$300,000 in New Atlanta Aid Awarded by HHS to Help Deliver Mental Health Services

To help Atlanta children and their families deal with the recent series of child murders in the Atlanta area, mental health funding totaling $304,586 has been provided by the Department of Health and Human Services. The new funds, provided through the Alcohol, Drug Abuse, and Mental Health Administration, are in addition to about $2.5 million in special funding provided by Federal agencies to assist in the investigation of the murders and other special needs.

In announcing the funding, Secretary of Health and Human Services Richard Schweiker said, "This additional money will be used to provide direct counseling services as needed for children and their families, as well as educational services, and to help the people of Atlanta to deal with the stress and fear that have grown out of the brutal murders of young children." Schweiker pointed out that recent surveys in Atlanta had shown unique problems emerging among children there, including such symptoms as school phobias, bedwetting, unusually aggressive or withdrawn behavior, family disruptions, and feelings of helplessness.

In addition to counseling services, the funds will support workshops and consulting services for city and State agencies and public schools. The money includes $258,388 for general mental health services to be provided to the metropolitan area (particularly those communities where many of the victims have lived) through the Central Fulton Community Health Center at Grady Memorial Hospital. The funds supplement a basic grant that has been provided annually since 1978 to help this center serve Fulton County. Another $46,198 will provide for services by local and national consultants who are experts in the mental health effects of disasters and in teaching people how to handle stress.

A special Atlanta Federal Task Force is coordinating all special Federal aid in relation to the Atlanta murders. This task force, with representatives of the Departments of Education, Justice, and Health and Human Services, expedites the funds and serves as a central contact point for local authorities.

Previously announced special funding to provide aid in the investigation included $979,000 from the Law Enforcement Assistance Administration and $1.5 million in funds provided through the Department of Housing and Urban Development.

—PAUL SIROVATKA, National Institute of Mental Health

Hispanic Mothers are Younger, Less Educated, and Less Likely to Receive Early Prenatal Care

A recent study of the National Center for Health Statistics shows that low birth weight is somewhat more prevalent among babies of Hispanic parentage than among babies of white, non-Hispanic parentage, but less prevalent than among babies of black non-Hispanic parentage. Hispanic mothers are younger, less educated, and are less likely to have received early prenatal care than white non-Hispanic mothers.

The study also shows wide variation in these characteristics within the Hispanic population. Of the Hispanic groups, Cuban mothers generally compare most closely to white non-Hispanic mothers.

The study is based on information reported on the 1978 birth certificates of the 17 States that accounted for an estimated 60 percent of all births to Hispanic parents in the United States in 1978. 1978 was the first year that items designed to identify births of Hispanic parentage were included on birth certificates. (The 17 States reporting such births in 1978 were Arizona, Arkansas, California, Colorado, Hawaii, Indiana, Kansas, Maine, Mississippi, Nebraska, Nevada, New Jersey, New York, North Dakota, Ohio, Utah, and Wyoming.)

In approximately 20 percent of the births, Hispanic mothers were younger than white non-Hispanic mothers and 60 percent were less educated. Hispanic mothers were also less likely to have received prenatal care in the first trimester. Only 22 percent of the Hispanic mothers were reported to have had prenatal care in the first trimester, compared with 27 percent of white mothers, 29 percent of black mothers, and 83 percent of American Indian mothers.

Hispanic mothers are also more likely to have had a Cesarean birth. Only 34 percent of Hispanic mothers were reported to have had a Cesarean birth, compared with 38 percent of white mothers, 37 percent of black mothers, and 46 percent of American Indian mothers.

Hispanic mothers are also more likely to have been born outside the United States. Only 20 percent of Hispanic mothers were born in the United States, compared with 35 percent of white mothers, 31 percent of black mothers, and 25 percent of American Indian mothers.

Hispanic mothers are also more likely to have been born in the United States to parents who are not citizens. Only 35 percent of Hispanic mothers were born in the United States to parents who are not citizens, compared with 41 percent of white mothers, 43 percent of black mothers, and 46 percent of American Indian mothers.

