ADAMHA Reorganized—Prevention, Treatment Functions to SAMHSA

As part of a major Federal effort to strengthen prevention and treatment of mental and addictive disorders, the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Public Health Service has been reorganized into the Substance Abuse and Mental Health Services Administration (SAMHSA).

SAMHSA's key mission is to strengthen service delivery nationwide, in large part by assisting State and local agencies to expand capacity and access, to improve the quality of services, and to develop community-wide approaches to addressing mental and addictive disorders. The new Agency administers the substance abuse and mental health treatment and prevention programs formerly in ADAMHA, and has launched several new programs authorized by Congress in the ADAMHA Reorganization Act of 1992 (P.L. 102-321).

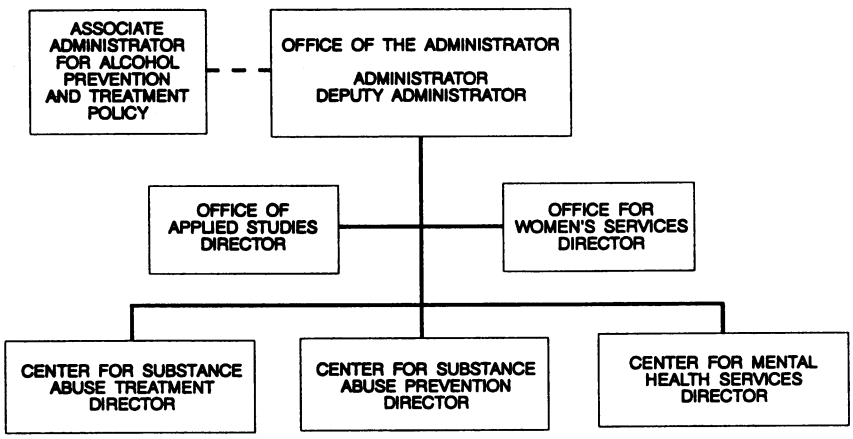
First authorized by the Congress in 1974, ADAMHA initially consisted of three institutes devoted primarily to research—the already existing National Institute of Mental Health (established in 1946), the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism. The Office for Substance Abuse Prevention was created in 1986, followed by the Office for Treatment Improvement in 1990, to enhance efforts geared toward service delivery. In the 1992 reorganization, the three research Institutes were transferred to the National Institutes of Health (NIH) where they will continue to maintain their separate identities.

Agency Structure

SAMHSA consists of three Centers, with central oversight and coordination provided by the Office of the Administrator (see chart).

The Center for Substance Abuse Treatment (CSAT) administers programs aimed at enhancing the quality of substance abuse treatment systems. Among these are treatment programs for substance-abusing pregnant and postpartum women and their children, and for persons within the criminal justice system; training programs for substance abuse counselors and other health professionals; and demonstration programs to improve services for special populations (adolescents, racial and ethnic minorities, residents of public housing, and the homeless).

Substance Abuse and Mental Health Services Administration



The Center for Substance Abuse Prevention (CSAP) administers two major grant programs—the Community Partnership Program that helps community coalitions develop partnerships using a systematic approach to prevent substance abuse, and the High Risk Youth Program, aimed at youngsters at high risk for alcohol or other drug use. CSAP also helps small business employers who cannot afford Employee Assistance Programs to establish them.

In addition, the Center administers training programs to prepare staff and volunteers to work in substance abuse prevention and a health professions development program in addictive disorders. CSAP also operates the national drug testing laboratory certification program. Further, it operates the National Clearinghouse for Alcohol and Drug Information and carries out a variety of media and public education campaigns aimed at preventing alcohol and other drug abuse.

The Center for Mental Health Services (CMHS) seeks to improve access to treatment, prevention, and rehabilitation services while reducing the impact of mental illness on families and communities. Among specific programs are those for children with serious emotional disturbances, for the homeless, and for clinical training of professional mental health workers.

Block Grants

SAMHSA administers two Block Grant Programs for the States, one for substance abuse services (up to $1.5 billion in Fiscal Year 1993), and one for mental health services (up to $450 million in the same period).

Other Functions

A new Office of Applied Studies serves as the focal point for the Agency's data gathering, analysis, and dissemination activities, while an Office for Women's Services addresses issues relating to substance abuse and mental health services for women. An Associate Administrator for Alcohol Prevention and Treatment Policy coordinates alcohol programs within the three Centers, as well as between SAMHSA and other public and private institutions.

Special Studies

SAMHSA is authorized to conduct several special studies. Selected subjects include the role of the private sector in development of anti-addiction medications for treatment of drug addiction, barriers to insurance coverage

of treatment for mental illness and substance abuse, and assessment of programs that distribute sterile hypodermic needles and bleach to drug abusers to try to reduce the risk of AIDs and related conditions.

