# The United States National Committee on Vital and Health Statistics

# JOHN STORCK, Ph.D.

THE FIRST World Health Assembly at its June-July 1948 meeting in Geneva recommended that countries establish national committees to coordinate their activities in vital and health statistics and serve as links with the assembly's Expert Committee on Health Statistics. An expressed purpose was to decentralize studies of certain statistical problems of public health importance to interested national groups. Accordingly, the U.S. National Committee on Vital and Health Statistics was established in 1949 by former Surgeon General of the Public Health Service Leonard A. Scheele. About 50 countries now have national committees or their equivalents, variously organized and active.

# **Origins of National Committee System**

The national committee idea was a byproduct of an international collaboration in solving a difficult problem in health statistics accomplished in 1948. The U.S. Committee on Joint Causes of Death had collaborated with experts from the United Kingdom, Canada, and the Health Section of the League of Nations in preparing a disease classification for coding both morbidity and mortality data. The previous classification was suitable for coding deaths only. The combined classification was adopted in 1948 by the Sixth International Conference for the Revision of the International Classification of Diseases.

A national committee had here been instrumental in developing an important statistical tool—a classification of diseases—through international collaboration. The revision conference therefore adopted the recommendation of Dr. Halbert L. Dunn, chief, National Office of Vital Statistics, and head of the U.S. delegation to the conference, that countries establish national committees on vital and health statistics to seek further technical developments in the field of health statistics. The First World Health Assembly approved this recommendation in 1948.

### Functions of United States Committee

Although the World Health Assembly did invite some countries to study particular problems, it laid no restrictions on the membership, organizational structure, working methods, or methodologies to be used by national committees. In most countries the primary function of the committee has been to coordinate the efforts of agencies that collect and compile vital statistics. In not a few countries the new committee has been hardly more than another aspect of the official health apparatus. Nothing in the mandate, however, required this. In effect national committees were given a broad opportunity to study any technical question in vital and health statistics.

The lines of interest of the U.S. committee were early formulated in "Functions and Policies of the National Committee on Vital and Health Statistics" (1):

a. Delineate statistical problems of public health importance which are of national or international interest;

Dr. Storck is a consultant to the Office of Information and Publications, National Center for Health Statistics, Public Health Service. b. Stimulate studies of such problems by other organizations and agencies whenever possible, or make investigations of such problems through subcommittees appointed for the purpose;

c. Review findings submitted by other organizations and agencies, or by its subcommittees, and make recommendations for national and/or international adoption;

d. Cooperate with other committees or organizations concerned with public health statistics in the United States so as to serve as a clearinghouse for activities dealing with public health statistics problems;

e. Serve as a link between the organizations in the United States engaged in public health statistics and the statistical secretariat of the World Health Organization, and other international agencies concerned with public health statistics; and

f. Cooperate with national committees of other countries in the study of problems of mutual interest.

# **Committee Organization and Procedures**

Typically the U.S. committee has had 11 members. While the secretary and a few other members have held official positions in the Public Health Service, most committee members, including the chairmen, have had other backgrounds.

As a principle in selecting members of the committee, it was early decided "that members should not represent organizations or agencies but rather that they should be chosen to represent a point of view, an area of interest, or a field of knowledge essential to the carrying out of the committee's responsibilities" (2). Initially committee members were appointed for indeterminate terms, but in 1958 a staggered 4-year term of service was initiated. Meetings are usually held twice a year, for the most part to consider subcommittee reports and to decide on future activities. The committee conducts practically all of its studies through specially appointed subcommittees.

Unlike typical subcommittees, these groups need not include members from the parent body, although the committee secretary is entitled to meet with all of them. Selecting subjects to study and persons to study them are among the more difficult tasks of the committee. Some 10 or 12 subcommittees with average memberships of around 7 specially chosen experts usually are active at any given time. Each subcommittee works on a charge framed by the parent body. Experience seems to suggest both that fairly definite charges can be helpful even to an energetic and able subcommittee, and that there is merit in giving most groups considerable leeway. Most subcommittees have met twice yearly, and most have reported regularly to the parent body.

In addition to subcommittees engaged in more formal studies, the committee has made considerable use of ad hoc groups, frequently drawn from its own ranks, to make recommendations on more limited matters, such as proposals for future study. Between 1949 and 1964 the committee established approximately 16 ad hoc groups and 31 subcommittees. Although the categories, and even the total number of groups employed, leave room for judgment, a liberal use of ad hoc groups is indicated.

