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APPROVED  
JUN 23 1976

86/23/76

THE WHITE HOUSE

DECISION

WASHINGTON

Last Day: June 23, 1976

June 22, 1976

TO ARCHIVES  
6/24/76

MEMORANDUM FOR THE PRESIDENT

FROM: JIM CANNON

SUBJECT: Enrolled Bill S. 1466 - National Consumer Health Information and Health Promotion Act of 1976

Posted  
6/24/76

Attached for your decision is S. 1466, which extends through FY 1978 existing communicable, venereal disease and lead-based paint poisoning prevention programs, as well as authorizing HEW to conduct under new authority health information and promotion programs.

BACKGROUND

The legislative authority for communicable disease control programs conducted by HEW expired June 30, 1975, and since then has been carried out under the authority of a continuing resolution. S. 1466 would renew the authority for these ongoing programs and also provide authorization for a new program to increase the individual's knowledge on how to use health care.

This is the first piece of legislation to emerge from the Congress that would continue a categorical program included in your health block grant proposal. We expect that several other bills will be passed this year which will continue other categorical grants. We do not expect the block grant proposal to become law during this session.

The National Influenza Immunization Program against swine flu is operated under one of the authorities in this bill. Although the programs involved could still be operated under continuing resolution this fiscal year, the visibility of the swine flu immunization program may make a veto difficult for the public to understand. Also, the same Committees that developed this legislation are the ones that will consider the Administration's request for special indemnity legislation for swine flu vaccine manufacturers.

During floor consideration of the legislation, it was noted that OMB strongly opposed the bill but no veto signal was given.

STAFF AND AGENCY RECOMMENDATIONS

HEW Approval. Strongly recommend that the President approve the enrolled bill in a private signing ceremony. "S. 1466 represents a negotiated compromise on the issues involved, in which our major objections have been met. These prevention and control activities may well do more in the long run to limit the continuing increase in health care costs in this country than other programs which require levels of funding much higher than those authorized by S. 1466."

OMB Disapproval. "Would serve as an occasion to stress your opposition to the proliferation of categorical grant programs...because S. 1466 is inconsistent with your block grant proposal... chances of sustaining a veto are very slim." (Jim Lynn's memorandum is attached at Tab A.)

HUD Defers to HEW and CPSC on lead-based paint provisions.

CPSC Favors veto of regulatory provisions concerning lead-based paint and defers on bill as a whole.

Buchen Approval. "Veto would be a futile gesture."  
(Lazarus)

Friedersdorf - Approval. "The bill passed both Houses by a voice vote. Veto would, of course, be difficult if not impossible to sustain."

Both Tim Lee Carter and Jim Broyhill supported the bill and believe their combined efforts with Paul Rogers (and HEW) succeeded in a bill the President could sign.

RECOMMENDATION

I recommend that you sign S. 1466.

DECISION



Approve (enrolled bill attached at Tab B).

Disapprove (sign veto message at Tab C, which has been cleared by Doug Smith).

APPROVED  
JUN 23 1976



EXECUTIVE OFFICE OF THE PRESIDENT  
OFFICE OF MANAGEMENT AND BUDGET  
WASHINGTON, D.C. 20503

JUN 17 1976

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill S. 1466 - National Consumer  
Health Information and Health Promotion  
Act of 1976  
Sponsor - Sen. Kennedy (D) Mass. and 7 others

Last Day for Action

June 23, 1976 - Wednesday

Purpose

Authorizes HEW to conduct a new health information and health promotion program; extends through fiscal year 1978 and expands existing communicable disease, venereal disease and lead-based paint poisoning prevention programs.

Agency Recommendations

Office of Management and Budget	Disapproval (Veto message attached)
Department of Health, Education, and Welfare	Approval
Department of Housing and Urban Development	Defers to HEW and CPSC on lead-based paint provisions
Consumer Product Safety Commission	Favors veto of regulatory provisions concerning lead-based paint, but defers on bill as a whole

Discussion

Legislative authorizations for the communicable disease and disease control programs conducted by HEW expired on June 30, 1975 and, since then, have been carried out

under the authority of a continuing resolution. S. 1466 would amend the Public Health Service (PHS) Act by extending and expanding these categorical health programs, and by authorizing HEW to initiate and conduct a new program of health information and health prevention.

Specifically, S. 1466 would:

-- extend for three years and expand the program of grants for the control and prevention of a number of communicable diseases, e.g., venereal diseases, rat control, and immunization,

-- extend the lead-based paint poisoning prevention program through fiscal year 1978 and redefine the responsibilities of the agencies involved in administering that program, and

-- authorize grants and contracts in the area of health education, and require the establishment of an Office of Health Information and Health Promotion in HEW.

Communicable and venereal diseases. S. 1466 would expand or modify communicable disease programs by:

-- authorizing new training and demonstration grants and contracts in the area of disease prevention and control,

-- broadening the definition of "disease control program" to include, in addition to communicable diseases, diseases or health conditions which are preventable or subject to amelioration, e.g., arthritis, diabetes, hypertension, pulmonary and cardiovascular diseases and RH disease, and

-- repealing the formula grant authority of the venereal disease program.

Your 1977 Budget proposed the "Financial Assistance for Health Care Act," to consolidate Medicaid with these other health programs into a single health block grant program. Draft legislation was submitted to Congress in February 1976. Under the Administration's legislative proposal, States would have the flexibility to determine priorities of health care in the communicable disease and disease prevention area. The Administration therefore

strongly opposed S. 1466, since it runs directly counter to the concept of the health block grant.

Lead-Based Paint Poisoning Prevention Act. S. 1466 would also modify the existing Lead-Based Paint Poisoning Prevention Act (first enacted in 1971 and extended in 1973), in several respects. It would:

-- require that the Consumer Product Safety Commission (CPSC), within six months of the enactment of S. 1466, determine whether or not a level of lead in paint which is greater than 0.06% but not in excess of 0.5% is safe. (If such a determination is not made, after 12 months the term "lead-based paint" would automatically be defined by S. 1466 to mean paint containing anything greater than 0.06% rather than the definition of 0.5% in present law.)

-- prohibit the application of lead-based paint to any cooking, drinking or eating utensils, toys or furniture manufactured after the date of enactment, or the use of such paint in residential structures built or rehabilitated with Federal assistance,

-- transfer from HEW to the Department of Housing and Urban Development (HUD) responsibility for controlling the application of lead-based paint to federally constructed or assisted housing, and

-- require that local governments give priority to the removal of lead-based paint hazards in dwellings where children with diagnosed lead-paint poisoning reside.

The Administration had proposed to include the lead-based paint poisoning prevention program in the health block grant proposal and therefore did not support its extension as a separate program or any amendments to the existing Act.

Health information and promotion. A principal purpose of S. 1466 is to increase public knowledge of the appropriate use of health care. Accordingly, the enrolled bill would add a new title to the Public Health Service Act which would:

-- authorize HEW to make grants and enter into contracts for research, community demonstration and training programs, and information programs in the area of health education,

-- require HEW to submit to the Congress within two years, and annually thereafter, a report on the status of health information and health promotion, preventive health services and education in the use of health care,

-- require the establishment of an Office of Health Information and Health Promotion under the Assistant Secretary for Health to coordinate all HEW activities designed to educate the public in the appropriate use of health care, and

-- require the establishment of a national health information clearinghouse.

The Administration strongly opposed the establishment of this new categorical health program since it conflicts with the Administration's objective of consolidating numerous existing health programs and since HEW already was using its general authority to conduct health information activities. Moreover, the effectiveness of health information activities in changing behavior is questionable.

Budget impact. Attached to this memorandum is a table comparing the appropriations authorizations in S. 1466 with the Administration's budget requests for fiscal years 1976 and 1977 and the levels projected for fiscal year 1978 in the 1977 Budget. In total, the authorizations in the enrolled bill for the three fiscal years amount to \$307 million. This compares with \$99 million requested or projected by the Administration. For fiscal year 1977 alone, the bill would authorize \$103 million compared to the budget request of \$33 million as part of the block grant for the programs involved.

Although the authorizations in S. 1466 are far above the requests, they are not sharply out of line with recent congressional appropriation trends.

#### Arguments For Approval

1. S. 1466 would specifically authorize HEW to continue its existing disease control and prevention programs. HEW argues that the bill is necessary at least until the Administration's proposed Financial Assistance for Health Care Act can be effected; enactment of that proposal does not appear likely in this session of the Congress.

2. The new health education categorical program has a relatively small authorization and, although it duplicates existing legal authority, it would not disrupt HEW organizational structure or require HEW to carry out an expensive new program.

3. According to HEW, S. 1466 "incorporates major concessions agreed to by the Congress after considering the Administration's objections." HEW cites those concessions as:

-- deletion of authority for a National Center for Health Promotion,

-- excision of all administrative authority of the Office of Health Education and Health Promotion,

-- deletion of authority for an interdepartmental health education committee,

-- elimination of authority for new water treatment and dental programs, and

-- lowering of appropriations authorizations to amounts below those originally provided in both House and Senate versions of the bill.

4. Congressional sponsors of the legislation indicated on the House and Senate floors that there had been negotiations with Administration representatives and that it was their understanding that the final version of S. 1466 which emerged from conference was acceptable to the Administration and that you would sign it.

#### Arguments Against Approval

1. S. 1466 runs directly counter to the efforts of the Administration over the past two years to consolidate the many fragmented health programs administered by HEW. Approval of S. 1466 would undermine your commitment to enactment of the Administration's health block grant proposal. This is the first such bill to emerge from Congress that would continue a categorical program that you included in your health block grant. Moreover, approval of S. 1466 would leave virtually no alternative but to approve two other bills extending narrow categorical health programs under final consideration by the Congress, i.e., Emergency Medical Service and alcoholism grants.



2. Extension of the appropriation authorizations to continue the programs pending enactment of the health block grant is not necessary. The programs involved are operating under continuing resolution this fiscal year without new authorizations. Disapproval of the enrolled bill could help maintain pressure on the Congress to enact the block grant proposal and would, at the same time, keep funding of the programs at lower levels under the continuing resolution than might be provided under the authorizations in the bill.

3. Over the three years, the authorization levels in S. 1466 exceed by \$208 million the levels requested in the 1976 and 1977 budgets. The authorizations in the Emergency Medical Services and alcoholism bills likely to be enrolled before July 1 could, if fully funded, result in additional budget outlays of approximately \$116 million in fiscal year 1977 and \$189 million in 1978.

4. OMB staff believe there are very few "concessions" in the compromise version of the bill. The only significant change is that new water treatment and dental programs would not be included. In addition, the authorization levels in the final "compromise" bill were, in some cases, higher than those in the original House and Senate bills and in total are still about 3 times more than the Administration request.

5. Statutory establishment of a new health information program and a new Office of Health Information and Health Promotion in HEW is clearly unnecessary and without program merit. HEW states that the main effect of these provisions "would be to give increased visibility to the area of health education." HEW already has an Office of Health Education in the Center for Disease Control, and carries out numerous health education activities.

6. The Consumer Product Safety Commission states that there are serious objections to the administrative process provided by S. 1466 for establishing and enforcing a safe level of lead in paint, depending on whether an agency proceeded under the Lead-Based Paint Act, the Consumer Product Safety Act or the Federal Hazardous Substances Act. CPSC states that S. 1466 could lead to differing federal standards and "undoubtedly will require duplicative proceedings on the precise same matter resulting in a massive waste of tax dollars." CPSC also concludes that "the

confusion which would result from different federal levels would be compounded by the statutory provisions applicable to preemption of various state and local laws and regulations."

#### Recommendations

HEW strongly recommends approval. The Department states that "S. 1466 represents a negotiated compromise on the issues involved, in which our major objections have been met. Actual funding levels will, of course, be determined through the appropriations process." HEW recommends "a private signing ceremony to which the principal Congressional participants in the development of S. 1466 would be invited."

HUD states that it has "no objection to the transfer to HUD of HEW's responsibility for controlling the application of lead-based paint to Federally constructed or assisted housing." HUD defers to HEW and CPSC on the other provisions relating to lead-based paint.

CPSC, in its letter, offers the following comment:

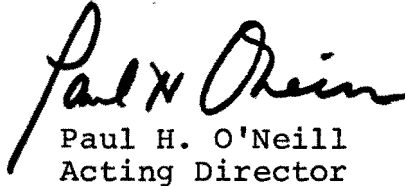
"Only insofar as the provisions of S. 1466 impact on the Consumer Product Safety Commission by amending the process for establishing a safe level of lead in paint does the Commission favor veto of the bill. The regulatory process which results from this portion of S. 1466 will be more costly and duplicative than is necessary without any increase in benefit to the public."

CPSC defers to HEW on the other provisions of S. 1466, but requests Administration support of efforts to amend the procedural provisions, should the bill be signed.

\* \* \* \* \*

We have strongly opposed S. 1466 because it is so clearly inconsistent with your proposal to consolidate categorical health programs into a single block grant. Moreover, S. 1466 does not contain authorities that we believe to be essential at this time. Disapproval of S. 1466 would serve as an occasion to stress your opposition to the proliferation of categorical grant programs by the Congress. We disagree with HEW that Congress made "major" concessions in the conference bill.

We realize that this enrolled bill was apparently viewed as noncontroversial, since it was passed by voice vote in both Houses. Chances of sustaining a veto are very slim. Nevertheless, we believe the policy considerations involved are sufficiently important to warrant your disapproval of S. 1466. We have attached a draft veto message for your consideration.

  
Paul H. O'Neill  
Acting Director

Enclosures

## Attachment

S. 1466 Appropriations Authorizations  
Compared with Budget Levels  
(\$ in millions)

<u>Program</u>	<u>Fiscal year</u>	<u>S. 1466 Authorizations</u>	<u>Budget levels</u>	<u>Difference</u>
Health education	1977	7	--	+7
	1978	10	--	+10
	1979	14	--	+14
Venereal disease	1976	37	20	+17
	1977	48	20	+28
	1978	51	20	+31
Rat control	1976	13	5	+8
	1977	14	5	+9
	1978	14	5	+9
Lead-based paint poisoning prevention	1976	10	3	+7
	1977	12	3	+9
	1978	14	3	+11
Immunization and other control programs	1976	13	5	+8
	1977	22	5	+17
	1978	28	5	+23
Total, all years		307	99	+208
Total, 1976		73	33	+40
Total, 1977		103	33	+70
Total, 1978		117	33	+84
Total, 1979		14	--	+14

c

period. At a time when the overall Federal deficit is estimated at over \$74 billion, I must oppose such excessive authorization levels.

Other bills now pending would also continue current narrow categorical Federal health programs. Rather than proceeding to extend and expand such programs, I urge the Congress to hold hearings and rapidly enact my proposed "Financial Assistance for Health Care Act."

THE WHITE HOUSE,

TO THE SENATE OF THE UNITED STATES:

I am returning, without my approval, S. 1466, a bill which would authorize duplicative health information and health promotion programs and would reauthorize and expand programs dealing with venereal disease, rat control, lead-based paint poisoning and other disease prevention and control.

This bill is based on a policy of perpetuating the existing maze of Federal health programs. Such an approach is a disservice to those who need effective delivery of health services and those who must pay the bills -- the taxpayers. In my 1977 Budget, I proposed a consolidation of 16 existing Federal health programs into a single block grant which would enable States and localities to assure that people in need receive comprehensive health care. I share the objectives of S. 1466 to assure the provision of important preventive health services, but I firmly believe that under my proposed health block grant those services would be provided in a more effective manner.

Fewer Federal programs, and a reduction in the various rules and regulations accompanying each of them, would allow States and local governments to respond more quickly to the particular health needs of their residents. Consolidation into a block grant will also better target Federal health assistance on those with low incomes, and distribute Federal funds more equitably among the States. Funding from the existing 16 categorical programs proposed for consolidation in the block grant varies from \$200 per low-income individual in some States to over \$800 in others. This inequity should not be continued.

In addition, the many Federal requirements imposed upon States and localities prevent them from bringing about needed efficiencies and coordination in their health programs. If the proposed health block grant were enacted instead of bills such as S. 1466, more Federal health dollars could go toward providing health services for our citizens rather than for the cost of burdensome administration.

S. 1466 would also create unnecessary and duplicative health education programs. The Department of Health, Education, and Welfare alone now spends more than \$80 million a year on health education of the public. The activities proposed in S. 1466 would only add to the already complicated array of Federal health education programs.

The bill would, moreover, create a special problem in the lead-based paint poisoning prevention program. It would require the determination of safe lead levels in paint but provides little, if any, guidance with respect to the procedures determining those levels. This could, accordingly, lead to the highly undesirable situation of differing Federal standards for lead in paint, depending on whether an agency proceeded under the Lead-Based Paint Poisoning Prevention Act, the Consumer Product Safety Act or the Federal Hazardous Substances Act. Thus, S. 1466 could not only create confusion in this area, but could require duplicative administrative proceedings on the same subject matter resulting in a massive waste of tax dollars as well as unnecessary delay and red tape, without any real benefit to the public.

Lastly, S. 1466 is objectionable since it would authorize appropriations of \$307 million -- more than three times my requested levels -- over a three-year



To: J. Cavanaugh  
6-18-76  
9:30 a.m.



EXECUTIVE OFFICE OF THE PRESIDENT  
OFFICE OF MANAGEMENT AND BUDGET  
WASHINGTON, D.C. 20503

JUN 17 1976

MEMORANDUM FOR THE PRESIDENT

Subject: Enrolled Bill S. 1466 - National Consumer  
Health Information and Health Promotion  
Act of 1976  
Sponsor - Sen. Kennedy (D) Mass. and 7 others

Last Day for Action

June 23, 1976 - Wednesday

Purpose

Authorizes HEW to conduct a new health information and health promotion program; extends through fiscal year 1978 and expands existing communicable disease, venereal disease and lead-based paint poisoning prevention programs.

Agency Recommendations

Office of Management and Budget	Disapproval (Veto message attached)
Department of Health, Education, and Welfare	Approval
Department of Housing and Urban Development	Defers to HEW and CPSC on lead-based paint provisions
Consumer Product Safety Commission	Favors veto of regulatory provisions concerning lead-based paint, but defers on bill as a whole

Discussion

Legislative authorizations for the communicable disease and disease control programs conducted by HEW expired on June 30, 1975 and, since then, have been carried out

THE WHITE HOUSE

ACTION MEMORANDUM

WASHINGTON

LOG NO.:

Date: June 18

Time: 1100am

FOR ACTION: Spencer Johnson *sign* cc (for information): Jack Marsh  
 Ken Lazarus *sign* Jim Cavanaugh  
 Max Friedersdorf *sign* Ed Schmults  
 Dawn Bennett *sign*  
 Steve McConahey *sign*

FROM THE STAFF SECRETARY

DUE: Date: June 19

Time: noon

SUBJECT:

S. 1466 - National Consumer Health Information and Health Promotion Act of 1976

ACTION REQUESTED:

- |   |   |
|---|---|
| <input type="checkbox"/> For Necessary Action         | <input type="checkbox"/> For Your Recommendations |
| <input type="checkbox"/> Prepare Agenda and Brief     | <input type="checkbox"/> Draft Reply              |
| <input checked="" type="checkbox"/> For Your Comments | <input type="checkbox"/> Draft Remarks            |

REMARKS:

Please return to Judy Johnston, Ground Floor West Wing

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a delay in submitting the required material, please telephone the Staff Secretary immediately.

\_\_\_\_\_  
K. R. COLE, JR.  
For the President

TO THE SENATE

I am returning, without my approval, S. 1466, a bill which would authorize duplicative health information and health promotion programs, and reauthorize and expand venereal disease, rat control, lead-based paint poisoning and other disease prevention and control programs.

This bill is based on a policy of perpetuating the existing maze of Federal health programs. Such an approach is a disservice to those who need effective delivery of health services and those who must pay the bills--the taxpayers. In my 1977 Budget, I proposed a consolidation of 16 existing Federal health programs into a single block grant which would enable States and localities to assure that people in need receive comprehensive health care. I share the objectives of S. 1466 to assure the provision of important preventive health services, but I firmly believe that under my proposed health block grant those services would be provided in a more effective manner.

Fewer Federal programs, and a reduction in the various rules and regulations accompanying each of them, would allow States and local governments to respond more quickly to the particular health needs of their residents. Consolidation into a block grant will also better target Federal health assistance on those with low incomes, and distribute Federal funds more equitably among the States. Funding from the existing 16 categorical programs proposed for consolidation in the block grant varies from \$200 per low-income individual in some States to over \$800 in others. This inequity should not be continued.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

JUN 1 1 1976

The Honorable James T. Lynn  
Director, Office of Management  
and Budget  
Washington, D. C. 20503

Dear Mr. Lynn:

This is in response to your request for a report on S. 1466, an enrolled bill "To amend the Public Health Service Act to provide authority for health information and health promotion programs, to revise and extend the authority for disease prevention and control programs, and to revise and extend the authority for venereal disease programs, and to amend the Lead-Based Paint Poisoning Prevention Act to revise and extend that Act."

We strongly recommend that the President sign the enrolled bill; the bill would authorize important activities in the area of disease control and represents a compromise in which our major objections have been met. We also recommend a private signing ceremony to which the principal Congressional participants in the development of the bill would be invited.

S. 1466 would authorize a small program in the area of health education through fiscal year 1979, to include grants and contracts for research, community demonstration programs, and information programs. The bill would establish an Office of Health Information and Health Promotion within this Department to coordinate Departmental health education activities; the Office would not be charged with direct administrative responsibility for any program.

S. 1466 would also extend our programs concerned with lead-based paint poisoning, venereal diseases, and other diseases amenable to reduction through fiscal year 1978. These programs would also be modified by:

- permitting training and demonstration grants and contracts in the area of disease prevention and control,
- broadening the concept of disease control programs to include diseases and other conditions which are of national significance and which are amenable to reduction, but are not of the traditional communicable type,
- repealing the venereal disease formula grant authority,
- redefining the respective roles of this Department, the Department of Housing and Urban Development and the Consumer Product Safety Commission (CPSC) as to the use of lead-based paint on certain products, so as to parallel the missions of these Departments and the CPSC, and
- requiring the CPSC, during the six-month period following enactment of the enrolled bill, to determine whether or not a level of lead in paint which is greater than 0.06 percent but not in excess of 0.5 percent is safe.

Appropriation authorizations in the bill (and Budget requests in the same areas) are set out in Tab A.

S. 1466 would enable us to continue the important disease control and prevention activities which this Department is currently carrying out. These prevention and control activities may well do more in the long run to limit the continuing increase in health care costs in this country than other programs which require levels of funding much higher than those authorized by S. 1466. Until we are able to effect enactment of our Financial Assistance for Health Care Act, we must have other authority to carry out these vital prevention and control activities.

The enrolled bill would also authorize a small program in the area of health education; this new authority essentially duplicates legal authority we already have, but without

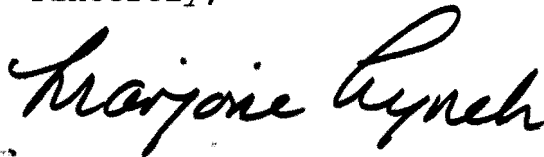
disrupting our Departmental organizational structure or requiring us to carry out a new and expensive program. The main effect of the enrolled bill would be to give increased visibility to the area of health education, which is all to the good.

S. 1466 as passed by the Congress incorporates major concessions agreed to by the Congress after considering the Administration's objections. For example, the establishment of a private center for health promotion, to be funded in part with Federal funds, was deleted; all administrative authority of the Office of Health Education and Promotion was excised; a provision for an interdepartmental health education committee was removed; programs related to water treatment and dental health were eliminated; and the total amount of appropriations authorized is below that originally provided in both the House and Senate versions of the bill.

S. 1466 represents a negotiated compromise on the issues involved, in which our major objections have been met. Actual funding levels will, of course, be determined through the appropriations process.

We therefore strongly recommend that the President sign the enrolled bill. We also recommend a private signing ceremony to which the principal Congressional participants in the development of S. 1466 would be invited.

Sincerely,

A handwritten signature in black ink that reads "Marjorie Lynch". The signature is written in a cursive, flowing style.

Under Secretary

Enclosure

TAB A--S. 1466 APPROPRIATION AUTHORIZATIONS  
AND RELATED BUDGET REQUESTS

(figures in millions of dollars)

		<u>S. 1466 Authorization</u>	<u>Budget Request</u>	<u>Continuing Resolution or Currently Authorized</u>
Health Education--	1977	\$ 7	0	
	1978	\$10	0	
	1979	\$14	0	
Rat Control--	1976	\$13.5	\$ 5.41*	\$20
	1977	\$14	\$ 5.41	
	1978	\$14.5		
Venereal Disease Research--	1976	\$ 5	0	0
	1977	\$ 6.6	0	
	1978	\$ 7.6		
Venereal Disease Project Grants--	1976	\$32	\$19.84	\$19.84
	1977	\$41.5	\$19.84	
	1978	\$43.5		
Lead-Based Paint--	1976	\$10	\$ 3.5	\$ 3.5
	1977	\$12	\$ 3.5	
	1978	\$14		
Immunizations and other control programs--	1976	\$13	\$ 4.96	\$ 4.96
	1977	\$22	\$ 4.96	
	1978	\$28		

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\*\$13.1 appropriated for FY 1976



THE GENERAL COUNSEL OF HOUSING AND URBAN DEVELOPMENT  
WASHINGTON, D. C. 20410

**JUN 14 1976**

Mr. James M. Frey  
Assistant Director for  
Legislative Reference  
Office of Management and Budget  
Washington, D. C. 20503

Attention: Ms. Ramsey

Dear Mr. Frey:

Subject: S. 1466, 94th Congress (Kennedy, et al)  
Enrolled Enactment

This is in response to your request for our views on the enrolled enactment of S. 1466, the proposed "National Consumer Health Information and Health Promotion Act of 1976".

The enrolled bill would provide for a program of research, information and demonstrations with respect to health promotion, preventive health services, and education in the appropriate use of health care, to be administered by an Office of Health Information and Health Prevention established in the Department of Health, Education and Welfare under the bill.

This bill would also extend and make some revisions in HEW's disease control and prevention programs. Of these revisions, the ones of particular interest to this Department are the proposed amendments to the Lead-Based Paint Poisoning Prevention Act.

These amendments to the Lead-Based Paint Poisoning Prevention Act would authorize additional appropriations through fiscal year 1978 for purposes of carrying out that Act. They would require that local detection and



treatment programs funded by HEW include a lead based paint hazard elimination component, with priority to be given to hazard elimination in dwellings in which reside children with diagnosed lead based paint poisoning.

The bill would also, in the case of paint manufactured one year after enactment, define lead based paint as paint having a lead content of more than 0.06 percent, or more than such higher level (but not in excess of 0.5 percent) as the Consumer Product Safety Commission determines to be safe. The 0.5 percent lead level under current law would continue to be used for establishing the safe level of lead in existing paint.

Finally, the amendment would reassign various responsibilities for controlling the use of lead based paint, and would specifically assign to this Department the responsibility for prohibiting the application of lead based paint in residential structures constructed or rehabilitated by the Federal government or with Federal assistance after the date of enactment of the bill. This overall responsibility for this function is assigned to the Secretary of Health, Education and Welfare under existing law, with various responsibilities assigned under HEW regulations to appropriate Federal agencies, including HUD. The Senate Committee Report accompanying S. 1664 (Report 94-634) indicates that the purpose of this provision is to clarify the respective jurisdiction of these agencies with respect to existing responsibilities, and we would interpret the provision as assigning HEW's current lead responsibility with respect to Federal and Federally assisted housing directly to HUD.

The Department has no objection to the transfer to HUD of HEW's responsibility for controlling the application of lead based paint to Federally constructed or assisted housing. We defer to HEW and the Consumer Product Safety

Commission, as appropriate, with respect to the desirability of the other provisions of the bill, including those provisions relating to the establishment of an acceptable level of lead in paint to be manufactured in the future.

Sincerely,

A handwritten signature in cursive script, appearing to read "Robert R. Elliott". The signature is written in dark ink and is positioned above the typed name.

Robert R. Elliott



U.S. CONSUMER PRODUCT SAFETY COMMISSION

WASHINGTON, D.C. 20207

JUN 10 1976

Honorable James T. Lynn  
Director  
Office of Management and Budget  
Washington, D.C. 20503

Attention: Assistant Director for Legislative Reference

Dear Mr. Lynn:

This letter is in response to the Office of Management and Budget's request for the views and recommendations of the Consumer Product Safety Commission on S. 1466, an enrolled bill

"To amend the Public Health Service Act to provide authority for health information and health promotion programs, to revise and extend the authority for disease prevention and control programs, and to revise and extend the authority for venereal disease programs and to amend the Lead-Based Paint Poisoning Prevention Act to revise and extend that Act."

Inasmuch as the provisions of section 204 of S.1644, more particularly subsections (b) and (c), are the only provisions of the bill which would impact on or involve the Consumer Product Safety Commission, the Commission will confine its comments to those provisions and will defer to the other affected departments with respect to other provisions of the bill.

Section 204(b) of S. 1466 would amend section 401 of the Lead-Based Paint Poisoning Prevention Act (LBPPPA, 42 U.S.C. 4831) to require the Secretary of Health, Education and Welfare to "take such steps and impose such conditions

as may be necessary or appropriate" to prohibit the application of lead-based paint to any cooking, drinking or eating utensil; to require the Secretary of Housing and Urban Development to take similar action with respect to the use of lead-based paint in residential structures constructed or rehabilitated by the Federal Government, or with federal assistance; and to require the Consumer Product Safety Commission to take similar action with respect to the application of lead-based paint to any toy or furniture article. This provision, by assigning responsibility with respect to toys and furniture articles to the Commission, conforms the LBPPPA to existing law with respect to jurisdiction over the safety of these products, which is vested in the Commission.

Section 204(c) of S.1466 would, inter alia, amend section 501(3) of the LBPPPA (42 U.S.C. 4841(3)) to provide that the term "lead-based paint" shall mean any paint containing more than .5 percent lead by weight. Further, the Commission would be required to determine, within six months of enactment of S. 1466, on the basis of available data and information and after providing for an oral hearing and consideration of other agencies' recommendations, whether another level of lead, greater than .06 percent by weight but not to exceed .5 percent is safe. If the Commission determines, in accordance with the requirements set forth above, that a level of lead other than .5 percent is safe, the term "lead-based paint" shall mean, with respect to paint which is manufactured after the expiration of six months from the date of the Commission's determination, paint containing more than such level of lead as the Commission has determined is safe. In the absence of such a determination by the Commission, the term "lead-based paint" shall mean, with respect to paint manufactured after the expiration of twelve months from the date of enactment of S. 1466, paint containing more than .06 percent lead.

This provision is similar to existing law, except that under the present provision, the Chairman alone rather than the full Commission is charged with the responsibility for determining the safe level of lead, and is presently not required to consult with the Secretary of Health, Education and Welfare or the National Academy of Sciences.

The Commission supports the goal of protecting the public, particularly children, from the hazards associated with lead-based paint. The Commission is currently conducting a rulemaking proceeding pursuant to a petition under the Federal Hazardous Substances Act (FHSA, 15 U.S.C. 1261 et seq.) to determine whether paint containing more than .06

percent lead should be banned. The same petition also requests that the Commission issue a consumer product safety rule pursuant to its authority under the Consumer Product Safety Act (CPSA, 15 U.S.C. 2051 et seq.) requiring that the composition of such paints contain not more than .06 percent lead.

The Commission, however, has several reservations concerning the approach of S.1466. First, the provision contained in section 204(c) of S. 1466, amending section 501(3) of the LBPPPA regarding the definition of "lead-based paint" offers little guidance with respect to the procedure to be followed in making the determination of a safe level and fails to indicate either the character of the proceeding or whether such determination is subject to judicial review. Since there appears to be no grant of rulemaking power, either express or implied, in the LBPPPA, the Commission presumes that the Administrative Procedure Act is not intended to apply. Similar uncertainty with respect to the applicable procedure under the present LBPPPA has led to a suit attacking Chairman Simpson's report to Congress regarding the safe level of lead in paint. (Consumer's Union of the United States, Inc., et al., v. Richard O. Simpson, Chairman, Consumer Product Safety Commission, et al., Civil Action No. 75-0243, D.D.C. filed February 24, 1975.)

Secondly, once the level of "lead-based paint" is established, S. 1466 directs the Commission to "take such steps and impose such conditions as may be necessary or appropriate" to prohibit the application of lead-based paint to toys or furniture articles. While congressional intent that the level found to be safe in the LBPPPA proceeding should apply to such articles is clear, the Commission is not specifically granted any substantive regulatory authority to implement this level. Under S. 1466 it would appear that the Commission would still have to make its determination on the safe level of lead in paint for toys and furniture articles as well as other paint sold to consumers under the pending FHSA or CPSA proceedings. Given the different procedures under the FHSA, the CPSA and the LBPPPA, there is a very real possibility that the lead levels arrived at in these various proceedings could be entirely different. This would lead to the highly anomalous and undesirable situation of differing federal standards for lead in paint depending on the act under which the paint is regulated. Moreover the LBPPPA, as drafted, undoubtedly will require duplicative proceedings on the precise same matter resulting in a massive waste of tax dollars. Finally, the confusion which would

result from different federal levels would be compounded by the statutory provisions applicable to preemption of various state and local laws and regulations.

To avoid the difficulties in the implementation of the LBPPPA, which enactment of S.1466 will create, to facilitate enforcement by the CPSC and the states and to provide the paint industry and consumers with a single standard, the Commission recommended that it should be permitted to make a single determination on the safe level of lead in paint in one proceeding. One means of achieving this would have been to include the following provision in the LBPPPA:

The determination by the Consumer Product Safety Commission with respect to the meaning of the term "lead-based paint" shall simultaneously constitute the establishment of a consumer product safety standard under the Consumer Product Safety Act. (15 U.S.C. 2051 et seq.) Such standard shall have the same force and effect as any consumer product safety standard promulgated and established under the Consumer Product Safety Act and shall become effective concurrent with the provisions of section 401 of the Lead-Based Paint Poisoning Prevention Act. No further proceeding shall be necessary to make the standard effective. The level of lead in paint established by such standard shall be the maximum permissible level for the following consumer products (as the term "consumer product" is defined in section 3(a)(1) of the Consumer Product Safety Act 15 U.S.C. 2052(a)(1)):

- (a) Any paint or similar surface-coating material;
- (b) Any toy or other article intended for use by children; and
- (c) Any furniture article.