—DEBORAH GOODMAN, Public Affairs Specialist, SAMHSA

HRSA Reorganizes Component Program Bureaus for 'Clarification'

A number of organizational components of the Health Resources and Services Administration (HRSA) of the Public Health Service have been restructured and realigned and new ones created in what HRSA officials called "a clarification of functions."

The name of the Bureau of Health Care Delivery and Assistance has been changed to the Bureau of Primary Health Care (BPHC). To reflect more accurately the Bureau's focus, four of its divisions also changed their names. Marilyn Gaston, MD, is Bureau Director.

Its function is to help assure that primary health care services are provided to the medically underserved and those with special health care needs. The Bureau is also responsible for the placement of health professionals in underserved areas.

BPHC programs include Community and Migrant Health Centers, Comprehensive Perinatal Health Care, Health Care for the Homeless, Services for Residents of Public Housing, and the National Health Service Corps.

The Office of Minority Health has been established formally to serve as HRSA's principal advisor and coordinator for health program activities that address the special needs and problems of minority and disadvantaged populations. This office provides guidance and direction for programs and activities within HRSA designed to improve the delivery of health services to racial and ethnic minority groups. Ileana Herrell, PhD, is Associate Administrator for Minority Health.

The Office of Public Health Practice has been established to serve as the focal point of efforts to strengthen the practice of public health in the nation. The office promotes public-private partnerships that respond to public health problems, strengthening the assessment, policy development, and quality assurance aspects of these collaborative efforts. Douglas Lloyd, MD, MPH, former State Health Director in Connecticut, is Associate Administrator for Public Health Practice.

The Office of Information Resources Management was transferred to the Office of the Administrator to serve as the focal point for all activities associated with computer resources and information mangagement.

The Healthy Start Program was transferred to the Maternal and Child Health Bureau. The program coordinates 15 demonstration programs in areas with high infant mortality rates that involve community efforts to reduce the mortality rates. It also administers a national public information and education campaign to raise awareness about infant mortality and about the importance of early and regular prenatal care. Thurma McCann, MD, MPH, serves as Program Director.

The Small and Disadvantaged Business Utilization function was transferred to the Office of Equal Opportunity and Civil Rights.

The Freedom of Information Act function was transferred from the Office of Communications to the Office of Operations and Management. Joel Levine is the agency's FOIA officer.

The AIDS-related grants programs of national significance were transferred from the AIDS Program Office to the Bureau of Health Resources Development.

The Trauma Care Program was established within the Bureau of Health Resources Development.

WHO Issues New Report on Reproductive Health

The World Health Organization's "Reproductive Health, A Key to a Brighter Future," the most comprehensive report of its kind ever compiled, reveals a number of major global trends in reproductive health.

- In developing countries, fertility rates have dropped from 6.1 children per woman to 3.9 in the past 20 years;
- Some 300 million couples, who do not want any more children, still do not have access to family planning services;
- Each year more than 500,000 women die from complications of pregnancy and childbirth;
- About 150,000 abortions are induced each day; one-third of these are in unsafe conditions and 500 women die;
- There are more than 60 million infertile couples in the world;
- Some 250 million new cases of sexually transmitted disease occur each year.

The report was compiled to mark the 20th anniversary of the World Health Organization (WHO) Special Program of Research, Development and Research Training in Human Reproduction established in 1972. The program, which is co-sponsored by the United Nations Development Program, the United Nations Population Fund, and the World Bank, has become the main institution for research on human reproduction within the United Nations system.

Contraceptives

The WHO report shows that the fertility rate—the average number of children per woman—in developing countries declined from 6.1 in the 1965–70 period to 3.9 in the 1985-90 time frame.

This corresponds to a rise in the use of contraceptives in developing countries—defined as the percentage of married women of reproductive age (or their husbands) using any form of contraceptive—from 9 percent in 1965–70 to 50 percent in 1985–90.

The most commonly used method of contraception is female sterilization, followed by the intrauterine device, the pill, condoms, and male sterilization. The world's population would have increased by more than 400 million over the current level had the global campaign been delayed by only 10 years. Projected to the year 2100, the additional increase would have amounted to 4.6 billion people.

To point out how rapidly some countries have changed, the report says that while the fertility rate in the United States took 58 years to drop from 6.5 to 3.5, the same drop took 27 years in Indonesia, 15 years in Colombia, 8 years in Thailand, and only 7 years in China.

Abortion

The report estimates that 36 million to 53 million induced abortions are performed each year, an annual rate of 32-46 abortions per 1,000 women of reproductive age.

Based on various estimates, 15 million are clandestine abortions, though

the actual number may be as high as 22 million.