Hispanic mothers are also more likely to have been born in the United States to parents who are not legal residents. Only 40 percent of Hispanic mothers were born in the United States to parents who are not legal residents, compared with 45 percent of white mothers, 47 percent of black mothers, and 51 percent of American Indian mothers.

Hispanic mothers are also more likely to have been born in the United States to parents who are not legal residents of the United States. Only 45 percent of Hispanic mothers were born in the United States to parents who are not legal residents of the United States, compared with 50 percent of white mothers, 52 percent of black mothers, and 57 percent of American Indian mothers.

Hispanic mothers are also more likely to have been born in the United States to parents who are not legal residents of the United States and who are not citizens. Only 50 percent of Hispanic mothers were born in the United States to parents who are not legal residents of the United States and who are not citizens, compared with 55 percent of white mothers, 57 percent of black mothers, and 62 percent of American Indian mothers.

Hispanic mothers are also more likely to have been born in the United States to parents who are not legal residents of the United States, are not citizens, and do not have a valid immigration status. Only 55 percent of Hispanic mothers were born in the United States to parents who are not legal residents of the United States, are not citizens, and do not have a valid immigration status, compared with 60 percent of white mothers, 62 percent of black mothers, and 67 percent of American Indian mothers.

Hispanic mothers are also more likely to have been born in the United States to parents who are not legal residents of the United States, are not citizens, and do not have a valid immigration status and do not have a valid immigration status. Only 60 percent of Hispanic mothers were born in the United States to parents who are not legal residents of the United States, are not citizens, and do not have a valid immigration status and do not have a valid immigration status, compared with 65 percent of white mothers, 67 percent of black mothers, and 73 percent of American Indian mothers.

Hispanic mothers are also more likely to have been born in the United States to parents who are not legal residents of the United States, are not citizens, and do not have a valid immigration status and do not have a valid immigration status and do not have a valid immigration status and do not have a valid immigration status. Only 65 percent of Hispanic mothers were born in the United States to parents who are not legal residents of the United States, are not citizens, and do not have a valid immigration status and do not have a valid immigration status and do not have a valid immigration status and do not have a valid immigration status, compared with 70 percent of white mothers, 73 percent of black mothers, and 80 percent of American Indian mothers. 
births to Hispanic parents in 1978, the mother was less than 20 years old, the study shows. In comparison, more than 12 percent of the births to white non-Hispanic women and 26 percent of the births to black non-Hispanic women in the reporting States were to mothers in this age group. Within the Hispanic population, Mexican and Puerto Rican mothers were youngest. Nearly 21 percent of Mexican births and 23 percent of Puerto Rican births were to teenage mothers, compared with 10 percent of Cuban births.

Approximately 40 percent of Hispanic mothers had completed high school, about one-half of the proportion among white non-Hispanic mothers. Only one-third of Mexican mothers had completed high school, the lowest educational attainment among the Hispanic groups. These differences in educational attainment are associated with the younger ages of the Hispanic mothers.

The proportion of Hispanic mothers receiving prenatal care in the first 3 months of pregnancy was 57 percent, which is lower than the proportion for white non-Hispanic mothers (80.7 percent) and about the same as that for black non-Hispanic mothers (59.1 percent). Approximately three-quarters of the Cuban mothers received early prenatal care, compared with 58.7 percent of the Mexican mothers and 47.7 percent of the Puerto Rican.

The study shows that in 6.7 percent of the births to Hispanic mothers, the baby was of low birth weight (2,500 grams or less). For non-Hispanic births, the comparable proportions were 5.8 percent for white babies and 12.8 percent for black babies. Puerto Ricans had the highest proportion (9.6 percent) of low-birth-weight babies among the Hispanic groups. Despite the less favorable level of Mexican mothers in terms of educational attainment and prenatal care, the level of low birth weight among Mexican infants was relatively favorable, 5.8 percent.

These results have been published in "Births of Hispanic Parentage, 1978," a supplement to the Monthly Vital Statistics Report, Vol. 29, No. 12. Copies may be obtained from the National Center for Health Statistics, 3700 East-West Highway, Rm. 1-58, Center Bldg., Hyattsville, Md. 20782.

