NIAAA Report Says U.S. Drinking Problem Ebbs

The Eighth Special Report to the Congress on Alcohol and Health shows declines in per capita alcohol consumption and liver cirrnosis deaths, as well as increased abstention and decreased heavy drinking across a broad range of age, sex, and demographic groups in the United States.

The report, prepared by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), details recent scientific progress in understanding, preventing, and treating alcoholism and alcohol abuse and their consequences.

NIAAA estimates that more than 15 million Americans ages 18 and older meet standard diagnostic criteria for alcohol abuse or alcoholism. In addition, many others are involved in alcohol-related traffic crashes or suffer from injuries and other problems associated with single drinking incidents.

Alcohol also is a substantial factor in a wide range of safety and behavioral problems, including domestic and criminal violence and high-risk sexual behaviors.

The report says raising the minimum drinking age has contributed to reduced fatal traffic crashes among persons younger than age 21. In particular, alcohol-related fatal crashes decreased between 1982 and 1989 by 47 percent among drivers ages 16–18 and 33 percent among drivers ages 18–20. Despite the older legal drinking age, alcohol remains the most frequently used drug among U.S. high school seniors.

The report also shows that estimated rates of alcohol abuse and alcoholism in young women are converging with rates for young men.

NIAAA Director Enoch Gordis, MD, said, "Heavy drinking has been linked with hypertension, weakened heart muscle, and arrhythmias; and chronic alcohol abuse with adverse effects on immune, endocrine, and reproductive functions, among other consequences."

Moderate drinking may reduce risk for coronary heart disease, but moderate use also has been associated with added risk of hemorrhagic stroke, motor vehicle crashes, and adverse drug interactions.

Alcoholism treatment research, conducted with increasingly sophisticated study designs, has documented promising psychological and pharmacological interventions. In recent studies, researchers identified pharmacological agents that appear to reduce alcohol craving and relapse in alcoholism treatment patients.

"The ultimate success of treatment efforts lies in uncovering the mechanisms involved in craving, impaired control, and other disease features of alcoholism," Gordis said.

In this pursuit, scientists are exploiting new tools in molecular biology, genetics, and neuroscience, including advanced biochemical tests, gene mapping, and a variety of brain imaging technologies.

The Eighth Special Report on Alcohol and Health may be obtained by calling 800–729–6686. An overview is available by mail or messenger by calling 301–443–3860.

1992 Emergency Room Visits for Drug Treatment Increased by 10 Percent

The 1992 Drug Abuse Warning Network (DAWN) showed a 10-percent nationwide increase in drug-related hospital emergency room (ER) episodes between 1991 and 1992, according to the Public Health Service's Substance Abuse and Mental Health Services Administration (SAMHSA).

Cocaine-related hospital visits increased by 18 percent, from 101,200 in 1991 to 119,800 episodes in 1992; heroin-related visits rose by 34 percent, from 35,900 in 1991 to 48,000 in 1992. In addition, marijuana-related episodes increased 48 percent in the same period, from 16,300 to 24,000.

Lee P. Brown, director of the Office of National Drug Control Policy in the White House, said the data show that "to make real headway against hardcore drug use, we must redouble our efforts to reduce demand. We must treat the disease as well as the episode. To accomplish this, we have included an expansion of drug treatment in the President's national health care reform plan. We will also continue efforts to build the capacity of our existing treatment infrastructure."

The DAWN survey, sponsored by SAMHSA, provides information on the impact of substance abuse on emergency rooms in the United States. It reports the number of episodes in which a person's visit to a hospital emergency room was directly related to the use of an illegal drug or the nonmedical use of a legally available drug. DAWN is not a measure of the prevalence of drug use, but rather of the health consequences of use.

Total Drug-Related ER Visits

Between 1991 and 1992, increases were noted in total drug episodes among men (from 189,500 to 219,600), whites (from 221,500 to 235,600), blacks (from 106,900 to 122,900), Hispanics (from 33,100 to 42,200), and those who live in major metropolitan areas, both in the central cities and beyond (from 136,400 to 158,900 in the central cities and from 64,700 to 70,400 outside the central cities).

Between 1991 and 1992, increases in total drug-related episodes were seen in 9 of 21 major metropolitan areas, with large increases occurring in Boston (34 percent), Chicago (27 percent), and New York (21 percent).

These data reflect a combination of possible factors, ranging from the cumulative effects of long-term drug abuse to changes in purity, price, and choice of drugs.

"The increases in medical emergencies revealed in the data are widespread across population groups and geographic areas of the country," said Assistant Secretary for Health Philip R. Lee, MD, head of the Public Health Service. "They are not isolated to inner cities or particular groups. So our preventive solutions must be broad."

Brown said the administration "will encourage a more far-reaching approach to the drug problem, one directed toward eradicating the underlying causes of substance abuse and addiction. To that end, we will work with others in and outside of government in support of job creation, better schools, accessible health care, decent housing, and safe communities."