The report describes a wide variety of laws on abortion among countries:

- 52 countries, with 25 percent of the world's population, permit abortion only when a woman's life is endangered;
- 42 countries, with 12 percent of the world's population, have laws that permit abortion on broader medical grounds—to avert a threat to the woman's general health and sometimes for genetic or judicial reasons, such as incest or rape;
- 13 countries, with 23 percent of the world's population, allow abortion for social or sociomedical reasons;
- 25 countries, with 40 percent of the world's population, permit abortion up to a certain point in gestation without requiring specific reasons.

The report also states that most women seeking abortion are married or living in stable unions and already have several children. In all parts of the world, however, a small but increasing proportion of abortion seekers are unmarried adolescents.

One surprising finding is that high abortion rates do not necessarily correlate with liberal abortion laws. For example, the Netherlands has one of the lowest abortion rates despite its liberal abortion law.

Infertility

The prevalence of infertility has been declining in recent years in several developing countries as a result of better preventive health care. Infertility trends in developed countries are difficult to estimate because of the high prevalence of voluntary infertility.

The most common and the most important cause of acquired infertility is pelvic infection resulting from sexually transmitted disease, an unsafe abortion, or childbirth-related infection, all of which are preventable.

In a standardized clinical investigation of infertility involving more than 10,000 infertile couples in 25 countries, infections accounted for female infertility in 36 percent of the cases in developed countries, 85 percent in Africa, 39 percent in Asia, 44 percent in Latin America, and 42 percent in the Eastern Mediterranean Region of WHO.

Sexually Transmitted Diseases

An estimated 250 million or more new cases of sexually transmitted infections—including syphilis, genital herpes, gonorrhea, the human immunodeficiency virus (HIV), and others—occur each year.

The infections include 120 million cases of trichomoniasis, 50 million of chlamydia, 30 million genital human papilloma virus, 25 million gonorrhea, 20 million genital herpes, 3.5 million syphilis, and 2 million chancroid.

WHO estimates that, as at early 1992, some 2 million cases of acquired immunodeficiency syndrome (AIDS) have occurred since the beginning of the pandemic, and at least 10–12 million HIV infections.

Although sexually transmitted infections have been increasing during the last 25 years, the advent and spread of HIV and AIDS has helped to increase the attention paid by governments, the health sector, and the public to such diseases and infections, lending new impetus to efforts to prevent and control them. In addition, WHO says fear of AIDS has prompted changes in sexual behavior leading, in some countries, to a stabilization or even a reduction in the level of some sexually transmitted infections.

Sexually transmitted infections threaten health in a variety of ways, particularly that of women. They can cause infertility, ectopic pregnancy and possibly even cancer. They threaten the newborn because they can be passed from infected mother to child. There is growing evidence that many sexually transmitted infections especially those that cause genital lesions or inflammations, can greatly increase the risk of sexual transmission of HIV.

According to Dr. Hiroshi Nakajima, Director-General of WHO, "Sexually transmitted infections and diseases, including AIDS, have reached epidemic proportions globally, and if sexual behavior is not modified and effective new prevention and control programs are not implemented immediately, the resulting disease and mortality rates will be even more staggering."

"Reproductive Health, A Key to a Brighter Future" is available for about $25 from WHO Publication Center USA, 49 Sheridan Ave., Albany, NY 12210.

12 States Get $8 Million for Health Care Reforms

Twelve States have been granted up to a total of $8.4 million to develop a wide range of plans to expand health insurance coverage and contain costs, as part of the Robert Wood Johnson Foundation's $25.5 million national program, State Initiatives in Health Care Financing Reform.

The 12 grantee States are Arkansas, Colorado, Florida, Iowa, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont, and Washington.

The 2-year development grants will assist the States in testing many of the ideas and options now being considered as strategies for national health care reform.

"The intent of the program is not only to help States develop new ideas and test models for reform, but for Federal policymakers to learn from these state-based experiments when they redesign national health policy," commented Steven A. Schroeder, MD, President of the Johnson Foundation, in announcing the awards.

While all the funded proposals share the ultimate goal of expanding access to health care, they span the political and theoretical spectrum of health care reform strategies, including individual health accounts, managed competition, play-or-pay mandates on employers, and single-payer systems.

Some highlights of the funded proposals include

- Three States propose to establish single payer or regulated multiple-payer systems.
- Four States will explore the use of establishing dollar limits or targets that will limit total expenditures for health care services or those paid to a provider annually.
- Four States propose to develop a play-or-pay mechanism in which all employers would provide basic coverage to their employees or pay into a State insurance pool.
- Six States intend to create a State insurance plan or to subsidize health insurance products that target special populations, such as small businesses or children.
- Four States propose to develop uniform claims processing and billing systems for insurance.

A total of 35 proposals were received by the foundation and reviewed by an independent national advisory committee of experts in the field of health care financing and delivery. Following the first phase of the program

in which the 12 grantees will use their funds to develop their proposed reforms, they will then be eligible to apply for up to 3 years of additional funding to support implementation of their efforts.