The average lifespan of a subcommittee, from appointment to discharge, has been a little under 4 years, giving an average effective working life of about 3 years. There is considerable variation, however. Six studies have been conducted by two fertility and population statistics subcommittees that have served in succession since 1949.

The subcommittees that worked on the Eighth Revision of the International Classification of Diseases constitute a special case, and not simply because they were supported by a coordinating subcommittee. Each had an average term of service of over 7 years; most constructed several drafts involving close consideration of details; several had to assay results of field tests and to absorb quite extensive comments from many sources; and the proposals of all had to be considered in the light of the sometimes quite different viewpoints of experts from other countries.

# Notable Committee Achievements

The task of accomplishing a 10-year revision of the International List makes long-continuing heavy demands on the experience, wisdom, and sometimes the political skill, of scores of experts from many countries, including those who serve the World Health Organization. The U.S. National Committee developed classification proposals for the Eighth Revision of the List in the areas of mental disorders; cardiovascular diseases; congenital defects; accidents, poisonings, and violence, by external cause (E code) and by nature of injury (N

# Current Members of the U.S. National Committee on Vital and Health Statistics

**N P** 

Dr. Robert Dyar, Chairman	Dr. Everett S. Lee	
Chief, Division of Research, California State Department	Professor of Sociology, University of Massachusetts	
of Public Health	Dr. Forrest E. Linder	
Dr. Robert L. Berg Chairman, Department of Preventive Medicine and Com-	Director, National Center for Health Statistics, Public Health Service	
munity Health, University of Rochester (N.Y.) Medical	Walter J. McNerney	
Center	President, Blue Cross Association	
Donald J. Davids	Dr. John R. Philp	
Chief, Records and Statistics Section, Colorado State De-	Director of Health, Kansas City Health Department	
partment of Public Health	Dr. Jacob Yerushalmy	
William M. Haenszel	Professor of Biostatistics, University of California School of	
Chief, Biometry Branch, National Cancer Institute, Public	Public Health	
Health Service	Dr. I. M. Moriyama, Executive Secretary	
Dr. Clyde V. Kiser	Chief, Office of Health Statistics Analysis, National Center	
Senior Member, Technical Staff, Milbank Memorial Fund	for Health Statistics, Public Health Service	

code); and causes of perinatal morbidity and mortality (3-8). No other task took as much committee time over the 6 years ending in 1965. Even now, although the eighth revision is not due to come into use until January 1, 1968, and a new revision is not expected for 10 years, the committee must soon be assessing the unfinished classification business still facing health statistics and the new problems that probably will emerge in relation to the ninth revision.

The new directions that can be opened up by International List revisions are illustrated by another achievement of the committee. As previously mentioned, the 1948 sixth revision had introduced a combined morbidity-mortality classification. The committee concluded that the International Classification of Diseases could also provide an efficient basis for the diagnostic indexing of hospital records. An adaptation of the classification for indexing hospital records based on the Sixth Revision of the International Classification of Diseases was subsequently developed, tested, and published in 1959 and then revised in 1962 (9).

Early in its career the committee developed definitions of live birth and fetal death which the World Health Assembly adopted in 1950 after slight editing. The United States endorsed these definitions the same year, and they are currently accepted by more than half of the country's registration areas. The definitions previously recommended by the United States were somewhat less explicit than the committee's definitions, which applied "irrespective of the duration of pregnancy." The previous definition of stillbirth had required at least 28 weeks of pregnancy.

As another aspect of its continuing interest in fetal-death and perinatal-death statistics, the committee sponsored studies which led to a revision of the fetal death certificate in 1955 that makes it agree more nearly with the birth certificate so far as personal particulars are concerned, and with the death certificate in establishing a sequential arrangement of conditions designed to identify the underlying cause of death (10).

In 1960 the committee published guidelines for obtaining uniform statistics on medicolegal deaths (11). From 300,000 to 450,000 deaths each year (20-30 percent of all deaths) come under the jurisdiction of a coroner or medical examiner, as the law may direct. These are deaths requiring an official determination of the cause and mode of death. The committee enumerated the kinds of deaths that medicolegal authorities should investigate to decide whether they should assume jurisdiction. It also elaborated other steps that should be taken to improve medicolegal death statistics.