Cocaine-Related ER Visits

Between 1991 and 1992, DAWN mentions of cocaine increased in almost every demographic category charted. Increases were seen among those ages 18 and older, blacks, Hispanics, men, and women. Among those ages 35 and older, the increase was 35 percent, from 30,600 to 41,300. In 1992, those ages 26 to 34 continued to have the highest visit rate per person for cocaine-related emergencies; the rate rose from 120.5 per 100,000 persons in 1991 to 139.3 per 100,000 persons in 1992.

In major metropolitan areas, increases in cocaine-related emergencies were seen in 7 of the 21 areas. In that period, large increases in cocaine-related emergencies were seen in Atlanta (57 percent), Boston (43 percent), and Chicago (47 percent).

Heroin-Related ER Visits

Between 1991 and 1992, a 34-percent increase in the number of heroin-related emergency room visits occurred, rising in every age group and most notably among those ages 35 and older, whose rate increased by 47 percent from 17,300 to 25,400. Notable increases were found among men (23,600 to 34,800), whites (13,400 to 17,900), blacks (15,200 to 18,600), and Hispanics (5,100 to 8,500). As with cocaine-related visits, the visit rate per person for heroin-related episodes remained highest for those between the ages of 26 and 34 (43.3 per 100,000).

Between 1991 and 1992, increases in heroin-related visits occurred in 9 of the 21 major metropolitan areas. Large increases were seen in Baltimore (31 percent), Boston (77 percent), Los Angeles (76 percent), and New York (39 percent).

Long-Term Trends in ER Visits

DAWN data show that since 1978, drug-related emergency room visits have increased dramatically (from 319,200 in 1978 to 433,500 in 1992), primarily due to increases in cocaine-related emergencies, which rose from 1 percent of drug-related visits in 1978 to 28 percent in 1992. In the same period, heroin-related emergency room visits increased from 4 percent of total drug-related visits in 1978 to 11 percent in 1992. The increases in total drug-related visits exceed what would normally be expected from increased use of emergency rooms for health care.

Copies of the 1992 DAWN report are available from the SAMHSA Press Office, tel. (301) 443–8956.

The PHS Response to the Midwest Floods

The Office of Emergency Preparedness (OEP) of the Public Health Service (PHS) measures its response to the summer floods that ravaged the Midwest from an early morning telephone call on Sunday, July 11, 1992.

PHS Regional Administrator Frank Berry in Kansas City made the call to inform headquarters in Washington of the possibility of dam failure that could affect the entire Des Moines, IA, area. The Des Moines and Raccoon Rivers did indeed overflow later that day, flooding the city's water supply plant and leaving Des Moines with no clean water for the next month.

OEP Director Frank E. Young, MD, PhD, quickly set in motion implementation of PHS' Federal Response Plan, consulting with other Federal officials and the Iowa State public health director about the health implications of the flooding.

Two PHS emergency operations officers, Joe Brennan from the Southeast regional office and Ron Burger from the Centers for Disease Control and Prevention (CDC) in Atlanta, both veterans of 1992's Hurricane Andrew in Florida, were sent to the Davenport, IA, disaster field office to coordinate health-related services.

On the flight to Iowa, Brennan said, they developed a sense of the kind of help that would be needed in the stricken area. They looked down on flooded roads and farmlands at the confluence of the Missouri and Mississippi Rivers.

The swollen waters stretched for miles, saturating homes and inundating private wells. The flooding had closed sanitation facilities, and Brennan and Burger knew the waters they saw were filled with raw sewage. When they arrived in Davenport, they found that the river had flooded eight or nine blocks into the city. Water seeped into basements and through first floor windows.

Brennan and Burger met with city officials to report their findings and describe the public health assistance that would be needed. Unlike in Flordia, Brennan said, people had time to evacuate their homes, so PHS' primary concerns were disease from contaminated water and injuries. Later would come a focus on measures to deal with potential vector-borne disease and the emotional exhaustion of people who had lost their homes and livelihoods to the flood.

Two days later, Brennan and Burger were joined by Kent Gray, chief of CDC's emergency response coordination, and Scott Lillibridge, MD, CDC disaster epidemiologist, and planning for the monumental health assessment of the area began.

OEP headquarters in Rockville, MD, set up a system of daily conference calls to brief all PHS personnel involved in flood relief efforts on the changing health needs and the situation in the Midwest.

On-call officers of PHS' Commissioned Corps recruited personnel for response activities, responded in round-the-clock 12-hour shifts to phone calls from the flood area as the disaster worsened and persisted, and prepared budgets for the pending supplemental funding initiative for flood relief.

On July 16, the first of a series of meetings was held in Des Moines among Federal, State, local, and private sector health officials. The Federal team consisted of Dr. Young, PHS' chief engineer, and representatives from CDC, the National Institute on Environmental Health Sciences, the Health Resources and Services Administration's Bureau of Primary Care, the Indian Health Service, the Substance Abuse and Mental Health Services Administration, the Administration on Aging, and the Health Care Financing Administration.