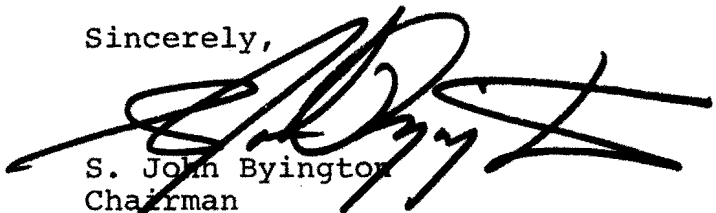
Provided, however, that, upon a finding that any special use for "lead-based paint" or that any product bearing such paint does not present an unreasonable risk of injury, the Commission may, by

rule in accordance with the procedures of 5 U.S.C. 553, exempt such product from the standard. Any existing exemption under the Federal Hazardous Substances Act 15 U.S.C. 1261 et seq. shall continue in effect and be treated as an exemption under this section unless withdrawn by rule.

Unfortunately, the Commission's suggestion was not adopted by Congress. Only insofar as the provisions of S.1466 impact on the Consumer Product Safety Commission by amending the process for establishing a safe level of lead in paint does the Commission favor veto of the bill. The regulatory process which results from this portion of S.1466 will be more costly and duplicative than is necessary without any increase in benefit to the public. However, the numerous other provisions of the bill affect the responsibilities of the Secretary of Health, Education and Welfare in the area of public health and safety. The Commission cannot properly assess the impact of or need for these provisions. If these other provisions of the bill are necessary and desirable, the Commission understands the need to approve the entire bill. Should such approval be forthcoming, CPSC would appreciate Administration support of our efforts to amend section 204 pursuant to the above language during this session.

The Commission is unable to estimate first-year or recurring costs or savings which may result from enactment of S.1466.

Sincerely,



S. John Byington  
Chairman

cc: Speaker of the  
House of Representatives


cc: President of the Senate

THE WHITE HOUSE

WASHINGTON

June 18, 1976

MEMORANDUM FOR: JUDY JOHNSTON

FROM: DAWN D. BENNETT 

RE: S. 1466 - National Consumer Health  
Information and Health Promotion Act  
of 1976

The above-entitled bill would essentially: amend the Public Health Service Act by extending and expanding the categorical health programs; authorize HEW to initiate and conduct a new health information and prevention program; give the Consumer Product Safety Commission jurisdiction over permissible lead paint levels; and transfer to HUD from HEW, the enforcement of lead base paint levels in federal housing.

I recommend approval for several reasons, inter alia:

a. The new categorical health education program is relatively small, authorization-wise, and does not disrupt the HEW organizational structure, nor require HEW to carry out an expensive new program.

b. S. 1466 would authorize HEW to continue its existing disease control and prevention programs i. e. Swine Flu type situations.

c. The bill appears to be a negotiated compromise which differs substantially from the original.

Though the bill is not perfect, i. e. , it calls for categorical grants as opposed to the block grant scheme which the President prefers, the good outweighs the bad, and on balance, I feel the President should sign it.



THE WHITE HOUSE  
WASHINGTON

June 18, 1976

MEMORANDUM FOR: JIM CAVANAUGH  
FROM: MAX FRIEDERSDORF *mf*  
SUBJECT: S. 1466 - National Consumer Health Information  
and Health Promotion Act of 1976

The bill passed both Houses by a voice vote. Veto would, of course, be most difficult if not impossible to sustain.

Both Tim Lee Carter and Jim Broyhill supported the bill and believe their combined efforts with Paul Rogers succeeded in watering down Title I enough that President could sign bill.

OMB was ambivalent on veto signal during Floor consideration and no veto signal given.

I recommend President sign S. 1466.

THE WHITE HOUSE

ACTION MEMORANDUM

WASHINGTON

LOG NO.:

Date: June 18

Time: 1100am

FOR ACTION: Spencer Johnson  
Ken Lazarus  
Max Friedersdorf  
Dawn Bennett  
Steve McConahey

cc (for information): Jack Marsh  
Jim Cavanaugh  
Ed Schmults

FROM THE STAFF SECRETARY

DUE: Date: June 19

Time: noon

SUBJECT:

S. 1466 - National Consumer Health Information  
and Health Promotion Act of 1976

ACTION REQUESTED:

For Necessary Action

For Your Recommendations

Prepare Agenda and Brief

Draft Reply

For Your Comments

Draft Remarks

REMARKS:

Please return to Judy Johnston, Ground Floor West Wing

Veto would be a futile gesture. Recommend  
approval for reasons set forth at pp. 4-5.

Ken Lazarus 6/18/76

PLEASE ATTACH THIS COPY TO MATERIAL SUBMITTED.

If you have any questions or if you anticipate a  
delay in submitting the required material, please  
telephone the Staff Secretary immediately.

James M. Cannon  
For the President

Steve McConahey's comments: S. 1466

Agree with concern over inclusion of certain block grant components, however, I understand this bill contains the swine flu appropriations and therefore feel we should sign it.

6/17

THE WHITE HOUSE

WASHINGTON

June 18, 1976

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FROM: MAX FRIEDERSDORF *mf*  
SUBJECT: S. 1466 - National Consumer Health Information  
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OMB was ambivalent on veto signal during Floor consideration and no veto signal given.

I recommend President sign S. 1466.

TO THE SENATE

I am returning, without my approval, S. 1466, a bill which would authorize duplicative health information and health promotion programs<sup>x</sup> and <sup>would</sup> reauthorize and expand <sup>programs dealing with</sup> venereal disease, rat control, lead-based paint poisoning and other disease prevention and control. ~~programs.~~

This bill is based on a policy of perpetuating the existing maze of Federal health programs. Such an approach is a disservice to those who need effective delivery of health services and those who must pay the bills--the taxpayers. In my 1977 Budget, I proposed a consolidation of 16 existing Federal health programs into a single block grant which would enable States and localities to assure that people in need receive comprehensive health care. I share the objectives of S. 1466 to assure the provision of important preventive health services, but I firmly believe that under my proposed health block grant those services would be provided in a more effective manner.

Fewer Federal programs, and a reduction in the various rules and regulations accompanying each of them, would allow States and local governments to respond more quickly to the particular health needs of their residents. Consolidation into a block grant will also better target Federal health assistance on those with low incomes, and distribute Federal funds more equitably among the States. Funding from the existing 16 categorical programs proposed for consolidation in the block grant varies from \$200 per low-income individual in some States to over \$800 in others. This inequity should not be continued.

In addition, the many Federal requirements imposed upon States and localities prevent them from bringing about needed efficiencies and coordination in their health programs. If the proposed health block grant were enacted instead of bills such as S. 1466, more Federal health dollars could go toward providing health services for our citizens rather than for the cost of burdensome administration.

S. 1466 would also create unnecessary and duplicative ~~new~~ health education programs. The Department of Health, Education, and Welfare alone now spends more than \$80 million a year on health education of the public. The activities proposed in S. 1466 would only add to the already complicated array of Federal health education programs.

The bill would, moreover, create a special problem in the lead-based paint poisoning prevention program. It would require the determination of safe lead levels in paint but provides little, if any, guidance with respect to the procedures determining those levels. This could, accordingly, lead to the highly undesirable situation of differing federal standards for lead in paint, depending on whether an agency proceeded under the Lead-Based Paint Poisoning Prevention Act, the Consumer Product Safety Act or the Federal Hazardous Substances Act. Thus, S. 1466 could not only create confusion in this area, but could require duplicative administrative proceedings on the same subject matter resulting in a massive waste of tax dollars as well as unnecessary delay and red tape, without any real benefit to the public.

Lastly, S. 1466 is objectionable since it would authorize appropriations of \$307 million--more than three times my requested levels--over a three-year period. At a time when the overall Federal deficit is estimated at over \$74

billion, I must oppose such excessive authorization levels.

Other bills now pending would also continue current narrow categorical Federal health programs. Rather than proceeding to extend and expand such programs, I urge the Congress to hold hearings and rapidly enact my proposed "Financial Assistance for Health Care Act."

THE WHITE HOUSE

June , 1976

*Edw. R. Roy  
6/21/76*

TO THE SENATE OF THE UNITED STATES:

I am returning, without my approval, S. 1466, a bill which would authorize duplicative health information and health promotion programs and would reauthorize and expand programs dealing with venereal disease, rat control, lead-based paint poisoning and other disease prevention and control.

This bill is based on a policy of perpetuating the existing maze of Federal health programs. Such an approach is a disservice to those who need effective delivery of health services and those who must pay the bills -- the taxpayers. In my 1977 Budget, I proposed a consolidation of 16 existing Federal health programs into a single block grant which would enable States and localities to assure that people in need receive comprehensive health care. I share the objectives of S. 1466 to assure the provision of important preventive health services, but I firmly believe that under my proposed health block grant those services would be provided in a more effective manner.

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THE WHITE HOUSE,

NATIONAL DISEASE CONTROL AND CONSUMER HEALTH  
EDUCATION AND PROMOTION ACT OF 1975

JULY 24 (legislative day, JULY 21), 1975.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Public Welfare,  
submitted the following

REPORT

[To accompany S. 1466]

The Committee on Labor and Public Welfare, to which was referred the bill (S. 1466) to amend the Public Health Service Act to extend and revise the program of assistance for the control and prevention of communicable disease, and to provide for the establishment of the Office of Consumer Health Education and Promotion and the Center for Health Education and Promotion to advance the national health; to reduce preventable illness, disability, and death; to moderate self-imposed risks; to promote progress and scholarship in consumer health education and promotion and school health education; and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

I. BILL SUMMARY

PURPOSE

The proposed Act has three titles: Titles I and II respectively revise and extend expiring communicable and other disease control programs and venereal disease prevention and control programs; and Title III authorizes consumer health education and promotion programs. The legislation would authorize the programs involved for fiscal years 1976 through 1978, with authorizations of appropriations as hereinafter indicated.

## TITLE I—DISEASE CONTROL

*Section 101.* This title, which is to be cited as the "Disease Control Amendments of 1975," revises and extends existing authorities for disease prevention and control programs found in section 317 of the PHS Act, for fiscal years 1976 through 1978.

### *Amendments Respecting Disease Control*

*Section 102.* Amends section 317 of the PHS Act with the following substantive modifications;

(1) Authorizes disease control programs for additional diseases and conditions by adding mumps, diabetes mellitus, and other diseases or conditions (other than venereal diseases) which are amenable to reduction and are determined by the Secretary to be of national significance. This amendment is intended to expand the scope of activities now carried out by the Center for Disease Control.

(2) Adds the word project before grant or grants each time it appears, to assure that grants for disease control (as provided under section 317 of the Public Health Service Act) are used for this purpose.

(3) The bill authorizes \$30,000,000 for fiscal year 1976, \$35,000,000 for fiscal year 1977, and \$40,000,000 for fiscal year 1978.

## TITLE II—VENEREAL DISEASE

*Section 201.* This title, which is to be cited as the "National Venereal Disease Prevention and Control Amendments of 1975," revises and extends existing authorities for venereal disease prevention and control programs found in section 318 of the PHS Act.

*Section 202.* This section sets forth the findings and declaration of purpose of Congress respecting venereal disease.

### *Amendments Respecting Venereal Disease*

*Section 203.* Amends section 318 of the PHS Act, "Projects and Programs for the Prevention and Control of Venereal Diseases," with the following substantive modifications:

(1) Expands technical assistance respecting research, training, and public health programs for the prevention and control of venereal disease to include nonprofit private entities in addition to public authorities and scientific institutions which are currently eligible.

(2) Specifies that project grants for States for venereal disease prevention and control may include routine laboratory testing and follow-up.

(3) Provides that grants for research, training and public health venereal disease prevention and control programs "contribute to national objectives."

(4) Deletes, as a method of diagnosis of gonorrhea and syphilis, "dark-field microscope techniques."

(5) Expands the definition of venereal disease, to include other sexually transmitted diseases in addition to syphilis and gonorrhea.

(6) Enables minors to seek and receive treatment for venereal diseases on their own, in conformance with current statutes in 49 of our 50 States.

(7) Authorizes;

(a) \$5,000,000 for each of fiscal years 1976, 1977, and 1978 for grants to States, political subdivisions of States, and any other public or nonprofit private entity for projects for the conduct of research, demonstrations, and training for the prevention and control of venereal disease.

(b) \$5,000,000 for fiscal year 1976, \$10,000,000 for fiscal year 1977, and \$15,000,000 for fiscal year 1978, to enable the Secretary to make grants to State health authorities to assist the states in establishing and maintaining adequate public health programs for the diagnosis and treatment of venereal disease.

(c) \$31,000,000 for fiscal year 1976, \$33,000,000 for fiscal year 1977, and \$36,000,000 for fiscal year 1978 for project grants to States and, in consultation with states, to political subdivisions of States, for venereal disease control activities described under 317(d)(1) of the Public Health Service Act, as amended by this bill.

## TITLE III—HEALTH EDUCATION AND PROMOTION

*Section 301.* States that the title may be cited as the National Consumer Health Education and Promotion Act of 1975.

*Section 302.* Amends the Public Health Service Act by adding the following new title:

### TITLE XVII—OFFICE OF CONSUMER HEALTH EDUCATION AND PROMOTION AND THE CENTER FOR HEALTH EDUCATION AND PROMOTION

*Section 302.* Also amends the Public Health Service Act by adding the following sections:

#### PART A—OFFICE OF CONSUMER HEALTH EDUCATION AND PROMOTION

*New Section 1701.* Establishes within HEW Office of Consumer Health Education and Promotion under the direction of a director, appointed by the Secretary and supervised by the Assistant Secretary for Health. To develop a health education and promotion strategy for the Nation, the Office would: engage in health education and promotion research, develop community health education programs, stimulate and coordinate communications in health education and promotion, and overview and coordinate Federal health education programs.

*New Section 1702.* The Secretary, acting through the Office, is authorized to undertake various programs to achieve a national health education and promotion strategy.

*New Section 1703.* Provides that the Secretary shall make grants and contracts to public and nonprofit private entities regarding health education programs.

The section also provides that the Secretary cannot make grants under either the Public Health Services Act or the Community Mental Health Centers Act unless the application contains assurances that consumer health education services will be provided during the period when assistance would be made available.

*New Section 1704.* Provides for the establishment of an Interdepartmental Committee on Consumer Health Education and Promotion comprised of various Federal agencies and offices administering programs directly affecting health education and promotion. The Secretary of Health, Education, and Welfare would chair the Committee.

*New Section 1705.* Establishes a nineteen member Advisory Council to be appointed by the Secretary, to advise the Secretary on matters of general policy with respect to the functions of the Office, and sets forth appropriate controls for selection of the members.

*New Section 1706.* Requires reports to be made to the President and the Congress by the Secretary regarding health education and promotion including recommendations for legislative initiative. The Office of Management and Budget may not revise the reports or delay their submission to either the President or the Congress.

*New Section 1707.* Authorizes appropriations for health education and promotion: \$11,000,000 for fiscal year 1976, \$11,000,000 for fiscal year 1977, and \$24,000,000 for fiscal year 1978.

#### PART B—CENTER FOR HEALTH EDUCATION AND PROMOTION

*New Section 1708.* Sets forth findings and declarations, concluding that a private corporation should be created to facilitate the development of a health education and promotion strategy for the Nation.

*New Section 1709.* Provides that the new Center shall have a 25 member board of directors appointed by the President with the advice and consent of the Senate, with broad representation of various regions of the country and of various kinds of bills and experiences appropriate to the functions and responsibilities of the Center. The members initially selected would serve as incorporators.

*New Section 1710.* States the terms and conditions of Board membership.

*New Section 1511.* Provides that the Center shall have a President and other officers that may be appointed by the Board.

*New Section 1712.* Provides that the Center shall have no power to issue any shares of stock or to declare or pay dividends; that no part of the income or assets of the Center shall inure to the benefit of any director, officer or employee of the Center; and that the Center may not contribute to or otherwise support any political party or candidate for elective office.

*New Section 1713.* Describes the objectives of the Center and the specific programs which the Center is to undertake to achieve its objectives.

*New Section 1714.* Provides that the Board shall appoint an Advisory Panel of 100 individuals with appropriate competencies and abilities to provide advice for members of the Board.

*New Section 1715.* Provides that the Center shall submit an annual report to the President for transmittal to Congress on its activities during the year, together with any recommendations it considers appropriate.

*New Section 1716.* Authorizes appropriations for expenses of the Center of \$1,000,000 in fiscal year 1976, \$1,000,000 in fiscal year 1977, and \$1,000,000 in fiscal year 1978. In addition to the sums authorized to be appropriated, the Center is authorized to receive income, grants, donations, bequests, or other contributions from non-Federal sources.

*New Section 1717.* Provides that the accounts of the Center shall be audited annually by independent public accountants certified or licensed by a regulatory authority of a State or other political subdivision of the United States.

*New Section 1718.* Authorizes \$2,000,000 for fiscal year 1976, \$3,000,000 for fiscal year 1977, and \$4,000,000 for fiscal year 1978 to be used by the Secretary for grants to public and private nonprofit entities to assist in initiating programs in elementary and secondary schools, and in communities, to reduce the incidence of oral disease and dental defects.

*New Section 1719.* Defines health education and promotion.

Section 303 of the bill authorizes the National Center for Health Statistics to make continuing surveys regarding consumer health education, and to report its findings, together with finding of other surveys and appropriate survey analyses to the Secretary, the Assistant Secretary for Health, and the Office of Consumer Health Education and Promotion. Of sums appropriated by Sec. 308 of the PHS Act, not less than \$1,000,000 for each of fiscal years 1977, 1978, and 1979 shall be available for the purposes authorized in this section.

#### II. THE NEED FOR GREATER EMPHASIS ON DISEASE CONTROL AND CONSUMER HEALTH EDUCATION AND PROMOTION

Between 1960 and 1974, annual expenditures for health increased from slightly less than \$26 billion to slightly over \$104 billion. Public expenditures for health each year increased from \$6.4 billion to \$41.3 billion. Private health insurance benefits increased in that time period from \$4.7 billion to \$23.1 billion annually, while the percentage of out-of-pocket costs to consumers decreased from 55 percent of personal health expenditures to 35 percent. Persons employed in the health industry increased from 2.5 million workers to almost five million today. Last year, the health industry provided over one billion physician and dentists visits and over 30 million short-term hospital services, alone.

Despite these accomplishments, it is clear to the Committee that progress in improving the health of the American people has not improved in proportion to our growing investment. Increasingly, questions are being raised regarding the efficacy of therapeutic medicine, which is the predominant emphasis of the health industry today, in improving the health of the American people.

In June of this year, the American College of Medicine and the Fogarty International Center of the National Institutes of Health jointly sponsored a National Conference on Preventive Medicine. An important outcome of the Conference were a series of Task Force Reports. One of the most valuable was the report of the Task Force on Consumer Health Education chaired by Annie R. Somers, a nationally-recognized expert in health care. In addressing the issue of the adequacy of therapeutic medicine, which consumes the great majority of our

health resources, the Task Force on Consumer Health Education noted the following:

Despite the vast increase in health care expenditures and the greatly improved access to care on the part of most Americans, illness, disability, and premature death show little—if any—signs of improvement. The statistics with respect to death rates are particularly disturbing. After half a century of steady and dramatic improvement, the total or "crude" death rate for the U.S. ceased to improve during the Sixties. It remained almost stable, fluctuating between 9.4 and 9.7 per 1000 population. The rate for 1973 is still 9.4.

The Task Force noted problems hidden beneath these general statistics:

The differential between male and female life expectancies has increased from one year in 1920 to 7.5 years in 1970.

The stability of the total death rate in the Sixties is primarily a function of changes in the population composition, not stable rates across time for all age groups. When this effect is controlled, substantial increases in the death rates for all age groups, 4-44, are revealed. Although there were some increases for women, the increases were primarily for males, and the upturn was even higher for blacks than for whites.

The death rate for homicides rose from 4.7 per 100,000 in 1960 to 9.4 in 1972 and seemed destined to continue rising.

The Task Force noted the continuing ineffectiveness of therapeutic medicine to deal with our major health problems:

The principal causes of death for the whole population in the late Sixties were still the familiar trio—heart disease, cancer, and stroke—plus accidents. In 1970, cardiovascular diseases accounted for 53 percent of all deaths. During the later Sixties, however, other causes accounted for most of the rising death rates for young men. The principal cause for men, 15-44, was automobile accidents; homicide and suicide were also important. None of these three phenomena is directly affected by the health care delivery system.

[Morbidity data is] . . . the best reported. But it is only the tip of the iceberg. For every youngster killed in an auto accident, thousands are injured each year; many permanently disabled. For every middle aged man who dies of cirrhosis, there are thousands of alcoholics or near-alcoholics. For every death from an overdose of heroin, hundreds are hooked perhaps for life, to a habit that will not only wreck their own lives but almost surely cause crime and other problems for their communities.

Thus, it appears that therapeutic medicine, important as it is, may have reached a point of diminishing returns. The 12-15 percent increases that we are adding to our hundred billion dollar health care bill each year—even the portion that is not caused by inflation—apparently have only a marginal utility.

Finally, the Task Force chose to comment on the performance of our health industry in the context of the limitations mentioned previously. They noted:

This judgment relates not only to the large amount of preventable illness but to the inadequacy of medical intervention *per se* in the management of serious illness. The reported exposés of miserable patient care in many nursing homes now expensively reimbursed under Medicare and Medicaid, the growing public demand for more professional attention to the humanities and even the amenities of death and dying, the renewed interest in euthanasia, and the increasing realization that technical virtuosity is not necessarily synonymous with effective care. All these developments indicate the public's growing impatience of the patient as a responsible agent in the treatment of his or her own illness.

The Committee concurs with the thrust of the Task Force on Consumer Health Education. The findings of the Task Force are consistent with the conclusions of an increasing number of experts who have looked at the performance of the health care field. The issue has been addressed in a variety of ways including the Administration's questioning of increases in the numbers (not the specialty or geographic distribution) of physicians, the numbers of hospital beds, the numbers of all forms of health manpower, and the numbers of prescription drugs. Increasingly, emphasis is shifting from overall quantities of resources to issues of the performance of those resources and their distribution. The Committee considers the recent increase in interest in preventive medicine and health education as another reflection of this shift.

The Committee commends this new emphasis; but it does so with a major caveat. Although the Committee considers the resurgence of interest in health education overdue, it does not intend to encourage "therapeutic nihilism." While there is justifiable concern regarding the inappropriate and excessive use of certain procedures such as certain surgical procedures, the great majority of therapies, at the minimum, relieve pain and suffering. In many instances, they limit disability, and in some instances, are responsible for the cures and the prevention of death. The Committee considers present efforts to improve the quality of therapeutic medicine, and to make it more widely available as essential components of our efforts to improve the health of Americans. But the Committee has also concluded that there must be far greater emphasis on finding ways to reduce the incidence of diseases and conditions which result in suffering, disability, and death. The control of communicable diseases through immunization, sanitation and pesticide programs has proven to be a successful demonstration of what scientists and health professionals, with adequate public support, can accomplish.

Although the etiology of disease is extremely complex, and the increases and decreases in the incidence of disease difficult to pinpoint precisely, there appears to be little question that scientific discoveries and the application of disease prevention and control programs have had a substantial impact in the reduction of many serious diseases. It is difficult for the Committee to imagine that malaria was still

prevalent in the South as late as the 1930's, that polio was dreaded until the 1950's, and a vaccine for measles was not developed until the 1960's. The fact that heart disease, cancer, and stroke are the major causes of death today is the result, in part, of our highly effective efforts against diseases which were major killers in the early part of this century. Death rates in 1900 were 17.2 per thousand; today they are less than 10 per 1,000. In 1900, about 15 percent of all babies would die by the end of their first year; today, the figure is approximately 2 percent.

Although dreaded infectious diseases have been virtually eradicated, there is no justification for complacency. Programs to control and prevent infectious diseases must be continually monitored to assure their continued effectiveness. Immunization levels against such diseases as polio and measles are below what is considered by the Center for Disease Control to be safe from the standpoint of preventing such diseases. A June 26, 1975 article in the New York Times reported that the immunization rate for polio for children between the ages of one and four was only 63 percent, while a minimum safe level is considered to be 80 percent. Polio immunization rates declined from 78.6 percent in 1964 to 60.4 percent in 1973. In some poor communities, rates as low as 15 percent have been found. In 1969-1971, there was a resurgence of measles owing to inadequate immunization levels.

In addition to immunization and other public health control measures, the greatest hope for reducing and delaying the incidence of the diseases affecting people today rests with health education programs. The evidence is conclusive that the environment and individual life styles are major determinants of such afflictions as heart disease, cancer, stroke, and accidents.

A study of the relationship between health practices and physical health status reported by Belloc and Breslow in *Preventive Medicine* in 1972 showed that persons engaged in good health practices lived longer. Health practices included hours of sleep, regularity of meals, physical activity, and smoking and drinking. The association between good health practices and good health, furthermore, was found to be independent of age, sex, and economic status. Belloc also reported on the relationship between health practices and mortality in *Preventive Medicine* in 1973, and found "a striking inverse relationship" between poor health practices and longer life. He further reported that the average life expectancy of men aged 45 who reported six or seven "good" practices was 11 years more than men reporting fewer than four.

A major issue considered by the Committee was not the potential benefit of health education, but the effectiveness of health education to cause or contribute to the changes necessary to improve health. Patient education programs, such as those associated with diabetes, heart disease, pain after surgery, and hemophilia have shown encouraging results. Persons with disease or other disabling conditions clearly can be motivated to lead healthier lives.

An ongoing demonstration by Stanford University reports promising results in changing health behavior such as reducing weight, cholesterol levels, and smoking. The objective of the study was to teach individuals between the age of 35 and 69 about heart risk factors,

and in the process to stimulate them to adopt more healthful behavior. University workers, researchers, and counselors examined three communities: One a control with no health education efforts, one using the media only for health education, and a third using both the media plus more intensive person-to-person efforts. The preliminary findings revealed that improvements were detected by using the media only. Using the media plus other person-to-person health education, however, showed more dramatic results. For example, the number of cigarettes smoked per day declined by forty percent in the maximum saturation town, during the period studied. Dr. Nathan Maccoby, director of the project, concluded that educational campaigns directed at an entire community can produce striking increases in the level of knowledge about heart disease and risk factors and marked improvements in risk factor levels.

Most health education experts acknowledge that there is a great need for greater understanding of how persons can be encouraged to adopt more healthful behavior and to retain a healthy life style. The Committee recognizes that imparting information alone is not sufficient to cause people to change their behavior. There is also apt to be great skepticism, particularly among the young, concerning any information provided, and the recognition that there are strong interests and pressures to adopt unhealthy life styles, including smoking, drinking, using drugs, and eating fatty foods. The Committee considers health education and promotion, despite these limitations and obstacles, an essential part of a national effort to improve the health of people in this country. It is our opinion that there is a great need for more health education and promotion information.

In addition to the task of educating the public to the benefits of healthier lifestyles, there is a great need for a better understanding of how better to use the health system. Despite widespread availability of screening programs for breast and cervical cancer, only half of American women over 17 had such tests in 1973 and nearly one-fourth had never had a breast screening examination. As mentioned earlier, immunization levels, in some cases, are dropping. There are still far too many persons, even those with adequate incomes, who fail to see a dentist regularly and to practice good dental hygiene. We eat the wrong foods, drive too fast and drink too much. Ours is a generation of excess. Providers of health care are not able to do their job to educate us with regard to negative health behavior.

Finally, the Committee considers it essential that the general public, the potential users of health services produced by the health industry, gain a more realistic picture of the values and limitations of the health industry, regarding its potential to cure illness, eliminate disability, and prolong life. Such a picture should include the limitations of both preventive and therapeutic medicine to redress the harm done by environmental hazards and unhealthy individual lifestyles.

### III. DISEASE CONTROL AND PREVENTION

#### 1. TITLE I

Title I of the Committee's bill, Disease Control Amendments of 1975, would continue a national program of assisting States in carrying out programs which are needed to protect the American people from

unnecessary suffering from communicable diseases, and to build upon our successes in communicable disease control by including an attack on other preventable conditions. These programs are an essential element in forging a truly effective health care policy for our country, and have the potential for undergirding work in reforming our system of health care financing and the delivery of personal health services.

The bill authorizes \$31,000,000 for project grants and contracts in fiscal year 1976 to carry out these programs, with \$35,000,000 and \$40,000,000 being authorized for fiscal years 1977 and 1978 respectively. These grants are to support projects at the State and local level, and are to be awarded on the basis of the extent of the problem in the State or local area and on the soundness of the applicant's proposed control program. The bill re-emphasizes the importance of carrying out public awareness programs in these projects so that, to the extent possible, citizens will be properly informed of disease risks and the services available to them to prevent illness. Grantees will continue to be able to draw on personnel and other resources of the Department of Health and Human Services in lieu of receiving direct financial assistance.

The definition of disease control program has been broadened to permit the Administration and the Congress to address other problems of national significance which are amenable to control through organized State and community programs such as those authorized by this bill. Venereal disease control programs, however, are addressed separately under Title II of the bill in recognition of the importance of a special attack on this problem. Similarly, lead based paint poisoning prevention grants are, in the Committee's view, best undertaken in the context of a comprehensive attack. This approach is reflected in Senate Bill 1664 which was ordered reported by the Committee on July 16, 1975.

## 2. TITLE II

Title II of the Bill, National Venereal Disease Prevention and Control Amendments of 1975, continues and strengthens the national campaign against venereal disease under Section 318 of the PHS Act, which was formulated by this Committee in 1972. The bill extends authority for the Secretary to provide technical assistance to other organizations in their conduct of research, training and public health programs for the control of venereal disease, and emphasizes the key role of private non-profit organizations in the national control effort. Research, demonstration, and training grants are also authorized to enable the Secretary to meet national needs in developing and upgrading control programs. The Committee has authorized \$5,000,000 annually for these grants in fiscal years 1976, 1977, and 1978.

In addition, the bill extends Section 318(c) formula grant authority for upgrading diagnostic and treatment services, and adds an additional requirement that the providers of clinic services begin to meet the needs of patients with genito-urinary diseases other than those which have been traditionally defined as venereal diseases. The funding authorizations for this program are \$5,000,000 for fiscal year 1976, \$10,000,000 for 1977, and \$15,000,000 for 1978.

Project grants for control programs under 318(d) of the Act are also continued with revisions to clarify the purposes of these grants. The Committee is encouraged by the early results which have been

achieved through 318(d) project grants, and is recommending a funding authority for the next three years which will avoid retrenchment at this critical phase of our all-out attack on venereal disease. In fiscal year 1976, \$31,000,000 is authorized for 318(d) grants, with \$33,000,000 in 1977, and \$36,000,000 in 1978.

The funding authorizations for each of the programs under Title I and Title II of the bill have been developed after careful consideration of the needs of the nation in disease control and the demands for restraint in Federal spending. Funding levels are lower than those authorized for the period 1972-1975, and are lower than our original estimates of the need for the next three years. They represent in each instance reasonable and minimal investments which must be made if we are to achieve the level of success in preventing illness which we, as a nation, have both the financial and technical capability to achieve.

## 3. HEARINGS

The need for the extension of the authority contained in section 317 and 318 of the PHS act in respect to disease control and the need for a special authority for venereal disease was supported by testimony from Mrs. Dale Bumpers, Chairperson, "Every Child by 1974," Little Rock, Arkansas, Dr. Eugene Fowinkle, Commissioner of Public Health, State of Tennessee, Mr. Donald P. Clough, Executive Director of the American Social Health Association, Dr. Leonard L. Heimoff, Associate Professor of Medicine, Cornell University Medical School, Mr. Samuel R. Knox, Director of the Association of Venereal Disease Programs, and Dr. James N. Miller, Professor of Microbiology and Immunology, UCLA School of Medicine. The Administration recommended against the enactment of both titles I and II of the Committee's bill.

## 4. BACKGROUND

In 1974, four American families were afflicted with polio. In 1952, there were over 55,000 cases in the United States. Yet, today, far too many one to four year olds are not fully protected against this dread disease, and in some population groups the level of protection is probably well below 50 percent. The major rubella epidemic predicted for 1971-1972 did not materialize, thanks to a massive nationwide rubella immunization campaign which was undertaken between 1969 and 1971. The percent of the population protected against rubella, however, has shown signs of declining since 1972. Levels of protection against the other childhood vaccine-preventable diseases also show signs of slipping. Since the early 1940's, deaths due to syphilis have declined 97 percent; first admissions to mental institutions due to syphilitic psychoses have declined 98 percent; and congenital syphilis has declined 92 percent. Yet, we continue to witness an increase in the incidence of syphilis, which portends a resurgence in serious complications in 10-20 years unless something is done now.

This history of communicable disease control contains grim lessons. It took a major epidemic in 1964 to direct the attention of the nation to the necessity for the control of rubella. Steady successes in syphilis control were eroded in the late 1950's because of the premature conclusion that the job was finished. We are still reaping the benefits of



syphilis control investments in the 1940's and early 1950's. The number of deaths and debilitating consequences of syphilis are still much below the pre-penicillin era. However, we lost the edge in containing the incidence of the diseases in the late 1950's, and between that time and the passage of the Communicable Disease Control Amendments of 1972, we ran hot and cold in our attention to this problem. Until gonorrhea surpassed a half million *reported* cases, the Federal government did not spend a penny in project grants to help States and cities carry out control programs.

In 1970, the Communicable Disease Control Act was passed, setting up a project grant program under Section 317 of the Public Health Service Act to assist States and cities address communicable disease control problems on a consistent, nationwide basis. This legislation was specifically designed to establish a Federal leadership role in the control of communicable diseases, and to signal to the States that we were serious about working with them in achieving control. It was a specific response to the existing Federal approach, which was to fund projects under the general health services project grant authority contained in Section 314(e) of the Public Health Service Act. That approach not only undermined the purpose of 314(e), but it created serious confusion in the States, because the nature of the Federal commitment to communicable disease control and the likelihood of continued funding remained in a state of flux.