To assist grantees in assessing their options, analyzing data, and understanding the legal and regulatory issues involved in reform, specialized technical assistance and consulting services will be supplied by the National Governors' Association, the Alpha Center, acting as the national program office, together with RAND and the Urban Institute, helping States with their analytical needs.

"We have made these funds available to the States to encourage them to go as far as they can to improve access and to control costs," added Dr. Schroeder. "Historically, States have paved the way for a number of new national policies, and in many ways they will be testing the reality of health care reform strategies."

North Carolina Opens First Center for Nursing Information, Planning

The North Carolina Center for Nursing, a new State agency, seeks to ensure access to quality nursing care for North Carolina residents.

"There is no comparable center anywhere and no public agency with the same kind of goals," said Judy Seamon, RN, of Morehead City, chairperson of the center's board of directors. "Some States have agencies that focus on recruitment and retention of nurses. Other States have boards of nursing focusing on data base information. The North Carolina Center for Nursing will be a comprehensive health-care resource."

The center was established in 1991 by the North Carolina General Assembly to address the nursing supply and demand issues of recruitment, retention, use of existing labor resources, strategies for allocating the State's resources directed toward nursing, and a strategic plan for nursing manpower.

"The nursing shortages of the 1980s, like those occurring in previous decades, created significant problems for the health-care system in North Carolina and the nation," said Shirley A. Girouard, PhD, RN, the center's executive director.

"While the most recent shortage in North Carolina has been eased, shortages still exist in rural and other geographic areas, and in certain nursing specialties. The center's primary purposes are to ensure that North Carolina avoids future shortages and that our nurses are well prepared to care for our citizens in the 21st century," Girouard added.

There are more than 52,000 practicing nurses in North Carolina today. They face a variety of challenges, Girouard noted, including increasingly sophisticated patient care technology, a growing number of elderly patients requiring nursing care, and escalating public health problems such as low immunizations rates, AIDS, substance abuse, and tuberculosis. The center will help North Carolina nurses prepare for these and future challenges, she said.

During the next year, the center plans to

- Develop a strategic statewide plan for nursing manpower in North Carolina by establishing and maintaining a data base on nursing, including current supply and demand and labor projections. The data base will help the center select and address priorities.
- Convene groups of nurses, other health care providers, business and industry leaders, consumers, legislators, and educators to review and comment on data analyzed by the center. They will recommend changes in the health care delivery system, including strategies for implementation and evaluation. They will report the results of these efforts to the General Assembly and others.
- Enchance and promote recognition, reward, renewal, and other positive image-building activities for nurses and nursing in North Carolina.

Girouard is a former program officer at the Robert Wood Johnson Foundation in Princeton, NJ. She also served a term in the New Hampshire House of Representatives.

The center is governed by a 16-member board of directors appointed by the Governor, President Pro Tempore of the State Senate, Speaker of the State House of Representatives, Board of Governors of the University of North Carolina, State Board of Community Colleges, North Carolina Association of Independent Colleges and Universities, and Area Health Education Centers.

FDA Approves Interferon Treatment for Hepatitis B

The Food and Drug Administration has approved recombinant interferon alfa-2b injections as the first treatment for chronic hepatitis B, an infectious liver disease that can lead to cirrhosis, liver cancer, and death.

Interferon alfa-2b has been approved since 1991 for treating Non-A, Non-B hepatitis (also called hepatitis C). It is a biotechnology-produced copy of a naturally occurring protein that is present at low levels within the human body and acts as an anti viral agent.

According to the Centers for Disease Control, approximately 750,000 to 1 million Americans currently are hepatitis B virus carriers, and one in four will eventually develop chronic active hepatitis. Infection may also progress to cirrhosis and hepatic cell carcinoma, a severe, generally fatal liver cancer.

Although several hepatitis B vaccines have been licensed, they are not widely used. Hepatitis B is transmitted through exposure to infected blood and blood products and through sexual contact. Also at risk are infants born to infected mothers.

"Every year, some 300,000 Americans become infected with the virus that causes hepatitis B," said FDA Commissioner David A. Kessler, MD. "It is fortunate that there is now a treatment that may halt the progression of the disease."

In two controlled clinical trials, patients with chronic hepatitis B were administered injections of interferon alfa for 4 months. Approximately 40 percent of the study group treated with either 5 million international units daily or 10 million international units three times a week showed improvement. Clinical improvement was determined by measuring virologic response defined by the loss of hepatitis B serum markers (HBeAg, HBVDNA). The level of liver enzyme (alanine aminotransferase) in the blood associated with liver cell damage was also measured.

None of the responding patients at either dose relapsed during the followup period, which ranged from 2 to 6 months after treatment ended.

Most patients experienced some mild to moderate adverse reactions, including rashes and irritability. However, most of these were manageable and were reversible following the end of therapy. More severe adverse reactions, which included flu-like symptoms

such as fatigue and fever, were reported in 21 to 44 percent of patients.