Following a presentation by each of the Federal representatives on general resources available from their agencies, the Iowa group conducted work sessions on specific needs, such as sanitation and mental health. One concern stressed in these smaller working sessions was the potential for depression as people faced weeks of flooding, loss of homes, and loss of jobs and businesses. Already, there were reports of farmers who had committed suicide.

The Federal team's visit to Des Moines was followed by similar visits and discussions with State health officials in Springfield, IL; Jefferson City, MO; and Lincoln, NE.

Water contamination and surveillance of vector-borne diseases were recurrent issues in the Federal-State discussions. Sanitation engineers and entomologists would be among the first Federal resources requested by the States to supplement their disease prevention activities.

Dr. Young attended the "flood summit" convened by President Clinton in St. Louis on July 17. The President, Vice President, 10 Cabinet Secretaries, Federal agency heads, and officials involved in flood relief efforts met with governors of the flood-torn States to discuss Federal disaster assistance.

PHS later explored issues raised in the flood summit in a State-Federal meeting on vector control, conducted by CDC in Kansas City on July 28–29, and then in a unique flood health meeting in St. Louis on August 3–4.

The flood health meeting, funded by the Federal Emergency Management Agency (FEMA) and orchestrated by OEP, brought together health offficials from the flood-stricken States of Missouri, Iowa, Illinois, Kansas, Nebraska, South Dakota, North Dakota, Wisconsin, and Minnesota, PHS, the Environmental Protection Agency, Army Corps of Engineers, Department of Veterans Affairs, Department of Defense agencies, and the U.S. Department of Agriculture.

In workshops on environmental health (with a focus on safe drinking water), communicable disease, primary care, mental health, and food safety, State health representatives identified their needs, and Federal participants discussed how to apply for Federal aid.

In previous disasters, which have usually been confined to a single State, disaster response grants have been awarded to individual States. State participants at this flood health meeting noted the unique public health nature of the flood. For instance, water flowing through the rivers in the 9-State area was carrying potential contamination from one State to another.

At the meeting, FEMA agreed to consider multi-State disaster assistance grants. Following the meeting, FEMA working in concert with the OEP agreed to a grant package that would fund a mosquito control program for the 9-state area and monitoring of environmental contaminants in the flood area waters.

On Oct. 12, President Clinton directed PHS to make available $65 million in relief contingency funds to nine States impacted by the summer flooding; $75 million for health and social services assistance had been appropriated earlier in the year.

The October funding will support health-related activities for longer term recovery in the impacted area, as well as social services aimed especially at children and the elderly. Supported activities include primary health care services as well as assistance in addressing mental health problems, including stress-related domestic violence and substance abuse, which are expected to grow in severity during the winter months.

In addition, the funds will support efforts to assure water guality, prevent mosquito-borne disease, carry out disease surveillance, and provide for dissemination of health-related information.

The public health impact of this wide-ranging disaster will continue for months, possibly years. The Public Health Service, working with the States and other Federal agency officials, agreed at the St. Louis meeting to document the disaster response so that multi-agency, multi-State activities for future events can be quickly coordinated.

— DALE BLUMENTHAL, Writer-Editor, Public Health Service.

States Channel Data Resources to Health Care Policy Efforts

Turning valuable health statistics into workable information for State policy makers is the focus of a national grant program called Information for State Health Policy launched by the Robert Wood Johnson Foundation.

California, Mississippi, New York, North Carolina, and South Carolina are part of a core group selected in 1992 to participate in the program. Each has been awarded a 4-year grant of up to $1 million to provide timely, detail-rich data on pertinent health care issues.

The grants are designed to help State policy makers make the most informed decisions about health programs that directly affect their populations. As part of the Information for State Health Policy Program, each State has established an interagency work group including consumers, health care providers, elected officials, payers, and health program administrators to identify their State's major health care needs.

"State officials constantly make decisions that directly affect people's health. Yet, most States lack the human and technological resources necessary to provide the high-quality, quick responses to the broad spectrum of questions posed by decision-makers," said Steven A. Schroeder, MD, president of the Robert Wood Johnson Foundation.

"States have been given a large role in developing health care policy, and with this responsibility there comes a whole range of issues that require a great deal of statistical information. It is this kind of information on which changes in health care services and financing will be based," Dr. Schroeder added.

Since 1981, when the Federal Cooperative Health Statistics System ceased funding all but vital statistics, State health agencies have had difficulty in maintaining adequate support for their data collection operations.