The 1972 amendments strengthened Section 317 grant programs, and specifically authorized for the first time a comprehensive attack on venereal disease under Section 318 of the Act. Funding of the various components of the new law, however, has never matched the amounts which the Committee authorized, and which we believed to be necessary. In many instances no funds have been provided to carry out parts of the law.

#### 5. COMMITTEE CONSIDERATION

The Committee wishes to draw attention to several other key changes in the law which are contained in Senate Bill 1466.

1. The word "project" is inserted throughout Section 317, as appropriate, to avoid any possible misconception about the purpose of grants and the criteria to be used in making awards. These grants are to be awarded on the basis of the problem and according to the soundness of the program to be supported.

2. Public awareness programs are to be considered integral parts of any control program funded under Section 317.

3. HEW should expand its focus in providing technical assistance in venereal disease control to working with the many private non-profit organizations engaged in combatting these diseases. These citizen groups and service agencies are vital allies to Federal, State, and local disease control agencies.

4. The technical assistance capabilities of the Center for Disease Control should be fully utilized in helping States and localities strengthen each of their control programs. The Committee was very concerned in hearing testimony about the Department's plan to require tuition payments from persons receiving technical training at the Center. It is a major objective of this bill to upgrade States and local control capabilities, and we view this as a Federal respon-

sibility. Tuition charges will certainly weaken the ability of the Center to help those States and cities which are in greatest need of assistance.

5. Formula grant authority under Section 318(c) to assist States in upgrading diagnostic and treatment services has been extended. The Committee views the lack of appropriations for this grant program with great concern. We agree with the testimony presented by the American Social Health Association stating that "re-emphasis of the formula grant mechanism to assist states in establishing and maintaining adequate public health programs for the diagnosis and treatment of venereal disease is but an honest recognition of the shortcomings of our current VD patient care delivery system." The Committee views improvement in public diagnostic and treatment programs as essential to the control of venereal disease, and sees the failure of many clinics to provide medical care to persons who seek care for genito-urinary diseases other than syphilis and gonorrhea as a major weakness in the system.

### IV. CONSUMER HEALTH EDUCATION AND PROMOTION

#### 1. LIFESTYLE AND HEALTH STATUS

Americans are paying—in the form of taxes, insurance contributions, and direct out-of-pocket expenses—over \$116 billion a year for health care and related expenditures. Of this staggering total, only about four percent go for prevention and health education combined. Why the anomaly?

Throughout recorded history, responsibility for health was placed on the individual. However, as better knowledge of the human body and disease mechanisms were acquired and medical practice became more scientific, society came to place increasing dependence on medical intervention. Concomitantly, decreasing emphasis was placed on individual behavior and individual responsibility. Society soon came to accept the curative role of the physician and the preventive role of the public health official as the appropriate avenue to health.

Yet, despite the vast increase in health care expenditures, illness, disability and premature death rates have shown little improvement. The statistics with respect to death rates are particularly disturbing. After half a century of steady and dramatic improvement, the total or "crude" death rate for the U.S. ceased to improve during the 1960's. It remained almost stable, fluctuating between 9.4 and 9.7 per 1,000 population. The rate for 1973 is still 9.4.

The principal causes of death for the whole population in the late 1960's were still the familiar trio of heart disease, cancer, and stroke, to which we should add accidents. In 1970, cardiovascular diseases accounted for 53 percent of all deaths. During the later 1960's, however, other causes accounted for most of the rising death rates for young men. The principal cause for men, aged 15 to 44, was automobile accidents with homicide and suicide following close behind. The committee recognizes that none of these three phenomena is directly affected by the health care delivery system.

Thus, it appears that therapeutic medicine, important as it may be, may have reached a point of diminishing return. The 12 to 15 percent

increase that we yearly add to our hundred billion dollar health care bill apparently has only a marginal utility. The committee believes that a health education and promotion strategy offers hope, a hope manifested by shifting emphasis from curative medicine, currently the predominant and extraordinarily expensive modality, to prevention and health maintenance.

## 2. DEFINITION OF HEALTH EDUCATION

The Committee found that there was no single acceptable definition of health education. Several were offered, all contributing to an understanding of its potential application.

In view, then, of the frequent inconsistency in use of the terms "health education" and "consumer health education," the Committee felt it essential to develop what it has chosen to call a "mega-definition." The term "consumer health education and promotion" subsumes a set of activities which:

- (1) inform people about health, illness, disability, and ways in which they can improve and protect their own health, including more efficient use of the delivery system;
- (2) motivate people to want to change to more healthful practices;
- (3) help them to learn the necessary skills to adopt and maintain healthful practices and lifestyles;
- (4) help other health professionals to acquire these teaching skills;
- (5) advocate changes in the environment that facilitate healthful conditions and healthful behavior; and
- (6) add to knowledge via research and evaluation concerning the most effective ways of achieving the above objectives.

In brief, consumer health education is a process that informs, motivates, and helps people to adopt and maintain healthy practices and lifestyles, advocates environmental changes as needed to facilitate this goal, and conducts professional training and research to the same end.

For purposes of this Report, the definition agreed to by the Committee is as follows:

"Health education and promotion" is a process that favorably influences understandings, attitudes, and conduct, including cultural awareness and sensitivity, in regard to individual and community health. Specifically, it affects and influences individual and community health behavior and attitudes in order to moderate self-imposed risks, maintain and promote physical and mental health and efficiency, and reduce preventable illness, disability, and death.

## 3. HEALTH EDUCATION TARGET GROUPS AND PROGRAMS

**A. Patient Education.**—A consumer becomes a patient when he or she recognizes a health problem or a potential problem and turns to a physician, clinic, hospital, or some other component of the health care delivery system for assistance. This is an important distinction: Patients have recognized a problem and made a commitment of time and frequently of money. They are, therefore, more receptive to medical intervention and health education efforts.

A large proportion of patient education is done on an informal one-to-one basis by physicians in their own offices, nurses, therapists, and other health professionals. They are usually under severe time constraints and cannot provide either in-depth coverage of the instructional material or follow up.

Hospital health education programs are scarce and inadequate. In those hospitals that do have formal programs, they commonly start in one of three types of activities: Classes for diabetics, cardiac patients, or others with serious chronic diseases or disability; classes for expectant parents; and pre-operative instruction. For each of these topics there is a large potential "student body" and the information and procedures are fairly well established. Instruction is usually provided upon referral by a doctor or nurse, on a group basis, and by a member of the professional staff. Good programs, however, go beyond teaching assorted courses. In some hospitals, the committee learned, there is a fulltime health education coordinator to identify problem areas, gather resources, and coordinate ongoing efforts as there is in the United Hospitals of St. Paul, Minnesota. Such hospitals also assume responsibility for teaching the teachers—nurses, and mid-level health practitioners.

Some health maintenance organizations and clinics are also operating formal health education programs. For many years, the Health Insurance Plan of Greater New York (HIP) operated a large-scale educational program under an experienced educator and several of the Kaiser-Permanente units operate health education activities—the Oakland program, with its large-scale audio-visual equipment, achieving particular fame.

A major theme in recent patient education efforts is that individuals must take responsibility for their own health. Diabetes programs, for example, attempt to formalize a patient's responsibility for health maintenance. Consider the treatment. What are the respective roles for the doctor and the patient? Ideally the disease should be discovered early. The physician makes a diagnosis and prescribes therapy. The patient must inject himself with the correct dosage of insulin every day, interpret his own urine samples and decide when a change is sufficient to warrant calling his physician. The patient must be motivated to lose weight, recognize and report side effects, learn proper techniques for foot and toenail care to avoid the devastating complication of infection and gangrene, recognize early symptoms of complications, and visit his physician when scheduled. The physician's role is essential to effective treatment; so too is the patient's. No amount of resources devoted to physician or hospital care can substantially reduce the cost of diabetes if the patient has not been adequately trained and motivated to do his part. The Committee recognizes, however, that there are and will continue to be very significant problems with regard to the management of diabetes. Education alone will not resolve the problems attendant to this disease, but it is an important aspect that needs emphasis.

When patient education programs are well thought out they have proved to be very successful. In the Los Angeles County Medical Center diabetes education program, a telephone "hotline" was introduced for information, medical advice and for obtaining prescription refills. Patients were educated to use this service through an aggressive campaign of pamphlets, posters and counseling sessions by physicians

and nurses. When the program was evaluated, it was found that the incidence of diabetic coma was reduced from 300 to 100, the number of emergency visits by the diabetic patients were reduced by half, and that 2,300 clinic visits were avoided. Over two years, total savings was estimated at more than \$1.7 million.

A modification of present education programs is the "self-help preventive medicine" offered by Georgetown University's Community Health Plan at Reston, Virginia. This organization has crystallized a concept, employed by a small but growing number of physicians, into an organized course consisting of seventeen weekly evening sessions of two hours each. Patients are taught what behavior practices are healthful; how to use basic medical equipment such as stethoscopes, sphygmomanometers, and otoscopes; and what to do in emergencies. The goals of the program are to create "activated patients" with a positive sense of their ability to affect their health, and to reduce some of the unnecessary, time-consuming, burdens currently placed upon the physician.

There is also a recognition in industry of the potential value of health education. Several companies, for example, have entered the field with films, tapes, cassettes, slides, models, teaching texts, and other audio-visual and printed teaching aides.

*B. School health education.*—The long run success of consumer health education programs rests on the behavior and health habits of children and youth. The public school system has the potential to influence these children, but the potential has not been adequately developed and, in general, the record is not impressive.

It is difficult to determine which states have effective school health education programs. Many have enacted legislation or issued administrative directives mandating health education in public schools. Frequently, however, funds have not been appropriated to implement and enforce these regulations.

School health education programs are faced with three major constraints: A tradition of low visibility and priority, a narrow definition of the appropriate jurisdiction for health education efforts, and a shortage of adequately trained health educators. The Committee considered the problems of school health education and decided to focus their attention on inservice education, establishing a program of grants to local education agencies and institutions of higher education for education opportunities for elementary and secondary school teachers in a broad scope of health education areas.

*c. Community Health Education.*—The goal of targeted community programs is to identify individuals who are at risk, make them aware of the risk and steps they can take to reduce that risk, and, if symptoms are brought to light, to direct them to the appropriate care setting. Targeted community programs frequently start with screening for hypertension, tuberculosis, breast cancer, and sickle cell anemia.

The value of multiphasic screening has been debated and recently preliminary results from a randomized controlled evaluation have become available. The results, from a study begun in 1964 by the Kaiser-Permanente Medical Care Program, for example, indicate that screening can reduce the number of "potentially postponable" deaths and reduce medical costs for older men by \$800 a year.

A major problem in all screening programs is the difficulty of obtaining follow-up compliance.

The informational "hot line" is another approach to community education that has been successfully used in some communities. At Monmouth Medical Center in Long Branch, N.J., a VD hotline gave diagnostic and treatment information and directed callers away from the hospital emergency room to the less costly clinic. The Committee favors the development and implementation of a model toll-free telephone system.

A unique example of targeted community education is the Stanford Heart Disease Prevention Program. The objectives of this large five-year interdisciplinary study are to teach individuals between the ages of 35 and 69 about heart risk factors and to stimulate them to adopt more healthful behavior. The study compared risk factor decreases in three similar California communities exposed to different mixes of television spots, printed materials, and personal instruction. The conclusion was that educational campaigns directed at an entire community could produce striking increases in the level of knowledge about heart disease and risk factors and marked improvements in risk factor levels.

It is research of this type that the Committee believes most imperatively should be funded. Changing behavior is a very complex phenomena and requires a series of longitudinal studies to identify the most effective methods. Funding should be available to qualified researchers from private nonprofit and public agencies and institutions for these purposes.

*D. Occupational Health Education.*—Individuals are exposed to environmental hazards in their place of work that can have severe implications for their health. The Occupational Safety and Health Administration (OSHA) identifies two categories of risk: (1) Safety hazards or dangerous physical conditions such as inadequate guards on machines; and (2) health hazards or unsafe levels of toxic substances and harmful physical agents such as asbestos and carbon monoxide.

Over the years, great progress has been made in reducing occupational safety and health hazards affecting American workers. It has been pointed out that for every industrial accident death there are now 50 cardiovascular casualties. However, in a dynamic technological society such as ours new hazards constantly arise and old ones reappear in new forms. In scattered instances, employers are still resistant to government- or union-inspired efforts to control toxic substances.

To detect and control new hazards and to inculcate in the employee better understanding of his own responsibilities and rights under the Federal occupational safety and health laws, OSHA has undertaken an extensive employee educational program. Employees can obviously affect the safety of their environment by following recognized safety practices such as wearing hard hats and ear plugs. However, in the more subtle area of health hazards, which are often difficult to detect without sophisticated equipment, their only protection often is knowing and acting on their legal rights. They can also request OSHA inspections when they suspect a hazardous health condition exists (and have their names withheld from their employers), and can review their employers' records for monitoring and measuring hazardous materials.

In fiscal years 1974 and 1975, OSHA allocated \$6.6 million for fifteen grants related to health education projects that test models of occupational health education. The formats and curricula OSHA obtains from these projects can be adapted by employees and employee groups to their own particular needs. A substantial multiplier effect is anticipated.

The largest contract, for \$3 million, was let to the National Safety Council, which has developed four short courses and implemented them through 39 participating local safety councils. The courses include orientation to rights and responsibilities under the Act and instructions on setting up safety and health programs within establishments. Over 100,000 individuals have already been reached by this massive, geographically dispersed, program.

Another contract demonstrates the feasibility of using community and junior colleges as part of the job safety and health education delivery system, while another entails the creation of thirty-minute television programs on selected job safety and health topics.

Training individuals to recognize health hazards is complex because the problems vary by occupations. OSHA has selected five "target industries" in which the disability and death rates are substantially above average including, longshoring, meat and meat products, roofing and sheet metal, lumber and wood products, and miscellaneous transportation equipment.

OSHA's work has been supplemented by that of a number of unions and companies that have initiated their own education programs in areas not related to occupational safety but using the workplace as a focus for more general health education. For example, the United Mine Workers Union, which administers its own prepaid health insurance plan, has hired full time health educators in several regions, and conducts programs in preventive care and specialized classes for diabetics and others.

The Connecticut Mutual Life Insurance Company in Hartford, Connecticut, and the Scoville Manufacturing Company in Waterbury, Connecticut, each have a program to help workers with alcohol or other drug problems. In addition, Connecticut Mutual offers employees periodic voluntary physical examinations, occasional videotape presentations during the lunch hour on topics such as heart disease or alcoholism, and frequent health articles in company publications.

The programs of both companies direct their promotional efforts largely toward supervisory personnel in the hope that they will refer workers who appear to have problems. Scoville no longer considers their program a cost item, because of the savings resulting from increased worker output. In fact, savings in the Waterbury plant alone, which employs about 4,000 of their 24,000 workers nationwide, are estimated to be more than \$200,000 for 1974.

Annual health examinations and counseling programs for executives, periodic screening of blue-collar employees, lunch-hour lectures on a variety of health topics for both blue-collar and white-collar workers: these and many other general health maintenance and educational activities are currently taking place throughout American business and industry. Such efforts, successful as they have proved to be in individual situations, have scarcely made a dent in the general health problems of American workers. The blame, however, cannot

be attributed primarily either to management or the unions. The major culprits are the same four that hamper other forms of health education—individual ignorance, public apathy, commercial pressures, and lack of any strong, positive leadership on the part of either the government or the health professions.

The Committee expects that programs authorized under this legislation will receive proper attention by the Office.

#### 4. NUTRITION

During the Great Depression it was a common fact that nearly one-third of the Nation was malnourished. Today, we have developed a neologism to describe the fact that the entire Nation may very well be "misnourished." We have the resources to buy sufficient food, but lack the knowledge to choose which foods are the best for us.

Many who are not hungry are the "new misnourished." They are the overweight who eat empty calories and consume too many processed foods. They are our children; they are often ourselves.

Jean Mayer, chairman of the White House Conference on Food, concluded that the "new misnourished" cost the Nation about \$30 billion a year. A fraction of this large sum could be spent on nutrition education. A tax dollar spent to give consumers a sensible scientific guide to spending their food dollars is an investment in our children. It is an investment with a dollar and cents return for spending more for nutritional education now will mean less sickness and lower costs later.

Often bills would encourage and expand nutrition education programs in schools of medicine and dentistry. The Committee believes it is important for physicians and dentists to understand the relationship between nutrition and health to better provide their patients with necessary nutritional information.

Such bills are presently pending before the Congress and it is anticipated that they will be the subject of hearings in September 1975.

The Committee recognizes this important subject and has included nutrition and nutrition experts in all of the appropriate policy design and implementation sections in the bill.

#### 5. MEDIA

The media are important vehicles for disseminating information and influencing behavior. Physicians and other health professionals are involved in presentations that reach a large audience. "House Call WCVB", a prime time television show in Boston, features a physician answering questions about health and medicine, and is viewed in 152,000 homes each week. Television and radio spots are used frequently to promote programs and to make consumers aware of particular problems. For example, Pearl Bailey is featured in a spot to create public awareness of a new Federal Drug Administration labeling program.

Unfortunately, the positive impact of these media efforts are largely offset by the misinformation often carried on TV advertising. A recent analysis of one week of television in a major metropolitan area concluded that five percent of the total broadcasting time was used to transmit inaccurate or misleading health information.

The Public Broadcasting System and other networks have produced several specials on important health issues. The Children Television Workshop has created an innovative television series focusing on health education. "Feeling Good" opened on PBS stations in November, 1974. The show, which was an attempt to combine health education and entertainment, was intended to appeal to adults, especially parents in low income families. Unhappily, the program failed. Dr. Carter Marshall, who testified before the Committee on May 8, 1975, stated that its basic difficulty was that "Feeling Good" was developed for low income audiences, when in fact viewers of public television are upper middle class and well educated. Media research, the Committee believes, is an important feature of the HEW-based Office of Consumer Health Education and Promotion. Media programming is expensive, but well worth the effort.

#### 6. HEALTH EDUCATION MANPOWER

The wide range of consumer health education programs is carried on by an even wider range of professional and occupational groups and individuals. These occupational groups include, in addition to health education specialists, physicians, hospital nurses, public health nurses, school nurses, physical education teachers, dentists, dental hygienists, pharmacists, dietitians, therapists of all types, psychologists, public health personnel, midwives, communications and audiovisual personnel, and appliance and drug manufacturers.

*A. Health Education Specialists.*—Dr. Scott Simonds, a well known health educator and member of the President's Committee on Health Education, has written that:

\* \* \* the total number of individuals prepared in health education at the baccalaureate, masters, or doctoral levels and working actively in the field of either public health education or school health education [is] no more than 12,500 [including] no more than 2,000 prepared in community or public health education.

Comparing Dr. Simonds' estimate of 12,500 with the 1974 resident civilian population—approximately 210 million—this comes to one health educator for over 16,800 persons. By comparison, there were, in 1973, one active physician for every 648 persons and one nurse for every 281.

Based on the information provided to the Committee, these training programs emphasize sophisticated educational, planning, and research techniques. The field needs these health education specialists; it also needs health education practitioners trained for actual community, patient and student contact.

*B. Physicians.*—Despite the impressive record of physician involvement, it is clear that we can look to the medical profession for only a small proportion of the nation's total health education needs. Physicians now consider their primary tasks to be diagnosis and therapeutic intervention. Too frequently they turn to maintenance and education when intervention fails or has limited results. Thus, to some extent the need for education is associated with therapeutic failure, and it is not surprising that many doctors lose interest at this

point. Although there is the necessity of greater involvement in patient and other health education programs it is obvious that the nation must look to other professions to supply most of its health education needs, even for those who are already patients.

*C. Nurses.*—The one profession that is doing the most consumer health education in the U.S. today is nursing. This is evident in the figures. In 1972, there were 748,000 active registered nurses; of whom 54,000 were in public health and school nursing and 35,000 in occupational health nursing. Much of their work is educational.

Many, perhaps most, of the 526,000 working in hospitals and nursing homes have extensive technical responsibilities and limited time to give to patient education. Nevertheless, for nurses, unlike physicians, patient education is now generally assumed to be an explicit part of the job responsibility, generally so stated in the state nursing practice acts and a component of all state licensing examinations. Moreover, the nurse, unlike the doctor, does not have the same professional and emotional preoccupation with diagnosis and intervention. The nurse is frequently more interested in the patient as a person and looks on maintenance and educational activities as a major challenge rather than evidence of failure.

Nurses today are not only doing more health education than any other group but they also constitute the most significant potential pool of professionals available for rapid upgrading toward expanded health education responsibilities.

*D. Other Professionals.*—Among the other professional and occupational groups that are contributing in some degree to health education, the following are especially important: Dentists and dental hygienists; physical, speech, and occupational therapists, pharmacists; nutritionists and dietitians. The average dentist and dental hygienist seems more concerned with prevention and patient education than the average physician. The dental profession as a whole has received too little credit for its consistent support of preventive and maintenance activities, including proper diet.

The 133,000 pharmacists come into frequent contact with consumers. Often the consumer will question the pharmacist about the impact or side-effects of prescription drugs and request advice on over-the-counter drugs. The role of the pharmacist in providing information and monitoring drug use could be upgraded; indeed, the Secretary's Task Force on Prescription Drugs urged pharmacists to become drug information specialists.

The Committee is also aware of the real and potential contributions of other types of personnel such as the licensed practical nurse, the newly emerging group of physician assistants and nurse practitioners, as well as numerous volunteers, such as the 10,000 volunteer teachers participating in the National Safety Councils Defensive Driving Course. Effective health education and promotion will depend on a wide variety of skilled practitioners, all making important contributions. The Committee does not foresee any primary role for any one specialty that currently exists, nor is the Committee anxious to develop such a specialty. Nevertheless, the Committee recognizes the need for adequately trained health education practitioners who will be engaged in health education teaching and research and in health education practice.

The Committee believes that emphasis should be placed on raising the level of training given to those who will enter the field of health education practice. Additionally, support should be given to those who are engaged in theoretical research in the field of health education and promotion since it is this group who develop the conceptual frameworks from which sound practice derives. Short-term continuing education programs should also be included to upgrade skills of a variety of health providers, including doctors, nurses, educational specialists, and midlevel health practitioners. The Committee places highest priority on multidisciplinary and cooperative approaches which will do the best job possible.

#### 7. FINANCING

Despite their low costs, health education programs face a constant struggle for funds. Most medical services are refunded almost automatically because their value is taken for granted and past budgets not only serve as precedents but are expected to increase as both quantitative growth and qualitative improvement are assumed to be desirable. But because health education programs are new—at least to the mainstream of the health care economy—they are constantly in the position of having to prove themselves and justify their existence.

Traditionally, public and community programs were financed by grants or direct allocations from government, philanthropic, voluntary agencies, or industry. This is still true of most of the new TV programs. "The Killers," "Feeling Good," "Drink, Drank, Drunk" and others have been supported by grants from the Robert Wood Johnson Foundation, the Commonwealth Fund, Public Broadcasting Corporation, Exxon, the 3M Company, and others.

The President's Committee reported \$30 million spent for "specific" health education programs in 1973 and \$14 million for "general," altogether less than one quarter of 1 percent of that year's HEW budget. Many feel those figures are generous. Presumably most of this went for programs involving smoking, drug addiction, alcoholism and related conditions. According to the same source, state governments spend less than one half of one percent for health education. In comparison, the annual budget for a well-known analgesic is \$28 million.

A major potential source of health education support is third party reimbursement, now the principal method of paying for patient care in the United States. As long as patient education was provided by doctors, nurses, and other health professionals as a routine and nonidentifiable part of patient care, most third-party payors did not question reimbursement. Today, however, as more and more separate programs are established and other personnel become involved, it is harder to "bury" the educational costs, small as they are, in routine care. A move has been under way to persuade all third-party payors, governmental and private, to recognize patient education as a legitimate component of patient care, one that need not hide itself but can appear as a separate item in the hospital budget or the physicians' bill.

The Health Insurance Benefits Advisory Council (HIBAC) addressed itself to this issue in a report to the Secretary in 1974. The report added nothing new but helped to clarify the position of Medicare and Medicaid. As far as Medicaid patients are concerned there

appears to be considerable leeway for educational activities, but not so with medicare recipients. Any activity that can be labelled "preventive" has to be disallowed for reimbursement under existing legislation.

In August 1974, the Blue Cross Association approved a position paper strongly endorsing the concept of patient education and urging member plans reimburse hospitals for such activities. The Committee welcomes this useful document, but BCA guidelines are one thing and individual plan implementation is another. There are only two such plans now reimbursing for patient education, one is New Jersey and the other is Montana.

#### 8. EFFECTIVENESS

Current health education programs are rarely evaluated. Despite compulsory instruction in many schools, young people are probably smoking, drinking, using more drugs and otherwise engaging in more health-threatening behavior than ever before. Despite the tremendous anti-smoking campaigns, 41 percent of those 17 to 25 years old were regular smokers in 1970. Screening programs for breast and cervical cancer are universally available; yet only half of American women over 17 had such tests in 1973 and nearly one-fourth had never had a breast examination. The proportion of individuals taking advantage of any such screening is reported to be levelling off at about three-fourths. Immunization rates also seem to have reached a peak and some, such as polio and DPT, have dropped significantly.

Even when positive results appear to be forthcoming, as in the recent decline in heart disease, it is virtually impossible to know whether to attribute this to the campaigns against cholesterol and other risk-factors or not.

In short, we do not know whether the record would have been better, or worse, or no different, if there had been no educational effort. Yet some progress has been achieved. Professor Lawrence Green of the Johns Hopkins School of Hygiene and Public Health, one of the foremost exponents of health education evaluation strategies, has reviewed the results and concludes that "the payoff is more than proportionate to the effort and costs."

The Blue Cross Association arrived at the same tentative conclusion, at least with respect to patient education. In a succinct summary of evaluation literature, the BCA 1974 policy statement concludes, that:

On balance, organized patient education has demonstrated its effectiveness in reducing the unnecessary utilization of certain health care services and in encouraging the use of the most appropriate, least cost settings for care.

Similar reports reveal conclusions that patient and health education programs pay off, in reduced hospital and emergency room readmissions, reduced morbidity and mortality and reduced costs. Research and evaluation of such programs, and the development of new demonstrations, are important features of S. 1466.

#### THE NEED FOR NATIONAL LEADERSHIP

Recently, health promotion and prevention have become major planning concerns of the Assistant Secretary for Health of HEW.

The Division of Health Protection has developed proposals to shift the focus of analytic activities toward broad health problem areas requiring comprehensive prevention efforts. The Committee is impressed with such developments, and awaits implementation of such programs.

The Committee also notes that the Administration has taken other cautious steps. Such programs as have been developed, however, the Committee finds do not match the magnitude of the problems. The official statement of mission of CDC's Bureau of Health Education, for example, is broad and comprehensive. However, its subordinate location in HEW and lack of visibility and resources contradict its broad mandate. The Bureau, however, has made a number of contributions both within and without the Federal structure, including support and leadership in the development of a private-sector Center for Health Education, the initiation of cooperation among Federal agencies in need of common health education objectives, and the development and funding of innovative health education projects. The Committee acknowledges the important work of the Bureau but favors an HEW-based Office of Consumer Health Education and Promotion. Organizationally located in the Assistant Secretary for Health's office, given visibility, resources and authority, the Office of Consumer Health Education and Promotion will better be able to establish a national strategy and new directional emphasis with respect to health education and promotion.

#### V. THE RESPONSE TO THE CHALLENGE

The cluster of concerns outlined and described in the preceding sections of this report urge us to continue our efforts to reorganize and restructure our health services delivery system and to continue to experiment with innovative financing mechanisms. Concurrent with our efforts to develop a better and more efficient system, however, the Committee sets forth a new strategy, one which shall assist us to understand the nature and causes of self-imposed risks, adds to our knowledge of illness, and educates patients and consumers about health maintenance and prevention.

The strategy is based on recent data which is both startling and troubling. The Committee has learned that in 1972, 92% of the \$95 billion spent for medical, hospital or health care was spent for treatment after illness occurred and that more than half of the remainder was spent for biomedical research. Prevention of illness and consumer health education and promotion share the meager balance. The Committee has additionally learned that hundreds of thousands of Americans have died prematurely from causes primarily related to lifestyles. Alcohol addiction, abusing pharmaceuticals, addiction to psychotropic drugs, cigarette smoking, overeating, high fat and carbohydrate intake, lack of recreation, promiscuity, and careless driving—an imposing litany of some of our more destructive habits—leads to the inevitable conclusion that for the majority of Americans morbidity and mortality rates will not be noticeably improved unless lifestyles are modified, self-imposed risks reduced and the social and physical environment changed.

The Committee has studied the Presidential messages and task force and Committee reports on health education, and is convinced that there is still no national recognition of the importance of this field and no adequate central force to stimulate and coordinate a comprehensive health education program. Efforts toward this end are fragmented. The moneys spent for health education and promotion are miniscule. There is no informational exchange between those in public and private agencies concerned with health education and promotion. There has been little evaluation of results among similar or related health education programs sponsored by different organizations. Information about health education theory, programs, and methods is not easily accessible. There is presently no public or private agency which is systematically reviewing the broad range of experience and theoretical experimentation in health education and promotion. And, there is no focal point or forum to facilitate communication and cooperation among the significant health public and private organizations which must work together if substantial improvement in health education and promotion is to be achieved.

The Committee recognizes that the needs and problems are so major and complex that progress will depend upon a major long-term commitment by both the public and private sectors of society. It is to meld such efforts, provide for a focal point for the Nation's multiple but disparate health education and promotion activities, improve the health status of Americans, design a mechanism by which we may establish a national health education and promotion strategy, that parts A and B of title III of S. 1466 have been proposed.

The concept of a complementary national public and private strategy to improve consumer health education and promotion is the result of four years of study and development. This concept was originated by the President's Committee on Health Education and has been further amplified by a study performed by the National Health Council, Inc. under the contract to the Center for Disease Control. Both studies based their findings and recommendations on the input of hundreds of citizens, including health educators, other health professionals and educators, consumers, and representatives of business and industry, labor unions and government drawn from all parts of the country.

The President's Committee on Health Education was charged to describe the "state of the art" in health education of the public and to propose a comprehensive, nation-wide plan to raise the level of health consumer citizenship. Through seven subcommittees, eight regional hearings and one national forum the Committee involved many hundreds of individuals of different backgrounds and expertise from all parts of the country in the development of their findings.

After two years of study, the President's Committee recommended the creation of two separate but complementary entities: (1) A governmental unit within HEW to make the federal government's involvement in health education more visible, effective, and efficient, and (2) a publicly chartered, private organization which would be a source of innovative problem-solving and policy guidance for health education efforts:

## 1. THE OFFICE OF CONSUMER HEALTH EDUCATION AND PROMOTION

Nestled in the bosom of the Center for Disease Control is the Bureau of Health Education, presently the Administration's major force point for better education activities. The committee recognizes the creditable performance of the Bureau which despite very limited resources in terms of both budget and personnel has made a number of creditable contributions both within and outside the Federal structure. A number of witnesses have applauded the Bureau for programmatic, consultative, and monetary assistance; others, however, are gravely concerned that the Bureau is an anomaly, pointing out that the subordinate location in CDC, its miniscule budget, and lack of resources contradict the Bureau's broad mandate. The Committee was persuaded by those skeptical of the Administration's commitment and by the apparent discrepancy between the Administration's promise (for bold health education and promotion initiatives) and reality.

A. *High-Level Office of Consumer Health Education and Promotions.*—The Committee considered a number of loci for the proposed Office of Consumer Health Education and Promotion, including a Center-model akin to the National Center for Health Statistics or the National Center for Health Services Research or creating an organization similar to the National Science Foundation. Ultimately, the Committee opted for a locus in the Office of the Secretary with adequate status, authority and resources to carry out policy design and implementation and other collaborative, oversight and coordinating functions. Policy direction and design, the Committee believed, could only be attained and implemented in a high-level Office of Consumer Health Education and Promotion. The proposed Office may very well consult with CDC and other organizations in HEW that have health education components to execute the programmatic aspects of health education, but the locus of policy activity must be in the Office of the Consumer Secretary for Health and not in an operating agency.

B. *Research Activities.*—Despite the considerable number of significant health education programs scattered across the country and the efforts of thousands of dedicated professionals, the general state-of-the-art is in need of greater precision and development. The large-scale program of public and private support recommended in this report must be accompanied by intensive efforts directed to improvement of health education principles, techniques, and methodologies, and the formulation of more precise criteria and protocols both for implementation and evaluation. This should include a delineation of areas of strength and weakness in knowledge, looking toward development of a national statement of priorities and realistic goals.

Much of the support, as well as initiative, for these efforts should come from the private sector. But there is a special need for Federal leadership. Federal support, with special emphasis on evaluation, should be made available to qualifying institutions, organizations and agencies.

The Committee notes the existence of a number of community "laboratory" populations for the study of problems in health education. Such communities should be encouraged to participate in the development and evaluation of health education methodologies. The Committee also endorses the development of large scale programs,

specifically designed to test health education hypotheses, such as the Stanford Heart Disease Prevention Program.

Closely related is the need for expansion of the present valuable surveys and studies of the National Center for Health Statistics to include more information on consumer health status, health behavior, and related data useful and necessary for planning and evaluation of health education programs and techniques. Relevant resources of CDC should also be fully explored and utilized.

C. *Regional and State Systems.*—Even with the severely limited funds and personnel now available for health education, there is considerable duplication and waste. More importantly, most American communities lack access to any comprehensive consumer health education.

To avoid these inefficiencies, to promote optimum utilization of both money and manpower, and to help develop a stable infrastructure for community and other programs, it is highly desirable to develop local, regional, and/or State networks. This can be accomplished through the coalescence of existing programs, new regional and state-wide initiatives under the leadership of a State health department, a university extension system, a State hospital or professional association, a medical school, regional medical program, or other organization with the concern and resources to play the coordinator role, or through a combination of various approaches.

The National Health Planning and Resource Development Act of 1974 provides a potential mechanism for promoting such networks.

D. *Health Education Training.*—Both quantitative and qualitative improvements in health education manpower are essential if the national efforts recommended in this report are to be effectively implemented. As a first step, we recommend a high-level review of personnel in all the extensive varieties noted in this report. Such a review would apply not only to health education specialists but to all the health and related professions currently involved in some aspect of health education and should address itself to the numbers and types needed, their preparation, credentialing, distribution, and continuing education.