After a brief 1951 study of what was indispensable for preparing national vital statistics, the committee published in 1957 a more extensive investigation of the objectives and program in that area (12). Among a number of more specific recommendations relating to registration completeness and other methods of improving the quality of vital statistics, the committee advised against obtaining the data in pretabulated form or through punchcards supplied by the registration areas, since doing so would prevent the national agency from controlling the quality of its tabulations and limit use of the records for research.

The committee has been responsible for four thorough studies of fertility and population questions in the United States setting, carried out in 1952, 1956, 1959, and 1965 (13-16). These investigations as well as two studies justifying the need for national marriage and divorce statistics done in 1957 and 1962 (12, 17) have helped demographers remain in contact with current national statistical needs and possibilities in areas of special interest to them. The 1965 recommendation that the national government engage in "sample collection of data on planned completed fertility" was only one of the many factors that led the National Center for Health Statistics, Public Health Service, to propose a national fertility survey program that would start in fiscal year 1968.

One achievement of the U.S. committee was the development in 1953 of the basic design for a continuing national health survey (18). It was in terms of the committee's study that the survey established in 1956 under Public Law 652, 84th Congress, was modeled. The 1953 recommendations outlined and gave details for nearly all of the fundamental features of the present health interview and health examination activities of the National Center for Health Statistics. These recommendations, tested in operation, could well have been influential in the deliberations that led to creation of the center in 1960.

In 1964 the committee enumerated areas relating to the economics of health where data were not available or not adequate for national health planning (19). The report covered physicians' and dentists' services, general and special short-term hospital services, long-term institutional services, drugs and appliances, and other services for noninstitutionalized patients. Categories considered were resources, use, price, costs, and quality.

It should not, however, be concluded that the committee's efforts have been immediately or uniformly successful. The records of the committee exhibit instances of repeated attacks on a problem before a satisfactory solution was attained and include a few aborted projects.

# **Anniversary Conference Recommendations**

On December 14–15, 1964, 22 of the 30 former and present committee members met to celebrate the committee's 15th anniversary by assessing its record in order to plan for its future. The author prepared a background document for the meeting as well as a summary of it (20, 21). The committee had benefited previously from two less formal 5-year reviews.

The 1964 conference reviewed the committee's substantive activities in demographic, health, and health resource and service statistics. Two discussants developed each subject under the chairmanship of a moderator. The discussions produced close to 100 suggestions of widely varied scope for the committee to consider, a good many of which have already been put into effect.

Most of the anniversary discussions were centered on problems needing investigation, rather than on exact studies that the committee might initiate if it decided to investigate problems. It was recognized that committee investigations are methodological rather than substantive. The following are summaries of those discussions.

Demographic statistics. The discussion emphasized that the country's vital statistics are a byproduct of administrative statistics, and that they are produced by a loosely organized Federal-State relationship involving the relatively free cooperation of many units with varying interests and resources. Mention was frequently made of problems raised by the confidentiality of the personal information on vital records, legal problems that may arise when individual records are used for research purposes, and additional load placed on State vital statistics offices from increased use of the records, whether for research or for establishing personal facts.

A population register system was suggested as a possible alternative to the present system of generating vital statistics directly from records of individual events—births, deaths, marriages, and divorces. Other discussants urged more use of sampling techniques in the vital statistics area. The need to keep up to date with respect to the possibilities of electronic equipment was emphasized. Each of these subjects was identified as a possible area of committee methodological studies.

Suggestions were offered for improving the quality of the data obtained from the present vital statistics system, as, for example, through verification studies of statements made on hospital and on vital records. There were many proposals for getting better family, marriage, and divorce statistics; natality measures that are more sensitive to current fertility changes; family-planning data; illegitimacy statistics; ways of analyzing multiple causes of death; and ways to focus on mortality differentials, including the social and economic correlates of mortality. In each case the committee was encouraged to make feasibility studies and assess suitable techniques.

It was held that more attention should be paid to internal migration, the chief demographic variable undergoing change in many parts of the country. Data are urgently needed for many geographic areas that are larger or smaller than those for which health statistics are now generally provided, such as economic subregions, standard metropolitan statistical areas, and census tracts. It was held that more attention needs to be paid to census over- and undercounts, to obtaining small-area estimates, and to making population projections. Methodological studies are in order on these and many other questions.

*Health statistics.* Several of the suggestions for committee study in the field of health statistics were directly related to the National Health Survey. Some proposed consideration of extensions of survey activities, while others called for analyses of the feasibility of other techniques for developing health statistics.