Those receiving the Johnson grants were recognized for the following initiatives:

- California Health and Welfare Agency: improved access to primary care services ($1 million);
- Mississippi Office of the Governor, Division of Medicaid: improved health care access, utilization of inpatient care, Medicare funds; coordination of preventive and primary ambulatory care ($924,187);
- New York Department of Health: increased access to health care, detailed information on special populations, health status and coverage, and studying substance service use and costs ($998,787);
- North Carolina Department of Environment, Health and Natural Resources: constraint of escalating health care costs; focus on maternal/child health, long-term care ($750,000); and
- South Carolina Division of Research and Statistical Services: improved access to health care through improved insurance coverage ($925,000).

The Information for State Health Policy Program is directed for the foundation by Ira Kaufman, clinical associate professor, Department of Environmental and Community Medicine at the University of Medicine and Dentistry of New Jersey Robert Wood Johnson Medical School.

HMOs to Explore Innovative Care Options for Chronically Ill

Health maintenance organizations (HMOs) will be encouraged to explore ways to improve care for people with chronic illnesses by a $5.6 million grant program from Robert Wood Johnson Foundation.

Memberships in HMOs and other managed care organizations are being offered more widely to employees by employers trying to control their health care costs. The number of people enrolled in HMOs has grown rapidly, from 10.8 million in 1982 to almost 40 million in 1992. Medicare has enrolled about 2.5 million elderly in prepaid health plans, and some 2.8 million Medicaid recipients are receiving some form of managed care.

"As the population enrolled in HMOs continues to grow older, HMOs will assume an ever increasing role in meeting the needs of people with chronic conditions," said Steven A. Schroeder, MD, president of the Robert Wood Johnson Foundation. "Although advances in medical science enable many people with chronic illnesses to live longer, there often is an inadequate and disjointed system of medical care and supportive services that negatively impacts on the quality of their daily lives. This foundation program challenges HMOs to move beyond current practices and create new ways to address the needs of people with chronic disorders," he said.

Under the program, Chronic Care Initiatives in HMOs, grant project staff members will be expected to develop new ways to organize the delivery of primary care to people with chronic conditions, to foster continuity of care over time, and to rethink the role of services such as home care, case management, rehabilitation, and community-based volunteer services.

Planning grants averaging $30,000 each will be awarded for feasibility studies, research protocols, or specific innovations. In addition, implementation grants of up to $500,000 each will be awarded for research, demonstration, and evaluation projects that are more fully developed.

The types of projects eligible for funding are

- coordination of services involving several disciplines, family caregivers, and community resources;
- new approaches for providing post-hospital care to reduce subsequent rehospitalization;
- programs for specific groups, such as children with mental or physical disabilities and patients with depression or dementia;
- evaluation of new ways to deliver primary care to patients living in the community who are frail or who have chronic conditions;
- evaluation of new ways to deliver primary care to HMO enrollees who are long-term nursing home residents.

Most grants will be awarded to HMOs, but organizations such as self-insured employers, Taft-Hartley trust funds, State Medicaid agencies, multispecialty group practices, and insurance carriers also may apply, if services, financing, and delivery are integrated.

There is no specific deadline for applications; funds will be available until expended.

Overall direction and technical assistance for the national program will be provided by Peter D. Fox at the Group Health Foundation.

Organizations wishing to apply for funds under this program should first submit four copies of a letter of intent, rather than a fully developed proposal.

The brochure outlining grant application guidelines can be obtained from Teresa Fama, Deputy Director, Chronic Care in HMOs, c/o Group Health Foundation, Suite 600, 1129 20th St., NW, Washington, DC 20036-3403; tel. 202-778-3284.

States Get $2.5 million from PHS for Rural Health

The Public Health Service (PHS) has awarded $2.5 million in matching grants to establish eight new State offices of rural health and maintain the 42 existing ones.

The grants were made under the State Office of Rural Health Grant Program administered by PHS' Health Resources and Services Administration.

With the 1993 grants, which average $50,000 per State, all 50 States now have rural health offices.

The eight new offices are in Connecticut, Delaware, Maryland, New Hampshire, Massachusetts, New Jersey, Rhode Island, and Tennessee.

In response to growing health care shortages in rural America, Congress authorized the State Office of Rural Health Grant Program in 1990 to provide matching grants for States to create and support offices of rural health. When the program began in 1991, there were only nine State rural health offices in the nation.

Under the program, each State office assists rural communities in four ways: by collecting and sharing information, recruiting health care providers for rural areas, coordinating rural health interests statewide, and providing communities with technical assistance to attract more State and Federal funding for rural health.

Examples of program successes include the placement of more than 200 physicians in rural Wisconsin and the development of 99 rural health clinics in Texas that now provide services in 71 percent of the State's underserved counties.

"State offices of rural health are playing a significant role in revitalizing health care services in rural communities," said Assistant Secretary for Health Philip R. Lee, MD, who heads the Public Health Service. "They are vital partners in our national endeavor to improve health care, not only for the 25 percent of Americans who live in rural areas, but for all Americans."

A list of the 1993 grants by State.