Special attention should be given to the introduction and development of health education concepts and methodologies into basic education for the various health professions, including medicine, dentistry, nursing, pharmacy, and public health. The time is ripe for such a new initiative. Witness the special attention paid to health education at the 1974 annual meeting of the Association of American Medical Colleges and the fact that most state nursing practice acts now specifically mandate patient education as a routine aspect of nursing care. Explorations, looking to increased health education content, are now in order with the American Association of Medical Colleges, the American Medical Association, the Coordinating Council on Medical Education, the National Board of Medical Examiners, the American Dental Association, the American Pharmaceutical Association, the American Nurses Association, National League for Nursing, the Association of Schools of Allied Health Professions, the National Commission for Accrediting, and other professional organizations.



Moneys should be made available for the training of health education specialists. For this group, special efforts are needed to determine the numbers of students required at entry levels, baccalaureate, master's, and doctor's levels, as well as the types of educators needed in the schools, health care institutions, industrial settings, community agencies, national health agencies, and the media; also the need for special research personnel and future teachers.

Finally, the Committee urges that in considering health education manpower, special attention be given to the definition and development of a new occupational category of indigenous community health education aides, advocates, or facilitators to act as a bridge between the community, especially in low-income areas, and health providers, including health educators. The success of programs utilizing such individuals, under various names, has been demonstrated in a number of locations, but the concept needs more precise definition, more standardized training, and some form of academic certification.

*E: School Health Education Training.*—The Committee considered S. 544 at some length with a view to including this Comprehensive School Health Education provision in this bill. The Committee recognizes that S. 544 is essential legislation if a meaningful preventive program to improve the health of the American people is to be a reality.

The Committee has included a portion of S. 544 as Section 1703d(1), (2), (3) of S. 1466. The language establishes a program of grants to local education agencies and institutions of higher education for inservice education opportunities for elementary and secondary school teachers in a broad scope of health education areas. The Committee believes this to be a pressing need at this time and recognizes that no program can be successfully developed in the schools until a cadre of career teachers is well prepared to deal professionally with the issues involved.

The bill will thus make available to presently employed teachers workshops, seminars and courses during summer and evening sessions. The workshops, seminars and courses will deal with the broad scope of issues including dental health, disease control, environmental health, human ecology, mental health, nutrition, physical health, safety and accident prevention, smoking and health, substance abuse, consumer health and such others as may be deemed appropriate. The Director is required to confer with, and receive the approval of, the Commissioner of Education in determining the recipients of the grants and the scope of the program.

Because of the alleged surplus of teachers the bill emphasizes inservice education rather than preservice education for persons who later may not be employed. The Committee feels this is a practical approach to the solution of the problem which presently exists in most schools where comprehensive health education programs are non-existent. It is essential that school health education begin in the primary grades and extend through the secondary curriculum. Too often health education is confined, if indeed provided at all, to students in their teens. It is the Committee's purpose to correct the situation by providing a practical, although somewhat limited opportunity, for inservice education in school health education for persons who are and will continue to be employed as elementary and secondary teachers

so that when broader, more comprehensive school health legislation is enacted in the future there will be no delay, owing to a lack of qualified personnel, in implementing the health education curriculae in the schools of the nation.

*F: Media Programming.*—The impact of television as an informational and motivational force in contemporary U.S. society, especially in relation to children and individuals with less-than-average schooling, can hardly be exaggerated. With respect to health-related behavior, it is difficult to say whether the net impact has been positive or negative.

The positive can be documented by a growing list of first-rate health documentaries, public service "spots", and even some of the theatrical programs presented by the Public Broadcasting System and the three commercial networks. The negative has been convincingly documented by a number of carefully designed professional studies, including two prestigious national commissions looking into the relationship between televised violence and individual behavior.

Despite this anomalous record, the Committee believes that with more consistent and accountable attention from the leadership of the industry, with more high-level assistance from representatives of the public and the health and education professions, and with identification of adequate sources of financing for constructive programs—the positive potential can be greatly enhanced and the negative minimized.

The Committee's emphasis on TV is by no means intended to belittle the influence of the press, radio, and other media which have also produced some excellent material and whose continuing participation should be enlisted in the national effort to improve consumer health education. Since TV's capacity for both positive and negative impact is so crucial, however, we think the primary effort, at the present time, should be aimed in this direction.

The Committee hopes that through Section 1703(c), the resources of television and advertising will be mobilized in the development of a long-range, multi-audience, multi-format series of programs, utilizing documentaries, theatrical programs, cartoon and news programs, public service spots, and all other appropriate formats, aimed at helping the American people increase their understanding of, and ability to cope with, health and health-related problems. Both commercial and public TV should be involved. Assistance in funding through public and private sources should be explored. The existence of such a formally designated industry council working through the Center for Higher Education (*infra.*) would also provide a body to which the public and the health and education professions could relate.

The Committee is aware that the National Advertising Council shares many of our concerns. The Advertising Council, however, is not intended to carry out the kind of concentrated systematic health education program outlined.

Another objective of sections 1703(e) and 1703(f) is to encourage the industry, the Food and Drug Administration, the FCC, and the FTC to intensify their efforts—through voluntary advertising codes, "Family viewing hours," and other means—at effective self regulation. The Committee expects that, through the use of fact-finding, publicity, non-governmental sanctions, and all the moral and political

force the Office of Consumer Health Education and Promotion commands, the elimination of material deemed, by objective professional opinion, to be injurious to the nation's health will be secured.

G. *Federal Programs.*—Areas that should come under such continuous monitoring include agricultural supports for harmful products such as tobacco, or those potentially harmful if used to excess, such as beef with high-fat content; school lunch and food assistance programs; food and drug advertising; and speed limits and other energy conservation measures. The conflicts or apparent conflicts between a number of existing programs in these areas and the goals of health promotion have been increasingly publicized in recent years.

The monitoring should extend not only to areas where harmful or allegedly harmful policies now exist but to those currently marked by the general absence of essential health promotion policies, including low-income housing, the control of violence, and public service employment. The irony of spending billions of Federal dollars to patch up the victims of big city violence, squalor, and frequently intolerable living conditions, while refusing to face up to the root causes cannot be indefinitely sustained as general economic conditions deteriorate, budgetary constraints increase, and various safety valves disappear.

The Committee is aware that policy development in health education and production cuts across Departmental lines and that HEW can do little or nothing alone. However, we feel strongly that the Department should be continuously engaged in monitoring such policies, in advising the President, the Congress, and the American people with respect to such policies, and in representing the health point of view in interdepartmental decision-making. Primary responsibility for policy design and staff work should be lodged in the proposed Office of Consumer Health Education and Production.

The importance of HEW involvement in broad policy issues, beyond the usual definition of health and medical care, was emphasized both by the Surgeon General's Committee on Smoking and Health and the subsequent Committee on Television and Social Behavior. Some would have preferred to see strong recommendations included in their reports. But, even without recommendations, the carefully documented findings, emerging from such a prestigious source, have been useful.

In initiating such a large new undertaking, an essential first step would be establishment of a list of goals and priorities. Criteria, both immediate and long-run, should include the firmness of the presumptive causal relationship between the policy in question and national health status, the financial cost to the nation of failure to take corrective action where needed, and the reasonable possibility of corrective action.

For example, in the case of tobacco, the causal relationship between cigarette smoking and health has been professionally and officially determined. The health care costs resulting from cigarette smoking is currently estimated by the National Center for Health Statistics at \$11.5 billion a year. Some corrective action, while difficult, has not proved insuperable, at least with respect to one form of advertising. The Surgeon-General acted reasonably a decade ago in allotting top priority to this area. It is now time for further initiatives.

4. *Budget.*—The Committee has tried to reconcile the competing claims of a non-inflationary Federal budget and the necessity of providing at least enough financial support to give the new program a chance of succeeding. Major elements of the projected first year budget might include:

*Cost estimate—Office of Consumer Health Education and Promotion*

	<i>Millions</i>
Extramural grants and contracts:	
Basic research programs.....	\$1.0
Academic centers.....	1.0
State networks.....	1.0
Experimental media research.....	1.0
Consumer health education training.....	4.0
School health education training.....	3.0
Total.....	11.0

The estimated cost of the basic research programs is related to the cost of a number of successful programs, including the Stanford Heart Disease Prevention Program and the Diabetes Control Program of the Los Angeles County General Hospital. The cost of the state networks is derived in part from the experience of the College of Medicine and Dentistry of New Jersey.

The media projection is far less than the \$7 million that it cost Public Broadcasting System's "Feeling Good."

With respect to the long-term costs, including those that might be met through third-party payments, school budgets, and voluntary agencies, the Committee has set a tentative goal of 6 percent of total national health care expenditures. Obviously, the Committee needs a more precise figure as well as a timetable for moving from the present one-quarter to one-half of 1 percent, the sum presently being spent by the Federal government, toward 6 percent and a study of alternative methods of financing. For example, should the financing of health education and promotion programs be closely related to that of national health insurance? How much reliance should there be on social security taxes or general revenues? Should there be special taxes on cigarettes, alcohol, other health-threatening products certain non-prescription drugs where overuse or other abuse is common?

The Committee recommends that the office consider such a study one of its priorities.

## 2. THE CENTER FOR HEALTH EDUCATION AND PROVISION

As defined by the President's Committee, health education is a process that bridges the gap between health information and health practices and motivates the change of behaviors destructive to health maintenance. The Committee saw this process as applying to institutions as well as to individuals. In order to improve the nation's health through educational means, the President's Committee concluded that fundamental changes in the attitude and behavior of our social institutions in general and within the health industry in particular are required. They saw a primary need to heighten awareness of and response to health needs as a major shift in emphasis and expansion of effort beyond the current focus on the treatment of disease and injury. It was their finding that such fundamental change would not occur

unless some mechanism could be created which would address and resolve complex and controversial issues of individual and social values and behaviors in a non-bureaucratic and non-coercive manner. They, therefore, recommended the establishment of a unique national private institution which they called a national Center for Health Education as the key component in the plan they presented to the President in 1973.

A. *The National Health Council's Project.*—As a follow-up to the Report of the President's Committee on Health Education the Department of Health, Education and Welfare took two actions in 1974: (1) a Bureau of Health Education was administratively created as a new unit of the U.S. Center for Disease Control in Atlanta, Georgia to coordinate federal health education efforts; and (2) a contract was awarded by C.D.C. to the National Health Council, Inc. to explore in detail the most appropriate and feasible objectives, functions, structure, staffing and financing pattern for a National Center for Health Education.

The Council's project was designed to build upon the work already accomplished by the President's Committee and to involve a large sample of organizations and individuals not limited to the Council's member agencies. Through the work of the project's Policy Committee, study groups and subcommittees, mail surveys and conferences, this project developed a model design for a private national Center which is complementary to and non-duplicative of either an expanded federal governmental program or of any existing private sector resources. The recommended design is for an open, non-bureaucratic problem-solving mechanism incorporating innovative elements of policy development and action program planning processes which have been tested in business and industry as well as community health planning agencies during the past decade. The project's findings and recommendations were provided to the Committee and are a primary source of referral for additional information concerning the intended nature and character of the Center for Health Education and Promotion.

B. *The Need for a Private Center for Health Education and Promotion.*—The arguments supporting the need for a private national Center for Health Education and Promotion focus on the advantages and benefits of voluntary, non-governmental leadership and action to improve the nation's health through educational means.

Health education is concerned with every facet of consumer beliefs, attitudes, and behaviors which contribute to the maintenance or self-destruction of health. This includes especially those choices the individual exercises concerning his or her private life—what and how much the individual eats and drinks, how much rest and exercise he or she gets, habits of personal hygiene, how the individual handles anger and frustration, how fast he or she drives, how early and often medical care is sought, career and family formation decisions, choice of dwelling, etc. It is also equally concerned with the content and quality of information and guidance the individual receives from health and social institutions, commercial enterprises, labor unions, civic associations, and from the mass media concerning appropriate and inappropriate health maintenance behaviors.

Thus, much of the content of consumer health education is concerned with precisely those areas which have traditionally been regarded as private matters. These are, however, also matters of growing public concern and rising medical costs. Whether through public tax payments or through insurance premiums, our society has assumed an increasing responsibility for the treatment of the individual's diseases and injuries. Society, therefore, also has an increased stake in affecting—to the extent possible—the frequency and severity of the individual's need for such treatment.

While governmental programs can and must be substantially improved and expanded, governmental action alone cannot provide the kind and scope of leadership and initiatives required to realize the potential benefits of improved consumer health education. Direct governmental efforts to modify citizens' behaviors, mass media content, and school curricula in ways that are scientifically sound, effective, and culturally acceptable represent extremely difficult issues. On the one hand the current state of the art of health education is probably inadequate to deliver effective and reliable results in the public interest from such interventions. On the other, to be effective, such action by a governmental agency may conflict with constitutionally guaranteed private freedoms.

Therefore, organized private action is needed to explore controversial issues and develop national guidance which reflects a general professional and consumer consensus on appropriate and acceptable directions of effort. Because such private policy does not have authority to compel compliance, it must necessarily include development of voluntary support and resolution of realistic constraints which are a fundamental part of the problem. Once the efficacy and acceptability of such privately developed initiatives has been demonstrated, then the need for and exact nature of additional governmental support to extend implementation will be both clearer and less likely to encounter opposition.

The voluntary health promotional agencies and health professional associations have traditionally carried the burden of consumer health education in this country. While much is being done in the private sector to inform the public about the actions they can take to protect and maintain their own health, the results can not be considered good. The reasons for this are numerous.

There is no consistent thread which defines and articulates health education content or methods. There are no generally recognized standards, guides and measures for evaluation of health education efforts. It is, therefore, virtually impossible to objectively discriminate against the ineffective, confusing or even potentially misleading information and education the consumer receives in great quantity from a multiplicity of sources.

There is no common frame of reference shared by the various disciplines and interests working in this field. There is little continuing communication, cooperative program planning or comparative evaluation of results among similar or related health education programs sponsored by different organizations. There is no unified or comprehensive perspective from which to assess results and determine which of alternative approaches is most appropriate to a given situation. And finally, with some notable exceptions, for the overwhelming

majority of agencies which dispense some form of health education to consumers, this activity is not their primary purpose and therefore does not receive top priority for their allocation of funds and program attention. Thus, very little of the current consumer health education efforts are as effective or efficient as they could be, were there some national focal point to improve communications and cooperation among the major programs within the private sector.

Clearly a nationally recognized source of policy development, guidance and technical assistance, cooperative program planning and coalition building, evaluation and advocacy could make a major impact on the kinds and quality of health education efforts in the private sector without a net increase in overall expenditures simply by reducing the fragmentation and discontinuity of current efforts.

Testimony given to the Committee strongly indicates the existence of considerable support from private sector sources for the creation of such an organization. The granting of a Congressional charter to such an organization would improve opportunities for:

1. Supporting private leadership in policy exploration and program development by the creation of an entity with quasi-official legitimacy and stability;
2. Integrating utilization of private and public resources in the development of concerted national strategies for improving consumer health education nationwide; and
3. Maintaining formal channels of communication, information exchange and public accountability between the governmental and private sectors.

C. *Activities of the Private Center.*—The mission of the Center will be to improve the health of people by encouraging and supporting the improvement and expansion of health educational activities throughout the nation.

The Center should be a mechanism which links together primarily non-governmental organizations and agencies involved in health education, including those which engage in health care, education, business and industry, social and civic purposes, consumer and labor representation and communications. The widest possible range of participants should be given significant, structured opportunities to debate, select and influence the development of Center policies and strategies.

The Center should manage an open decision-making process for the development of national private sector policy concerning key issues in the field of health education. The Center should coordinate the review and analysis of consumer health education needs, provider resources, the impact of alternative health education approaches and other factors on health status to determine which lines of development offer the best opportunities for the improvement of the nation's health through educational means.

Through participatory processes it should seek to identify the locus of responsibility for addressing identified consumer needs and for the development of the resources required to meet these needs. The Center should also provide a forum for the determination of the most appropriate and acceptable roles it can play in stimulating and energizing the actions required to secure widespread endorsement and implementation of its goals and policies.

Policy guidance alone cannot secure the improvement of program services; frequently there are challenging impediments to the development of improved methods which require extended problem-solving and strategy design efforts. The Center, therefore, should coordinate a variety of activities, programs, and developmental projects which draw upon external sources of support and expertise to develop improved methodologies, especially concerning appropriate and acceptable ways to influence positive consumer behavioral changes, and concerning realistic and acceptable criteria for evaluation of health education programs. To encourage similar activities by other organizations, the Center also should organize a national network of technical assistance in the planning, implementation and evaluation of health education programs utilizing not only its own but the expertise available for other cooperating agencies.

D. *Board of Directors.*—The Center for Health Education and Promotion will be directed by a twenty-five member Board of Directors to be appointed by the President of the United States. Its functions should include:

- (1) Final Center policy and strategy design determinations;
- (2) Center program direction;
- (3) Center financial policy determinations, including direction of the basic funding strategy for Center programs and approval of budgets and resource allocations;
- (4) Representation of the Center to and liaison with outside organizations;
- (5) Charge and appointments to committees, task forces and study groups; and
- (6) Appointment of the Center's President.

Members of the Center's Board should serve as individuals and not as the official representatives of outside organizations. The Board as a whole should reflect a balanced mix of experts representing the fields of health education, health services delivery, education, consumer representation and advocacy, news media and communications, business and industry, organizational management, and public and private finance.

In addition, the Board as a whole should reflect a diversity of personal backgrounds and interests which assures not only the development of broad policy direction but facilitates the acceptance of its findings and recommendations by those asked to implement these recommendations.

During its deliberations this Committee considered a number of specific nominations for appointment to this Board. The following individuals are suggested as representative of the type and quality of members the Board should reflect:

Stanley Bergen, Newark, New Jersey; Lisle Carter, Atlanta, Georgia; Paul Ellwood, Minneapolis, Minnesota; Howard Ennes, Craryville, New York; Paul S. Entmacher, New York, New York; Robert H. Felix, Saint Louis, Missouri; Evalyn S. Gendel, Topeka, Kansas; William Griffiths, Berkeley, California; M. Alfred Haynes, Los Angeles, California; Howard Hiatt, Boston, Massachusetts; Magda Hinojosa, San Antonio, Texas; Robert L. Johnson, Berkeley, California; Philip M. Klutznick, Chicago,

Illinois; A. M. Lilienfeld, Baltimore, Maryland; J. Alexander McMahon, Chicago, Illinois; Lois Michaels, Pittsburgh, Pennsylvania; Walter J. McNerney, Chicago, Illinois; Mary Mulvey, Providence Rhode Island; Arthur C. Nielsen, Jr., Northbrook, Illinois; Eva M. Reese, New York, New York; Samuel Sherman, Los Angeles, California; Elena M. Sliepecevic, Carbondale, Illinois; Anne Somers, Princeton, New Jersey; Frank N. Stanton, New York, New York; James Howard Walker, Charleston, West Virginia; and Harold M. Wiseley, Indianapolis, Indiana.

E. *Advisory Panel.*—In addition to the Board of Directors, there should be a large panel of at least one hundred individuals representing the same kinds of competencies and abilities as those described for Board membership. The principal function of this panel should be to provide advice to the Board. The Advisory Panel should routinely be requested to review and comment on Center reports and policy drafts. The Panel should also be the primary source for appointments to special committees and study groups created by the Policy Board to explore a particular problem or subject area in depth.

F. *Program Priorities.*—In a field as diverse and fragmented as health education there are no immediately obvious, generally acceptable, and logically appropriate priority rankings among the long list of potential specific program objectives the Center could select for action in its first years of operation. Consequently an organizing phase is indicated for the Center's initial activities. In this period, the open, in-depth analysis of alternative opportunities to achieve nationally significant impacts and the consensus selection of initial program priorities by the Board based on input from the Advisory Panel and a large sample of outside organizations and agencies should be the Center's top priority objective.

G. *External Relationships.*—The organizations, groups and individuals to be involved in any given phase in the Center's policy process will vary depending on the nature of the needs or problems being explored. Although the Center will not be a membership organization, it should be linked to a comparatively large number of external organizations by a variety of both formal and informal mechanisms. The Center should seek ties with representative health, education, welfare, and civic organizations and associations. It should also seek the support and endorsement of major corporations in business and industry, labor unions, and private foundations. The Center should involve these constituents in all aspects of its policy and program development both on an individual basis and through the formation of special purpose coalitions and consortia. The Center also should develop mechanisms to involve outside organizations in its processes for the periodic review and assessment of its policies and performance.

Private and public financial supporters of the Center should be publicly identified in the Center's annual report. Outside organizations unable to support the Center financially but wishing to affiliate with its goals and policies should be given the opportunity to formally signify their endorsement after action by the Center's and the respective agency's policy body. All organizations, groups and individuals who participate in Center activities, advisory groups, and projects should be listed in relevant reports.

H. *Center Funding.*—The Center should be funded by varying combinations of private and public funds, including direct appropriations, grants, contracts and unrestricted donations as appropriate for its general support and the financing of various special projects and activities.

The authorized \$1 million of core support for the Center for its first three years of operation is intended to provide for the establishment of its core policy process and staffing; i.e. to provide for the costs associated with the meeting and other expenses of the Board and its communications with the Advisory Panel, and to support the acquisition of a competent core staff. The Center's internal staff organization should be headed by a President to be named by the Board and such other members as he selects. The staff organization should be modeled on a matrix (rather than a bureaucratic) organizational design which stresses the accomplishment of tasks by ad hoc teams and special project activity in combination with routine program functions. The initial core staff should be small in number and emphasize coordinative, program design and management, group process, and communication skills. Members of the Board and advisory panel, staff on loan from cooperating organizations and outside consultants should be utilized in addition to Center staff to complete special project activities.

It is estimated that full scale Center operation will require approximately \$5 million annually. Funds to support the increased costs should be raised from private sources.

In addition to support for core operating costs of the Center, it is expected that the Center will also seek variable additional amounts in grants and contracts from both private and public sources in order to accomplish a variety of special projects. Thus the total annual income required to achieve the Center's program objectives in any given year should vary substantially depending on changes in program priorities and on the extent to which external organizations voluntarily undertake the performance of Center designed projects without using the Center as a fiscal intermediary.

A modest but relatively secure core operating budget combined with the necessity to secure additional, earmarked financial support to accomplish non-routine tasks and special projects is inherent to our concept of the Center as a non-bureaucratic, private sector based problem-solving mechanism. The Committee recognizes that the burden of securing the support and resources required to perform projects on a case-by-case basis can be quite high. The Committee believes, however, that the quality, feasibility, and general acceptability of proposed Center projects should be tested "realistically"; i.e. by their ability to attract endorsement and allocation of resources from outside organizations.

### 3. GRANTS FOR WATER TREATMENT PROGRAMS

Section 178 of the Committee's bill provides a modest authorization of \$9 million for communities which wish to seek partial Federal assistance in order to treat their water supplies. The Committee is convinced of the safety and effectiveness of fluoridation as a powerful preventive weapon in the battle against dental disease. The efficacy of fluorida-

tion has been widely known for many years, and the Committee has received overwhelming testimony from both scientific and professional groups to this effect.

Dental caries is the most prevalent disease in the United States today and one of the most costly of all chronic diseases. By age two, approximately one-half of the children in this Nation have experienced tooth decay. By age fifteen, the average child has 11 decayed, missing, or filled teeth.

Bringing the level of fluoridation in community water supplies to the optimum level is the safest, most effective, and most economical way to prevent tooth decay. Fluoridation prevents 40-60 percent of the dental caries usually experienced by children. The effects of fluoridation have been studied in the United States since 1945 and all communities involved have reported significant reduction in tooth decay as a result of this public health measure.

Fluoride occurs naturally in most water supplies and raising it to the optimum level to prevent tooth decay, usually one part per million, has never been proved to be hazardous to health. Adjusting the fluoride content of the water will not increase the likelihood of cancer, heart disease, kidney disease, allergies, or any other physical or mental illness. Indeed, fluoride is considered an essential trace element vital to proper nutrition, growth, and development.

Adjusting the fluoride level in a community's water supply costs a maximum of 10 or 15 cents per person annually. It results in a 50 percent or more savings in a family's dental bill. For every dollar spent on fluoridation, \$30-50 can be saved in dental care costs. Other methods for the prophylactic application of fluoride are available, however, none are as effective or as economical as fluoridation of drinking water. Its benefits are conferred on everyone, regardless of socio-economic level. It is effective without the need for any action by the individual.

A report released this year by the Director-General of the World Health Organization renewed that organization's support of water fluoridation and said that "unless there are overriding technical reasons, no nation can afford the luxury of not fluoridating every central water supply system containing less than the optimum concentrations of fluoride." The WHO report affirmed that fluoridation of the water supply should be the cornerstone of any national program of dental caries prevention.

The need for this provision is expressed by the professional organizations concerned with dental health care, as follows:

AMERICAN DENTAL ASSOCIATION,  
*Washington, D.C., July 15, 1975.*

Hon. JACOB JAVITS,  
*Russell Senate Office Building,  
Washington, D.C.*

DEAR SENATOR JAVITS: It is my understanding that you are planning to offer as an amendment to S. 1466, the Disease Control Amendments Act, a provision authorizing grants for water treatment programs which is identical to that contained in section 1702 of S. 2026, the Children's Dental Health Act of 1975. I am writing to express the support of the American Dental Association for this amendment.

The preventive benefits of water fluoridation have long been recognized by the dental profession. Water fluoridation programs such as those which would be promoted under your amendment would be extremely helpful in preventing oral disease for the citizens of this nation.

As Senator Magnuson indicated in his introductory remarks on S. 2026 "it has been estimated that at least \$2.6 billion could be saved over the first fifteen years of a national health insurance program provided universal fluoridation were in effect at the start of that program." Monetary savings of that magnitude, as well as the potential for improved oral health, are examples of the significant benefits which can be gained from a general water fluoridation program.

On behalf of the American Dental Association, let me again express my support for this amendment which you will be proposing. If I or my Association can provide you with any further information, please do not hesitate to call on us.

Sincerely yours,

PAUL W. KUNKEL, Jr., D.M.D.,  
*Chairman, Council on Legislation.*

## VI. COMMITTEE VIEWS

### TITLE I

1. The lessons of the history of communicable disease control are several. First, apparent success has fostered premature relaxation. This complacency has resulted in a resurgence of disease and untold unnecessary personal suffering. The Committee is concerned, after reviewing the Administration's funding level proposal, as set forth in their hearing testimony and their bill (Senate Bill 1756), that this lesson has not been learned well. We are particularly concerned that while measles, rubella, and polio are at their lowest points ever, too much of the population is not protected against these diseases and a relaxation of our national commitment to support efforts to immunize children will have dire, totally preventable, consequences. This also characterizes the Administration's commitment to tuberculosis control. In addition to not requesting appropriations for tuberculosis control project grants, the Administration is requesting that 314(d) public health formula grant funding be terminated as well. That program is the only existing source of Federal funding available to States to support tuberculosis control programs. Rather than turn our attention away from tuberculosis, the committee believes we should seize the opportunity to accelerate the decline and eventual eradication of this disease.

2. The second lesson is in many ways the most critical, and is certainly one that experience has taught time after time. The control of communicable disease is not and should not be solely the responsibility of State and local governments. They cannot do the job alone and communicable disease does not recognize State boundaries. The prolonged debate over the appropriateness of Federal help in controlling these diseases has been a key factor in many of our missed opportunities of the past. The Committee reiterates its conviction that States acting singly and according to their own financial capabilities and interests will not result in the control of these diseases.

3. The Center for Disease Control should strengthen its role in providing leadership in achieving the national elimination of preventable diseases and conditions. Its full technical and personnel capabilities should be mobilized to achieve this goal. This will necessitate support of on-going disease control programs and the ability to respond to disease outbreaks and health emergencies which, by their unpredictable nature, few States are equipped to address. In testimony before the Committee, the Association of State and Territorial Health Officers testified to the effectiveness of the CDC system of assigning personnel, upon request, to the States to assist them in carrying out disease control programs and in responding to disease outbreaks and health emergencies. The Committee supports and wages the continuation of that unique and effective approach to Federal/State cooperation.

4. Finally, the challenge before us is not solely to apply all available technology to the job of controlling communicable diseases, and to ensure this through sustained leadership at the national level, but to use this approach to eliminate or ameliorate other diseases and conditions which are susceptible to reduction through organized community programs. As we as a nation address inequities in the quality and accessibility of health care services, we must invest appropriate resources in the prevention of disease, disability, and premature death. Some preventive health services can be delivered on a personal, one-to-one, basis in the health care system, and can be financed accordingly. Other preventive health services, such as the types of programs carried out in the areas of disease control, including health education, must be carried out on a communitywide and nationwide basis, and financed accordingly. It is the Committee's conviction that preventive health programs are essential to improving the health of the American people, and they will be a major factor in containing cost and improving the quality of health services. Senate Bill 1466 as reported by the Committee is intended to lay the groundwork for an expanded effort in disease prevention.

#### TITLE II

1. The Committee recognizes that epidemic venereal disease is still very much a problem. The magnitude of the problem of venereal disease, with its particular inability to recognize state boundaries, and the unique social implications of venereal disease, the Committee believes necessitates a separate categorical program to attack the problem. The combined reported incidence of infectious syphilis and gonorrhea has risen to an unprecedented level of nearly 900,000 cases annually. Evidence suggests that the actual incidence level, which includes those cases of venereal disease that are not reported to public health authorities, is much greater. While this level of disease poses a most serious threat to the health and welfare of the public, the Committee notes it is encouraging that efforts to control this epidemic have not been in vain. Specifically, gonorrhea, while still increasing is doing so at a smaller rate. In addition, infectious syphilis incidence has declined for the first time in six years. These positive indications are largely due to the various control and prevention activities—screening, contact tracing, information and education diligently pursued by public health authorities with the support and assistance

of the Center for Disease Control and the American Social Health Association, a voluntary agency—and achieved through a separate categorical program authorized in law. Furthermore, it is encouraging the Committee notes, that the National Institute of Allergy and Infectious Disease, through numerous research grants and awards in the area of venereal disease, is aggressively seeking to broaden our understanding of these conditions. The Committee hopes that the acquisition of such knowledge will someday permit the development of effective vaccines against the venereal diseases.

2. Title II of the Committee reported bill, based on legislation authored by Senator Javits (S. 1454), would continue to authorize essentially the same sound public health approach (research, technical assistance, pilot and demonstration projects, improved clinical services, prevention and control activities such as screening, contact tracing, and public information and education) to the VD problem as in the past three years. In addition, this title would redefine the term "venereal disease", as provided in S. 1454, to include all sexually transmitted diseases that are of public health significance. To continue to ignore these other serious diseases would tend to foster the same condition that originally permitted gonorrhea to reach epidemic proportions.

3. It is the findings of this committee that the authorities created by this bill stem from and support a sound and logical public health approach to the venereal disease epidemic. The committee notes with some dismay that not all of the authorized resources available to combat these diseases were utilized during the past three fiscal years. The Committee urges that serious consideration be given to employing all authorities and means available to prevent and control venereal disease in the three fiscal years covered by this bill.

#### TITLE III

1. The Committee was impressed the important and often crucial role the individual can play in maintaining his own health, a role rarely clearly explained or adequately described.

2. Similarly, the Committee believes that while the need and demand for health care services have been rising, health education and promotion has been neglected. Many, perhaps the major causes of sickness and death can be affected, certainly prevented, by moderating self-imposed risks. This could be greatly facilitated if the field of health education were not so fragmented, uneven, and lacking a focal point. Until quite recently, no agency inside or outside of government has been responsible for, or assists in setting goals, developing national policy, maintaining criteria of performance of measuring results.

3. The Committee focused on nutrition as a major area of concern, recognizing that what is taught to children about this subject is inadequate. Nutrition studies reveal that teenagers often damage their health through poor eating habits. One researcher has pointed out that if intervention to modify coronary risks is put off until adulthood, it is too late. Such risks are directly related to nutrition. The Committee considers nutrition education an important feature of the reported bill and intends that nutritionists will affect the policy

direction of both the Office of Consumer Health Education and Promotion and the Center for Health Education and Promotion. The Committee looks for guidance in this endeavor to the Select Committee on Nutrition and Human Needs. A nutrition education proposal will be the subject of Senate hearings in September 1975.

4. The Committee recognizes that over 88% of the people look to their physicians or rely upon television commercials for information about health. Evidence reveals that physicians are too busy to do an effective job in educating their patients and that too many television messages are primarily concerned with product promotion rather than with true consumer health education. Providers of care, including hospitals, do little to overcome deficiencies even though such programs of patient health education have proven to be cost effective. Neither voluntary health organizations nor insurance carriers (private or non-profit) have exploited fully their opportunities.

5. The Committee has reviewed research studies of patient and community health education programs and is encouraged by the results. The studies reveal that as a result of sound programs, morbidity and mortality, hospital days, emergency visits, and costs have been significantly reduced. Other evaluations showed the nutritional status and knowledge about other risk factors were markedly increased as a result of carefully developed programs. Such research is vitally necessary and will serve to determine the directional emphasis for policy design in both the Office and the Center.

6. The Committee was troubled by the lack of adequate data about the needs, attitudes, knowledge, and behavior of the American public regarding health. Through the reported bill the Committee directs the National Center for Health Statistics to make continuing surveys to obtain such information.

7. The Committee recognizes the need for adequately trained health education practitioners who will be engaged in health education teaching research and in health education practice. Emphasis should be placed on raising the level of training given to those who will enter the field of health education practice. Additionally, support should be given to those who are engaged in theoretical research in the field of health education and promotion since it is this group who develop the conceptual frameworks from which sound practice derives. Short-term continuing education programs should also be included to upgrade skills of a variety of health providers, including doctors, nurses, educational specialists, and mid-level health practitioners.

