 89–73.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Programs under the Older Americans Act are just becoming operational. Hence, it is too early for measurable economic effects. On

the basis of plans submitted by the States to date, it may be anticipated that Federal funds, supplemented with funds from non-Federal sources, will support a great variety of services such as increasing the availability of community programs and services, providing information and counseling, educational and recreational services, part-time employment in the regular work force and in community service occupations, concerted services in housing developments for older people, and preventive, maintenance, and restorative services to older people in their own homes. It is anticipated, further, that some of these programs will involve the employment of older people and that some will lead to improved health and participation in the regular work force.

10. Economic classification of program expenditures

Not applicable; program not in operation in 1965.

Grants and Contracts for Research, Development, and Specialized Training

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

Not answered.

2. Operation

Not answered.

3. History

See the preceding statement.

Program: Grants and contracts for research, development, and specialized training.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Administration on Aging.

Table 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(a) Magnitude (appropriation)	(1)	(1)	$1,500,000	$3,000,000
(b) Applicants (agencies and institutions)	(1)	(1)	50	85
(c) Federal unobligated appropriations available	(1)	(1)	0	0
(d) Matching appropriations	(1)	(1)	$300,000	$600,000
(e) Number of Federal employees administering the program	(1)	(1)	15	15
(f) Non-Federal personnel employed	(1)	(1)	None	None

[1] Not applicable; program not in existence.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

The program is being set up and will be conducted with reference to demonstrated needs and with reference to established grant programs of other agencies. Experience of the Administration on Aging,

guidance from advisory committees, and needs of States and communities will guide those responsible for the grant program.

Contact has been established with other agencies such as the Public Health Service, Welfare Administration, Vocational Rehabilitation Administration, and Office of Economic Opportunity for the purposes of: (*a*) encouraging research and demonstration projects and training programs in new areas; (*b*) closing support gaps which have existed; and (*c*) avoiding program overlap and duplication.

8. Laws and regulations

See titles IV and V, Public Law 89–73.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

Since no grants or contracts have been awarded as yet, there have been no economic impacts of the program. It is anticipated, however, that during the second half of the fiscal year (1966), a number of training, research, and demonstration projects will be initiated. Training and research programs may be expected to increase the competencies of personnel for employment in services to older persons; demonstration projects will result in the employment of some older persons; and all projects should help to improve the capacities of older people for self-sufficiency and involve some of them in paid or unpaid services to their communities.

10. Economic classification of program expenditures

Not applicable; program not in operation in 1965.

Foster Grandparent Program [1]

PART I. DESCRIPTION OF THE PROGRAM

1. Objectives

The foster grandparent program (FGP) began as a demonstration to employ impoverished persons 60 years of age and older in offering adult attention, love, training, and guidance to dependent, neglected, helpless, and/or otherwise needy infants and children in institutions. Initially directed toward children 0 to 5 years of age, the program has been extended to children 6 to 16 years of age and to mentally retarded children.

The program benefits the infants and children served and the older people by giving them a useful role and wages to supplement their meager incomes.

2. Operation

The program is administered jointly between the Administration on Aging (AOA) and the Office of Economic Opportunity (OEO). Funds for approved locally initiated demonstration projects are provided by OEO under section 207 of the Economic Opportunity Act. AOA is responsible for promoting and supervising the projects. The foster grandparent program director (AOA) is responsible for general program development, reviewing project applications, recommending approval of projects, supervising ongoing projects, and serving as liaison between AOA and OEO, and between individual projects and OEO.

[1] This is a cooperative program with the Office of Economic Opportunity to employ impoverished older people in providing services to special groups in the population.

The individual projects are developed and submitted by local agencies throughout the country. They are reviewed by AOA and, if approved, funded by OEO. The local projects become a part of the national demonstation-evaluation effort. The recruitment, training, and assignment of the elderly to the institution is a local responsibility supervised by the agency receiving the grant from OEO. The AOA assists the local group through consultation during the project and supervises the collection and evaluation of data from the local projects. These data are assembled and published by OEO.

Currently, community-initiated projects which do not include a new element or feature are supported from local community action funds (sec. 205) but are under the oversight of the Administration on Aging.

3. History

In the spring of 1965, the AOA (then the Office of Aging) and OEO jointly conducted an investigation into the needs of institutionalized children which might be met by the elderly.

In May 1965 notification of interest in the development of a demonstration-evaluation program was released through the regional offices of HEW. Agencies and institutions indicating an interest in further discussion regarding the potential of the program were invited to meetings in Washington held on June 12 and 22, 1965. Seventy representatives attended. Some 52 institutions from 22 communities submitted applications. On August 28, 1965, President Johnson announced the approval and funding of the 22 projects, mainly for infants and children up to 5 years of age.

During September 1965, plans were developed for extending the program to older children. Projects are constructed to demonstrate and evaluate the benefits and problems of this type of employment opportunity for the elderly. Each project initially is for a demonstration period of a year. Additional funding was authorized by OEO in December.

4. Level of operations. (See table 1.)

Program: Foster grandparent program.

Department or agency, and office or bureau: Department of Health, Education, and Welfare; Administration on Aging in cooperation with the Office of Economic Opportunity.