Alabama	$49,579
Alaska	61,365
Arizona	53,015
Arkansas	57,608
California	47,616
Colorado	48,239
Connecticut	47,619
Delaware	47,619
Florida	47,616
Georgia	61,302
Hawaii	46,210
Idaho	51,300
Illinois	50,426
Indiana	47,616
Iowa	61,594
Kansas	61,939
Kentucky	57,360
Louisiana	46,214
Maine	47,616
Maryland	47,619
Massachusetts	47,619
Michigan	53,450
Minnesota	55,982
Mississippi	24,819
Missouri	59,006
Montana	67,539

Nebraska	57,317
Nevada	47,616
New Hampshire	45,503
New Jersey	47,619
New Mexico	57,791
New York	47,616
North Carolina	64,263
North Dakota	54,103
Ohio	21,932
Oklahoma	47,616
Oregon	53,789
Pennsylvania	47,616
Rhode Island	47,619
South Carolina	[1]0
South Dakota	55,237
Tennessee	47,619
Texas	70,219
Utah	47,616
Vermont	43,602
Virginia	48,216
Washington	47,616
West Virginia	47,718
Wisconsin	46,381
Wyoming	57,405

[1]1992 funding carried over into 1993.

HRSA Approves HIV-AIDS Grants for Adolescents, Native Americans

The Public Health Service's Health Resources and Services Administration (HRSA) has awarded more than $750,000 in special grants to prevent and treat HIV-AIDS among young people and Native Americans.

One of the grants, for $215,693, went to the University of Alabama at Birmingham School of Medicine to expand and ensure access to health and support services for 10–24-year-old disadvantaged, high-risk adolescent girls in Jefferson County, AL.

A $194,196 grant went to Walden House in San Francisco which treats teenagers with AIDS who also have substance abuse and mental health problems.

The 3-year grants began on Oct. 1, 1993, and each addresses the continuum of care for adolescents: integrating mental health services and substance abuse treatment into primary care systems, HIV testing, education, outreach services, and family counseling and support. A second funding cycle of adolescent programs will take place early this year.

Under the Special Projects of National Significance Program of the Ryan White Comprehensive AIDS Resources Emergency Act, a total of $342,186 was awarded on Sept. 1, 1993, to eight projects from both rural reservation areas and urban communities to implement innovative projects to improve HIV-AIDS service delivery to Native Americans.

The grants, which are for a 1-year period, were made through the National Native American AIDS Prevention Center of Oakland, CA, whose mission is to stop the spread of HIV and related diseases, including sexually transmitted diseases and tuberculosis, among American Indians and Alaskan and Hawaiian Natives.

The eight grants were awarded to the following organizations:

$49,987 to the Chugachmuit tribal organization in Anchorage, AK;

$50,000 to Indian Community Health Service, Inc., Phoenix, AZ;

$12,150 to Indian Health Council, Pauma Valley, CA;

$55,382 to Milwaukee Indian Health Board, Milwaukee, WI;

$49,755 to Native American HIV/AIDS Coalition, Kansas City, MO;

$58,360 to Papa Ola Lokahi, Honolulu, HI;

$48,092 to the Seattle Indian Health Board, Seattle, WA; and

$50,000 to the Tuscarora Tribe of North Carolina, Pembroke, NC.

$18.4 Million to States for Breast and Cervical Cancer Screening

The Department of Health and Human Services (HHS) has awarded $18.4 million to 21 State health departments to expand a national breast and cervical cancer early detection program.

The goal of the program is to reduce breast cancer deaths by 30 percent and cervical cancer deaths by more than 90 percent through increased mammographic and Papanicolaou (Pap) testing. States are required to match each $3 of Federal funds with $1 of State funds.

A total of 45 States will now participate in a comprehensive, strategic approach among government, private sector, and voluntary organizations to bring more women into screening programs.

Authorized by the Breast and Cervical Cancer Mortality Prevention Act of 1990 and administered by the Centers for Disease Control and Prevention, this program began 3 years ago in eight States. State awards made previously in 1993 total $44.4 million.

The early detection program relies heavily on outreach and educational systems to ensure widespread participation among all women. The benefit of such programs are particularly important for women of racial and ethnic minorities where mortality rates are disproportionately high.

Educating health professionals as well as consumers is the cornerstone of this effort that seeks to guarantee women the most available, accessible, and technically sound screening and followup experience possible. Sophisticated surveillance and evaluation systems monitor program progress.

Funds are provided to States to build programs in two phases. Comprehensive awards, supporting fully implemented programs, averaging $3 million each, went to Massachusetts, New York, Ohio, Pennsylvania, Washington, and Wisconsin.

Planning awards, averaging $150,000, went to Alabama, Delaware, Florida, Hawaii, Kansas, Louisiana, Mississippi, Montana, New Hampshire, New Jersey, North Dakota, Oklahoma, Utah, Virginia, and Wyoming.

Although breast and cervical cancers exhibit different patterns of disease, early detection and prompt treatment can alter the natural progression of both of these diseases and can reduce mortality.