Interferon alfa-2b is also already marketed for treatment of hairy cell leukemia, AIDS-related Kaposi's sarcoma, and genital warts, as well as for hepatitis C.

Schering-Plough Corp. of Madison, NJ, manufactures interferon alfa-2b, which will be distributed under the trade name Intron A.

U.S Dental Bill Not Nearly as Painful Now, NIDR Declares

Americans saved nearly $100 billion in dental bills during the 1980s because of improvements in oral health, according to the National Institute of Dental Research (NIDR).

Annual spending on dental services, adjusted for inflation, has grown very slowly since the late 1970s. From 1950 to 1978, the nation's total dental bill increased 5 percent a year; it grew only 1 percent annually from 1979 to 1989. Per capita spending on dental services, or the average amount spent on each American, has been at a virtual standstill since 1979, data compiled by the Commerce Department show.

Economists at NIDR and the University of Connecticut developed a statistical model to identify the factors responsible for the flattening of dental expenditures since the late 1970s.

"We found that economic factors alone cannot explain it," said Dr. L. Jackson Brown, NIDR's chief epidemiologist and an economist.

In fact, he said, economic factors were moving in a direction to increase dental expenditures over the past decade: the U. S. population grew during the 1980s, there were more dentists, more Americans had dental insurance, and Americans had more disposable income.

The most important factor in holding down dental expenses was improvement in oral health, according to Dr. Brown and his collaborators, economists Dr. Tryfon Beazoglou and Dr. Dennis Heffley of the University of Connecticut.

At the same time that dental expenditures leveled off, Dr. Brown noted, national surveys showed significant declines in tooth decay among children. In the early 1970s, schoolchildren ages 5 to 17 had an average of seven cavities; that number had dropped to three by 1987. Surveys also showed a significant decline in tooth loss among working-age adults from the early 1970s to the mid-1980s.

The savings that can be attributed to improvements in oral health amounted to $99.1 billion (in 1990 dollars) for the 11-year period from 1979 to 1989, the economists calculated.

Much of that savings—$60 billion—is related to a decline in the per capita consumption of refined sugar, according to the model developed by Dr. Brown and his colleagues. During the 1980s, consumption of refined sugar fell 33 percent, as consumption of noncaloric sweeteners increased by more than 200 percent. Refined sugar in the diet contributes to the development of tooth decay, while noncaloric sweeteners do not.

The other $39.1 billion in savings was attributed to more effective prevention of dental disease as a result of research advances. These advances have led to the widespread use of fluorides, better oral hygiene practices, and a significant increase in preventive services by dental practitioners.

A recent survey by the American Dental Association showed that dentists spend more time on diagnosis and prevention today than they did 10 years ago, and less time on restorative treatment, which is more expensive. A substantial part of the $39 billion savings in dental spending was accrued by adults who did not have to buy dentures, the NIDR's economic analysis showed.

NIA Research on Melatonin and the Circadian Clock Aimed at Improving Sleep

The National Institute on Aging (NIA) has awarded researchers at Oregon Health Sciences University nearly $1 million to begin studying the role of the natural hormone melatonin in controlling sleep and wakefulness. Their findings could benefit millions of older Americans, shift workers, and others who often report troubled sleep.

NIA estimates that more than half the nation's 29 million people older than age 65 experience disrupted sleep. In addition, millions of other Americans don't get enough sleep because of work schedules. For older people, inadequate sleep can worsen illness and cause frustration, confusion, and depression. For shift workers, it also can reduce productivity, lower cognitive performance, and increase the likelihood of accidents.

According to Dr. Andrew Monjan of NIA's Neuroscience and Neuropsychology of Aging Program, the Oregon sleep study has two goals: to understand the influence of melatonin on the parts of the brain that generate circadian or sleep-alertness rhythms, and to understand the importance of aging on this system.

"We hope the findings will show us how to reset the circadian clock and ultimately, make it possible for millions of Americans to get that elusive 'good night's sleep' without having to resort to drugs," he said.

Basic scientists will conduct studies in animals to find out how melatonin works on the brain structures that control sleep and wakefulness. At the same time, clinical scientists will study humans to see if administering melatonin at certain times can correct the sleep deficits and the changes in the circadian clock that are associated with aging. The studies are expected to take 5 years.

Dr. Robert L. Sack, Professor of Psychiatry at Oregon Health Sciences University and Director of Research at the Pacific Northwest Sleep Wake Disorders Program, Good Samaritan Hospital, is the project's principal investigator.

NIA is one of 13 institutes at the National Institutes of Health, a component of the Public Health Service.

NLM Director to Head National Office of High Performance Computing

The Director of the National Library of Medicine (NLM), Donald A. B. Lindberg, MD, has been named as the first director of the National Coordination Office for High Performance Computing and Communications. Dr. Lindberg will hold both directorships concurrently.