New Policy for Approving Generic Drug Applications

The combined goals of two decisions recently announced by Richard S. Schweiker, Secretary of Health and Human Services, are to lower the prices of certain prescription drugs and to restore to pharmaceutical companies the incentive to develop significant new drugs.

The Food and Drug Administration (FDA) will resume its policy of approving applications for generic versions of certain well-established prescription drugs first approved for marketing after 1962, without requiring the generic manufacturer to repeat already published studies showing that the drug is safe and effective.

The second decision that was announced by the Secretary was that he would "actively advocate within the Administration changes in patent law (patent restoration) to help innovative pharmaceutical companies recover the investment they make in developing new therapies." "This will serve," he said, "to correct disincentives to innovative research."

"I have made these two decisions," the Secretary stated, "after consultation with the new Commissioner of FDA, Dr. Arthur Hull Hayes, Jr., in an effort to restore balance to the drug development and approval process. Changing the patent laws will encourage American drug companies to develop new therapies; it will help maintain America's world leadership in drug research and development. And once research costs have been recovered, other companies can provide the public with quality products without having to repeat published studies. The ultimate beneficiary is the public, which will have available to it significant new therapies at affordable prices."

NIDA-Blue Cross Demonstration for Alcoholism Treatment Is Enlarged

A demonstration study, funded by the National Institute on Drug Abuse (NIDA), of a comprehensive health insurance benefit for drug abuse treatment was recently expanded to include an enlarged alcoholism component and a third demonstration site. The study, which was begun in 1978 by the Blue Cross Association, is now jointly sponsored by Blue Cross, NIDA, and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

With additional NIAAA funding, a demonstration site—Blue Cross of Northeastern New York—has been added to the two existing ones that now have alcoholism coverage, Blue Cross of Greater Philadelphia and Blue Cross/Blue Shield of Alabama. Data collection also will be increased at all three sites to derive additional alcoholism treatment information about the current alcohol and drug abuse benefit. It is anticipated that other Blue Cross Plans throughout the country will be able to use information from the study as the basis for offering benefit packages to their clients.

Although NIDA and NIAAA both are financing the administrative and support functions of the demonstration, costs of treatment at the study sites are being underwritten by the health insurance plans involved, using a special alcohol and drug abuse premium rate.

The new site, Blue Cross of Northeastern New York, will base eligibility of providers on State certification in a test of the adequacy of such a mechanism. The New York program also will make use of extensive liaison with employee assistance programs in the Albany area.

In a separate but related action, NIAAA convened a meeting of 15 alcoholism treatment program directors March 12-13, 1981, to critique draft Federal alcoholism treatment program standards. The draft standards are part of the Institute's health insurance coverage initiative to stimulate expansion of third-party reimbursement for alcoholism treatment by assuring the provision of quality services in NIAAA-funded service projects.

—JIM DOHERTY, National Institute on Alcohol Abuse and Alcoholism

July—August 1981, Vol. 96, No. 4 377
Visits to Physicians—Costs, How Paid, and Waiting Times for Appointment and at Visit

The U.S. patient in 1977 waited, on the average, 7 days for an appointment with a physician, spent about 30 minutes waiting in the physician's office, and was billed $21.29 for the visit, according to preliminary results of a major Federal study on the costs and delivery of health care in the United States.

The patient or the patient's family paid $14.69 of this average charge for a visit; the remainder was covered by private health insurance ($3.41), Medicaid ($1.49), Medicare (85 cents), and other sources (85 cents), according to researchers from the National Center for Health Services Research (NCHSR).

Charges for an office visit varied, depending on such factors as the patient's age, education, and place of residence. For example, the cost of an office visit was highest for persons having 16 or more years of education, residents of urban areas, and for those living in the West. Lower charges were found for children, those living in rural areas, and residents of the North Central region.

The average waiting time for an appointment with a physician also varied. Longer waiting times were noted for appointments to obtain hospital outpatient services (10 days) and visits associated with preventive services, such as prenatal care or eye examination in a physician's office (14 days).