It was held that the committee should investigate the response-error problem in health surveys. Also suggested was identification of desirable new areas of morbidity reporting, as the reporting of leukemia and congenital malformations. Also mentioned were ways to measure the impact of medical care programs on the incidence, prevalence, and prognosis of chronic disease and new measures of the health status of the aged.

Feasibility studies of local and regional household health surveys modeled on and coordinated with the National Health Survey should be initiated. Inquiries were needed into the possibility of model physician and model hospital reporting areas. Ways of establishing closer liaison in measurement, research, and planning with schools of public health and other health institutions should be developed.

Many epidemiologic uses of National Health Survey procedures and analyses needed emphasis, including the possibility of NHS record-based epidemiologic studies.

Finally, investigation was suggested into the need for, and the possibility of creating, "a national archives of vital and health records" enabling epidemiologists, in their enlarging function of hypothesis testing, to make more effective use of individual records and gain access to material linked to individual records.

Health resource and service statistics. It was recognized that routine reporting of health resources, facilities, and personnel was as reasonable as routine reporting of mortality and morbidity information, but that much fundamental investigation would be needed to organize this relatively new area of health statistics. It was suggested that this type of investigation should be engaged in by the committee.

The functions to be performed by varying types of institutions, such as short-stay hospitals, chronic disease hospitals, and nursing homes, need clearer definition. The kinds of information required by users of the various types of medical services had to be more clearly identified. Adequate specifications had to be developed with respect to the interrelations of professional and nonprofessional health serv-Guidelines were required concerning reices. lationships between the private and governmental sectors in providing health care. The possibility of routine reporting, especially by households, of expenditures for and utilization of health-related services required analysis.

Suitable measures were lacking for measuring the quality of health services, including medical care and work standards in the medical field. How could one measure in what ways the organization of medical services, as for example with or without group practice, affected admission rates, services rendered, results secured, and costs incurred ?

It was argued that explorations were needed into the bearings on each other of demographic facts, traditional health statistics, and the newer statistics of health resources and facilities.

# Assessment of Committee Activities

Can other study groups, which may be situated in areas of activity quite unlike the province of the U.S. National Committee, learn anything from the experience of the committee that might be of use to them in conducting their own investigations? The author feels that certain characteristics of the committee's activities may be relevant beyond the special situation in which it has worked, and beyond also the personal characteristics of those who have guided its activities.

The committee studies only technical statistical questions, in total divorcement from specific program responsibilities. It has no continuing program axe to grind or special interest to further or protect. The limitation to technical, nonprogram-oriented problems appears to be an indispensable ingredient of the committee's success. In the case of other groups the specific technical orientation need not be statistical.

Great attention is paid to the selection of committee and subcommittee members. They are selected because they are fit to work with their peers on the tasks at hand. This is a toolittle recognized aspect of the continuing task of administering the affairs of the committee the submerged but balancing portion of the iceberg of administrative responsibility. This high degree of attention to the people who are selected to perform tasks lies within the reach of other study groups.

The committee is located at two important interfaces in public health: between national and international concerns and, in the national area, between public health and demographic concerns that are expressed organizationally by the Public Health Service and the Bureau of the Census. The importance of this location is suggested by the infrequency with which the committee has considered conducting studies on the country's regional public health problems or on special U.S. public health questions—as, for example, metropolitan areas, the nonwhite population, and income or occupational groups. The committee did, however, appoint a subcommittee in January 1965 to outline statistics needed to delineate major health problems of American Indians.

Another coordinating study group might well seek to identify pertinent interfaces that could serve to sharpen problems and suggest directions for their solution.

The committee works in terms of a layered or buffering structure composed of the secretariat, the committee itself, and the subcommittees. This type of organization has considerable merit when each of the layers combines competence with objectivity and industry. Perhaps it works best when professional people are dealing with professional problems under conditions where self-interest and other human frailties are not too prominent. At the same time, however, one of its examples is the balance of powers within the national government and between Federal and State interests. Neither the committee nor the secretariat have interpreted their responsibilities as being formal and perfunctory; nor have they or the subcommittees grasped for power.

This manner of functioning stresses the importance of getting people who can work together to solve problems without overemphasizing extraneous considerations.