The presidential initiative on High Performance Computing and Communications (HPCC) is widely hailed as one of the most important national technology programs ever undertaken. With a current funding level of $800 million and wide Congressional support, the HPCC Program seeks to develop in 5 years a family of computers with scalable performance up to a trillion operations per second (tera-op machines) and a digital network (the National Research and Education Net-

work) capable of transmitting a billion bits per second.

According to the White House Office of Science and Technology Policy, the mission of HPCC is not exclusively technical. Through a series of "grand challenge" applications, it seeks to realize the benefits of high performance computing and networking as early as possible and distribute them widely. Although only in its first year as a unified interagency program, HPCC has already made progress toward its goals, and its catalytic effect is widely felt. The establishment of a national coordination office recognizes the need for, not only a single point of coordination as HPCC progresses in its implementation, but also a primary interface to Congress, academia, and the industrial sector.

Dr. Lindberg served as the representative of the Department of Health and Human Services on the Federal Coordinating Committee for Science, Engineering, and Technology (FCCSET) High Performance Computing Working Group. In 1990, FCCSET and the President's Office of Science and Technology Policy proposed a multiagency High Performance Computing Program to strengthen the nation's research computing enterprise. The Program includes representatives of the major Federal agencies involved in conducting and supporting science.

High-performance computers and high-speed computer networks are key technologies for the future of biomedical science. Grand challenges in biomedicine, such as the analysis of the human genome, prediction of biological structure and function from genetic code, and rational drug design, will require new and faster computers, advanced software, a National Research and Education Network, and expanded training of scientists in the use of computer-based tools.

"We see our role as ensuring that American medical scientists and health care professionals have access to the world of biomedical information made accessible through the higher performance computing technology and high-speed network resulting from HPCC," Dr. Lindberg said.

NLM, at the National Institutes of Health, has several programs that fall under the HPCC rubric. The National Research and Education Network will greatly increase the number of users of NLM's databases as the nation's universities, libraries, hospitals, and research institutions become members of the network. Other components of the new initiative that tie into NLM programs include Basic Research and Human Resources, such as medical informatics training and fellowships, and Advanced Software Technology and Algorithms, such as the "Visible Human" project and biotechnology research programs.

HRSA Proposes Changes in Vaccine Injury Compensation Program

The Health Resources and Services Administration (HRSA) of the Public Health Service proposes to revise parts of the table used by the Federal Government to determine whether persons injured by childhood vaccines are enititled to financial compensation. Some conditions would be redefined, removed, or added.

The National Vaccine Injury Compensation Program, created by the Congress in 1986 to address instances of vaccine-related injuries, provides a no-fault system to compensate those who have been injured by diphtheria, tetanus, pertussis, polio, measles, mumps, or rubella vaccines.

Petitions for compensation under the program are filed with the United States Claims Court, and HRSA reviews injury claims and makes recommendations to the court as to whether claims meet the requirements for compensation. To do this, a Vaccine Injury Table that lists illnesses and conditions presumed to be caused by the vaccines is used. So called "Table" injuries entitle the petitioner to a presumption of eligibility for compensation under the Vaccine Injury Compensation Program.

The Congress recognized that the table as devised in 1986 might compensate some persons whose injuries were not actually caused by the vaccines and mandated that a review be undertaken by the Institute of Medicine (IOM), a component of the National Academy of Sciences, to examine the medical and scientific information on adverse reactions to vaccines.

The changes proposed are based on the findings of the August 1991 IOM report "Adverse Effects of Pertussis and Rubella Vaccines," as well as recommendations made by two advisory bodies—the National Vaccine Advisory Committee and the Advisory Commission on Childhood Vaccines.

The removal of a condition from the table will not necessarily result in compensation being denied where it would have previously been awarded. Instead, the automatic presumption that the vaccine caused the injury will no longer apply. Petitioners may still prevail by providing proof that injuries were vaccine-related.

"Since 1986, approximately $250 million has been awarded to children and their families through the Vaccine Injury Compensation Program," said Fitzhugh Mullan, MD, Director of the Bureau of Health Professions that administers the program. "We want to ensure that every child eligible for compensation receives it."

The public comment period on the proposed regulation expires in mid-February 1993. There will be a public hearing as well. Only claims filed on or after the effective date of the regulation would be adjudicated using the revised table.

The proposed changes were published in the Federal Register on August 14, 1992. Written comments should be addressed to HRSA, Rm. 8-05, Parklawn Bldg., 5600 Fishers Lane, Rockville, MD 20857.

HHS Task Force Plans February Conference on Private Health Records

The Department of Health and Human Services (HHS) Task Force on the Privacy of Private Sector Health Records is chairing a conference on "Health Records: Social Needs and Personal Privacy" to be held February 11–12, 1993, in Washington, DC.