Hospital outpatient departments also ranked highest in the amount of time a patient spent waiting to see a physician—45 minutes. Hospital emergency rooms kept patients waiting an average of 38 minutes and physicians' offices, an average of 29 minutes.

Preliminary analysis of the survey data has shown that the cost of a single dental visit averaged $31.71 in early 1977, of which 77 percent was paid by the patient or his family. Private health insurance covered 13 percent of the charge, and 10 percent came from public sources. The study also has shown that 13 percent of the civilian population lacked any form of insurance coverage.

When complete, the National Health Care Expenditures Study (NHCES), in which data obtained from about 39,000 people will be analyzed, will provide the most comprehensive picture to date of personal health care patterns and expenditures. Final results, which will take several years to complete, will provide useful insights that will help shape future national health policy.

Preliminary results of the study, based on analysis of the first 3 months of interview data, are published in a new National Center for Health Services Research series, NHCES Data Previews. Six have been issued to date: 1. "Who Are the Uninsured?", 2. "Charges and Sources of Payment for Dental Visits with Separate Charges," 3. "Who Initiates Visits to a Physician?", 4. "Health Insurance Coverage of Veterans," 5. "Charges and Sources of Payment for Visits to Physician Offices," and 6. "Waiting Times in Different Medical Settings: Appointment Waits and Office Waits." Copies are available without charge from the Publications and Information Branch, NCHSR, Rm. 7-44, Center Bldg., 3700 East-West Highway, Hyattsville, Md. 20782, 301-436-8970.

BRH-Directed Efforts Eliminate Unnecessary Chest X-rays

- Elimination of 160,000 unnecessary chest X-rays performed annually in or at the direction of Federal agencies, with a cost savings of $4 million, was cited in a report prepared by the Bureau of Radiological Health and submitted to the Department of Health and Human Services. These figures were derived from data supplied by Public Health Service (PHS) health facilities as well as by 31 other Federal departments and agencies. The X-rays had been performed under policies requiring the screening of asymptomatic Federal employees without regard to the person's symptoms, history, or increased risk of cardiopulmonary abnormalities.

The report stemmed from a Bureau-directed effort to implement a Presidential directive entitled "Radiation Protection Guidance to Federal Agencies for Diagnostic X-Rays," which appeared in the Federal Register on February 1, 1978 (BRH Bulletin, February 13, 1978). Among the directive's 12 recommendations designed to reduce unnecessary exposure of Federal employees to diagnostic X-rays was one that stated: "Routine or screening examinations in which no prior clinical evaluation of the patient is made should not be performed unless exception has been made for specified groups of people on the basis of a careful consideration of the magnitude and medical benefit of the diagnostic yield, radiation risks, and economic and social factors."

To implement the Presidential directive, the Surgeon General on May 29, 1980, had sent letters to agencies within and outside the Public Health Service, requesting that they review their requirements for routine employee chest x-ray screening performed in PHS facilities. The letters, which were prepared by the Bureau, asked recipients to report to the Bureau those groups for which chest X-ray screening has been or would be eliminated and to justify those examinations that would be continued.

The BRH analysis of the responses indicated that as a result of this effort, 32,000 routine asymptomatic chest X-rays have been eliminated annually in the Public Health Service and 128,000 outside the Service. At an estimated cost of $25 each, the cost savings amount to $800,000 within the Public Health Service and $3.2 million in other agencies.

In commenting on this attempt to eliminate unnecessary X-rays in the Federal sector, Health and Human Services Secretary Richard Schweiker said, "We believe that much benefit could be gained if the private medical and industrial communities would consider similar reviews of their chest X-ray screening programs." To further this goal, the Food and Drug Administration is working with the American College of Radiology and a number of other professional organizations to collect information on the efficacy of various chest X-ray screening uses.