8. The proposed creation of an Office of Health Education in the Department of Health, Education, and Welfare is not intended by the Committee to reflect negatively upon the efforts of the new Bureau of Health Education in the Center for Disease Control which was assigned initial responsibility for developing a health education focus but rather to emphasize the Committee's concern with the need for greater focus and commitment by the Department of Health, Education, and Welfare. The Bureau, in its ten months of existence with very limited resources in terms of both budget and personnel, has made many important contributions both within and outside the Federal structure, including support and leadership in the development of a private-sector National Center for Health Education, the initiation of cooperation among Federal agencies in pursuit of common health education objectives, and the development of innovative health

education projects. The proposed Office of Consumer Health Education and Promotion may very well rely upon the Center for Disease Control as well as the other organizations in HEW that are responsible for health education activities to execute the programmatic aspects of health education but the Committee believes a higher level focus, as provided in the Committee reported bill, is essential.

9. The Committee considered S. 544 with a view to including this Comprehensive School Health Education provision to S. 1466. The Committee recognizes that S. 544 is essential legislation if a meaningful preventive program to improve the health of the American people is to be a reality. A portion of S. 544, accordingly, has been included in S. 1466. The language establishes a program of grants to local education agencies and institutions for inservice education opportunities for elementary and secondary school teachers in a broad scope of health education areas.

10. The Committee recognizes that dental caries is the most prevalent disease in the United States and one of the most costly of all chronic diseases. By age two, approximately one-half of the children of this nation have experienced tooth decay. By age fifteen, the average child has eleven decayed, missing, or filled teeth. Section 1718 of the Committee reported bill therefore provides a modest authorization for communities voluntarily wishing to seek partial federal assistance in order to fluoridate their water supplies, which is a proven effective health prevention methodology.

11. The Committee considered who should serve as members of the Board of Directors for the publicly chartered, private Center for Health Education and Promotion. A sampling of these have been listed in an earlier part of this report as a guide for the President in selecting a Board representative of the prerequisite skills, competencies and disciplines necessary for fulfillment of the Committee's objectives, as provided in the reported bill.

12. The Committee has determined that current funding levels for health education programs are grossly inadequate by every measure applied, including comparison with total U.S. health care expenditures, the Federal health budget, individual hospital budgets, the cost of individual programs, and—most dramatically—by comparison with the advertising budgets of over-the-counter drugs. Health education expenditures, as a percentage of national health expenditures or individual hospital budgets are in the order of magnitude of one-fourth to one-half of one percent, which the Committee believes is not sufficient to do the job.

13. While the effectiveness of health education as a whole is widely debated, the Committee believes that there is now evidence from a number of studies that well-designed programs, incorporating the various elements of health education included in the reported bill definition, can be effective in producing desired behavior change if accompanied by national policies and mass communications programs designed to reinforce, rather than undermine, the educational goals.

14. Authorizations of appropriations in the Committee reported bill have been consistently reduced from the bills as introduced and upon which the reported has been based. Committee action in this regard is not intended to express the need for funding of such programs but rather to provide realistic funding levels in line with congressional appropriations.



## VII.—ADMINISTRATION VIEWS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,  
July 16, 1975.

HON. HARRISON A. WILLIAMS, JR.,  
Chairman, Committee on Labor and Public Welfare,  
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your requests of April 23 and 24 for reports on S. 1466, a bill "To amend the Public Health Service Act to extend and revise the program of assistance for the control and prevention of communicable diseases," to be cited as the "Disease Control Amendments Act of 1975;" and S. 1454, a bill "To revise and extend the Public Health Service Act, and for other purposes," to be cited as the "National Venereal Disease Prevention and Control Amendments, 1975."

S. 1466 would amend the Public Health Service Act to expand the scope of the present section 317 by eliminating the word communicable each time it appears, and to authorize grants for control of "other conditions," rodent control and lead poisoning control. Project grant funds are authorized to be appropriated in the amount of \$111 million for the fiscal year ending June 30, 1976, and for each of the next two succeeding fiscal years. For each of these fiscal years there are authorized \$11 million for tuberculosis control; \$25 million for vaccine-preventable diseases; \$35 million for rodent and lead poisoning control; and \$40 million for other diseases or conditions (except those already specified). In addition, it continues the appropriation ceiling of \$5 million for health emergencies for the fiscal year ending June 30, 1976, and for each of the next two succeeding fiscal years.

The bill also provides that nonprofit organizations which received grants during 1975 for rat control and lead based paint project grants will be eligible for continuation.

The bill defines a disease control program as a program which is designed and conducted so as to contribute to national protection against tuberculosis, rubella, measles, Rh disease, poliomyelitis, diphtheria, tetanus, whooping cough, mumps, diabetes mellitus, lead poisoning, rodent infestations, or other diseases or conditions (other than venereal disease) which are amenable to reduction, and are determined by the Secretary to be of national significance. The definition includes vaccination programs, casefinding programs, public and professional education programs, other preventive health programs, laboratory services, and studies to determine the communicable disease control needs of States and political subdivisions of States and the means of best meeting their needs.

S. 1454 would amend section 318 of the Public Health Service Act to extend the authorization for grants for the prevention and control of venereal diseases. The proposed legislation reauthorizes and extends grants for venereal disease control and authorizes a total of \$87 million for grants for the fiscal year ending June 30, 1976, and for each of the four succeeding fiscal years. Of this total \$12 million is authorized for project grants for research, demonstration, and training for each fiscal year through 1980; \$30 million is authorized for formula grants for venereal disease diagnostic and training services for each fiscal year through 1980; and \$45 million is authorized for project grants for con-

trol programs each fiscal year through 1980. The bill adds a new section 318(i), which defines venereal disease as syphilis and gonorrhea and any other sexually transmitted diseases which the Secretary finds to be of national significance and which, with respect to project grants under 318(d), is amenable to control. A new subsection is added to section 318(c), formula grants for venereal disease diagnostic and treatment services, to require that recipients of grants provide to the extent feasible diagnostic and treatment services for a wide range of gastro-urinary conditions. It also eliminates the requirement that grantees provide darkfield microscopic techniques for diagnosis of both syphilis and gonorrhea.

In addition, section 318(d) is expanded to add to the list of supportable activities routine testing, including attendant laboratory and follow-up system costs. It also changes the purpose of special studies and demonstrations from evaluation of control to evaluation of prevention and control strategies and activities. The bill also adds nonprofit private entities as eligible recipients for technical assistance.

As Dr. Cooper testified on May 7, 1975, the Department opposes enactment of these two bills. First, we oppose the continuation of separate categorical grant authorities. The two bills would extend seven different categorical grant authorization ceilings from three to five fiscal years. The establishment of several legislative authorities causes considerable hardship on State and local health agencies trying to carry out well balanced, effective preventive programs and continues to make Federal assistance unnecessarily complicated. In addition, we strongly oppose the funding authorizations in S. 1466 and S. 1454 which, at \$203 million per year, are nearly six times the President's budget request of \$34 million for 1976. The appropriation authorizations should recognize the demonstration nature of Federal lead and rat-control project grants and place greater reliance on the discretion and capabilities of State and local governments and the private sector in disease control. Federal spending commitments must be consistent with the need to reduce Federal spending and to generate increased commitment to these programs by State and local governments.

We therefore recommend against enactment of these bills. We recommend, instead, enactment of S. 1756 introduced by Senator Schweiker on behalf of the Administration. The bill combines sections 317 and 318 into a single authority and authorizes amounts adequate to meet program objectives.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program and that enactment of S. 1466 and S. 1454 would not be consistent with the Administration's objectives.

Sincerely,

CASPAR W. WEINBERGER,  
Secretary.

## VIII. COST ESTIMATE

The Committee's bill include authorization for:

1976-----	\$83, 000, 000
1977-----	95, 000, 000
1978-----	121, 000, 000

279.

## IX. TABULATION OF VOTES CAST IN COMMITTEE

Pursuant to section 133(b) of the Legislative Reorganization Act of 1946, as amended, the following is a tabulation of votes in Committee:

Motion to report the measure to the Senate carried unanimously.

## X. A SECTION-BY-SECTION ANALYSIS

## TITLE I—DISEASE CONTROL

## SHORT TITLE

Sec. 101 states that this title may be cited as the "Disease Control Amendments Act of 1975".

## AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT

Subsection 102(a) amends subsection (a) of section 317 of the Public Health Service Act (42 U.S.C. 247b) by—

- (1) inserting "project" before "grants" in the first sentence;
- (2) inserting "project" before "grant" each time it appears;
- (3) striking "communicable" each time it appears in the second sentence;
- (4) inserting "or conditions" after "diseases" in the second sentence; and
- (5) striking "disease" in the second sentence.

Subsection 102(b)(1) amends subsection (b) of such section by inserting "project" before "grant" each time it appears.

Subsection 102(b)(2) amends subsection (b)(2)(B) of such section by—

- (A) inserting "or conditions" after "diseases";
- (B) striking "of the importance of immunization against such diseases, to encourage such persons to seek appropriate immunization and to facilitate access by such persons to immunization services" and inserting in lieu thereof "including the methods and services available to prevent these diseases or conditions".

Subsection 102(b)(3) provides that the amendment made by paragraph (2) shall be effective for fiscal years beginning after June 30, 1975.

Subsection 102(c) amends subsection (b)(2)(C) of such section by—

- (1) striking "communicable" each time it appears;
- (2) inserting "or condition" after "disease" the first time it appears; and
- (3) striking "disease" the second time it appears and inserting in lieu thereof "related".

Subsection 102(d)(1) amends subsection (c) by inserting "project" before "grant" each time it appears.

Subsection 102(d)(2) amends subsection (c)(2) of such section by inserting before the period at the end thereof, and such amount shall be deemed as part of the grant and deemed to have been paid to the recipient".

Subsection 102(e) amends subsection (f)(1) of such section by—

- (1) striking "communicable";
- (2) inserting "or conditions" after "disease"; and
- (3) inserting "project" after "grants" each time it appears.

Subsection 102(f) amends subsection (g) of that section by—

- (1) inserting "or conditions" after "diseases" in clauses (1) and (2), and
- (2) inserting "and conditions" after "diseases" in clauses (3) and (4).

Subsection 102(g) amends subsection (h)(1) to read as follows:

"(1) The term 'disease control program' means a program which is designed and conducted so as to contribute to national protection against tuberculosis, rubella, measles, Rh disease, poliomyelitis, diphtheria, tetanus, whooping cough, mumps, diabetes mellitus, or other disease or conditions (other than venereal disease) which are amenable to reduction, and are determined by the Secretary to be of national significance. Such term includes vaccination programs, case-finding programs, public and professional education programs, other preventive health programs, laboratory services, and studies to determine the communicable disease control needs of States and political subdivisions of State and the means of best meeting such needs."

Subsection 102(h) amends (i) of such section by—

- (1) striking "communicable"; and
- (2) inserting "project" before "grants".

Subsection 102(i) is amended by adding after subsection (i) the following new subsection:

"Subsection 102(j) provides that for the purpose of payments pursuant to project grants and contracts under section 317 of the Act there are authorized to be appropriated \$30,000,000 for the fiscal year ending June 30, 1976, \$35,000,000 for the fiscal year ending June 30, 1977, and \$40,000,000 for the fiscal year ending June 30, 1978."

## TITLE II—VENEREAL DISEASE

Sec. 201 states that this title may be cited as the "National Venereal Disease Prevention and Control Amendments of 1975."

## FINDINGS AND DECLARATION OF PURPOSE

Subsection 202(a) states that the Congress finds and declares that—

- (1) the number of reported cases of venereal disease continues in epidemic proportions in the United States;
- (2) the number of patients with venereal disease reported to public health authorities is only a fraction of those actually infected;
- (3) the incidence of venereal disease is particularly high in the 15-29-year age group, and in metropolitan areas;
- (4) venereal disease accounts for needless deaths and leads to such severe disabilities as sterility, insanity, blindness, and crippling conditions;
- (5) the number of cases of congenital syphilis, a preventable disease, tends to parallel the incidence of syphilis in adults;

(6) it is conservatively estimated that the public cost of care for persons suffering the complications of venereal disease exceed \$80,000,000 annually;

(7) medical researchers have no successful vaccine for syphilis or gonorrhea, and have no blood test for the detection of gonorrhea among the large reservoir of asymptomatic females;

(8) school health education programs, public information and awareness campaigns, mass diagnostic screening and case followup activities have all been found to be effective disease intervention methodologies;

(9) knowledgeable health providers and concerned individuals and groups are fundamental to venereal disease prevention and control;

(10) biomedical research leading to the development of vaccines for syphilis and gonorrhea is of singular importance for the eventual eradication of these dreaded diseases; and

(11) a variety of other sexually transmitted diseases, in addition to syphilis and gonorrhea, have become of public health significance.

Subsection 202(b) states that in order to preserve and protect the health and welfare of all citizens, it is the purpose of this Act to establish a national program for the prevention and control of venereal disease.

Subsection 203(a) amends subsection 318(a) of the Public Health Service Act (42 U.S.C. 247c) by inserting "and nonprofit private entities" after "authorities".

Subsection 203(b) amends subsection 318(b)(1) of such Act by inserting "which will contribute to national objectives" after "training".

Subsection 203(c) amends subsection 318(b)(2) of such Act by inserting before the period at the end thereof "and \$5,000,000 for the fiscal year ending June 30, 1976, \$5,000,000 for the fiscal year ending June 30, 1977, and \$5,000,000 for the fiscal year ending June 30, 1978".

Subsection 203(d) amends subsection 318(c)(1) of such Act by adding at the end thereof "and \$5,000,000 for the fiscal year ending June 30, 1976, and \$10,000,000 for the fiscal year ending June 30, 1977, and \$15,000,000 for the fiscal year ending June 30, 1978".

Subsection 203(e) amends subsection 318(e)(2)(C) of such Act by striking "(including dark-field microscope techniques for the diagnosis of both gonorrhea and syphilis)".

Subsection 203(f). Paragraphs (D), (E), (F), (G), and (H) of section 318(c)(2) of such Act are redesignated as (E), (F), (G), (H), and (I), and the following new paragraph is inserted after paragraph (C) as follows:

"(D) to the extent feasible as determined by criteria developed by the Secretary, the provision of clinical services for persons affected with venereal disease which includes diagnosis and care for persons with a wide range of genitourinary diseases and conditions, which, because of their symptoms and clinical presentations, are commonly present in persons with actual or suspected venereal disease;"

Subsection 203(g) amends subsection 318(d)(1)(B) of such Act by inserting before the semicolon at the end thereof the following: "and routine testing, including attendant laboratory and followup systems costs thereof".

Subsection 203(h) amends subsection 318(d)(1)(D) of such Act by inserting "targeted" before "professional".

Subsection 203(i) amends subsection 318(d)(1)(E) of such Act by striking "control" and inserting in lieu thereof "prevention and control strategies or activities".

Subsection 203(j) amends subsection 318(d)(2) of such Act by inserting before the period at the end thereof "and \$31,000,000 for the fiscal year ending June 30, 1976, \$33,000,000 for the fiscal year ending June 30, 1977, and \$36,000,000 for the fiscal year ending June 30, 1978".

Subsection 203(k) amends subsection 318(h) of such Act by striking "treated or to have any child or ward of his".

Subsection 203(l) amends section 318 of such Act by adding at the end thereof the following:

"(m) As used in this section, the term 'venereal disease' means syphilis and gonorrhea and any other sexually transmitted disease which the Secretary finds to be of national significance and which, with respect to grants under subsection (d), the Secretary finds to be amenable to control."

### TITLE III—HEALTH EDUCATION AND PROMOTION

#### SHORT TITLE

SEC. 301 states that this title may be cited as the "National Consumer Health Education and Promotion Act of 1975".

#### AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT

SEC. 302 amends the Public Health Service Act by adding after title XVI the following new title:

"TITLE XVII—OFFICE OF CONSUMER HEALTH EDUCATION AND PROMOTION AND THE CENTER FOR HEALTH EDUCATION AND PROMOTION

"PART A—OFFICE OF CONSUMER HEALTH EDUCATION AND PROMOTION

"ESTABLISHMENT OF OFFICE OF CONSUMER HEALTH EDUCATION AND PROMOTION

"SEC. 1701. (a) Establishes in the Department of Health, Education, and Welfare the office of Consumer Health Education and Promotion (hereafter in this Act referred to as the 'Office') which shall be under the direction of a Director who shall be appointed by the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the 'Secretary') and supervised by the Assistant Secretary for Health (or such other officer of the Department as may be designated by the Secretary as the principal adviser to him for health programs),"

Subsection 1702(b) provides that the Office, in order to facilitate the development of health education and promotion strategy for the Nation, shall carry out the following functions: Engage in research in health education programs, stimulate and coordinate communications in health education, and overview and coordinate Federal programs.

## GENERAL AUTHORITY

Sec. 1702 provides that the Secretary, acting through the Office shall—

(1) design and implement national goals and strategies with respect to health education and promotion;

(2) determine health education and promotion needs and resources, and recommend appropriate educational certifying policies for health education and promotion manpower;

(3) incorporate appropriate health education and promotion strategies into every facet of our society and increase the application of health knowledge, skills, and practices by the general population in their patterns of daily living;

(4) increase the effectiveness and efficiency of health education and promotion programs through improved planning, implementation of tested models, and evaluation of results;

(5) establish systematic processes for the exploration, development, demonstration, and evaluation of innovative health education concepts; and

(6) foster information exchanges and cooperation among health education providers, consumers, and supporters.

The Secretary shall carry out this title in a manner consistent with the national health priorities set forth in section 1502 of the Public Health Service Act and with activities undertaken under title XV of the Public Health Service Act (relating to health planning and development).

## SPECIFIC FUNCTIONS

## Research Programs

Subsection 1703(a)(1) provides that the Secretary shall by grants and contracts to public or nonprofit private entities conduct and support research in health education and promotion in the manner described in this subsection.

Subsection 1703(a)(2) provides that the Secretary in carrying out his responsibilities under this section, shall use the findings of the continuing surveys of the needs, interests, attitudes, knowledge, and behavior of the American public regarding health as conducted by the National Center for Health Statistics as a basis for formulating policy with respect to health education and promotion.

## Community Programs

Subsection 1703(b)(1) provides that the Secretary shall support and encourage innovative programs in health education and promotion in the manner described in this subsection.

Subsection 1703(b)(2)(A) provides that the Secretary is authorized to make grants and contracts to public or nonprofit private entities for the purpose of developing programs of health care education for a defined geographic region pursuant to and in accordance with those established in section 1511 of the Public Health Service Act and with activities undertaken under title XV of the Public Health Service Act (relating to health planning and development). In awarding such grants and contracts the Secretary shall assure an equitable geographic and demographic distribution of all funds appropriated.

Subsection 1703(b)(2)(B) provides that projects which receive Federal funds under this subsection shall—

(1) utilize in a coordinated manner such health education methods as may be appropriate to provide effective health education services to the population of the applicable region; and

(2) evaluate the effectiveness of each health education method utilized and identify its particular advantages or disadvantages.

## Health Education Training

Subsection 1703(c) provides that the Secretary acting through the Director is authorized to make grants and contracts to public or nonprofit private entities to provide for the training for health personnel in health education and promotion.

## School Health Education Training

Subsection 1703(d)(1) provides that the Secretary acting through the Director may make grants to local educational agencies and institutions of higher education for teacher training with respect to the provision of comprehensive health education programs in schools. The subsection describes the manner in which such grants may be used, and the scope of the term 'health education and health problems' for purposes of this subsection.

Subsection 1703(d)(2) provides that the Director, in exercising authority with respect to (a) determination of criteria for the selection of grants, and (b) selection of grants from eligible applicants, shall consult with, and obtain the approval of, the Commissioner of Education.

Subsection 1703(d)(3) provides that in establishing criteria for the award of grants under this section, such criteria must include priority for applications for support of programs which provide: (1) inservice rather than preservice training, except in such cases where an applicant has demonstrated that: (A) inservice training is not practicable, and (B) reasonable opportunity exists for persons undergoing preservice training to obtain positions in which they shall apply such training, and (2) training of persons who, as a result of such training, will have as their major responsibility, work in health education in schools.

## Requirements Applicable to Providers of Institutional Care

Subsection 1703(e) provides that the Secretary may not approve an application of any health care facility for a grant or contract under the Public Health Service Act or the Community Mental Health Centers Act for a fiscal year beginning after the date of enactment of this act unless the application contains or is supported by assurances satisfactory to the Secretary that, during the period for which the assistance is applied is to be made available, the applicant will provide such consumer health education for individuals receiving inpatient or outpatient services through such health care facility as the Secretary shall by regulation prescribe.

## Communications in Health Education and Promotion

Subsection 1703(f) provides that the Secretary shall establish liaison with the Office, providers of health education services, and the communications media and prescribes the manner in which the Secretary shall effect such liaison.

This subsection also provides that in the case where materials are developed, through activities funded under this title and/or through activities of the Office and where the materials have commercial value, the moneys which result from the license, sale, rent, grant or other transaction of said materials shall be paid into the public treasury. The Director with consultation of the Secretary shall determine the fair market value of such materials and shall have the authority to authorize such transactions.

## Federal Programs

Section 1703(g) provides that the Secretary, in conjunction with the Interdepartmental Committee on Consumer Health Education and Promotion established by section 1704, shall make recommendations to the Congress for the inclusion in appropriate legislation of provisions respecting health education and promotion. The Secretary shall—

(1) promote the coordination, communication, and collaboration of health education and promotion programs within the Department of Health, Education, and Welfare;

(2) establish a liaison with other Federal agencies engaged in health education and promotion, including the Consumer Product Safety Commission, the Department of Agriculture, the Environmental Protection Agency, the Department of Transportation, and the Defense; and

(3) identify and make public those Federal programs and actions which are not in the interest of public health and determine methods for reviewing and commenting on such programs and actions as identified pursuant to section 1704(d).

## Interdepartmental Committee on Consumer Health Education and Promotion

Subsection 1704(a) establishes an Interdepartmental Committee on Health Education and Promotion (hereinafter referred to in this section as the "Committee") which shall be responsible for overview and coordination of all Federal programs and activities relating to health education and promotion to assure the adequacy and effectiveness of such programs and activities and to provide for the communication and exchange of information necessary to promote these functions.

Subsection 1704(b) provides that the Secretary or his designee shall serve as Chairman of the Committee, and prescribes the membership of the Committee.

Subsection 1704(c) provides that the Committee shall meet at the call of the Chairman, but not less often than four times a year.

Subsection 1704(d) provides that the Committee shall identify Federal programs and actions which are not in the interest of public health and determine methods for reviewing and commenting on

such programs and actions, including recommendations for legislation and administrative action within the executive branch.

Subsection 1704(e) provides that the Secretary shall provide the Committee with such full-time professional and clerical staff, information, other support, and the services of such consultants as may be necessary to assist in carrying out effectively its functions under this section.

## Advisory Council

Subsection 1705(a) establishes the Consumer Health Education and Promotion Advisory Council to be appointed by the Secretary, prescribes its make-up, and terms and conditions of membership. This subsection also provides that the Secretary may appoint, in addition, special advisory and technical committees.

Subsection 1705(b) provides that it shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to the functions of the Office. The Advisory Council shall make an annual report to the Secretary and to the Congress on the performance of its functions, including any recommendations it may have with respect thereto.

Subsection 1705(c) provides that the Advisory Council is authorized to engage such technical assistance and receive such additional support as may be required to carry out its functions.

## Reports

Subsection 1706(a) provides that the Secretary shall make an annual report (not later than December 1 of each year except in the year this title is enacted into law) to the Congress on the activities and policy recommendations of the Office.

Subsection 1706(b) provides that the Secretary, acting through the Office, shall assemble and submit to the President and the Congress not later than December 1 of each year—

(1) a report of the activities, findings, and recommendations of the Office, and

(2) recommendations, based on the findings and recommendations of the Office, and the Interdepartmental Committee on Consumer Health Education and Promotion for legislation and administrative action within the executive branch.

Subsection 1706(c) provides that the Office of Management and Budget may review any report, recommendations or submission made by the Secretary, the committee, or the Advisory Council in regard to this Act before its submission to the Congress, but the Office of Management and Budget may not revise the report or delay its submission, and it may submit to the Congress its comments (and those of other departments or agencies of the Government) respecting such submission.

## Authorization of Appropriations

Sec. 1707 provides that to carry out this title there are authorized to be appropriated \$11,000,000 for the fiscal year ending June 30, 1976; \$11,000,000 for the fiscal year ending June 30, 1977, and \$24,000,000 for the fiscal year ending June 30, 1978.

**PART B—CENTER FOR HEALTH EDUCATION AND PROMOTION**

**Congressional Declaration of Policy**

Sec. 1708 states that the Congress finds and declares that—

- (1) it is in the public interest to inform the public about health and about ways to best protect and improve personal health;
- (2) the public must develop the ability to examine, and weigh consequences of personal decisions respecting health;
- (3) the public must be motivated to desire changes supportive of more healthful lifestyles;
- (4) impediments that inhibit the voluntary adoption and maintenance of more healthful practices by the public must be identified and mitigated or removed;
- (5) to achieve these goals it is necessary for the Federal Government to complement, assist, and support a national policy that will advance the national health, reduce preventable illness, disability, and death, moderate self-imposed risks, and promote progress and scholarship in consumer health education and promotion; and
- (6) a private corporation should be created to facilitate the development of a health education and promotion strategy for the Nation.

**Board of Directors**

Subsection 1709(a) provides that the Center shall have a Board of Directors consisting of twenty-five members appointed by the President, by and with the advice and consent of the Senate.

Subsection 1709(b) prescribes the methods of selecting board members, who shall serve as incorporators, and shall develop a non-profit corporation within sixty days from the effective date of this title.

Sec. 1710 provides that the members of the Committee shall serve as first members of the Board, and prescribes the terms and conditions of Board membership.

**Officers and Employees**

Subsection 1711(a) provides that the Center shall have a President, and such other officers as may be named and appointed by the Board for terms and at rates of compensation fixed by the Board, and prescribes the terms and conditions of employment for such officers.

**Nonprofit and Nonpolitical Nature of the Center**

Subsection 1712(a) provides that the Center shall have no power to issue any shares of stock or to declare or pay any dividends.

Subsection 1712(b) provides that no part of the income or assets of the Center shall inure to the benefit of any director, officer, employee, or any other individual except as salary or reasonable compensation for services.

Subsection 1712(c) provides that the Center may not contribute to or otherwise support any political party or candidate for elective public office.

**Functions**

Subsection 1713(a) prescribes the functions that the Center shall carry out to facilitate the development of a health education and promotion strategy for the Nation.

Subsection 1713(b) provides that the Center in carrying out its functions under this section may prescribe such regulations as it deems necessary.

**Advisory Panel**

Sec. 1714 provides that the Board shall appoint an advisory panel comprised of one hundred individuals with appropriate competencies and abilities. The principal function of the advisory panel shall be to provide advice for members of the Board. Additionally, it shall serve as a primary source for appointments to special committees, task forces, and conferences. The advisory panel shall receive all Center reports.

**Report to Congress**

Sec. 1715 provides that the Center shall submit an annual report to the President for transmittal to the Congress. The report shall include a comprehensive and detailed report of the Center's operations, activities, financial condition, and accomplishments under this title and may include such recommendations as the Center deems appropriate.

**Financing**

Subsection 1716(a) provides that there are authorized to be appropriated to the Center for the purposes of carrying out the functions enumerated in section 1716 of this Act \$1,000,000 for fiscal year ending June 30, 1976; \$1,000,000 for the fiscal year ending June 30, 1977; and \$1,000,000 for the fiscal year ending June 30, 1978.

Subsection 1716(b) provides that in addition to the sums authorized to be appropriated by paragraph (a) of this subsection, the Center is authorized to receive income, grants, donations, bequests, or other contributions from non-Federal sources.

**Records and Audits**

Sec. 1717 provides that the accounts of the Center shall be audited annually, and prescribes the method and content of such audits.

**Grants for Water Treatment Programs**

Subsection 1718(a) authorizes appropriations of \$2,000,000 for the fiscal year ending June 30, 1976; \$3,000,000 for the fiscal year ending June 30, 1977; and \$4,000,000 for the fiscal year ending June 30, 1978; which shall be used by the Secretary to make grants to States, political subdivisions of States, and other public or nonprofit private agencies, organization, and institutions to assist them in initiating water treatment programs designed to reduce the incidence of oral disease or dental defects among residents of communities or the students in elementary and secondary schools.

Subsection 1718(b) provides that grants under this section may be utilized for (but are not limited to) the purchase and installation of water treatment equipment.

#### Definitions

Sec. 1719 defines health education and promotion as—

“(A) ‘Health education and promotion’ is a process that favorably influences understandings, attitudes, and conduct, including cultural awareness and sensitivity, in regard to individual and community health. Specifically, it affects and influences individual and community health behavior and attitudes in order to moderate self-imposed risk, maintain and promote physical and mental health and efficiency, and reduce preventable illness, disability, and death.”

#### Technical Amendments

Subsection 303(a) amends subsection (c) of section 306 of the Public Health Service Act by redesignating subsection (c)(2), and inserting a new subsection (c)(2) immediately preceding subsection (c)(2), to read as follows:

“(c)(1) The Center shall make a continuing survey of the needs, interests, attitudes, knowledge, and behavior of the American public regarding health. The Center shall transmit the findings of such surveys and of the findings of similar surveys contracted for or otherwise obtained by the Center and conducted by national health education organizations and community health education organizations accompanied by appropriate Center analysis, if any, to the Secretary, the Assistant Secretary for health, and to the Office of Consumer Health Education and Promotion for their use in formulating policies respecting health education and promotion.”

Subsection 303(b) amends subsection (i) of section 308 of the Public Health Service Act by adding the following new paragraph (3) after paragraph (2):

“(3) Of those sums appropriated by Congress under section 308 of the Act not less than \$1,000,000 for the fiscal year ending June 30, 1976, \$1,000,000 for the fiscal year ending June 30, 1977, and \$1,000,000 for the fiscal year ending June 30, 1978, shall be made available to carry out the activities of section 306(c)(1).”

#### XI. CHANGES IN EXISTING LAW

In compliance with subsection (4) of Rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill as repeated are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

### PUBLIC HEALTH SERVICE ACT

#### TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

##### GRANTS FOR VACCINATION PROGRAMS AND OTHER COMMUNICABLE DISEASE CONTROL PROGRAMS

SEC. 317. (a) The Secretary may make *project* grants to States and, in consultation with the State health authority, to agencies and political subdivisions of States to assist in meeting the costs of [communicable] disease control programs. In making a *project* grant under this section, the Secretary shall give consideration to (1) the relative extent, in the area served by the applicant for the grant, of the problems which relate to one or more of the [communicable] diseases or conditions referred to in subsection (h)(1), and (2) the design of the applicant's [communicable disease] program to determine its effectiveness.

(b) (1) No *project* grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Except as provided in paragraph (2), such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

(2) An application for a *project* grant for a fiscal year beginning after June 30, 1973, shall—

(A) set forth with particularity the objectives (and their priorities, as determined in accordance with such regulations as the Secretary may prescribe) of the applicant for each of the programs he proposes to conduct with assistance from a *project* grant under this section;

(B) contain assurances satisfactory to the Secretary that, in the fiscal year for which a *project* grant under this section is applied for, the applicant will conduct such programs as may be necessary to develop an awareness in those persons in the area served by the applicant who are most susceptible to the diseases or conditions referred to in subsection (h)(1) [of the importance of immunization against such diseases, to encourage such persons to seek appropriate immunization, and to facilitate access by such persons to immunization services] including the methods and services available to present these diseases or conditions; and

(C) provide for the reporting to the Secretary of such information as he may require concerning (i) the problems, in the area served by the applicant, which relate to any [communicable] disease or condition referred to in subsection (h)(1), and (ii) the [communicable disease] related control programs of the applicant.

(3) Nothing in this section shall be construed to require any State or any agency or political subdivision of a State to have a communicable disease control program which would require any person, who objects to any treatment provided under such a program, to be treated or to have any child or ward of his treated under such a program.

(c) (1) Payments under *project grants* under this section may be made in advance on the basis of estimates or by way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of this section.

(2) The Secretary, at the request of a recipient of a *project grant* under this section, may reduce such *project grant* by the fair market value of any supplies (including vaccines and other preventive agents) or equipment furnished to such recipient and by the amount of the pay, allowances, travel expenses, and any other costs in connection with the detail of an officer or employee of the Government to the recipient when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such recipient and for the purpose of carrying out the program with respect to which the *project grant* under this section is made. The amount by which any such *project grant* is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such *project grant* is based and such amount shall be deemed as part of the grant and deemed to have been paid to the recipient.

(d) (1) There is authorized to be appropriated \$11,000,000 for the fiscal year ending June 30, 1973, \$11,000,000 for the fiscal year ending June 30, 1974, and \$11,000,000 for the fiscal year ending June 30, 1975, for grants under this section for communicable disease control programs for tuberculosis.

(2) There is authorized to be appropriated \$6,000,000 for the fiscal year ending June 30, 1973, \$6,000,000 for the fiscal year ending June 30, 1974, and \$6,000,000 for the fiscal year ending June 30, 1975, for grants under this section for communicable disease control programs for measles.

(3) There is authorized to be appropriated \$23,000,000 for the fiscal year ending June 30, 1973, \$23,000,000 for the fiscal year ending June 30, 1974, and \$23,000,000 for the fiscal year ending June 30, 1975, for grants under this section for communicable disease control programs other than communicable disease control programs for which appropriations are authorized by paragraph (1) or (2).

(4) Not to exceed 50 per centum of the amount appropriated for any fiscal year under any of the preceding paragraphs of this subsection may be used by the Secretary for *project grants* for such fiscal year under (A) programs for which appropriations are authorized under any one or more of the other paragraphs of this subsection if the Secretary determines that such use will better carry out the purposes of this section, and (B) section 318.

(e) The Secretary shall develop a plan under which personnel, equipment, medical supplies, and other resources of the Service and other agencies under his jurisdiction may be effectively utilized to meet epidemics of, or other health emergencies involving, any disease referred to in subsection (h) (1). There is authorized to be appropriated to the Secretary \$5,000,000 for the fiscal year ending June 30, 1973, \$5,000,000 for the fiscal year ending June 30, 1974, and

\$5,000,000 for the fiscal year ending June 30, 1975; for costs incurred in succeeding fiscal years, for costs incurred in utilizing such resources in accordance with such plan.

(f) (1) Except as provided in section 318(g), no funds appropriated under any provision of this Act other than subsection (d) may be used to make *project grants* in any fiscal year for [communicable] disease or conditions control programs if (A) *project grants* for such programs are authorized by this section, and (B) all the funds authorized to be appropriated under that subsection for that fiscal year have not been appropriated for that fiscal year and obligated in that fiscal year.