The conference, jointly sponsored by the Assistant Secretary of HHS for Planning and Evaluation and the Agency for Health Care Policy and Research of the Public Health Service, will explore the most appropriate and effective methods to maintain a balance between the privacy of private sector health records and the legitimate needs for information.

The conference speakers and participants will examine the uses of health information, the effect of health information on individual rights, and the best means for society to strike the balance between the privacy of private sector health records and the need for data in the future.

The conference is part of the work being undertaken by the HHS Task

Force on Privacy that is examining the extent to which a problem exists regarding the use of personally identifiable records in the absence of a Federal policy to protect individuals from invasion of their privacy. The Task Force is also reviewing current State laws on the privacy of private sector health records as well as the status of the recommendations of the Privacy Protection Study Commission.

Further information about either the conference or the Privacy Task Force may be obtained from the project contractor, Kunitz and Associates, Inc., tel. 301-770-2730 or FAX 301-770-4183.

AHCPR Panel to Study Post-Stroke Treatment

The Agency for Health Care Policy and Research (AHCPR) of the Public Health Service has formed a 17-member panel of private sector medical experts to develop guidelines for rehabilitating patients who have suffered acute strokes.

The guidelines are designed to assist health care providers improve the quality and effectiveness of after-stroke care by identifying the treatment methods or medical interventions that are most likely to benefit patients.

The recommended procedures, being developed under a contract to the Center for Health Economics Research of Waltham, MA, a nonprofit organization, will be completed in 1993. Extensive review by other experts and a trial by clinicians will be conducted before the guidelines are published.

The economic cost and social impact of strokes, that afflict some 500,000 people in the United States every year, are enormous, according to AHCPR officials. The financial loss to those who survive strokes has been estimated to be between $7.5 billion and $11.2 billion per year, including the cost of care and loss of earnings.

Members of the guidelines panel were selected on the basis of education, clinical experience, and research related to stroke and vascular disease—conditions affecting blood vessels and the circulatory system. The panel represents a spectrum of health care specialties that include medicine, nursing, psychology, speech, occupational and physical therapy, as well as consumers.

The panel is cochaired by Glen E. Gresham, MD, Professor and Chairman, Department of Rehabilitation Medicine, State University of New York at Buffalo, and Director of Rehabilitation Medicine-Medical Director, Erie County Medical Center, Buffalo; and Pamela W. Duncan, PT, PhD, Associate Professor, Graduate Program in Physical Therapy and Senior Fellow, Center for Aging and Human Development, Duke University, Durham, NC.

Three guidelines—on the prevention and treatment of post-operative pain, of bedsores and of urinary incontinence—have been published by AHCPR, and a dozen are under way, not counting the new one on stroke.

NIDA Campaign Spotlights Drugs-Alcohol-HIV Link

The Advertising Council has joined the National Institute on Drug Abuse (NIDA) of the Public Health Service to wage a nationwide public education campaign called "Get High, Get Stupid, Get AIDS" to warn young people that drug and alcohol abuse can lead to deadly HIV infection.

NIDA surveys reveal that more than 43 percent of college students and 34 percent of their noncollege peers engage in "binge" drinking. Approximately 26 percent of both groups used marijuana within the past year. There is strong evidence linking the use of alcohol and other drugs with high-risk sexual behavior among young adults.

Research indicates that young adults form a growing group of HIV-infected people. Currently, one-fifth of all people with AIDS were diagnosed between ages 20 and 29 years, according to the Centers for Disease Control of the Public Health Service. These young adults were often infected as teenagers.

According to Ruth A. Wooden, president of the Advertising Council, the public service advertisements use animation techniques to drive home the message that drug and alcohol abuse can impair judgment and cause someone to do something stupid, such as having unprotected sex.

"The unusual cartoon format was selected to convey a sensitive message in a way that is very popular with this age group," said Ms. Wooden. "The animated characters and use of humor provide a palatable and compelling way for the viewer to be drawn into an important health education message." (see opposite page.)

Reviewed in the concept stage by extensive focus group testing, the animation approach was determined to be extremely effective in reaching the target group. The use of animated characters also allows a range of viewers, whatever their ethnic background, to identify with "universal characters."

The campaign is being carried out by the Advertising Council, a private nonprofit organization of volunteers from the communications industries who create advertising campaigns for the public good. The volunteer advertising agency that produced the creative public service ads was Della Femina McNamee, Inc. of New York City. NIDA provided the $550,000 cost of the campaign, which is part of the larger efforts under the National Drug Control Strategy to combat substance abuse and HIV transmission.

The new campaign is the second phase of advertising on drug abuse and AIDS prevention that began in 1990 with a theme line, "AIDS. Another way drugs can kill," aimed at ages 12-16. In such campaigns, the Federal Government pays production costs but media space and time are donated. The advertising for this campaign garnered $68 million worth of donated media time and space.