Breast cancer is the most common cancer in American women and is second only to lung cancer as a cause of premature mortality. For 1993, the American Cancer Society estimates 181,000 new cases and 46,000 deaths. Although incidence rates are increasing, early detection and improved treatment have kept mortality rates stable over the past 50 years.

In recent decades, cervical cancer has declined in incidence and mortality. Since 1950, the incidence of cervical cancer has decreased 76 percent, and mortality from the disease has decreased 74 percent, attributed to widespread use of the Pap test.

Since the early 1980s, however, the rate of decline of invasive cervical cancer has leveled. The American Cancer Society estimates 13,500 new cases of cervical cancer and 4,400 deaths in 1993.

WHO AIDS Program Director Calls for Revamping of Medical Education

Dr. Michael Merson, Executive Director of the World Health Organization (WHO) Global Program on AIDS has called for a fresh look at the way physicians are educated.

"AIDS is a catastrophe in slow motion that will be with us for decades to come," he said. "It poses a challenge to medical education because of the kind of care it requires, the approaches needed for AIDS prevention, and in its interactions with society.

"Physicians need to learn how to work as part of a team with other health and social workers, and they need to encourage and support families in caring for their loved ones at home. Above all, they need to consider the patients as knowledgeable allies, not as passive recipients of care, and involve them fully in the entire care process, including decision-making about treatment."

Dr. Merson said that the physician of the future would need

- greatly improved communications skills,
- a better understanding of the interplay between health and human rights,
- greater familiarity with infectious diseases,
- a serious grounding in public health, and
- an appreciation of the social environment of disease.

The existing medical school curriculum must be changed to meet the needs not only of AIDS but also of other diseases, Dr. Merson added. He cited as examples chronic diseases such as arthritis and diabetes that lend themselves far less to cure than long term care and support with the full involvement of the patients themselves, preventable conditions like lung cancer and heart disease, where information and education about lifestyle is the key to prevention, and drug dependency where a sound public health approach including provision for needle exchange and other supportive programs should take priority over repressive practices.

"If the challenges I have outlined were confined to AIDS and AIDS alone, I would not be arguing for a revamped medical school curriculum," he added. "Medical education needs rethinking precisely because AIDS is not unique. Many of the features of AIDS can be seen in illnesses prevalent today not only in the industrialized world but in developing countries as well."

He concluded, "The challenges of AIDS are, increasingly, the challenges posed by other afflictions of modern society. They call for a fresh look at how we educate our physicians. In this sphere as in so many others, AIDS is like a beacon, pointing up our weaknesses and helping us chart the best way forward."

The full text of Dr. Merson's speech is available from Christopher Powell, Public Information Officer, WHO, tel. 41 22 791–4673.

New Asian American and Pacific Islander Journal of Health Makes Appearance

The inaugural issue of the Asian American and Pacific Islander Journal of Health made its appearance in the summer of 1993.

The goal of the journal, according to Editor Moon S. Chen, Jr., PhD, MPH, is to be "the most comprehensive and scientifically credible refereed publication dedicated to the scholarly examination of the health status of Asian and Pacific Islander Americans . . ."

The reason for the goal, according to Chen, is that there is a paucity of literature retrievable on the National Library of Medicine's data base, MEDLINE, that addresses the health status of Asian and Pacific Islander Americans. The relative percentage of retrievable citations on MEDLINE using the term, Asian American actually declined between 1981 and 1992, he said.

Chen pointed out that Asian Pacific Islander Americans have been the fastest growing population group of any U.S. racial-ethnic grouping for the last two decades.

"And just when more scholarly literature on them needs to be retrievable on computer-based literature data bases, the relative proportion of articles about their health status has decreased even though there has been an increase in citations in absolute numbers," he added.

Two Asian Americans from the Public Health Service were prominently featured in the journal's first issue. Jane S. Lin-Fu, MD, Chief, Genetic Service Branch, Maternal and Child Health Bureau, Health Resources and Services Administration, contributed an article, "Asian and Pacific Islander Americans: An Overview of Demographic Characteristics and Health Care Issues." Samuel Lin, MD, PhD, Assistant Surgeon General, was himself the subject of a profile written by Chen.

The journal, with offices in Dublin, OH, is to be published quarterly.

Consensus Conference on Corticosteroids' Perinatal Effect Planned

The Effect of Corticosteroids for Fetal Maturation on Perinatal Outcomes is the subject of a consensus development conference sponsored by the National Institutes of Health (NIH) scheduled for February 28–March 2, 1994, in Masur Auditorium of the NIH Clinical Center in Bethesda, MD. The purpose of the conference is to reach agreement on the following key questions:

1. For what conditions and purposes are antenatal corticosteroids used, and what is the scientific basis for that use?
2. What are the short- and long-term benefits of antenatal corticosteroid treatment?
3. What are the short- and long-term adverse effects for the infant and mother?
4. What are the economic consequences of this treatment?
5. What is the influence of type of corticosteroid dosage, timing and circumstances of administration, and associated therapy on treatment outcome?
6. What are the recommendations for use of antenatal corticosteroids?
7. What research is needed to guide clinical care?