(2) No funds appropriated under any provision of this Act other than subsection (e) may be used in any fiscal year for costs incurred in utilizing resources of the Service in accordance with a plan developed in accordance with that subsection if all the funds authorized to be appropriated under that subsection for that fiscal year have not been appropriated for that fiscal year and obligated in that fiscal year.

(g) The Secretary shall submit to the President for submission to the Congress on January 1 of each year a report (1) on the effectiveness of all Federal and other public and private activities in preventing and controlling the diseases or conditions referred to in subsection (h) (1), (2) on the extent of the problems presented by such diseases or conditions, (3) on the effectiveness of the activities, assisted under *project grants* under this section, in preventing and controlling such diseases and conditions, and (4) setting forth a plan for the coming year for the prevention and control of such diseases and conditions.

(h) For the purposes of this section:

[(1) The term "communicable disease control program" means a program which is designed and conducted so as to contribute to national protection against tuberculosis, rubella, measles, Rh disease, poliomyelitis, diphtheria, tetanus, whooping cough, or other communicable diseases (other than venereal disease) which are transmitted from State to State, are amenable to reduction, and determined by the Secretary to be of national significance. Such term includes vaccination programs, laboratory services, and studies to determine the communicable disease control needs of States and political subdivisions of States and the means of best meeting such needs.]

(1) The term "disease control program" means a program which is designed and conducted so as to contribute to national protection against tuberculosis, rubella, measles, Rh disease, poliomyelitis, diphtheria, tetanus, whooping cough, mumps, diabetes mellitus, or other diseases or conditions (other than venereal disease) which are amenable to reduction, and are determined by the Secretary to be of national significance. Such term includes vaccination programs, casefinding programs, public and professional education programs, other preventive health programs, laboratory services, and studies to determine the communicable disease control needs of States and political subdivisions of States and the means of best meeting such needs.

(2) The term "State" includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, the Virgin Islands, and the District of Columbia.



(i) Nothing in this section shall limit or otherwise restrict the use of funds which are granted to a State or to an agency or a political subdivision of a State under provisions of Federal law (other than this Act) and which are available for the conduct of [communicable] disease control programs from being used in connection with programs assisted through project grants under this section.

“(j) For the purpose of payments pursuant to project grants and contracts under section 317 of the Act there are authorized to be appropriated \$30,000,000 for the fiscal year ending June 30, 1976, \$35,000,000 for the fiscal year ending June 30, 1977, and \$40,000,000 for the fiscal year ending June 30, 1978.

PROJECTS AND PROGRAMS FOR THE PREVENTION AND CONTROL OF  
VENEREAL DISEASE

SEC. 318. (a) The Secretary may provide technical assistance to appropriate public authorities and nonprofit private entities and scientific institutions for their research, training, and public health programs for the prevention and control of venereal disease.

(b) (1) The Secretary is authorized to make grants to States, political subdivisions of States, and any other public or nonprofit private entity for projects for the conduct of research, demonstrations, and training which will contribute to national objectives for the prevention and control of venereal disease.

(2) For the purpose of carrying out this subsection, there is authorized to be appropriated \$5,000,000 for the fiscal year ending June 30, 1976, \$5,000,000 for the fiscal year ending June 30, 1977, and \$5,000,000 for the fiscal year ending June 30, 1978.

(c) (1) There is authorized to be appropriated, \$5,000,000 for the fiscal year ending June 30, 1976, \$10,000,000 for the fiscal year ending June 30, 1977 and \$15,000,000 for the fiscal year ending June 30, 1978, to enable the Secretary to make grants to State health authorities to assist the States in establishing and maintaining adequate public health programs for the diagnosis and treatment of venereal disease. For purposes of this subsection, the term “State” means each of the several States of the United States, the District of Columbia, the Virgin Islands, Guam, American Samoa, the Trust Territory of the Pacific Islands, and the Commonwealth of Puerto Rico.

(2) Any State desiring to receive a grant under this subsection shall submit to the Secretary a State plan for a public health program for the diagnosis and treatment of venereal disease. Each State plan shall—

(A) provide for the administration or supervision of administration of the State plan by the State health authority;

(B) set forth the policies and procedures to be followed in the expenditure of the funds paid to the State under this subsection;

(C) provide that the public health services furnished under the State plan will include the provision of Statewide laboratory services [including dark field microscope techniques for the diagnosis of both gonorrhea and syphilis], which services will be provided in accordance with standards prescribed by regulations, including standards as to the scope and quality of such services;

(D) to the extent feasible as determined by criteria developed by the Secretary, the provision of clinical services for the persons affected with venereal disease which includes diagnosis and care for persons with a wide range of genitourinary diseases and conditions, which, because of their symptoms and clinical presentations, are commonly present in persons with actual or suspected venereal disease;

[(D)] (E) contain or be supported by assurances satisfactory to the Secretary that (i) not less than 70 per centum of the funds paid to the State under this subsection will be used to provide and strengthen public health services in its political subdivisions for the diagnosis and treatment of venereal disease; (ii) such funds will be used to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided under this subsection and will not supplant any non-Federal funds which would otherwise be available for such purposes; and (iii) the plan is compatible with the total health program of the State;

[(E)] (F) provide that the State health authority will from time to time, but not less often than annually, review and evaluate its State plan approved under this subsection, and submit to the Secretary appropriate modifications thereof;

[(F)] (G) provide that the State health authority will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

[(G)] (H) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the State under this subsection; and

[(H)] (J) contain such additional information and assurances as the Secretary may find necessary to carry out the purposes of this subsection.

The Secretary shall approve any State plan and any modification thereof which meets the requirements of this paragraph.

(3) (A) Grants under this subsection shall be made from allotments to States made in accordance with this paragraph. For each fiscal year the Secretary shall, in accordance with regulations, allot the sums appropriated under paragraph (1) for such year among the States on the basis of the incidence of venereal disease in, and the population of, the respective States; except that no State's allotment shall be less than \$75,000 for any fiscal year.

(B) Any amount allotted to a State (other than the Virgin Islands, American Samoa, Guam, the Trust Territory of the Pacific Islands, and the Commonwealth of Puerto Rico) under subparagraphs (A) for a fiscal year and remaining unobligated at the end of such year shall remain available to such State, for the purposes for which made, for the next fiscal year (and for such year only), and any such amount shall be in addition to the amounts allotted to such State for such purpose for such next fiscal year; except that any such amount, re-

remaining unobligated at the end of the sixth month following the end of such year for which it was allotted, which the Secretary determines will remain unobligated by the close of such next fiscal year, may be reallocated by the Secretary, to be available for the purposes for which made until the close of such next fiscal year, to other States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this subsection, and any amount so reallocated to a State shall be in addition to the amounts allotted and available to the States for the same period. Any amount allotted under subparagraph (A) to the Virgin Islands, American Samoa, Guam, the Trust Territory of the Pacific Islands, or the Commonwealth of Puerto Rico for a fiscal year and remaining unobligated at the end of such year shall remain available to it for the purposes for which made, for the next two fiscal years (and for such years only), and any such amount shall be in addition to the amounts allotted to it for such purposes for each of such next two fiscal years; except that any such amount, remaining unobligated at the end of the first of such next two years, which the Secretary determines will remain unobligated at the close of the second of such next two years, may be reallocated by the Secretary, to be available for the purposes for which made until the close of the second of such next two years, to any other of such named States which have need therefor, on such basis as the Secretary deems equitable and consistent with the purposes of this subsection, and any amount so reallocated to any such named State shall be in addition to any other amounts allotted and available to it for the same period.

(4) The amount of any grant under this subsection for public health programs under an approved State plan shall be determined by the Secretary, except that no grant for any such program may exceed 90 per centum of its cost (as determined under regulations of the Secretary). Payments under grants under this subsection shall be made from time to time in advance on the basis of estimates by the Secretary or by way of reimbursement, with necessary adjustments on account of previous underpayments or overpayments.

(d) (1) The Secretary is authorized to make project grants to States and, in consultation with the State health authority, to political subdivisions of States, for—

(A) venereal disease surveillance activities, including the reporting, screening, and followup of diagnostic tests for, and diagnosed cases of, venereal disease;

(B) casefinding and case followup activities respecting venereal disease, including contact tracing of infectious cases of venereal disease and routine testing, including attendant laboratory and followup systems costs thereof;

(C) interstate epidemiologic referral and followup activities respecting venereal disease;

(D) targeted professional and public venereal disease education activities; and

(E) such special studies or demonstrations to evaluate or test venereal disease [control] preventive and control strategies or activities as may be prescribed by the Secretary.

(2) For the purpose of carrying out this subsection, there is authorized to be appropriated \$31,000,000 for the fiscal year ending June 30,

1976, \$33,000,000 for the fiscal year ending June 30, 1977, and \$36,000,000 for the fiscal year ending June 30, 1978.

(e) (1) Grants made under subsection (b) or (d) of this section shall be made on such terms and conditions as the Secretary finds necessary to carry out the purposes of such subsection, and payments under any such grants shall be made in advance or by way of reimbursement and in such installments as the Secretary finds necessary.

(2) Each recipient of a grant under this section shall keep such records as the Secretary shall prescribe including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the project or undertaking in connection with which such grant was given or used and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

(3) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients of grants under this section that are pertinent to such grants.

(4) The Secretary, at the request of a recipient of a grant under this section, may reduce such grant by the fair market value of any supplies or equipment furnished to such recipient and by the amount of pay, allowances, travel expenses, and any other costs in connection with the detail of an officer or employee of the United States to the recipient when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such recipient and for the purpose of carrying out the program with respect to which the grant under this section is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies, equipment, or personal services on which the reduction of such grant is based; and, in the case of a grant under subsection (c), such amount shall be deemed a part of the grant to such recipient and shall, for the purposes of that subsection, be deemed to have been paid to such recipient.

(5) All information obtained in connection with the examination, care, or treatment of any individual under any program which is being carried out with a grant made under this section shall not, without such individual's consent, be disclosed except as may be necessary to provide service to him. Information derived from any such program may be disclosed—

(A) in summary, statistical, or other form, or

(B) for clinical or research purposes,

but only if the identity of the individuals diagnosed or provided care or treatment under such program is not disclosed.

(f) Except as provided in section 317(d)(4), no funds appropriated under any provision of this Act other than this section may be used to make grants in any fiscal year for programs or projects respecting venereal disease if (1) grants for such programs or projects are authorized by this section, and (2) all the funds authorized to be appropriated under this section for that fiscal year have not been appropriated for that fiscal year and obligated in that fiscal year.

(g) Not to exceed 50 per centum of the amounts appropriated for any fiscal year under subsections (b), (c), and (d) of this section may be used by the Secretary for grants for such fiscal year under section 317.

(h) Nothing in this section shall be construed to require any State or any political subdivision of a State to have a venereal disease program which would require any person, who objects to any treatment provided under such a program, to be [treated or to have any child or ward of his] treated under such a program.

(i) As used in this section, the term "venereal disease" means syphilis and gonorrhea and any other sexually transmitted disease which the Secretary finds to be of national significance and which, with respect to grants under subsection (d), the Secretary finds to be amenable to control.

## CONSUMER HEALTH EDUCATION AND PROMOTION

### SHORT TITLE

SEC. 301. This may be cited as the "National Consumer Health Education and Promotion Act of 1975".

### AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT

SEC. 302. The Public Health Service Act is amended by adding after title XVI the following new title:

## TITLE XVII—OFFICE OF CONSUMER HEALTH EDUCATION AND PROMOTION AND THE CENTER FOR HEALTH EDUCATION AND PROMOTION

### PART A—OFFICE OF CONSUMER HEALTH EDUCATION AND PROMOTION

#### ESTABLISHMENT OF OFFICE OF CONSUMER HEALTH EDUCATION AND PROMOTION

SEC. 1701. (a) There is established in the Department of Health, Education, and Welfare the Office of Consumer Health Education and Promotion (hereafter in this Act referred to as the 'Office') which shall be under the direction of a Director who shall be appointed by the Secretary of Health, Education, and Welfare (hereafter in this Act referred to as the "Secretary") and supervised by the Assistant Secretary for Health (or such other officer of the Department as may be designated by the Secretary as the principal adviser to him for health programs).

(b) To facilitate the development of health education and promotion strategy for the Nation, the Office shall carry out the following functions: Engage in research in health education and promotion, develop community health education programs, stimulate and coordinate communications in health education, and overview and coordinate Federal programs.

#### GENERAL AUTHORITY

SEC. 1702. The Secretary, acting through the Office, shall—

(1) design and implement and national goals and strategies with respect to health education and promotion;

(2) determine health education and promotion needs and resources, and recommend appropriate educational and certifying policies for health education and promotion manpower;

(3) incorporate appropriate health education and promotion strategies into every facet of our society and increase the application of health knowledge, skills, and practices by the general population in their patterns of daily living;

(4) increase the effectiveness and efficiency of health education and promotion programs through improved planning, implementation of tested models, and evaluation of results;

(5) establish systematic processes for the exploration, development, demonstration, and evaluation of innovative health education concepts; and

(6) foster information exchanges and cooperation among health education providers, consumers, and supporters.

The Secretary shall carry out this title in a manner consistent with the national health priorities set forth in section 1502 of the Public Health Service Act and with activities undertaken under title XV of the Public Health Service Act (relating to health planning and development).

#### SPECIFIC FUNCTIONS

##### Research Programs

SEC. 1703. (a) (1) The Secretary shall by grants and contracts to public or nonprofit private entities conduct and support research in health education and promotion. The Secretary shall—

(A) determine the scope and nature of health education research;

(B) rank research projects in order of priority;

(C) initiate, stimulate, and fund projects that are determined to be necessary;

(D) provide consultation to persons preparing research proposals or those who are conducting research;

(E) determine the best methodologies to disseminate information on the value of preventive measures in health care and to implement health education and promotion strategies;

(F) determine the best methods to increase the awareness of health providers regarding the cultural sensitivities of population groups which may affect such groups willingness or ability to seek and accept services, including preventive health services;

(G) ascertain the costs and cost-benefit of disseminating such information and of implementing health education and promotion strategies;

(H) determine factors in social behavior which impact on health and determine the interaction of sociological determinants with the field of health education;

(I) review those factors which affect environmental and occupational health, ascertain those programs and areas for which educational and preventive measures could be implemented to improve environmental and occupational health, and engage in research and policy formulation in such areas as accidents, nutrition, dental care, occupational health and safety, and environmental stress; and

(J) conduct a review of biological-genetic factors which, acting independently or in concert with environmental factors, can affect health and ascertain whether education of the public concerning these factors, and their detection, can improve health.

(2) The Secretary in carrying out his responsibilities under this section, shall use the findings of the continuing surveys of the needs, interests, attitudes, knowledge, and behavior of the American public regarding health as conducted by the National Center for Health Statistics as a basis for formulating policy with respect to health education and promotion.

#### Community Programs

(b) (1) The Secretary shall support and encourage innovative programs in health education and promotion and shall specifically—

(A) support demonstration programs, including training, in health education and promotion, which programs (i) are within hospitals, ambulatory care settings, and other appropriate settings, (ii) focus on goals and objectives that are measurable, and (iii) emphasize the prevention or moderation of illness or accidents that appear controllable through individual behavior;

(B) provide consultation to organizations in planning or evaluating health education and promotion programs;

(C) develop health education and promotion model curricula with appropriate representatives from medical, dental, and nursing schools, schools of public health, and other institutions engaged in training health personnel for the purpose of implementing such curricula within these institutions;

(D) establish continuing education programs to disseminate the most recent research findings in the field; and

(E) support by grant or contract the development and implementation of a model toll-free telephone system to provide the public with health information, information on available health services, crisis information, and directions for obtaining health related publications.

(2) (A) The Secretary is authorized to make grants and contracts to public or nonprofit private entities for the purpose of developing programs of health care education for a defined geographic region pursuant to and in accordance with those established under section 1511 of the Public Health Service Act and with activities undertaken under title XV of the Public Health Service Act (relating to health planning and development). In awarding such grants and contracts the Secretary shall assure an equitable geographic and demographic distribution of all funds appropriated.

(B) Projects which receive Federal funds under this subsection shall—

(1) utilize in a coordinated manner such health education methods as may be appropriate to provide effective health education services to the population of the applicable region; and

(2) evaluate the effectiveness of each health education method utilized and identify its particular advantages or disadvantages.

#### Health Education Training

(c) The Secretary acting through the Director is authorized to make grants and contracts to public or nonprofit private entities to provide for the training for health personnel in health education and promotion.

#### School Health Education Training

(d) (1) The Secretary acting through the Director may make grants to local educational agencies and institutions of higher education for teacher training with respect to the provision of comprehensive health education programs in schools. Such grants may be used by such agencies and institutions to develop and conduct training programs for elementary and secondary teachers with respect to teaching methods and techniques, information, and current issues relating to health and health problems. For purposes of this Act the term 'health education and health problems' includes dental health, disease control, environmental health, human ecology, mental health, nutrition, physical health, safety and accident prevention, smoking and health, substance abuse, consumer health, and such others as may be deemed appropriate by the Director in concurrence with the Commissioner of Education.

(2) The Director, in exercising authority with respect to (a) determination of criteria for the selection of grants, and (b) selection of grants from eligible applicants, shall consult with, and obtain the approval of, the Commissioner of Education.

(3) In establishing criteria for the award of grants under this section, such criteria must include priority for applications for support of programs which provide: (1) inservice rather than preservice training, except in such cases where an applicant has demonstrated that: (A) inservice training is not practicable, and (B) reasonable opportunity exists for persons undergoing preservice training to obtain positions in which they shall apply such training, and (2) training of persons who, as a result of such training, will have as their major responsibility, work in health education in schools.

#### Requirements Applicable to Providers of Institutional Care

(d) The Secretary may not approve an application of any health care facility for a grant or contract under the Public Health Service Act or the Community Mental Health Centers Act for a fiscal year beginning after the date of enactment of this Act unless the application contains or is supported by assurances satisfactory to the Secretary that, during the period for which the assistance applied is to be made available, the applicant will provide such consumer health education for individuals receiving inpatient or outpatient services through such health care facility as the Secretary shall by regulation prescribe.

#### Communications in Health Education and Promotion

(e) The Secretary shall establish liaison with the Office, providers of health education services, and the communications media. The Secretary shall—

(1) inventory the existing health education information data systems, encourage further development of such systems, and work to coordinate the efforts of all major groups involved in health education information data systems;

(2) make health information available to the public and to organization involved in health education and promotion;

(3) continually evaluate the effectiveness of existing health information and health education and promotion services to enhance their scope and quality;

(4) encourage pretesting and expert evaluation of health information materials;

(5) bring together the major national health educational organizations to share ideas, to identify gaps and overlaps in health education and promotion programs and research, and to find ways in which the organizations can cooperate to make efforts more effective;

(6) find ways in which the communications media and the Office can cooperate to provide effective public service programming in health education and promotion;

(7) seek ways of promoting general public health education and promotion programs and of reducing misleading media advertising and other health-threatening behavior in communications programs designed for children and families; and

(8) establish the Office as a source of information and expertise which can be used in planning and creating both commercial and noncommercial material in health education and promotion.

In the case where materials are developed, through activities funded under this title and/or through activities of the Office and where the materials have commercial value, the moneys which result from the license, sale, rent, grant or other transaction of said materials shall be paid into the public treasury. The Director with consultation of the Secretary shall determine the fair market value of such materials and shall have the authority to authorize such transactions.

#### Federal Programs

(f) The Secretary, in conjunction with the Interdepartmental Committee on Consumer Health Education and Promotion, in accordance with section 1704, shall make recommendations to the Congress for the inclusion in appropriate legislation of provisions respecting health education and promotion. The Secretary shall—

(1) promote the coordination, communication and collaboration of health education and promotion programs within the Department of Health, Education, and Welfare;

(2) establish a liaison with other Federal agencies engaged in health education and promotion, including the Consumer Product Safety Commission, the Department of Agriculture, the Environmental Protection Agency, the Department of Transportation, and the Department of Defense; and

(3) identify and make public those Federal programs and actions which are not in the interest of public health and determine methods for reviewing and commenting on such programs and actions as identified pursuant to section 1704(d).

#### INTERDEPARTMENTAL COMMITTEE ON CONSUMER HEALTH EDUCATION AND PROMOTION

SEC. 1704. (a) There is established in the Office of the Secretary an Interdepartmental Committee on Health Education and Promotion (hereinafter referred to in this section as the 'Committee') which shall be responsible for overview and coordination of all Federal programs and activities relating to health education and promotion to assure the adequacy and effectiveness of such programs and activities and to provide for the communication and exchange of information necessary to promote these functions:

(b) The Secretary or his designee shall serve as Chairman of the Committee, the membership of which shall include appropriate representation from the Department of Agriculture, the Environmental Protection Agency, the Department of Transportation, the Department of Defense, the Veterans' Administration, the National Science Foundation, the Federal Communications Commission, the National Academy of Sciences, the Consumer Product Safety Commission, and such other Federal agencies and offices (including appropriate agencies and offices of the Department of Health, Education, and Welfare, including the Office of Education and the National Institute for Occupational Safety and Health, the Office of Child Development, the National Institute of Drug Abuse, and the National Institute of Alcoholism and Alcohol Abuse) as the Secretary determines administer programs directly affecting health education and promotion; less often than four times a year;

(c) The Committee shall meet at the call of the Chairman, but not

(d) The Committee shall identify Federal programs and actions which are not in the interest of public health and determine methods for reviewing and commenting on such programs and actions, including recommendations for legislation and administrative action within the executive branch; and

(e) The Secretary shall provide the Committee with such full-time professional and clerical staff, information, other support, and the services of such consultants as may be necessary to assist it in carrying out effectively its functions under this section.

#### ADVISORY COUNCIL

SEC. 1705. (a) There is established the Consumer Health Education and Promotion Advisory Council (hereafter in this section referred to as the "Advisory Council") which shall consist of nineteen members appointed by the Secretary. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who have distinguished themselves in the fields of medicine (including preventive medicine), dentistry, health education, nursing, the social and behavioral sciences, nutrition, and the provision of health services; persons who are representative of the interests of the general public (including representatives of business, labor, and consumer groups); and persons from government. Each member shall hold office for a term of four years, except that the Secretary may stagger the terms of members first appointed to the Advisory Council, and any member appointed to fill a vacancy occurring prior to the expira-

tion of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms. The Secretary may, at the request of the Director, appoint such special advisory professional or technical committees as may be useful in carrying out this title. Members (other than members who are officers or employees of the United States) of the Advisory Council or of such committees, shall be entitled to receive for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the Advisory Council or committee compensation at rates fixed by the Secretary, but not exceeding \$100 per day, and while so serving away from their homes or regular places of business each member may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of five or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.

(b) It shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to the functions of the Office. The Advisory Council shall make an annual report to the Secretary and to the Congress on the performance of its functions, including any recommendations it may have with respect thereto.

(c) The Advisory Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the advisory council such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare, as the advisory council may require to carry out its functions.

#### REPORTS

SEC. 1706. (a) The Secretary shall make an annual report (not later than December 1 of each year except in the year this title is enacted into law) to the Congress on the activities and policy recommendations of the Office.

(b) The Secretary, acting through the Office, shall assemble and submit to the President and the Congress not later than December 1 of each year—

(1) a report of the activities, findings, and recommendations of the Office, and

(2) recommendations, based on the findings and recommendations of the Office, and the Interdepartmental Committee on Consumer Health Education and Promotion for legislation and administrative action within the executive branch.

(c) The Office of Management and Budget may review any report, recommendations or submission made by the Secretary, the committee, or the Advisory Council in regard to this Act before its submission to the Congress, but the Office of Management and Budget may not revise the report or delay its submission, and it may submit to the Congress its comments (and those of other departments or agencies of the Government) respecting such submission.

#### AUTHORIZATION OF APPROPRIATIONS

SEC. 1707. To carry out this title there are authorized to be appropriated \$11,000,000 for the fiscal year ending June 30, 1976, \$11,000,000 for the fiscal year ending June 30, 1977, \$24,000,000 for the fiscal year ending June 30, 1978.

#### PART B—CENTER FOR HEALTH EDUCATION AND PROMOTION

##### CONGRESSIONAL DECLARATION OF POLICY

SEC. 1708. The Congress finds and declared that—

(1) it is in the public interest to inform the public about health and about ways to best protect and improve personal health;

(2) the public must develop the ability to examine and weigh consequences of personal decisions respecting health;

(3) the public must be motivated to desire changes supportive of more healthful lifestyles;

(4) impediments that inhibit the voluntary adoption and maintenance of more healthful practices by the public must be identified and mitigated or removed;

(5) to achieve these goals it is necessary for the Federal Government to complement, assist, and support a national policy that will advance the national health, reduce preventable illness, disability, and death, moderate self-imposed risks, and promote progress and scholarship in consumer health education and promotion, and

(6) a private corporation should be created to facilitate the development of a health education and promotion strategy for the Nation.

##### CREATION OF CORPORATION

##### BOARD OF DIRECTORS

SEC. 1709. The Center shall have a Board of Directors (hereinafter in this title referred to as the 'Board') consisting of twenty-five members appointed by the President, by and with the advice and consent of the Senate.

(b) The members of the Board (1) shall be selected from among citizens of the United States (not regular full-time employees of the United States) who are eminent in such fields as, and represent, health education, health care services delivery, nursing, nutrition, general education, consumer representation and advocacy, communications, labor and business, planning and organizational management, and public and private finance, and (2) shall be selected so as to provide as nearly as practicable a broad representation of various regions of the country and of various kinds of skills and experiences appropriate to the functions and responsibilities of the Center. They shall serve as incorporators and shall take whatever actions are necessary to create a nonprofit corporation to be known as the Center for Health Education and Promotion (hereafter in this title referred to as the 'Center') under the District of Columbia Nonprofit Corporation Act within sixty days from the effective date of this title. The Center and its

articles of incorporation, bylaws, and all other rules and regulations shall incorporate by reference and be subject to this title.

SEC. 1710. (a) The members of the Committee shall serve as the members of the first Board.

(b) The term of office of each member of the Board shall be four years; except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; (2) the terms of office of members first taking office shall begin on the date of incorporation and shall expire, as designated at the time of their appointment, nine at the end of one year, eight at the end of two years, and eight at the end of four years; and (3) a member whose term has expired may serve until his successor has qualified. No member shall be eligible to serve in excess of two consecutive terms of four years each.

(c) Any vacancy in the Board shall not affect its power, but shall be filled in the manner in which the original appointments were made.

(d) The members of the Board shall elect one of their members as Chairman; thereafter the members of the Board shall annually elect one of their number as Chairman. The members of the Board shall also elect one or more of them as a Vice Chairman or Vice Chairmen.

(e) The members of the Board shall not, by reason of such membership, be deemed to be employees of the United States. They shall, while attending meetings of the Board or while engaged in duties related to such meetings or in other activities of the Board, be entitled to receive compensation at the rate of \$100 per day including traveltime, and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, equal to that authorized by law (5 U.S.C. 5703) for persons in the Government service employed intermittently.

#### OFFICERS AND EMPLOYEES

SEC. 1711. (a) The Center shall have a President, and such other officers as may be named and appointed by the Board for terms and at rates of compensation fixed by the Board. No individual other than a citizen of the United States may be an officer of the Center. No officer of the Center, other than the Chairman and any Vice Chairman, may receive any salary or other compensation from any source other than the Center during the period of his employment by the Center. All officers shall serve at the pleasure of the Board.

#### NONPROFIT AND NONPOLITICAL NATURE OF THE CENTER

SEC. 1712. (a) The Center shall have no power to issue any shares of stock or to declare or pay any dividends.

(b) No part of the income or assets of the Center shall inure to the benefit of any director, officer, employee, or any other individual except as salary or reasonable compensation for services.

(c) The Center may not contribute to or otherwise support any political party or candidate for elective public office.

#### FUNCTIONS

SEC. 1713. (a) to facilitate the development of a health education and promotion strategy for the Nation the Center shall carry out the following functions:

(1) The Center shall establish communications with, provide a forum for the involvement of, and seek the advice and support of, organizations, agencies, and groups involved in health care, education, labor and business, social and civic organizations, consumer organizations, and communications. The Center shall review and analyze the need, and resources available, for health education and promotion and the effectiveness of alternative health education methods and procedures on health status to determine which methods and procedures offer the best opportunities for improving the Nation's health. Specifically, the Center shall—

(A) provide a private focal point for the coordination of a structured national exchange on health education issues and problems involving all of the various concerned disciplines and interests;

(B) identify and express the superordinate health education policies and guides to which many different organizations, agencies, and groups can subscribe and incorporate voluntarily into their own health education efforts;

(C) stimulate, sponsor, coordinate, and support the development of new health education initiatives and programs in which many organizations and agencies can participate;

(D) develop national policy recommendations which are supportive of long-range preventive approaches to national health improvement; and

(E) provide a forum for nongovernmental organizations to participate in comprehensive national planning, action, and evaluation of health education efforts.

(2) The Center shall coordinate and stimulate a variety of projects involving other organizations, agencies, and groups to develop such strategy designs or design components as are required to increase the appropriateness, acceptability, and effectiveness of health education efforts nationwide. In the performance of this function, the Center shall—

(A) in order to indicate directions for improving the Nation's health, develop a perspective and definition of the role of health education, its placement in the health and education systems, and its relationships to prevention and general health maintenance practices;

(B) review, analyze, and summarize unmet consumer health education needs and identify the critical gaps or deficiencies in personal preventive practices, in the use of health and related social services, and in programs to improve social and environmental conditions and other conditions affecting health care and education;

(C) review, analyze, and assess the state of health education and promotion theory and practices in relation to identi-

fied consumer needs and identify the possibilities for the development of new or improved technologies and practices;

(D) identify the types and availability of the resources required to meet consumer needs; and

(E) develop action plans for the development or increased allocation of resources required to produce significant results in meeting consumer health education needs.

(3) The Center shall assist in stimulating, developing, implementing, and assessing a total communications program utilizing a full range of media available to reach diversified groups in order to increase national understanding and support for the value of health education and the role each citizen and every organization, institution, and agency can and should play to improve individual, community, and, ultimately, the national health through educational means. In performance of this function, the Center shall—

(A) be an active participant in the efforts of organized elements at all levels in the health and educational systems and work with all interested organizations, agencies, and groups to assist in the development of more concerted, cooperative approaches to meeting consumer needs;

(B) publicize the latest information on technological developments in health education and on effective health education practices;

(C) develop opportunities which will enable consumer's and citizen's groups to become effective advocates for health education in their communities; and

(D) publicize and work with other public or private organizations, agencies (including the Office), and groups to secure widespread endorsement and implementation of the Center's policies and recommendations.

(4) The Center shall assist in accelerating the incorporation of improved technology into health education practice by establishing a system of technical assistance and training and by making available the expertise of other cooperating organizations, as well as its own staff, in response to the needs of National, State, and local groups for assistance in improving the planning, implementation, and evaluation of their health education programs. In the performance of this function, the Center shall—

(A) identify individuals with specialized skills, knowledge, and experience for involvement in the Center's policy and strategy functions, for work on specialized cooperative projects, and for response to external requests for assistance;

(B) develop a cadre of consultants and trainers and establish mechanisms for their use by organizations, agencies, and groups requesting the Center's assistance;

(C) stimulate and assist in the development and provide practical and tested models, instruments and procedures for health education program planning and assessment, for training of health education providers, and for consumer and community involvement in the planning, implementation, and evaluation of health education strategies and programs; and

(D) identify information, training, research, and planning

deficiencies generally current in health education practices and develop programs or projects for the correction of such deficiencies.

(5) The Center shall encourage the development and utilization of valid and acceptable research and evaluation methods for a wide variety of health education programs and technologies. It shall develop coalitions and consortium arrangements with other organizations and agencies for cooperative efforts in model design and testing and for joint sponsorship and exchange of information on comparable research and evaluation projects. In the performance of this function, the Center shall—

(A) stimulate and support the development of valid techniques and strategies to measure the appropriateness, acceptability, and effectiveness of the process and outcomes of experimental and demonstration health education projects;

(B) establish mechanisms for continuing communication concerning program test experience, modifications, and evaluation;

(C) analyze, summarize, and disseminate information regarding experiences of diversified applications of recommended models, components, and evaluation approaches; and

(D) selectively field test measures, instruments, techniques, and model components as required for Center strategy design activities.

(6) Included in the activities of the Center authorized for accomplishment of the purposes set forth in this section are among others not specifically named—

(A) to obtain grants from and to make contracts with individuals and with private, State, and Federal agencies, organizations and institutions.

(b) The Center in carrying out its functions under this section may prescribe such regulations as it deems necessary.

#### ADVISORY PANEL

SEC. 1714. The board shall appoint an advisory panel comprised of one hundred individuals with appropriate competencies and abilities. The principal function of the advisory panel shall be to provide advice for members of the Board. Additionally, it shall serve as a primary source for appointments to special committees, task forces, and conferences. The advisory panel shall receive all Center reports.

#### REPORT TO CONGRESS

SEC. 1715. The Center shall submit an annual report to the President for transmittal to the Congress. The report shall include a comprehensive and detailed report of the Center's operations; activities, financial condition, and accomplishments under this title and may include such recommendations as the Center deems appropriate.

#### FINANCING

SEC. 1716. (a) There are authorized to be appropriated to the Center for the purposes of carrying out the functions enumerated in section



1716 of this Act \$1,000,000 for fiscal year ending June 30, 1976; \$1,000,000 for the fiscal year ending June 30, 1977; \$1,000,000 for the fiscal year ending June 30, 1978.

(b) In addition to the sums authorized to be appropriated by paragraph (a) of this subsection, the Center is authorized to receive income, grants, donations, bequests, or other contributions from non-Federal sources.

#### RECORDS AND AUDIT

SEC. 1714. The board shall appoint an advisory panel comprised in accordance with generally accepted auditing standards by independent licensed public accountants certified or licensed by a regulatory authority of a State or other political subdivision of the United States. The audits shall be conducted at the place or places where the accounts of the Center are normally kept.