The committee has unremittingly sought suggestions of study subjects, although it has never delegated its responsibility for making decisions to others. It has managed to attain a fairly high level of self-awareness without incurring a high degree of self-consciousness.

It would appear that the committee, like most groups, cannot easily break entirely new ground. It is at its best in lending support and giving concrete form to ideas and purposes that have begun to take shape but still need some assistance in being realized. It has not so much generated wholly new ideas in health statistics as it has performed helpful services in accomplishing the fulfillment of well-conceived proposals.

#### Summary

The U.S. National Committee on Vital and Health Statistics was established in 1949 by the Surgeon General of the Public Health Service in accordance with a recommendation of the First World Health Assembly to study technical statistical questions in its areas of competence.

Some of the committee's achievements are development of classification proposals for the Eighth Revision of the International List of Diseases, adaptation of the Sixth Revision of that List for diagnostic use, definitions of live birth and fetal death, and revision of the 1955 United States fetal death certificate. It has also provided guidelines for obtaining uniform statistics of medicolegal deaths, various studies of vital statistics problems and needs, including four analyses of fertility and population questions in the U.S. setting, the basic design for a continuing national health survey, and needed statistics in health economics.

At the 15th anniversary conference of the committee in December 1964, suggestions for studies in demographic, health, and health resource and service statistics were developed.

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## Permits Required for Septic Tanks

Property owners who install septic tank systems in Wisconsin are now responsible for obtaining a permit before the tank may be purchased or installed. This is required under a new law passed by the 1965 legislature and effective August 1, 1966. Installation of private sewage disposal systems may be made only by plumbers or restricted plumbers licensed by the Wisconsin State Board of Health.

#### **Driver Improvement Course**

The Wisconsin State Board of Health sponsored its first driver improvement course for State employees in July. The motor vehicle department safety division supplied the instructors.

#### Maternity Clinics in Albuquerque

Weekly maternity clinics which began on October 27, 1966, at the Griegos Community Center in Albuquerque, N. Mex., mark the second phase of a cooperative program to bring low-cost, quality care to mothers of low-income families within their own neighborhoods. A similar program established during May 1966 at the South Barelas Community Center has an average attendance of 32 patients weekly double the number anticipated when the project was planned.

The Office of Economic Opportunity contributed the Griegos Community Center facility and helps provide funds for a nurse's salary. The secretary of the center donates clerical services. The State health department's division of maternal and child health serves as a consultant agency and supplies the equipment.

#### Maternity Care for More Women

A recent study on the extent of maternity care in the United States in the period 1953-63 indicates that increasing proportions of pregnant women have been obtaining such care. The study results included these figures on the percent of pregnant women who saw a physician by the end of various months of pregnancy:

Month	<b>1953</b>	<i>195</i> 8	1963
1	38	51	52
3	65	77	78
1	79	84	88
B	92	96	96
9	97	99	98

If only women who saw a physician at least once during pregnancy or delivery are considered, the proportion receiving care early in pregnancy increased markedly between 1953 and 1958 and began to level off in 1963—Progress in Health Services, Health Information Foundation, University of Chicago.

#### Laboratory Services After Tornado

The tornado that slashed through Topeka, Kans., June 8, 1966, left a swath about 15 miles long and 4 blocks wide.

The building housing the State health department's laboratory services was badly damaged. In less than a week, however, after the tornado, the laboratories resumed services with temporary facilities.

The first employees entering the laboratory building after the disaster turned off all gases, including a hydrogen tank, and salvaged what equipment they could. Since some tubes of tuberculosis cultures were broken, the area was flooded with disinfectant.

Neighboring State health departments offered their laboratory services in the emergency. Kansas health department personnel did some tests in private laboratories. Local public health laboratories were also used.

## W. Va. Health Referral Service

The Armed Forces rejected 3,339 young men in West Virginia for medical reasons during fiscal year 1965-66. By October 11, 1966, the staff of the State's health referral service had interviewed 2,873 of these men, explaining why they were rejected and encouraging them to seek medical care. In 10 months, the health referral service had also completed followup on 697 cases.

Information that the health referral service has available enables its personnel to direct the medically disqualified men to the most appropriate and conveniently located resources in their own communities. The most frequent diseases discovered among West Virginia's disqualified youth were diseases of the eyes and ears.

Items for this page: Health departments, health agencies, and others are invited to share their program successes with others by contributing items for brief mention on this page. Flag them for "Program Notes" and address as indicated in masthead.