The conference will bring together specialists in neonatology and other relevant fields. On the first 2 days, experts will present current scientific thinking about the diagnosis and management of the effect of corticosteroids for fetal maturation on perinatal outcomes, and concerned voluntary organizations will be invited to make statements.

On the third day, after considering the scientific evidence, the consensus

panel will present its draft report and invite comments from the audience.

Larry Gilstrap, MD, Southwestern Medical Center, University of Texas, will chair the panel.

Information and registration may be obtained from Debra Steward, Technical Resources, Inc., 3202 Tower Oaks Blvd., Rockville, MD 20852; tel. (301) 770–0610; FAX (301)–468–2245.

IOC, WHO Join Forces for 'Sport and Health for All by the Year 2000'

The International Olympic Committee (IOC) and the World Health Organization (WHO) have signed a cooperative agreement that stresses that "the essential objective of cooperation between IOC and WHO shall be sport for all and health for all by year 2000."

An IOC-WHO Working Group will be set up to formulate the details of a joint program of health promotion and disease prevention through physical activities and healthy lifestyles.

The two organizations have agreed, as a first step, to give their patronage to the 5th World Congress of Sport and Health for All organized by the National Olympic Committee of Uruguay to be held in the Republic of Uruguay in March 1994.

It is no coincidence that the cardiovascular diseases program is responsible for WHO's contribution to the joint working group. WHO believes that physical activity has a profound effect on both the primary and the secondary prevention of cardiovascular diseases, the leading killer diseases in both developed and developing countries after age 5. The benefits of physical activity are also well recognized in the prevention and treatment of other chronic diseases and conditions, such as osteoporosis, hypertension, diabetes, and obesity.

WHO's tobacco or health program has been instrumental in making the 1992 Summer and Winter Olympic Games in Barcelona, Spain, and Albertville, France, tobacco-free.

"WHO feels very strongly that sport and the use of tobacco are incompatible", said WHO Director Dr. Hiroshi Nakajima, "Literally millions of lives could be saved if societies were tobacco-free. In the 1990s, 3 million premature deaths a year are caused by tobacco use. If current trends continue, tobacco-related deaths will reach a global figure of 10 million by the year 2025. Working with IOC we can help to persuade the younger generation to adopt healthier lifestyles and to reject cancer- and heart disease-causing behavior."

WHO's World No Tobacco Day, observed each year since 1988 on May 31, aims at promoting tobacco-free lifestyles. In 1996, it will be dedicated to "Sports and the arts without tobacco."

Highway Safety Conference Slated for March 1994 in Washington, DC

A symposium sponsored by the National Highway Traffic Safety Administration and other national organizations involved with highway safety will be held March 8–11, 1994, in Washington, DC.

It will highlight the important role Washington plays in shaping the country's highway safety agenda. Participants will have an opportunity to visit with key Executive Branch officials, legislators, and their staff members to discuss issues affecting all areas of highway safety.

The symposium will examine how Congressional decisions affect the scope of State highway safety programs. The program will also include workshops on key highway safety issues and forums for exchanging ideas with Legislative and Executive Branch leaders.

Further information about registration and accommodations can be obtained from Lifesavers Conference, c/o Mary Magnini, P.O. Box 30045, Alexandria, VA 22310; FAX 703–922–7780.

OTA Advises Congress on Options for Dealing with TB Outbreak

In "The Continuing Challenge of Tuberculosis," the Congressional Office of Technology Assessment (OTA) synthesizes current scientific understanding of TB in this country and considers the Federal role in its control. OTA is an analytical arm of the Congress whose function is to help lawmakers anticipate and plan for the positive and negative effects of technological changes.

After declining for more than 30 years, the number of new cases of tuberculosis reported each year in the United States is now on the rise, having increased 20 percent since 1985.

In addition to the 26,673 reported cases in the United States in 1992, an estimated 10 to 15 million people are infected with the bacteria that cause TB but are not sick. Over the years, TB has also become more concentrated among particular portions of the population, especially economically disadvantaged people, racial and ethnic minorities, and foreign-born persons. Particularly disturbing is the emergence of TB strains resistant to the most commonly used drug treatments.

Unchecked, these recent trends represent a serious threat to communities already saddled with poor health, poverty, and other social problems. This threat is greatest for people with HIV. Furthermore, the disease could become an additional major burden to the nation's health care system.

No one single factor has brought about this new threat. Rather, it has multiple causes, including human immunodeficiency virus (HIV), homelessness, incarceration, immigration from countries with high levels of TB, and reduced resources available for TB control.