(b) The report of each such independent audit shall be included in the annual report required by section 208. The audit report shall set forth the scope of the audit and include such statements as are necessary to present fairly the Center's assets and liabilities, surplus or deficit, with an analysis of the changes therein during the year, supplemented in reasonable detail by a statement of the Center's income and expenses during the year, and a statement of the sources and application of funds, together with the independent auditor's opinion of those statements.

#### GRANTS FOR WATER TREATMENT PROGRAMS

SEC. 1718. (a) There are hereby authorized to be appropriated \$2,000,000 for the fiscal year ending June 30, 1976; \$3,000,000 for the fiscal year ending June 30, 1977; and \$4,000,000 for the fiscal year ending June 30, 1978; which shall be used by the Secretary to make grants, only in such instances where the applicant voluntarily requests such assistance, to States, political subdivisions of States, and other public or nonprofit private agencies, organizations, and institutions to assist them in initiating, in communities, or in public elementary or secondary schools, water treatment programs designed to reduce the incidence of oral disease or dental defects among residents of such communities or the students in such schools (as the case may be).

(b) Grants under this section may be utilized for (but are not limited to) the purchase and installation of water treatment equipment.

(c) Grants under this section shall not exceed 80 per centum of the cost of the treatment program with respect to which such grant under this section is made.

#### DEFINITIONS

SEC. 1719. For purposes of this Act—

(A) "Health education and promotion" is a process that favorably influences understanding, attitudes, and conduct, including cultural awareness and sensitivity, in regard to individual and community health. Specifically, it affects and influences individual and community health behavior and attitudes in order to moderate self-imposed risks; maintain and promote physical and mental health and efficiency, and reduce preventable illness, disability and death.

#### TECHNICAL AMENDMENTS

SEC. 303. (a) Subsection (c) of section 306 of the Public Health Services Act is redesignated subsection (c) (2), and a new subsection (c) (1) is inserted immediately preceding subsection (c) (2), to read as follows:

(c) (1) The Center shall make a continuing survey of the needs, interests, attitudes, knowledge, and behavior of the American public regarding health. The Center shall transmit the findings of such surveys and of the findings of similar surveys contracted for or otherwise obtained by the Center and conducted by national health education organizations and community health education organizations accompanied by appropriate Center analysis, if any, to the Secretary, the Assistant Secretary for Health, and to the Office of Consumer Health Education and Promotion for their use in formulating policies respecting health education and promotion.

(b) Subsection (i) of section 308 of the Public Health Service Act is amended by adding the following new paragraph (3) after paragraph (2):

(3) Of those sums appropriated by Congress under section 308 of the Act not less than \$1,000,000 for the fiscal year ending June 30, 1976, \$1,000,000 for the fiscal year ending June 30, 1977, and \$1,000,000 for the fiscal year ending June 30, 1978, shall be made available to carry out the activities of section 306(c) (1).

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LEAD-BASED PAINT POISONING PREVENTION  
AMENDMENTS OF 1976

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 FEBRUARY 17, 1976.—Ordered to be printed
 

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Mr. KENNEDY, from the Committee on Labor and Public Welfare,  
submitted the following

## REPORT

[To accompany S. 1664]

The Committee on Labor and Public Welfare, to which was referred the bill (S. 1664) to amend the Lead-Based Paint Poisoning Prevention Act having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

## I. PURPOSE

The purpose of the Committee reported bill, S. 1664, is to extend the provisions of the Lead-Based Paint Poisoning Prevention Act, P.L. 91-695, and to improve the procedures to achieve that goal.

The provisions of the committee reported bill do not revise the principal purpose of existing legislation.

The Lead Based Paint Poisoning Prevention Act, Public Law 91-695, was enacted into law January 13, 1971, and seeks to eliminate childhood lead based paint poisoning by screening and testing children for high blood lead levels. The law also authorizes the Department of Health, Education, and Welfare to conduct programs to eliminate the hazards of lead based paint poisoning. Under the provisions of the Lead Based Paint Poisoning Prevention Act, the Secretary of the Department of Health, Education, and Welfare is authorized to make grants to units of local and State government for community based testing, screening, and hazard elimination programs.

In addition, the Secretary of the Department of Housing and Urban Development (in consultation with the Secretary of the Department of Health, Education, and Welfare) is authorized to conduct research to determine the most effective means for removing the hazards of lead poisoning in those residences that present a high risk to the health of young children. Under the Appropriations Act of August 10, 1971,

for the Departments of Labor and Health, Education, and Welfare and related agencies, \$7.5 million were appropriated to carry out the provisions of Titles I and II of the Lead Based Paint Poisoning Prevention Act for FY 1972; and for these same titles \$7.5 million were appropriated for FY 1973, under a continuing resolution.

The appropriations act for the Departments of Labor, Health, Education, and Welfare and related agencies dated December 18, 1973 allocated \$9 million for these titles for FY 1974, the same amount was allocated for FY 1975, and \$3.5 million is the budget request for FY 1976. However, because no authorization was approved for FY 1976, funding remained at the level approved for the previous fiscal year.

The Administration requested appropriations of \$8.5 million under the authority of Section 314(e) of the Public Health Service Act for fiscal year 1973. The Congress appropriated \$12 million for program operations during 1973 as authorized by Titles I and II of P.L. 91-695. However, as a result of the presidential veto of HEW appropriations for fiscal year 1973, Lead Poisoning programs were continued at the 1972 level.

Appropriations have never been provided for the research authority specified under Title III of the Act, which provides an authorization of \$3 million per year. However, the Secretary of the Department of Housing and Urban Development conducted research as directed by Title III during fiscal years 1971, 1972, and 1973, utilizing general research authorities of the Department.

## II. COMMITTEE CONSIDERATION

S. 1664 was introduced on May 6, 1975 by Senator Kennedy for himself, Mr. Bayh, Mr. Brooke, Mr. Case, Mr. Clark, Mr. Philip A. Hart, Mr. Haskell, Mr. Humphrey, Mr. Inouye, Mr. Jackson, Mr. Javits, Mr. McGee, Mr. McGovern, Mr. Magnuson, Mr. Pell, Mr. Percy, Mr. Randolph, Mr. Ribicoff, Mr. Schweiker, Mr. Hugh Scott, Mr. Stafford, Mr. Stevenson, Mr. Cranston and Mr. Williams.

The Senate Subcommittee on Health received testimony on the provisions of S. 1664 in a hearing on June 16, 1975.

Witnesses appearing before the Health Subcommittee on S. 1664 included:

1. David J. Sencer, M.D., Director, Center for Disease Control Public Health Service, Department of Health, Education, and Welfare, accompanied by Vernon N. Houk, M.D., Director, Environmental Health Services Division, Bureau of State Services, Center for Disease Control.
2. Claude Barfield, Deputy Assistant Secretary, Office of Research and Demonstration, Division of Policy Development and Research, Department of Housing and Urban Development, accompanied by Donald G. Glascoff, Jr., Associate Deputy General Counsel; David Engel, Program Manager of the Department's Lead-Based Paint Research Project.
3. Barbara Hackman Franklin, Commissioner, U.S. Consumer Product Safety Commission, accompanied by Constance B. Newman, Commissioner, Consumer Product Safety Commission.
4. Doctor Herbert Needleman, Children's Hospital Center, Boston, Massachusetts.

5. Doctor Ellen Silbergeld, a Joseph P. Kennedy Fellow in Neurosciences, Department of Environmental Medicine, The Johns Hopkins University.

6. Dr. Laurence Finberg, Montefiore Hospital and Medical Center, Bronx, New York, American Academy of Pediatrics.

7. Doctor Nahman Greenberg, Medical Director, Childhood Lead Poisoning Control Program, City of Chicago Board of Health.

8. Mr. Mark Silbergeld, Counsel Consumers' Union, Washington, D.C.

9. Robert A. Roland, Executive Vice President, National Paint and Coatings Association, accompanied by John M. Montgomery, General Counsel, and Rayla A. Brown, Technical Director.

### *Panel consisting of*

10. Robert Klein, Director, Massachusetts Childhood Lead Poisoning Prevention Program;

11. Ronald R. Jones, Director, Massachusetts Lead Poisoning Prevention Program;

12. Mrs. Grace Dalton;

13. Mrs. Carolyn Gibbs, Director, Childhood Lead Poisoning Prevention Program, Lynn, Massachusetts.

## III. SUMMARY OF S. 1664

The provisions of S. 1664 are essentially designed to:

1. Provide assistance for protecting against the lead based paint poisoning hazard in homes where cases of childhood lead based paint poisoning have been actually identified.

2. Authorize the Dept. of Health, Education & Welfare to safeguard against the application of lead based paints to any cooking, drinking or eating utensil.

3. Authorize the Dept of Housing and Urban Development to restrict the application of lead based paint in residential structures constructed or rehabilitated by the federal government, or with federal assistance.

4. Authorize the Consumer Product Safety Commission to prohibit the application of lead based paints to any toy or furniture article.

5. Limit the amount of lead contained in residential interior paints to no more than .06 percent, unless a majority of the members of the Consumer Product Safety Commission agrees to another level, not to exceed one half of one percent lead by weight. This provision stipulates that such recommendation must be made within six months after the date of enactment of the bill.

These provisions are designed to seek needed support for those programs that local authorities insist must be adequately reinforced if the hazards of lead based paint poisoning are to be reduced.

## IV. AUTHORIZATIONS

As introduced on May 6, 1975, the bill amending the Lead Based Paint Poisoning Prevention Act authorized appropriations that substantially exceeded the level of appropriations authorized under pre-

vious legislation in order to provide funding authorizations necessary to begin addressing the increase demand for aid to communities that are seeking adequate help in the battle against the continuing hazards of childhood lead poisoning. However, the Committee reported bill sets forth revisions to the authorizations provided in the original bill in an effort to realistically accommodate the restraints that such health programs have met in attempting to improve their funding. The total annual authorization approved in the bill reported by the committee amounts to \$91.5 million for three years beginning with fiscal year 1976: \$37.5 million for Title I—testing and screening programs administered by the Department of Health, Education, and Welfare; \$45 million for Title II—hazard elimination programs administered by the Department of Housing and Urban Development; and \$9 million for Title III—research and demonstration programs administered by both The Departments of Health, Education, and Welfare and Housing, and Urban Development.

#### V. COMMITTEE AMENDMENTS

The committee reported bill includes two significant revisions to the bill originally introduced on May 6, 1975.

First, the committee bill amends the original bill to establish the lead content in paint at no more than 0.06% after six months from the date of enactment of this bill unless a majority of the members of the Consumer Product Safety Commission recommends another level of lead in paint; that does not exceed 0.5% lead in paints intended for use on interior residential surfaces.

Second, the committee bill revised the authorized funding levels to provide:

For screening programs under Title I: \$10 million in fiscal year 1976; \$12.5 million in fiscal year 1977; and \$15 million in fiscal year 1978.

For hazard elimination programs under Title II: \$5 million in fiscal year 1976; \$15 million in fiscal year 1977; \$25 million in fiscal year 1978.

For research programs: \$3 million during each of the fiscal years from fiscal year 1976 through 1978.

The committee bill also specifies the jurisdiction for each of the appropriate federal agencies that are involved in helping to guard against the hazards caused by lead based paint poisoning. Accordingly, the Department of Health, Education, and Welfare is charged with the responsibility to guard against the use of lead based paints on any cooking, eating or drinking utensil. The Department of Housing and Urban Development is responsible for safeguards that will prohibit the use of lead based paints on the surfaces of any residences that are constructed or rehabilitated with federal assistance. And the Consumer Product Safety Commission is responsible for safeguards that can prohibit the use of lead based paints on any toy or item of furniture.

#### VI. COMMITTEE VIEWS

Throughout the life of the programs authorized by this legislation, it has been the committee's intention that two fundamental purposes be advanced by the Lead Based Paint Poisoning Prevention Act:

First, the Act is intended to spearhead the campaign for the elimination of the hazards caused by existing lead based paint on the surfaces of residential structures housing those young children who are exposed to environmental health hazards. The Act also is intended to provide resources to support programs that will search out those youngsters already sickened by lead poisoning so that they may receive appropriate medical attention.

Since 1971 when the Lead Based Paint Poisoning Prevention Act was enacted it has been clear to the Committee that we do not need extensive research to determine how to protect America's young children from lead based paint poisoning. We have the technology to eliminate this pollutant and we know how to halt the damaging effects of the disease.

Limiting the content of lead in paint has been the subject of continuing debate by many in the health field. The Committee seeks to establish the minimum feasible paint lead level content that will both safeguard the health of children and meet technological manufacturing standards.

Witnesses testified before the committee that a majority of those paints currently produced for use in residences contain safe lead levels. According to the testimony latex paints contain no more than 0.06% lead. Today's latex paints are used on most interior residential surfaces and are reported to account for at least 75% of all paints used in America's homes. The testimony of consumer advocates and medical experts support a lead content that includes no more than 0.06% lead in paint. It is the committee's intention to require that limit for all interior residential paints. Thus, the Consumer Product Safety Commission has been directed to obtain available evidence for establishing a safe lead level that might range between 0.06% and 0.5% lead in paint. Because the committee intends for an acceptable lead level to be established as efficiently as possible, the committee bill mandates the 0.06% lead limit if a majority of the Consumer Product Safety Commission members have not recommended a different lead limit not to exceed 0.5% lead content, within six months of the date of enactment of this legislation.

At the same time, the executive departments charged with the responsibility for administering the lead poisoning programs must also continue to implement the provisions of the law. The committee therefore detailed the specific lines of concern and jurisdiction for the relevant agencies of the Federal government. Hopefully, by timely establishment of safe lead levels and with vigorous implementation of provisions for cleaning up the lead poisoning hazard in the homes of sick children, there will be fewer and fewer lead poisoning victims.

The committee was deeply impressed by those witnesses who insist that the effort to search out lead sick victims must continue in concert with programs that are designed to remove the lead poisoning hazard from exposure to young children who have been lead sickened.

#### *Revised Lead Content Requirements*

The allowable amounts of lead in paint have been reviewed since 1973 when amendments to the Lead Based Paint Poisoning Prevention Act established levels of lead content for residential interior paints under the existing statute. Under the present law such paints are re-

quired to contain no more than .5% lead, prior to December 31, 1974; and after December 31, 1974, such paints would be required to contain no more than .06% lead, unless, the Chairman of the Consumer Product Safety Commission (hereinafter referred to as CPSC) recommended to the Congress "that another level of lead, not to exceed five tenths of 1 per centum, is safe." And, if so recommended, the other level would then become effective.

The CPSC Chairman, Richard O. Simpson, submitted recommendations to the Congress on December 23, 1974, in which he called for a continuation of the existing requirement that lead levels for interior residential paints remain at .5%. Immediate criticism of the Chairman's report was received by the Health Subcommittee from the medical community, from consumer groups and from authorities in the Chicago, Illinois Department of Health, where the lower lead level of .06% had already been enacted under a city ordinance.

Criticism of Chairman Simpson's decision centered on the research and methodology used in the experiments, conducted by the New York University Medical Center Department of Environmental Medicine and the Southwest Foundation for Research and Education. Experts testified in hearings before the subcommittee that the conclusions of the CPSC Chairman may not be validly applied to the effects of lead in small children.

As Dr. Lawrence Feinberg, who represented the American Academy of Pediatrics, indicated in his testimony, ". . . a significant number of children would ingest a good deal more in the way of paint chips or painted plaster than they assumed for the purpose of the experiment. Moreover, many children would ingest at an irregular rate, rather than at a slow steady rate, with large, transintestinal gradients and sudden influxes of lead. Moreover the animals used in the experiments were fed an iron-rich diet which increases their tolerance of lead; whereas the characteristic lead poisoned child has a deficient diet to begin with and thereby has an even lower resistance to lead."

Other objections to the studies were concerned with the age of the animals used for the experiments. Dr. Feinberg's testimony indicated that "the age in the animals of the studies would not necessarily be comparable for lead absorption as it relates to children. There are some good data showing that absorption of lead from the intestine varies with age. The younger the animal, the higher the percent absorption." This information is crucial since the threat of lead paint poisoning is more prevalent among children under the age of five where the condition known as pica is more prevalent. Critics contended that the age factor was not adequately considered during the review of the effects of lead on young children in the studies upon which the CPSC Chairman based his recommendations.

Mr. Robert R. Roland, Executive Vice President, of the National Paint and Coatings Association, in his testimony before the subcommittee, supported the evaluation of CPSC Chairman Richard Simpson.

Mr. Roland said, "I do not think there is a risk, and I do not think that empirical data, outside human data, epidemiological data, has shown that the half percent presents a risk." He added, ". . . This evaluation by the Chairman and the staff of the government agency whose prime purpose is to make determinations of product safety,

concludes that there is no need for a .06 percent standard because no unreasonable hazard is shown at the current (0.5 percent level)."

Essentially the controversy about .5% versus .06% centers on two fundamentals; first, there is the technological issue of whether the lower limit can be actually attained using current manufacturing procedures. And second, there is the medical demand to maximize the safety of young children by minimizing those health hazards to which young children may be exposed. The subcommittee had received testimony in 1972 that "lead free" paints can be and are being produced. Officials from the DHEW testified in 1975 that approximately 70% of all interior residential paints currently produced in this country contain no more than 0.06% lead. And medical authorities insist that the maximum possible safe limit ought to be provided if we are seriously committed to the demand to guard against the lead poisoning hazard.

Since the Congress intended to involve all the members of the CPSC in the determination of what constitutes a safe level of lead in paint under provisions of the 1973 amendments to P.L. 91-695, and since it is clear that only the Chairman was involved in issuing a recommendation to the Congress, the Committee reported bill adopted an amendment requiring the CPSC to submit a recommendation to the Congress based upon a majority vote of all members of the Commission, within six months of the date of enactment of the 1975 amendments. To develop its evaluation, the Commission is authorized to obtain public testimony, and available scientific evidence including recommendations from the Center for Disease Control, the American Academy of Pediatrics and the National Academy of Sciences. In the absence of a recommendation from the Commission within six months from the date of enactment of the amendment, the lower level, 0.06%, will become effective.

#### *Prohibitions Against the Use of Lead Based Paint*

The 1973 amendments to the Lead Based Paint Poisoning Prevention Act prohibited the application of lead paints to toys, furniture, utensils used for eating, cooking, and drinking, and to the interior surfaces of federally controlled residential structures. The committee favorably considered an amendment to assign authority for providing safeguards against the use of lead paint to specific federal agencies and the bill reported by the committee—

1. Authorized the Department of Health, Education, and Welfare to develop procedures that will prohibit the application of lead based paint to any utensil used for cooking, eating or drinking;
2. Authorized the Department of Housing and Urban Development to control the application of lead paints to residential structures receiving federal assistance for any purpose including assistance for construction and rehabilitation; and
3. Authorized the Consumer Product Safety Commission to take the steps necessary to prohibit the application of lead based paints on any toy or an article of furniture.

These agencies had already assumed the responsibilities described and the purpose of this provision is to clarify their respective jurisdictions.

### Grants For Hazard Elimination Programs

The Lead Based Paint Poisoning Prevention Act authorized the Department of Health, Education, and Welfare to conduct programs in local communities that would eliminate the lead poisoning hazard in those homes where the risk of lead poisoning is greatest. Upon enactment of the law, the Department of Health, Education, and Welfare sought to establish programs that would identify those youngsters suffering from the effects of this disease. Since enactment of the law in 1971, local health officials have realized that the treatment of lead sick children cannot be effective without eliminating the lead hazard from the homes in which the affected children reside.

Authorities from Boston City Hospital testified that lead sick children received direct medical attention in their treatment facility. During hospitalization, Boston City Hospital employees are assigned to remove the lead paint hazard from the walls of the child's home. Once they are returned home, those children receive continued protection because the source of the disease has been removed. Doctors know that paint chips peeling from the walls of deteriorating homes can be the principal source of lead poisoning for those young children whose parents cannot prevent them from swallowing the sweet tasting particles. For that reason, the reported bill authorizes the Department of Health, Education, and Welfare to allow local lead poisoning screening programs to include a hazard elimination component, that can operate in concert with the local effort to search out and refer for treatment, those youngsters who are found to be lead sick.

### VII. TABULATION OF VOTES CAST IN COMMITTEE

Pursuant to section 133(b) of the Legislative Reorganization Act of 1946 as amended, the following is a tabulation of votes in committee: Motion to report the bill to the Senate carried without objection.

### VIII. COST ESTIMATES PURSUANT TO SECTION 252 OF THE LEGISLATIVE REORGANIZATION ACT OF 1970

	<i>Millions</i>
1976 -----	\$18. 0
1977 -----	30. 5
1978 -----	43. 0
Total -----	91. 5

### IX. SECTION BY SECTION ANALYSIS

Section (a) labels this bill as the "Lead Based Paint Poisoning Prevention Amendments of 1976."

Section (b) amends section 101(c)(3) of the Lead Based Paint Poisoning Prevention Act by authorizing the Department of Health, Education, and Welfare to conduct hazard elimination programs as follow-up procedures that can clean up those areas most likely to cause lead poisoning in the homes of children who have been found to be lead sick.

Section (c) amends Section 10(f) of such Act by requiring the Secretary of Health, Education, and Welfare to insure that local

screening and follow-up hazard elimination programs are conducted by those local authorities receiving funds for that purpose.

Section (d) amends Section 401 of such Act by authorizing the following agencies to provide safeguards against the use of lead based paint as follows:

The Secretary of Health, Education, and Welfare shall take steps necessary to prohibit the application of lead based paint to any utensil used for eating, cooking or drinking; the Secretary of Housing and Urban Development shall take appropriate steps to prohibit the use of lead based paints in any residential structure receiving federal assistance for any purpose including construction or rehabilitation; and the Consumer Product Safety Commission shall take appropriate steps to prohibit the application of lead based paint to any toy or to any article of furniture.

Section (e) amends Section 501(3) of such Act by establishing allowable limits of lead contained in paints intended for use on interior residential structures. Under the provisions of this section such paints may contain no more than 0.06% lead within six months from the date this amendment is enacted.

During that period, the Consumer Product Safety Commission is authorized to obtain evidence from public testimony to determine whether the allowable level of lead in paint should be established beyond .06%, but not to exceed 0.5%. By a majority vote of all the Commissioners, the allowable level will be determined based upon the Commissioner's review of available scientific evidence including recommendations of the Center for Disease Control, the National Academy of Sciences and the American Academy of Pediatrics.

Section (f)(1) amends Section 503(a) of such Act by extending the authorization levels to \$10 million for FY 1976; \$12.5 million for FY 1977, and \$15 million for FY 1978.

Section (f)(2) amends Section 503(b) of such Act by extending the authorization levels to \$5 million for FY 1976; \$15 million for FY 1977 and \$25 million for FY 1978.

Section (f)(3) amends Section 503(c) of such Act by extending the authorization levels to \$3 million for each fiscal year until June 1978.

### CHANGES IN EXISTING LAW

In compliance with paragraph 4 of the rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

#### LEAD-BASED PAINT POISONING PREVENTION ACT, AS AMENDED

[Public Law 91-695, January 13, 1971]

[Public Law 93-151, November 9, 1973]

AN ACT To provide Federal financial assistance to help cities and communities to develop and carry out intensive local programs to eliminate the causes of lead-based paint poisoning and local programs to detect and treat incidents of such poisoning, to establish a Federal demonstration and research program to

study the extent of the lead-based paint poisoning problem and the methods available for lead-based paint removal, and to prohibit future use of lead-based paint in Federal or federally assisted construction or rehabilitation.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Lead-Based Paint Poisoning Prevention Act".*

## TITLE I—GRANTS FOR THE DETECTION AND TREATMENT OF LEAD-BASED PAINT POISONING

### GRANTS FOR LOCAL DETECTION AND TREATMENT OF LEAD-BASED PAINT POISONING

SEC. 101. (a) The Secretary of Health, Education, and Welfare (hereafter referred to in this title as the "Secretary") is authorized to make grants to *public agencies* of units of general local government in any State and to *private nonprofit organizations* in any State for the purpose of assisting such units in developing and carrying out local programs to detect and treat incidents of lead-based paint poisoning.

(b) The amount of any such grant shall not exceed [75] 90 per centum of the cost of developing and carrying out a local program, as approved by the Secretary, during a period of three years.

(c) A local program should include—

(1) educational programs intended to communicate the health danger and prevalence of lead-based paint poisoning among children of inner city areas, to parents, educators, and local health officials;

(2) development and carrying out of intensive community testing programs designed to direct incidents of lead-based paint poisoning among community residents, and to insure prompt medical treatment for such afflicted individuals;

(3) development and carrying out of intensive followup programs to insure that identified cases of lead-based paint poisoning are protected against further exposure to lead-based [paints] *paint hazards* in their living [environment; and] *environment by eliminating lead-based paint hazards from surfaces in and around residential dwelling units or houses when the owner of said units or houses is financially unable to eliminate such lead-based paint hazards. Priority for local lead elimination programs shall go to units or houses where there reside children with elevated body lead burden or diagnosed lead-based paint poisoning, or both; and*

(4) any other actions which will reduce or eliminate lead-based paint poisoning.

(d) Each local program shall afford opportunities for employing the residents of communities or neighborhoods affected by lead-based paint poisoning, and for providing appropriate training, education, and any information which may be necessary to inform such residents of opportunities for employment in lead-based paint poisoning elimination programs.

(e) *The Secretary is also authorized to make grants to State agencies for the purpose of establishing centralized laboratory facilities for analyzing biological and environmental lead specimens obtained from local lead based paint poisoning detection programs.*

(f) (1) *No grant may be made under this section unless the Secretary determines that there is satisfactory assurance that (A) the services to be provided will constitute an addition to, or a significant improvement in quality (as determined in accordance with criteria of the Secretary) in, services that would otherwise be provided, and (B) Federal funds made available under this section for any period will be so used as to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds that would, in the absence of such Federal funds, be made available for the program described in this section, and will in no event supplant such State, local, and other non-Federal funds.*

(2) *No grant may be made under this section unless the Secretary determines that there is satisfactory assurance that the services to be provided will be carried out in accordance with subsections (c) and (d) of this section.*

## TITLE II—GRANTS FOR THE ELIMINATION OF LEAD-BASED PAINT POISONING

SEC. 201. The Secretary of Health, Education, and Welfare is authorized to make grants to *public agencies* of units of general local government in any State and to *private nonprofit organizations* in any State for the purpose of assisting such units in developing and carrying out programs that identify those areas that present a high risk to the health of residents because of the presence of lead-based paints on interior surfaces, and then to develop and carry out programs to eliminate the hazards of lead-based paint poisoning.

(a) A local program should include:

(1) development and carrying out of comprehensive testing programs to detect the presence of lead-based paints on surfaces of residential housing;

[ (2) the development and carrying out of a comprehensive program requiring the prompt elimination of lead-based paints from all interior surfaces, porches, and exterior surfaces to which children may be commonly exposed, of residential housing on which lead-based paints have been used as a surface covering, including those surfaces on which non-lead-based paints have been used to cover surfaces to which lead-based paints were previously applied; and ]

(2) *the development and carrying out of procedures to remove from exposure to young children all interior surfaces of residential housing, porches, and exterior surfaces of such housing to which children may be commonly exposed, in those areas that present a high risk for the health of residents because of the presence of lead based paints. Such programs should include those surfaces on which non-lead-based paints have been used to cover surfaces to which lead based paints were previously applied; and*

(3) any other actions which will reduce or eliminate lead-based paint poisoning.

(b) Each such program shall—

(1) be consistent with the appropriate local program assisted under section 101, and

(2) afford, to the maximum extent feasible, opportunities for employing the resident of communities or neighborhoods affected

by lead-based paint poisoning, and for providing appropriate training, education, and any information which may be necessary to inform such residents of opportunities for employment in lead-based paint elimination programs.

(c) Any public agency, of a unit of local government or private nonprofit organization which receives assistance under this Act shall make available to the Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, for purposes of audit and examination, any books, documents, papers, and records that are pertinent to the assistance received by such public agency of a unit of local government or private nonprofit organization under this Act.

### TITLE III—FEDERAL DEMONSTRATION AND RESEARCH PROGRAM; FEDERAL HOUSING ADMINISTRATION REQUIREMENTS

#### FEDERAL DEMONSTRATION AND RESEARCH PROGRAM

SEC. 301. (a) The Secretary of Housing and Urban Development, in consultation with the Secretary of Health, Education, and Welfare, shall develop and carry out a demonstration and research program to determine the nature and extent of the problem of lead-based paint poisoning in the United States, particularly in urban areas, [and the methods by which lead-based paint can most effectively be removed from interior surfaces, porches, and exterior surfaces to which children may be commonly exposed, of residential housing. Within one year after the date of the enactment of this Act the Secretary shall submit to the Congress a full and complete report of his findings and recommendations as developed pursuant to such program, together with a statement of any legislation which should be enacted, and any changes in existing law which should be made, in order to carry out such recommendations.] *including the methods by which the lead based paint hazard can most effectively be removed from interior surfaces, porches, and exterior surfaces of residential housing to which children may be exposed.*

(b) *The Chairman of the Consumer Product Safety Commission shall conduct appropriate research on multiple layers of dried paint film, containing the various lead compounds commonly used, in order to ascertain the safe level of lead in residential paint products. No later than December 3, 1974, the Chairman shall submit to Congress a full and complete report of his findings and recommendations as developed pursuant to such programs, together with a statement of any legislation which should be enacted or any changes in existing law which should be made in order to carry out such recommendations.*

#### FEDERAL HOUSING ADMINISTRATION REQUIREMENTS

SEC. 302. *The Secretary of Housing and Urban Development (hereafter in this section referred to as the "Secretary") shall establish procedures to eliminate as far as practicable the hazards of lead based paint poisoning with respect to any existing housing which*

*may present such hazards and which is covered by an application for mortgage insurance or housing assistance payments under a program administered by the Secretary. Such procedures shall apply to all such housing constructed prior to 1950 and shall as a minimum provide for (1) appropriate measures to eliminate as far as practicable immediate hazards due to the presence of paint which may contain lead and to which children may be exposed, and (2) assured notification to purchasers and tenants of such housing of the hazards of lead based paint, of the symptoms and treatment of lead based paint poisoning, and of the importance and availability of maintenance and removal techniques for eliminating such hazards. Such procedures may apply to housing constructed during or after 1950 if the Secretary determines, in his discretion, that such housing presents hazards of lead based paint. The Secretary may establish such other procedures as may be appropriate to carry out the purposes of this section. Further, the Secretary shall establish and implement procedures to eliminate the hazards of lead based paint poisoning in all federally owned properties prior to the sale of such properties when their use is intended for residential habitation.*

### TITLE IV—PROHIBITION AGAINST FUTURE USE OF LEAD-BASED PAINT

#### [PROHIBITION AGAINST USE OF LEAD BASED PAINT IN CONSTRUCTION OF FACILITIES AND THE MANUFACTURE OF CERTAIN TOYS AND UTENSILS

[SEC. 401. The Secretary of Health, Education, and Welfare, in consultation with the Secretary of Housing and Urban Development, shall take such steps and impose such conditions as may be necessary or appropriate—

(1) to prohibit the use of lead based paint in residential structures constructed or rehabilitated by the Federal Government, or with Federal assistance in any form, after the date of enactment of this Act, and

(2) to prohibit the application of lead based paint to any toy, furniture, cooking utensil, drinking utensil, or eating utensil manufactured and distributed after the date of enactment of this Act.]

#### PROHIBITION AGAINST USE OF LEAD-BASED PAINT IN CONSTRUCTION OF FACILITIES AND THE MANUFACTURE OF CERTAIN TOYS AND UTENSILS

SEC. 401. (a) *The Secretary of Health, Education, and Welfare shall take such steps and impose such conditions as may be necessary or appropriate to prohibit the application of lead-based paint to any cooking utensil, drinking utensil, or eating utensil manufactured and distributed after the date of enactment of this Act.*

(b) *The Secretary of Housing and Urban Development shall take such steps and impose such conditions as may be necessary or appropriate to prohibit the use of lead-based paint in residential structures constructed or rehabilitated by the Federal Government, or with Federal assistance in any form after the date of enactment of this Act.*



(c) *The Consumer Product Safety Commissions shall take such steps and impose such conditions as may be necessary or appropriate to prohibit the application of lead-based paint to any toy or furniture article.*

## TITLE V—GENERAL

### DEFINITIONS

SEC. 501. As used in this Act—

(1) the term "State" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the territories and possessions of the United States;

(2) the term "units of general local government" means (A) any city, county, township, town, borough, parish, village, or other general purpose political subdivisions of a State, (B) any combination of units of general local government in one or more States, (C) and Indian tribe, or (D) with respect to lead-based paint poisoning elimination activities in their urban areas, the territories and possessions of the United States; and

[(3) the term "lead based paint" means—

(A) prior to December 31, 1974, any paint containing more than five-tenths of 1 per centum lead by weight (calculated as lead metal) in the total nonvolatile content of liquid paints or in the dried film of paint already applied;

(B) after December 31, 1974, any paint containing more than six one-hundredths of 1 per centum lead by weight (calculated as lead metal) in the total nonvolatile content of liquid paints or in the dried film of paint already applied, except that if prior to December 31, 1974, the Chairman of the Consumer Product Safety Commission, based on studies conducted in accordance with section 301(b) of this Act, determines that another level of lead, not to exceed five-tenths of 1 per centum, is safe, then such other level shall be effective after December 31, 1974.]

(3) the term "lead-based paint" means—

(A) within 6 months of the date of enactment of this amendment any paint containing more than five-tenths of 1 percentum lead by weight (calculated as lead metal) in the total nonvolatile content of lead paints, or the equivalent measure of lead in the dried film of paint already applied, or both;

(B) after 6 months from the date of enactment of the amendment, any paint containing more than six-hundredths of 1 percentum lead by weight (calculated as lead metal) in the total nonvolatile content of lead paints, or the equivalent measure of lead in the dried film of paint already applied, or both, except that

(C) the Consumer Product Safety Commission shall on the basis of public testimony and available scientific evidence (which shall include the recommendations of the Center for Disease Control, the American Academy of Pediatrics and the National Academy of Sciences) determine within 6 months of the date of enactment of this amendment whether another level of lead, not to exceed five-tenths of 1 percentum, is safe, in which case such other level shall be effective after 6 months from the date of enactment of this amendment.

