tions are not yet available. It is critical, however, that this view of surveillance and evaluation not be considered a mere research effort or a process independent of programs. The feedback loop to programmatic decisions must be strong and regularly exercised; without it, data collection and analysis become sterile and programs become inefficient.

Thus, the NIMS effort will be a success if these baseline efforts become incorporated at the State and local levels as systematic regular monitoring and evaluation of program effectiveness. The concerns that we all have regarding the slow rate of decline of infant mortality demand that this be done in order to resume the progress in reducing infant deaths.

Robert E. Windom, MD
Assistant Secretary for Health

ADAMHA Goes into High Gear in the Prevention, Research, and Treatment of Drug and Alcohol Abuse

This is a challenging and exciting time for the public health field and everyone in the nation concerned about alcohol and drug problems in our country. The President and the Congress have set in motion an unprecedented program to reduce these problems significantly.

The President launched a national crusade last autumn to reach six goals: to achieve drug-free workplaces, to develop drug-free schools, to improve and expand drug abuse treatment, to increase public awareness and prevention of alcohol and drug abuse, to improve international cooperation, and to strengthen law enforcement against drug abuse.

In response to proposals from the President and the expressed concerns of the American people, Congress enacted the Anti-Drug Abuse Act of 1986, which President Reagan signed on October 27. This law authorized $1.7 billion in fiscal year 1987 for a sweeping new program, including both "demand reduction" and "supply reduction" in the drug abuse equation. The law brings into being a new level and scope of prevention, research, and treatment activities for the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) of the Public Health Service, and it provides the funds needed to have a decisive impact. A total of $262 million above the agency's regular budget was included in the fiscal year 1987 Continuing Resolution both to buttress the agency's ongoing efforts in treatment, prevention, and research, and to launch new efforts.

With $163 million of these funds, ADAMHA will award a new Alcohol and Drug Treatment and Rehabilitation block grant to each State to expand the availability of treatment for persons seeking it. Forty-five percent of each State's grant will be based on the size of its population and 55 percent on the basis of need, as determined by the Secretary of the Department of Health and Human Services. In addition, the new law increases the total funds available for awards to the States under the preexisting Alcohol, Drug Abuse, and Mental Health Service block grants by $13.9 million, to a total of $509 million.

The law also calls for a number of "prevention enhancement" activities to be carried out by a new Office of Substance Abuse Prevention (OSAP) ADAMHA. OSAP went into business on November 24, 1986, with a budget of $43 million. It will make grants for prevention, treatment, and rehabilitation demonstration projects for high-risk youth, such as the children of substance abusers, school dropouts, and "latchkey" kids. OSAP also will operate an alcohol and drug information clearinghouse, conduct media prevention campaigns, and provide fast-service technical assistance to the thousands of parent and community groups that are so crucial to successful drug abuse prevention nationwide.

The new prevention funds also will be used to execute the ADAMHA's responsibilities under President Reagan's Drug-Free Workplace Executive Order. These responsibilities include developing scientific and technical guidelines for drug testing of Federal employees, developing accreditation standards for the laboratories around the country which analyze and report drug test results, and providing assistance to businesses and industries seeking to establish programs to prevent and reduce alcohol and drug abuse in their workforce. The National Institute of Drug Abuse, ADAMHA, has established a toll-free "Drug-Free Workplace Helpline" for firms looking for such assistance.

In still another vital ingredient of this sweeping new national anti-drug abuse effort, research funds

have been dramatically increased to speed the development of more answers on such pressing problems as cocaine and crack use, drug use in the workplace, acquired immunodeficiency syndrome (AIDS) among intravenous drug users, and drug and alcohol abuse treatment evaluation. The research budget of the National Institute on Drug Abuse for fiscal year 1987 was boosted by $27 million, to a total of $107 million, and that of the National Institute on Alcohol Abuse and Alcoholism by $3 million, to a total of $69 million, both historic high levels of investment in research on these problems.

ADAMHA also will collaborate with the Department of Education in a $2 million school initiative included in the President's crusade.

We look forward to these steps making deep inroads into the serious alcohol and drug problems affecting our citizens. The year 1987 will be recognized as the year the nation decided that alcohol and drug abuse would no longer be tolerated—either among our youths or in the adult population—and started to reestablish a truly "drug-free" America.

Donald Ian Macdonald, MD
Administrator
Alcohol, Drug Abuse, and Mental Health Administration

Setting an Agenda for the Council on Graduate Medical Education

With increasing pressure to reduce the Federal budget, the Federal Government is undertaking a fundamental re-examination of its role in subsidizing medical education. Congress has made a number of changes in recent years in the way physician training is financed by Medicare—the single largest source of payment for medical education. Some of the latest changes are contained in the budget reconciliation bill known as COBRA—the Consolidated Omnibus Budget Reconciliation Act of 1985—which authorized the Council on Graduate Medical Education.

I was privileged, as a former staff member of the Senate Committee on Labor and Human Resources, to have worked on this legislation and now I am pleased to be able to help implement it. Support services for the newly established Council are being provided by the Health Resources and Services Administration (HRSA), which I direct, and Dr. Robert E. Windom, Assistant Secretary for Health, has designated me to represent him on the Council.

When Congress was considering the legislation that emerged as COBRA, it was impossible to reach a consensus on many provisions. There was agreement, however, that decisions based largely on financial considerations were having major implications for the training of physicians and other health professionals. There was concern that cost-cutting efforts be balanced by the need to assure a sound financing system for the clinical training required to produce an adequate supply of health practitioners. A high-level body was needed to look at the issues in depth. Both the Senate and the House agreed that the Council was a good idea.

It should be recognized that the Council on Graduate Medical Education was envisioned by Congress as a simpler effort than the Graduate Medical Education National Advisory Committee (GMENAC). That Committee advised the Secretary of Health and Human Services (HHS) on physician supply and requirements by specialty in a seven-volume final report issued in 1980. The Council does not have the resources to mount a similar large-scale undertaking.

In view of this limitation, it is vital that the Council focus its efforts. The statute mentions a broad range of concerns, and if the Council attempts to evaluate all of them equally, it could become bogged down in laborious tasks. I would recommend that it be concerned with the larger issues.

Dr. Otis R. Bowen, HHS Secretary, told the Council at its first meeting: "We need Federal policies in graduate medical education that will not fan the flames of medical care price inflation, and we need your best advice on how to accomplish that. As I see it, that is your biggest challenge."

Financing may be an excellent topic around which to structure the Council's agenda. In terms of financing, the Council could discuss changes regarding foreign medical graduates, changes in reimbursement regarding teaching facilities and ambulatory settings, and so forth. The Council should not only look at financing through Medicare and Medicaid but also at alternative mechanisms.