TABLE 1.—*Level of operations or performance, fiscal years 1964–67*

Measure	Fiscal year 1964	Fiscal year 1965	Fiscal year 1966 estimate	Fiscal year 1967 estimate
(*a*) Magnitude of the program (allotment)	[1]	[1]	$5,400,000	$5,400,000
(*b*) Applicants or participants:				
State government agencies			15	15
Local communities or governments			20	20
Individuals or families			0	0
Other nonprofit voluntary agencies			25	25
(*c*) Federal finances:				
Unobligated appropriations available			$2,700,000	$2,700,000
Obligations incurred			0	0
Allotments or commitments made			$2,700,000	$2,700,000
(*d*) Matching or additional expenditures for the program			$375,000	$375,000
(*e*) Number of Federal Government employees administering, operating, or supervising the activity			12	12
(*f*) Non-Federal personnel employed in the program			[2]	[2]
(*g*) Other measures of level or magnitude of performance			[3]	[3]

[1] Not applicable; program not in operation.
[2] 200 staff, 2,500 FGP's.
[3] See narrative.

NOTE.—This program is also included as part of the community action program of the Office of Economic Opportunity.

5. Estimated magnitude of program in 1970

Not answered.

6. Prospective changes in program orientation

Not answered.

7. Coordination and cooperation

(*a*) *Within AOA.*—This program is conducted as an activity of the Office of State and Community Services of the Administration on Aging. The entire facilities of the Administration including the Office of the Commissioner and the Office of Program Policy and Information are involved from time to time in the development, conduct, and evaluation of this program.

(*b*) *Other units of the Department of Health, Education, and Welfare.*—A Technical Advisory Committee of representatives from the Welfare Administration, the Childrens Bureau, the Bureau of Family Services, and other units as determined appropriate, meets periodically to review the program. Communications regarding the program are sent regularly to the regional representatives of these Bureaus and Divisions within HEW.

(*c*) *Other Federal Government departments or agencies.*—Communication with departments and agencies indicating an interest and concern for employment of older Americans has been established and will be maintained. Present work with the Public Housing Administration, Bureau of Indian Affairs, Department of Agriculture, President's Commission on Mental Retardation, etc., will continue.

(*d*) *With State governments or their instrumentalities.*—Through State commissions on aging and State departments of public welfare and State departments of health, the location of appropriate project sponsors and the use of their resources for consultation on other assistance in the successful conduct of the program has been and will continue to be stressed.

(*e*) *With local governments or communities.*—Present sponsorship by local welfare departments, community action bodies of the economic opportunity program, and similar organizations have been and will be sought. Some 5 such groups presently serve as sponsors of the first 22 programs.

(*f*) *With foreign governments or international organizations.*—Sponsorship of these organizations is not applicable to this program.

(*g*) *With nonprofit organizations or institutions.*—The primary source of sponsorship for foster grandparent program stems from this type of organization. Included in the existing programs are health and welfare councils, bureaus of Catholic charities, family service agencies, and local church and local senior citizens organizations. Such sponsorship will continue to be encouraged.

(*h*) *With business enterprises.*—The program is set up for conduct through nonprofit organizations. Therefore, this category is not applicable to the foster grandparent program.

(*i*) *With others.*—At this time no other organizations, institutions, or agencies have indicated an interest or submitted a proposal in this program.

8. Laws and regulations

The Economic Opportunity Act, Public Law 88–452, 88th Congress, August 20, 1964, section 207 is a primary authority for the foster

grandparent program. Public Law 89–73, 89th Congress, dated July 14, 1965, creating the Administration on Aging and section 202 specifying the functions of the AOA provide the authority for the Administration to participate with OEO in this program. The specific agreement between these two agencies is set forth in a letter of memorandum between them dated June 30, 1965, and in a subsequent memorandum of agreement dated December 3, 1965.

PART II. DATA BEARING ON ECONOMIC ASPECTS AND IMPACTS OF THE PROGRAM

9. Economic effects

(*a*) It is estimated that approximately $3,100,000 of the $5,400,000 allotted for the program will be paid to impoverished older people; that $1,600,000 will be paid in salaries to supervisory personnel; and that $500,000 will be paid for nonwage and salary items. As indicated in the table above, there will be an estimated aggregate contribution of $375,000 by local sponsors.

(*b*) The program provides 200 new supervisory positions and 2,500 placements of older persons. It is anticipated that a considerable number of these people will continue to have employment by the sponsoring organizations or by similar agencies.

(*c*) Not applicable.

(*d*) Almost the entire expenditure for the program should be reflected in employment and increased purchasing power of the wage and salary recipients.

(*e*) It is expected that there will be at least three notable noneconomic effects: (1) improved personality development, social participation, and life satisfaction for the recipients of the services; (2) a knowledge on the part of the foster grandparents that they still have a contributory, hence, a useful place in society; and (3) recognition on the part of professional personnel that low-income, lay older persons have the interest, energy, and skills to provide significant services to other people.

(*f*) No observance of differentials as yet.

(*g*) Not measurable except that 86 percent of the allotment of $5,400,000 or $4.9 million represents a new contribution to the GNP and to aggregate national income and purchasing power.

10. Economic classifications of program expenditures

Not applicable; the program was not in operation during 1965.

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