### CONSULTATION WITH OTHER DEPARTMENTS AND AGENCIES

SEC. 502. In carrying out the authority under this Act, the Secretary of Health, Education, and Welfare shall cooperate with and seek the advice of the heads of any other departments or agencies regarding any programs under their respective responsibilities which are related to, or would be affected by, such authority.

### APPROPRIATIONS

SEC. 503. (a) *There is hereby authorized to be appropriated to carry out the provisions of title I of this Act not to exceed \$10,000,000 for fiscal year 1976; \$12,500,000 for fiscal year 1977 and \$15,000,000 for fiscal year 1978;*

(b) *There is hereby authorized to be appropriated to carry out the provisions of title II of this Act not to exceed "\$5,000,000 for the fiscal year 1976, \$15,000,000 for the fiscal year 1977, and \$25,000,000 for the fiscal year 1978"; and*

(c) *There is hereby authorized to be appropriated to carry out the provisions of title III of this Act not to exceed "\$3,000,000 for each of the fiscal years 1976, 1977, and 1978".*

(d) Any amounts appropriated under this section shall remain available until expended when so provided in appropriation Acts; [and any amounts authorized for the fiscal year 1971 but not appropriated may be appropriated for the fiscal year 1972.] *and any amounts authorized for one fiscal year but not appropriated may be appropriated for the succeeding fiscal year.*

### ELIGIBILITY OF CERTAIN STATE AGENCIES

SEC. 504. *Notwithstanding any other provision of this Act, grants authorized under sections 101 and 201 of this Act may be made to an agency of State government in any case where State government provides direct services to citizens in local communities or where units of general local government within the State are prevented by State law from implementing or receiving such grants or from expending such grants in accordance with their intended purpose.*

### ADVISORY BOARDS

SEC. 505. (a) *The Secretary of Health, Education, and Welfare, in consultation with the Secretary of Housing and Urban Development, is authorized to establish a National Childhood Lead Based Paint Poisoning Advisory Board to advise the Secretary on policy relating to the administration of this Act. Members of the Board shall include residents of communities and neighborhoods affected by lead based paint poisoning. Each member of the National Advisory Board who is not an officer of the Federal Government is authorized to receive an amount equal to the minimum daily rate prescribed for GS-18, under section 5332 of title 5, United States Code, for each day he is engaged in the actual performance of his duties (including traveltime) as a member of the Board. All members shall be reimbursed for travel, subsistence, and necessary expenses incurred in the performance of their duties.*

(b) *The Secretary of Health, Education, and Welfare, in consultation with the Secretary of Housing and Urban Development, shall promulgate regulations for establishment of an advisory board for each local program assisted under this Act to assist in carrying out this*

*program. Two-thirds of the members of the board shall be residents of communities and neighborhoods affected by lead based paint poisoning. A majority of the board shall be appointed from among parents, who, when appointed, have at least one child under six years of age. Each member of a local advisory board shall only be reimbursed for necessary expenses incurred in the actual performance of his duties as a member of the board.*

EFFECT UPON STATE LAW

*SEC. 506. It is hereby expressly declared that it is the intent of the Congress to supersede any and all laws of the States and units of local government insofar as they may now or hereafter provide for a requirement, prohibition, or standard relating to the lead content in paints or other similar surface-coating materials which differs from the provisions of this Act or regulations issued pursuant to this Act. Any law, regulation, or ordinance purporting to establish such different requirement, prohibition, or standard shall be null and void.*

TITLE III—GENERAL POWERS AND DUTIES  
OF PUBLIC HEALTH SERVICE

PART A—RESEARCH AND INVESTIGATION

IN GENERAL

\* \* \* \* \*

Project Grants for Health Services Development

(e) There are authorized to be appropriated \$90,000,000 for the fiscal year ending June 30, 1968, \$95,000,000 for the fiscal year ending June 30, 1969, \$80,000,000 for the fiscal year ending June 30, 1970, \$109,500,000 for the fiscal year ending June 30, 1971, \$135,000,000 for the fiscal year ending June 30, 1972, and \$157,000,000 for the fiscal year ending June 30, 1973, for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost (including equity requirements and amortization of loans on facilities acquired from the Office of Economic Opportunity or construction in connection with any program or project transferred from the Office of Economic Opportunity) of (1) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services (including related training). Any grant made under this subsection may be made only if the application for such grant has been referred for review and comment to the appropriate areawide health planning agency or agencies (or, if there is no such agency in the area, then to such other public or nonprofit private agency or organization (if any) which performs similar functions) and only if the services assisted under such grant will be provided in accordance with such plans as have been developed pursuant to subsection (a).

*No funds appropriated pursuant to the authorization of this subsection shall be available for lead based paint poisoning control of the type authorized under the Lead Based Paint Poisoning Prevention Act (84 Stat. 2078).*

# Ninety-fourth Congress of the United States of America

AT THE SECOND SESSION

*Begun and held at the City of Washington on Monday, the nineteenth day of January,  
one thousand nine hundred and seventy-six*

## An Act

To amend the Public Health Service Act to provide authority for health information and health promotion programs, to revise and extend the authority for disease prevention and control programs, and to revise and extend the authority for venereal disease programs, and to amend the Lead-Based Paint Poisoning Prevention Act to revise and extend that Act.

*Be it enacted by the Senate and House of Representatives of the  
United States of America in Congress assembled,*

### TITLE I—HEALTH INFORMATION AND HEALTH PROMOTION

#### SHORT TITLE

SEC. 101. This title may be cited as the "National Consumer Health Information and Health Promotion Act of 1976".

#### AMENDMENT TO PUBLIC HEALTH SERVICE ACT

SEC. 102. The Public Health Service Act is amended by adding at the end thereof the following new title:

### "TITLE XVII—HEALTH INFORMATION AND HEALTH PROMOTION

#### "GENERAL AUTHORITY

"SEC. 1701. (a) The Secretary shall—

"(1) formulate national goals, and a strategy to achieve such goals, with respect to health information and health promotion, preventive health services, and education in the appropriate use of health care;

"(2) analyze the necessary and available resources for implementing the goals and strategy formulated pursuant to paragraph (1), and recommend appropriate educational and quality assurance policies for the needed manpower resources identified by such analysis;

"(3) undertake and support necessary activities and programs to—

"(A) incorporate appropriate health education components into our society, especially into all aspects of education and health care,

"(B) increase the application and use of health knowledge, skills, and practices by the general population in its patterns of daily living, and

"(C) establish systematic processes for the exploration, development, demonstration, and evaluation of innovative health promotion concepts;

"(4) undertake and support research and demonstrations respecting health information and health promotion, preventive health services, and education in the appropriate use of health care;

“(5) undertake and support appropriate training in, and undertake and support appropriate training in the operation of programs concerned with, health information and health promotion, preventive health services, and education in the appropriate use of health care;

“(6) undertake and support, through improved planning and implementation of tested models and evaluation of results, effective and efficient programs respecting health information and health promotion, preventive health services, and education in the appropriate use of health care;

“(7) foster the exchange of information respecting, and foster cooperation in the conduct of, research, demonstration, and training programs respecting health information and health promotion, preventive health services, and education in the appropriate use of health care;

“(8) provide technical assistance in the programs referred to in paragraph (7); and

“(9) use such other authorities for programs respecting health information and health promotion, preventive health services, and education in the appropriate use of health care as are available and coordinate such use with programs conducted under this title.

The Secretary shall administer this title in a manner consistent with the national health priorities set forth in section 1502 and with health planning and resource development activities undertaken under titles XV and XVI.

“(b) For payments under grants and contracts under this title there are authorized to be appropriated \$7,000,000 for the fiscal year ending September 30, 1977, \$10,000,000 for the fiscal year ending September 30, 1978, and \$14,000,000 for the fiscal year ending September 30, 1979.

“(c) No grant may be made or contract entered into under this title unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be submitted in such form and manner and contain such information as the Secretary may prescribe. Contracts may be entered into under this title without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

#### “RESEARCH PROGRAMS

“SEC. 1702. (a) The Secretary is authorized to conduct and support by grant or contract (and encourage others to support) research in health information and health promotion, preventive health services, and education in the appropriate use of health care. Applications for grants and contracts under this section shall be subject to appropriate peer review. The Secretary shall also—

“(1) provide consultation and technical assistance to persons who need help in preparing research proposals or in actually conducting research;

“(2) determine the best methods of disseminating information concerning personal health behavior, preventive health services and the appropriate use of health care and of affecting behavior so that such information is applied to maintain and improve health, and prevent disease, reduce its risk, or modify its course or severity;

“(3) determine and study environmental, occupational, social, and behavioral factors which affect and determine health and ascertain those programs and areas for which educational and preventive measures could be implemented to improve health as it is affected by such factors;

“(4) develop (A) methods by which the cost and effectiveness of activities respecting health information and health promotion, preventive health services, and education in the appropriate use of health care, can be measured, including methods for evaluating the effectiveness of various settings for such activities and the various types of persons engaged in such activities, (B) methods for reimbursement or payment for such activities, and (C) models and standards for the conduct of such activities, including models and standards for the education, by providers of institutional health services, of individuals receiving such services respecting the nature of the institutional health services provided the individuals and the symptoms, signs, or diagnoses which led to provision of such services;

“(5) develop a method for assessing the cost and effectiveness of specific medical services and procedures under various conditions of use, including the assessment of the sensitivity and specificity of screening and diagnostic procedures; and

“(6) enumerate and assess, using methods developed under paragraph (5), preventive health measures and services with respect to their cost and effectiveness under various conditions of use.

“(b) The Secretary shall make a periodic survey of the needs, interest, attitudes, knowledge, and behavior of the American public regarding health and health care. The Secretary shall take into consideration the findings of such surveys and the findings of similar surveys conducted by national and community health education organizations, and other organizations and agencies for formulating policy respecting health information and health promotion, preventive health services, and education in the appropriate use of health care.

#### “COMMUNITY PROGRAMS

“SEC. 1703. (a) The Secretary is authorized to conduct and support by grant or contract (and encourage others to support) new and innovative programs in health information and health promotion, preventive health services, and education in the appropriate use of health care, and may specifically—

“(1) support demonstration and training programs in such matters which programs (A) are in hospitals, ambulatory care settings, home care settings, schools, day care programs for children, and other appropriate settings representative of broad cross sections of the population, and include public education activities of voluntary health agencies, professional medical societies, and other private nonprofit health organizations, (B) focus on objectives that are measurable, and (C) emphasize the prevention or moderation of illness or accidents that appear controllable through individual knowledge and behavior;

“(2) provide consultation and technical assistance to organizations that request help in planning, operating, or evaluating programs in such matters;

“(3) develop health information and health promotion materials and teaching programs including (A) model curriculums for the training of educational and health professionals and paraprofessionals in health education by medical, dental, and nursing schools, schools of public health, and other institutions engaged in training of educational or health professionals, (B) model curriculums to be used in elementary and secondary schools and institutions of higher learning, (C) materials and programs

for the continuing education of health professionals and paraprofessionals in the health education of their patients, (D) materials for public service use by the printed and broadcast media, and (E) materials and programs to assist providers of health care in providing health education to their patients; and

“(4) support demonstration and evaluation programs for individual and group self-help programs designed to assist the participant in using his individual capacities to deal with health problems, including programs concerned with obesity, hypertension, and diabetes.

“(b) The Secretary is authorized to make grants to States and other public and nonprofit private entities to assist them in meeting the costs of demonstrating and evaluating programs which provide information respecting the costs and quality of health care or information respecting health insurance policies and prepaid health plans, or information respecting both. After the development of models pursuant to sections 1704(4) and 1704(5) for such information, no grant may be made under this subsection for a program unless the information to be provided under the program is provided in accordance with one of such models applicable to the information.

“(c) The Secretary is authorized to support by grant or contract (and to encourage others to support) private nonprofit entities working in health information and health promotion, preventive health services, and education in the appropriate use of health care. The amount of any grant or contract for a fiscal year beginning after September 30, 1978, for an entity may not exceed 25 per centum of the expenses of the entity for such fiscal year for health information and health promotion, preventive health services, and education in the appropriate use of health care.

#### “INFORMATION PROGRAMS

“Sec. 1704. The Secretary is authorized to conduct and support by grant or contract (and encourage others to support) such activities as may be required to make information respecting health information and health promotion, preventive health services, and education in the appropriate use of health care available to the consumers of medical care, providers of such care, schools, and others who are or should be informed respecting such matters. Such activities may include at least the following:

“(1) The publication of information, pamphlets, and other reports which are specially suited to interest and instruct the health consumer, which information, pamphlets, and other reports shall be updated annually, shall pertain to the individual's ability to improve and safeguard his own health; shall include material, accompanied by suitable illustrations, on child care, family life and human development, disease prevention (particularly prevention of pulmonary disease, cardiovascular disease, and cancer), physical fitness, dental health, environmental health, nutrition, safety and accident prevention, drug abuse and alcoholism, mental health, management of chronic diseases (including diabetes and arthritis), and venereal diseases; and shall be designed to reach populations of different languages and of different social and economic backgrounds.

“(2) Securing the cooperation of the communications media, providers of health care, schools, and others in activities designed to promote and encourage the use of health maintaining information and behavior.

“(3) The study of health information and promotion in advertising and the making to concerned Federal agencies and others such recommendations respecting such advertising as are appropriate.

“(4) The development of models and standards for the publication by States, insurance carriers, prepaid health plans, and others (except individual health practitioners) of information for use by the public respecting the cost and quality of health care, including information to enable the public to make comparisons of the cost and quality of health care.

“(5) The development of models and standards for the publication by States, insurance carriers, prepaid health plans, and others of information for use by the public respecting health insurance policies and prepaid health plans, including information on the benefits provided by the various types of such policies and plans, the premium charges for such policies and plans, exclusions from coverage or eligibility for coverage, cost sharing requirements, and the ratio of the amounts paid as benefits to the amounts received as premiums and information to enable the public to make relevant comparisons of the costs and benefits of such policies and plans.

“(6) Assess, with respect to the effectiveness, safety, cost, and required training for and conditions of use, of new aspects of health care, and new activities, programs, and services designed to improve human health and publish in readily understandable language for public and professional use such assessments and, in the case of controversial aspects of health care, activities, programs, or services, publish differing views or opinions respecting the effectiveness, safety, cost, and required training for and conditions of use, of such aspects of health care, activities, programs, or services.

“REPORT AND STUDY

“SEC. 1705. (a) The Secretary shall, not later than two years after the date of the enactment of this title and annually thereafter, submit to the President for transmittal to Congress a report on the status of health information and health promotion, preventive health services, and education in the appropriate use of health care. Each such report shall include—

“(1) a statement of the activities carried out under this title since the last report and the extent to which each such activity achieves the purposes of this title;

“(2) an assessment of the manpower resources needed to carry out programs relating to health information and health promotion, preventive health services, and education in the appropriate use of health care, and a statement describing the activities currently being carried out under this title designed to prepare teachers and other manpower for such programs;

“(3) the goals and strategy formulated pursuant to section 1701(a)(1), the models and standards developed under this title, and the results of the study required by subsection (b) of this section; and

“(4) such recommendations as the Secretary considers appropriate for legislation respecting health information and health promotion, preventive health services, and education in the appropriate use of health care, including recommendations for revisions to and extension of this title.

“(b) The Secretary shall conduct a study of health education services and preventive health services to determine the coverage of such services under public and private health insurance programs, including the extent and nature of such coverage and the cost sharing requirements required by such programs for coverage of such services.

“OFFICE OF HEALTH INFORMATION AND HEALTH PROMOTION

“SEC. 1706. The Secretary shall establish within the Office of the Assistant Secretary for Health an Office of Health Information and Health Promotion which shall—

“(1) coordinate all activities within the Department which relate to health information and health promotion, preventive health services, and education in the appropriate use of health care;

“(2) coordinate its activities with similar activities of organizations in the private sector; and

“(3) establish a national information clearinghouse to facilitate the exchange of information concerning matters relating to health information and health promotion, preventive health services, and education in the appropriate use of health care, to facilitate access to such information, and to assist in the analysis of issues and problems relating to such matters.”.

TITLE II—DISEASE CONTROL

SHORT TITLE

SEC. 201. This title may be cited as the “Disease Control Amendments of 1976”.

AMENDMENTS TO SECTIONS 311 AND 317

SEC. 202. (a) Effective with respect to grants under section 317 of the Public Health Service Act made from appropriations under such section for fiscal years beginning after June 30, 1975, section 317 of such Act is amended to read as follows:

“DISEASE CONTROL PROGRAMS

“SEC. 317. (a) The Secretary may make grants to States and, in consultation with State health authorities, to public entities to assist them in meeting the costs of disease control programs.

“(b) (1) No grant may be made under subsection (a) unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, be submitted in such manner, and contain such information as the Secretary shall by regulation prescribe and shall meet the requirements of paragraph (2).

“(2) An application for a grant under subsection (a) shall—

“(A) set forth with particularity the objectives (and their priorities, as determined in accordance with such regulations as the Secretary may prescribe) of the applicant for each of the disease control programs it proposes to conduct with assistance from a grant under subsection (a);

“(B) contain assurances satisfactory to the Secretary that, in the year during which the grant applied for would be available, the applicant who are most susceptible to the diseases or conditions to develop an awareness in those persons in the area served by



the applicant who are most susceptible to the diseases or conditions referred to in subsection (f) of appropriate preventive behavior and measures (including immunizations) and diagnostic procedures for such diseases, and (ii) to facilitate their access to such measures and procedures; and

“(C) provide for the reporting to the Secretary of such information as he may require concerning (i) the problems, in the area served by the applicant, which relate to any disease or condition referred to in subsection (f), and (ii) the disease control programs of the applicant for which a grant is applied for.

In considering such an application the Secretary shall take into account the relative extent, in the area served by the applicant, of the problems which relate to one or more of the diseases or conditions referred to in subsection (f) and the extent to which the applicant's programs are designed to eliminate or reduce such problems. The Secretary shall give special consideration to applications for programs which (A) will increase to at least 80 per centum the immunization rates of any population identified as not having received, or as having failed to secure, the generally recognized disease immunizations, and (B) to the fullest extent practicable, will cooperate and use public and nonprofit private entities and volunteers. The Secretary shall give priority to applications submitted for disease control programs for communicable diseases.

“(c)(1) Each grant under subsection (a) shall be made for disease control program costs in the one-year period beginning on the first day of the first month beginning after the month in which the grant is made.

“(2) Payments under grants under subsection (a) may be made in advance on the basis of estimates or by way of reimbursement, with necessary adjustments on account of underpayments or overpayments, and in such installments and on such terms and conditions as the Secretary finds necessary to carry out the purposes of this section.

“(3) The Secretary, at the request of a recipient of a grant under subsection (a), may reduce the amount of such grant by—

“(A) the fair market value of any supplies (including vaccines and other prevention agents) or equipment furnished the grant recipient, and

“(B) the amount of the pay, allowances, and travel expenses of any officer or employee of the Government when detailed to the recipient and the amount of any other costs incurred in connection with the detail of such officer or employee,

when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience of and at the request of such recipient and for the purpose of carrying out a program with respect to which the recipient's grant under subsection (a) is made. The amount by which any such grant is so reduced shall be available for payment by the Secretary of the costs incurred in furnishing the supplies or equipment, or in detailing the personnel, on which the reduction of such grant is based, and such amount shall be deemed as part of the grant and shall be deemed to have been paid to the recipient.

“(d)(1) The Secretary may conduct, and may make grants to and enter into contracts with public and nonprofit private entities for the conduct of—

“(A) training for the administration and operation of disease prevention and control programs, and

“(B) demonstrations and evaluations of such programs.

“(2) No grant may be made or contract entered into under paragraph (1) unless an application therefor is submitted to and approved by the Secretary. Such application shall be in such form, be submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

“(e) The Secretary shall coordinate activities under this section respecting disease control programs with activities under other sections of this Act respecting such programs.

“(f) For purposes of this section, the term ‘disease control program’ means a program which is designed and conducted so as to contribute to national protection against diseases or conditions of national significance which are amenable to reduction, including tuberculosis, rubella, measles, poliomyelitis, diphtheria, tetanus, pertussis, mumps, and other communicable diseases (other than venereal diseases), and arthritis, diabetes, diseases borne by rodents, hypertension, pulmonary diseases, cardiovascular diseases, and Rh disease. Such term also includes vaccination programs, laboratory services, studies to determine the disease control needs of the States and the means of best meeting such needs, the provision of information and education services respecting disease control, and programs to encourage behavior which will prevent disease and encourage the use of preventive measures and diagnostic procedures. Such term also includes any program or project for rodent control for which a grant was made under section 314(e) for the fiscal year ending June 30, 1975.

“(g) (1) (A) For the purpose of grants under subsection (a) for disease control programs to immunize children against immunizable diseases (including measles, rubella, poliomyelitis, diphtheria, pertussis, tetanus, and mumps), there are authorized to be appropriated \$9,000,000 for fiscal year 1976, \$17,500,000 for fiscal year 1977, and \$23,000,000 for fiscal year 1978.

“(B) For the purpose of grants under subsection (a) for disease control programs for diseases borne by rodents there are authorized to be appropriated \$13,500,000 for fiscal year 1976, \$14,000,000 for fiscal year 1977, and \$14,500,000 for fiscal year 1978.

“(C) For the purpose of grants under subsection (a) for disease control programs, other than programs for which appropriations are authorized under subparagraph (A) or (B), and for the purpose of grants and contracts under subsection (d), there are authorized to be appropriated \$4,000,000 for fiscal year 1976, \$4,500,000 for fiscal year 1977, and \$5,000,000 for fiscal year 1978.

“(D) Not to exceed 15 per centum of the amount appropriated for any fiscal year under any of the preceding subparagraphs of this paragraph may be used by the Secretary for grants and contracts for such fiscal year for programs for which appropriations are authorized under any one or more of the other subparagraphs of this paragraph if the Secretary determines that such use will better carry out the purpose of this section, and reports to the appropriate committees of Congress at least thirty days before making such use of such amount his determination and the reasons therefor.

“(2) Except as provided in section 318, no funds appropriated under any provision of this Act other than paragraph (1) of this subsection may be used to make grants in any fiscal year for disease control programs if (A) grants for such programs are authorized by subsection (a), and (B) all the funds authorized to be appropriated under this subsection for that fiscal year have not been appropriated for that fiscal year and obligated in that fiscal year.

“(h) The Secretary shall submit to the President for submission to the Congress on January 1 of each year (1) a report (A) on the

effectiveness of all Federal and other public and private activities in controlling the diseases and conditions referred to in subsection (f), (B) on the extent of the problems presented by such diseases, (C) on the effectiveness of the activities, assisted under grants and contracts under this section, in controlling such diseases, and (D) setting forth a plan for the coming year for the control of such diseases; and (2) a report (A) on the immune status of the population of the United States, and (B) identifying, by area, population group, and other categories, deficiencies in the immune status of such population.

“(i) (1) Nothing in this section shall limit or otherwise restrict the use of funds which are granted to a State or to an agency or a political subdivision of a State under provisions of Federal law (other than this Act) and which are available for the conduct of disease control programs from being used in connection with programs assisted through grants under subsection (a).

“(2) Nothing in this section shall be construed to require any State or any agency or political subdivision of a State to have a disease control program which would require any person, who objects to any treatment provided under such a program, to be treated or to have any child or ward treated under such a program.”

(b) Section 311(c) of the Public Health Service Act is amended to read as follows:

“(c) (1) The Secretary is authorized to develop (and may take such action as may be necessary to implement) a plan under which personnel, equipment, medical supplies, and other resources of the Service and other agencies under the jurisdiction of the Secretary may be effectively used to control epidemics of any disease or condition referred to in section 317(f) and to meet other health emergencies or problems involving or resulting from disasters or any such disease. The Secretary may enter into agreements providing for the cooperative planning between the Service and public and private community health programs and agencies to cope with health problems (including epidemics and health emergencies) resulting from disasters or any disease or condition referred to in section 317(f).

“(2) The Secretary may, at the request of the appropriate State or local authority, extend temporary (not in excess of forty-five days) assistance to States or localities in meeting health emergencies of such a nature as to warrant Federal assistance. The Secretary may require such reimbursement of the United States for assistance provided under this paragraph as he may determine to be reasonable under the circumstances. Any reimbursement so paid shall be credited to the applicable appropriation for the Service for the year in which such reimbursement is received.”

(c) Section 311(b) of such Act is amended by inserting at the end thereof the following new sentence: “The Secretary may charge only private entities reasonable fees for the training of their personnel under the preceding sentence.”

#### AMENDMENTS RESPECTING VENEREAL DISEASES

SEC. 203. (a) The Congress finds and declares that—

- (1) the number of reported cases of venereal disease continues in epidemic proportions in the United States;
- (2) the number of patients with venereal disease reported to public health authorities is only a fraction of those actually infected;
- (3) the incidence of venereal disease is particularly high in the 15-29-year age group, and in metropolitan areas;

(4) venereal disease accounts for needless deaths and leads to such severe disabilities as sterility, insanity, blindness, and crippling conditions;

(5) the number of cases of congenital syphilis, a preventable disease, tends to parallel the incidence of syphilis in adults;

(6) it is conservatively estimated that the public cost of care for persons suffering the complications of venereal disease exceed \$80,000,000 annually;

(7) medical researchers have no successful vaccine for syphilis or gonorrhea, and have no blood test for the detection of gonorrhea among the large reservoir of asymptomatic females;

(8) school health education programs, public information and awareness campaigns, mass diagnostic screening and case followup activities have all been found to be effective disease intervention methodologies;

(9) knowledgeable health providers and concerned individuals and groups are fundamental to venereal disease prevention and control;

(10) biomedical research leading to the development of vaccines for syphilis and gonorrhea is of singular importance for the eventual eradication of these dreaded diseases; and

(11) a variety of other sexually transmitted diseases, in addition to syphilis and gonorrhea, have become of public health significance.

(b)(1) Section 318(b)(2) of the Public Health Service Act is amended to read as follows:

“(2) For the purpose of carrying out this subsection, there are authorized to be appropriated \$5,000,000 for fiscal year 1976, \$6,600,000 for fiscal year 1977, and \$7,600,000 for fiscal year 1978.”

(2) Subsection (d)(2) of such section is amended to read as follows: “(2) For the purpose of carrying out this section there is authorized to be appropriated \$32,000,000 for fiscal year 1976, \$41,500,000 for fiscal year 1977, and \$43,500,000 for fiscal year 1978.”

(c) Subsection (a) of such section is amended by striking out “public authorities and” and inserting in lieu thereof “public and non-profit private entities and to”.

(d) Subsection (d)(1)(B) of such section is amended by inserting before the semicolon at the end the following: “and routine testing, including laboratory tests and followup systems”.

(e) Subsection (d)(1)(E) of such section is amended by striking out “control” and inserting in lieu thereof “prevention and control strategies and activities”.

(f)(1) Subsection (c) is repealed.

(2) Subsection (e)(1) of such section is amended by striking out “or (d)” and inserting in lieu thereof “or (c)”.

(3) Subsection (e)(2)(C) of such section is amended by striking out “(including dark-field microscope techniques for the diagnosis of both gonorrhea and syphilis)”.

(4) The last sentence of subsection (e)(4) of such section is amended by striking out the semicolon and all that follows through “paid to such recipient”.

(5) The first sentence of subsection (e)(5) of such section is amended by inserting before the period the following: “or as may be required by a law of a State or political subdivision of a State”.

(6) Subsection (g) of such section is amended by striking out “, (c), and (d)” and inserting in lieu thereof “and (c)”.

(7) Subsection (h) of such section is amended by striking out “treated or to have any child or ward of his”.

(8) Subsections (d), (e), (f), (g), and (h) of such section are redesignated as subsections (c), (d), (e), (f), and (g), respectively.

(g) Subsection (e) of such section (as so redesignated) is amended by striking out "317(d)(4)" and inserting in lieu thereof "317(g)(2)."

(h) Such section is amended by adding at the end thereof the following new subsection:

"(h) For purposes of this section and section 317, the term 'venereal disease' means gonorrhea, syphilis, or any other disease which can be sexually transmitted and which the Secretary determines is or may be amenable to control with assistance provided under this section and is of national significance."

(i) Section 318(b)(1) is amended by inserting "education," before "and training".

EXTENSION AND REVISION OF LEAD-BASED PAINT POISONING PREVENTION ACT

SEC. 204. (a) (1) Section 101(c) of the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. 4801(c)) is amended by inserting after and below paragraph (4) the following:

"Follow-up programs described in paragraph (3) shall include programs to eliminate lead-based paint hazards from surfaces in and around residential dwelling units or houses, including programs to provide for such purpose financial assistance to the owners of such units or houses who are financially unable to eliminate such hazards from their units or houses. In administering programs for the elimination of such hazards, priority shall be given to the elimination of such hazards in residential dwelling units or houses in which reside children with diagnosed lead-based paint poisoning."

(2) (A) Section 101(c) of such Act is amended by striking out "should include" and inserting in lieu thereof "shall include".

(B) Section 101(f) of such Act is amended by (i) striking out "and (B)" and inserting in lieu thereof "(B)", and (ii) by inserting before the period at the end the following "and (C) the services to be provided will be provided under local programs which meet the requirements of subsections (c) and (d) of this section".

(b) Section 401 of such Act (42 U.S.C. 4831) is amended to read as follows:

"PROHIBITION AGAINST USE OF LEAD-BASED PAINT IN CONSTRUCTION OF FACILITIES AND THE MANUFACTURE OF CERTAIN TOYS AND UTENSILS

"SEC. 401. (a) The Secretary of Health, Education, and Welfare shall take such steps and impose such conditions as may be necessary or appropriate to prohibit the application of lead-based paint to any cooking utensil, drinking utensil, or eating utensil manufactured and distributed after the date of enactment of this Act.

"(b) The Secretary of Housing and Urban Development shall take steps and impose such conditions as may be necessary or appropriate to prohibit the use of lead-based paint in residential structures constructed or rehabilitated by the Federal Government, or with Federal assistance in any form after the date of enactment of this Act.

"(c) The Consumer Product Safety Commission shall take such steps and impose such conditions as may be necessary or appropriate to prohibit the application of lead-based paint to any toy or furniture article."

(c) (1) Section 501(3) of such Act (42 U.S.C. 4841(3)) is amended to read as follows:

“(3) (A) Except as provided in subparagraph (B), the term ‘lead-based paint’ means any paint containing more than five-tenths of 1 per centum lead by weight (calculated as lead metal) in the total nonvolatile content of the paint, or the equivalent measure of lead in the dried film of paint already applied, or both.

“(B) (i) The Consumer Product Safety Commission shall, during the six-month period beginning on the date of the enactment of the National Health Promotion and Disease Prevention Act of 1976, determine, on the basis of available data and information and after providing opportunity for an oral hearing and considering recommendations of the Secretary of Health, Education, and Welfare (including those of the Center for Disease Control) and of the National Academy of Sciences, whether or not a level of lead in paint which is greater than six one-hundredths of 1 per centum but not in excess of five-tenths of 1 per centum is safe. If the Commission determines, in accordance with the preceding sentence, that another level of lead is safe, the term ‘lead-based paint’ means, with respect to paint which is manufactured after the expiration of the six-month period beginning on the date of the Commission’s determination, paint containing by weight (calculated as lead metal) in the total nonvolatile content of the paint more than the level of lead determined by the Commission to be safe or the equivalent measure of lead in the dried film of paint already applied, or both.

“(ii) Unless the definition of the term ‘lead-based paint’ has been established by a determination of the Consumer Product Safety Commission pursuant to clause (i) of this subparagraph, the term ‘lead-based paint’ means, with respect to paint which is manufactured after the expiration of the twelve-month period beginning on such date of enactment, paint containing more than six one-hundredths of 1 per centum lead by weight (calculated as lead metal) in the total nonvolatile content of the paint, or the equivalent measure of lead in the dried film of paint already applied, or both.”

(2) Section 501 of such Act is amended (1) by striking out “the term” in paragraphs (1) and (2) and inserting in lieu thereof “The term”, (2) by striking out the semicolon at the end of paragraph (1) and inserting in lieu thereof a period, and (3) by striking out “; and” at the end of paragraph (2) and inserting in lieu thereof a period.

(d) Section 502 of such Act (42 U.S.C. 4842) is amended by striking out “In carrying out the authority under this Act, the Secretary of Health, Education, and Welfare shall” and inserting in lieu thereof “In carrying out their respective authorities under this Act, the Secretary of Housing and Urban Development and the Secretary of Health, Education, and Welfare shall each”.

(e) (1) Section 503 of such Act (42 U.S.C. 4843) is amended by striking out subsections (a), (b), and (c) and inserting in lieu thereof the following:

“(a) There are authorized to be appropriated to carry out this Act \$10,000,000 for the fiscal year 1976, \$12,000,000 for the fiscal year 1977, and \$14,000,000 for the fiscal year 1978.”

(2) Subsection (d) of such section is redesignated as subsection (b).

TITLE III—MISCELLANEOUS AMENDMENT

SEC. 301. (a) Section 2(f) of the Public Health Service Act is amended to read as follows:

“(f) Except as provided in sections 314(g) (4) (B), 355(5), 361(d), 1002(c), 1201(2), 1401(13), 1531(1), and 1633(1), the term ‘State’ includes, in addition to the several States, only the District of Columbia, Guam, the Commonwealth of Puerto Rico, and the Virgin Islands.”

(b) (1) Section 361(d) is amended by adding at the end thereof the following: “For purposes of this subsection, the term ‘State’ includes, in addition to the several States, only the District of Columbia.”

(2) Section 1401 is amended by adding after paragraph (12) the following new paragraph:

“(13) The term ‘State’ includes, in addition to the several States, only the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands.”

*Speaker of the House of Representatives.*

*Vice President of the United States and  
President of the Senate.*

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June 11, 1976

Dear Mr. Director:

The following bills were received at the White House on June 11th:

S.J. Res 168 ✓  
S. 532 ✓  
S. 1466 ✓  
S. 2760 ✓  
S. 3187 ✓

Please let the President have reports and recommendations as to the approval of these bills as soon as possible.

Sincerely,

Robert D. Linder  
Chief Executive Clerk

The Honorable James T. Lynn  
Director  
Office of Management and Budget  
Washington, D.C.