About Tuberculosis

To develop active TB that is contagious and causes illness, a person must first be infected with the bacillus *Mycobacterium tuberculosis*. On average, only 10 percent of otherwise healthy adults infected with *M.tuberculosis*. ever develop active TB. People at higher risk are children, people with HIV, and those with chronic illnesses. Active TB can affect various parts of the body, with the lungs being the most common. If untreated, TB can result in destruction of affected parts of the body and death.

Major Findings

Some of the 148-page report's other major findings—

The risk of tuberculosis. To be infected, a person must breathe an airborne particle containing *M. tuberculosis*. expelled by a contagious person. Brief, casual contact with an infectious person is unlikely to lead to infection, but the risk is not zero.

Co-infection with HIV greatly increases a person's chances of progressing to active TB to an estimated 8

percent chance per year. Drug-susceptible TB is treatable among most people with HIV except during the most advanced stages of HIV disease.

The full extent of multidrug resistant TB (MDR–TB) is unknown because the Centers for Disease Control and Prevention (CDC) only began regularly collecting drug-susceptibility data on each reported case of TB in 1993.

Prevention. The effectiveness and cost-effectiveness of individual infection control technologies, including various types of masks, ventilation devices, and germicidal ultra-violet lights, have not been well studied for their ability to reduce risk of *M. tuberculosis* infection in clinical settings.

Screening for *M. tuberculosis* infection and the provision of preventive therapy could be an effective strategy to control drug-susceptible TB among high-risk people younger than age 35 and not infected with HIV. Implementation has been limited by the availability of funding and other resources, and a lack of knowledge about the most cost-effective methods of providing these services.

Treatment. The prices of drugs to treat drug-susceptible TB have increased at an average annual rate of about 9 percent per year since 1986. Prices of some drugs used to treat drug-resistant TB have increased at a higher rate.

On average, 75 percent of U.S. TB patients complete treatment within a year, although completion rates vary greatly across the country.

Treatment failure can result from prescribing errors, a lack of resources for accessible, high-quality TB services, and patients' unwillingness or inability to complete treatment. To design better TB services, there is great need to document the relative importance of each of these factors.

A combination of treatment strategies, including supervised treatment, is needed. The extent of supervision necessary to achieve higher rates of treatment completion is uncertain, however, and probably varies by community. Little systematic evidence on the cost-effectiveness of alternative approaches exists to guide the design of such services.

One form of supervised treatment, directly observed therapy (DOT), can be very effective in achieving treatment completion. At a cost of $2,000 to $3,000 per patient above that of unsupervised therapy, however, it probably would not be the most cost-effective strategy for patients who appear to be completing treatment through less intensive strategies.

Federal Involvement. TB control is primarily a public health task that will not be achieved or greatly helped by reform of health care insurance and financing.

The Federal Government provides major funding, technical expertise, leadership, and coordination of the nation's TB control efforts with CDC playing the lead role. Although the Executive Branch has detailed the efforts necessary to combat TB in a national action plan, it has not requested sufficient funds from the Congress to implement these plans.

Options to Consider

Among the congressional options OTA identifies and analyzes in its report are the following:

Option. Fully fund the public health activities identified in CDC's 1992 National Action Plan to Combat Multidrug Resistant Tuberculosis.

Full funding of the 1992 National Action Plan, estimated to be $484 million for CDC alone in 1994, would dramatically increase resources available for TB control and alert the country to the threat posed by this disease. On the other hand, the public health and research infrastructure may currently lack the capacity to absorb such a large influx of cash as efficiently as it could if the increases came more gradually.

Option. Establish a mechanism for direct Federal intervention in cities and other jurisdictions with extraordinarily high levels of active tuberculosis, MDR–TB, or HIV and TB coinfection.

This option would require that the Federal Government define more precisely the criteria by which it would decide to intervene and how it would staff such an effort. In addition, decision makers would need to consider whether Federal intervention would be more cost-effective than local governments and private organizations acting alone.

Option. Directly purchase anti-tuberculosis drugs and distribute them to State and local authorities.

CDC currently has the statutory authority to purchase all anti-TB drugs used by State and local governments. Shifting the cost of drug purchasing to the Federal Government would provide additional funds to State and local governments for other purposes. Although CDC estimates that such purchases would cost $80 million in 1993, the actual cost savings that could be achieved through such large-volume purchases are difficult to predict.

The pharmaceutical industry has suggested that centralized, discounted purchases would provide a disincentive for firms to invest in research to develop new anti-TB drugs by limiting revenues needed to recoup initial research and development expenses for these new drugs.

Option. Support the creation of additional regional "centers of excellence" for TB treatment, research, and training.

It is not clear that additional centers of excellence are the most efficient means of achieving their goals. In addition, it is not clear what number of such centers would be commensurate with the threat posed by TB.

Copies of the report, "The Continuing Challenge of Tuberculosis," S/N052–003–01341–0, can be ordered from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250–7954; tel. 202–783–3238.

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