The new campaign is part of the Public Health Service's broader $1.48 billion anti-drug abuse effort and its $1.97 billion effort against AIDS. About $400 million of the total is aimed at AIDS prevention and education, with the rest used for research and health services.

The ads include a toll-free number, 1-800-662-HELP, for more information on drug and alcohol abuse prevention. Television, radio, and printed versions of the ads will be distributed nationwide. The Advertising Council hopes to place the ads on network, cable, and local television and radio stations, as well as in newspapers, magazines, shopping malls, movie theaters, and college campuses.

Copies of the public service advertisements can be obtained by calling the Advertising Council at 1-800-933-PSAs (1-800-933-7727).

New Directory Offers One-Stop Shopping For NHLBI Materials

The National Heart, Lung, and Blood Institute (NHLBI) has issued a new publication, "Life in the Health Lane," to provide a single, comprehensive overview of the resources available through the Institute. Intended for browsing as well as reference, it also includes ideas on how to use NHLBI materials.

The directory provides descriptions and ordering information for reports, posters, fact sheets, and other materials. It was prepared for health professionals, program planners, and others who work to promote cardiovascular and respiratory health and to enhance the nation's blood supply.

"Life in the Health Lane" also contains brief descriptions of all NHLBI's educational programs and activities, from the oldest—the National High Blood Pressure Education Program, founded in 1972—to the youngest—the National Heart Attack Alert Program and NHLBI Obesity Education Initiative that were launched in 1991.

Copies of the directory and information on available materials may be obtained from the NHLBI Information Center, P.O. Box 30105, Bethesda, MD 20824-0105; tel. 301-951-3260.

U.S. Leads In Funding AIDS Prevention Projects in Third World Countries

To counter what it said was a large amount of misinformation, particularly concerning the role of the United States in addressing AIDS in developing countries, at the global conference in Amsterdam, the Netherlands, in July 1992, the U.S. Agency for International Development (USAID) has issued a fact sheet on its AIDS activities.

According to the USAID summary, the United States leads the world in funding for HIV-AIDS prevention and control activities with 700 programs in more than 70 developing countries. A total of $249 million has been allocated for AIDS programs since 1986, and another $400 million has been committed for the the next 5 years.

Copies of the USAID Fact Sheet and additional information can be obtained from J. D. Deming at 202-647-4274.

NIAMS Schedules Workshop on Epidemiology of Skin Diseases in March 1993

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) is planning a Workshop on the Epidemiology of Skin Disease on March 25–26, 1993.

The workshop will be held in Building 31, Conference Room 10, at the National Institutes of Health in Bethesda, MD.

Its objectives will be to

- present a current overview of the present status of epidemiologic research into skin diseases, including but not limited to chronic cutaneous ulcers, dermatologic aspects of HIV infection, ichthyosis, nonmelanoma skin cancer, psoriasis, and toxic epidermal necrolysis,
- identify areas in which epidemiologic studies could advance the understanding, management, and prevention of skin diseases, and
- encourage more research into the epidemiology of skin diseases.

Potential participants include dermatologists and epidemiologists with an interest in skin diseases.

Information may be obtained from Suzanne Sangalan at 301-496-0803.

LETTERS TO THE EDITOR

Environment, Behavior, and Injuries

The article by Sugarman, et al. (*1*), is outrageous. They state that "The health problems of American Indians are related primarily to behavioral risks" and go on to present data from "behavioral risk factor surveys" as indicators of the prevalence of risks that need to be changed. In fact, injury related to environmental factors is the leading cause of deaths of Native Americans and the behavioral surveys have been shown to be invalid.

Among U.S. Navy personnel, Native Americans were hospitalized for alcoholism three times more often than whites, but their hospitalizations for injury per capita were 13 percent less that those of whites (*2*). When environments are similar, injury rates are similar.

Native Americans live disproportionately in rural isolated areas where roads, housing, and other facilities are particularly hazardous.

Surveillance of road conditions in Native American communities and modifications of roads and lighting of roads at high-risk sites have resulted in remarkable reductions in injuries (*3*). A case-control study of falls indicated large differences in dimensions and levelness of stairs as well as falls on stairs at night among people using outhouses because of the lack of indoor plumbing (*4*). A study of child pedestrian injuries indicated that children were often playing in the road because the playground equipment was too dilapidated for use (*5*).

Attribution of injuries to behavior when such conditions are the result of discrimination and poverty is victim-blaming of the worst sort.

Responses to questions in the behavioral risk factor surveys regarding drinking and driving and seat belt use have been shown to be invalid indicators of alcohol involvement in crashes and objectively observed seat belt use among the States (*6*). Alcohol can be objectively measured in drivers in crashes and seat belt use can be observed at roadside locations.

Deaths from infectious diseases among Native Americans were greatly reduced when the Indian Health Service introduced environmental measures and improved health