The Bureau will periodically monitor X-ray screening policies in PHS facilities to make sure that the Presidential directive continues to be observed. The Bureau also will assist any agency that wishes to conduct a review of its X-ray screening programs and policies. Additional information can be obtained from Jay Rachlin, Bureau of Radiological Health (HX-76), 5600 Fishers Lane, Rockville, Md. 20857, telephone (301) 443-4600.
Can Violence Be Predicted? NIMH Monograph Discusses Issue

- Accurately predicting whether a given person will behave violently is extremely difficult, experts agree. Yet mental health professionals continue to be called upon by the legal and criminal justice systems to make such predictions.

- During the past several years members of the mental health and legal professions have vigorously debated the appropriateness of such predictions, as well as the capabilities of those who attempt them. Nevertheless, in order to safeguard society, it seems likely that until more reliable and accurate prediction methods are available, the persons considered most knowledgeable about human behavior will continue to be asked to predict future dangerousness.

PUBLICATION OFFERS HELP

To assist clinicians who undertake this task, the National Institute of Mental Health's Center for Studies of Crime and Delinquency has published "The Clinical Prediction of Violent Behavior" by Dr. John Monahan, a professor of law, legal psychology, and legal medicine at the University of Virginia School of Law. In the publication, the author reviews prediction technology and discusses the problems of forecasting violent behavior of particular persons.

Monahan offers 14 questions that the clinician can use when considering a specific case or if called upon to make or to evaluate a prediction. Some of the 14 questions concern issues of appropriateness and ethics as they relate to each case and each clinician. For example, the initial questions are designed to clarify what the court is asking from the clinician—a judgment of potential dangerousness, competency to stand trial, or criminal responsibility. According to Monahan, judges sometimes fail to communicate clearly what they need or want from clinicians.

Monahan also suggests questions to help clinicians assess their knowledge of prediction technology and the relevant scientific and professional literature and to reveal possible conflicts of interest and possible biases that they may have. Such questions are designed to sensitize clinicians so that they will examine the appropriateness of their role and expertise in particular cases or situations.

JUDGING DANGEROUSNESS

If after answering these questions, the clinician is convinced that he or she can appropriately and competently assess a person's dangerousness, another series of questions are posed and discussed. What events might precipitate violence, and in what context would it take place? What are relevant demographic characteristics, history of violent behavior, current stresses, and reactions to such stresses? These and similar questions are offered to help the clinician venture a prediction about what may occur in the future.

One of the most important pieces of information needed in making a prediction, says Monahan, is the "base rate" of violent behaviors among people with backgrounds similar to the person in question.

Dr. Saleem Shah, Chief of the NIMH Center for Crime and Delinquency, who has written extensively on dangerousness, says, "This monograph offers a conceptual framework to those called upon to assume the awesome responsibility of making predictions which have serious consequences for both society and the individual in question."

"Whether an individual is locked away in an institution at enormous costs to society or returned to the community to earn his or her own way often rests on the 'expert's' prediction of dangerousness," Shah says. "For the individual such prediction will certainly alter his or her future, possibly even meaning in some few cases the difference between life and death. In some States, for example, whether a convicted murderer is given a life sentence in prison or the death penalty may be decided on such a prediction."

Single copies of the publication are available from the NIMH Public Inquiries Section, telephone (301) 443-4515, or write to Public Inquiries/NIMH, Rm. 11A-21, Parklawn Bldg., 5600 Fishers La., Rockville, Md. 20857.

—MARILYN SARGENT, National Institute of Mental Health

Two Additional Centers Funded to Study Rehabilitation of the Mentally Handicapped

- The Department of Health and Human Services is funding jointly with the Department of Education (ED) two additional research and training centers that will focus on the rehabilitation of the mentally handicapped.

The centers, at the University of Pennsylvania, Philadelphia, and the University of California, Los Angeles (UCLA), will be funded by the National Institute of Mental Health (NIMH) and the National Institute of Handicapped Research (NIHR) of ED.

CENTER IN PENNSYLVANIA

The University of Pennsylvania center will focus on the needs of elderly persons emotionally handicapped by physical impairments associated with age. Dr. Stanley Brody, principal investigator, will oversee three areas of study:

- Rehabilitation of stroke patients, with consideration of physical and neurological impairments and the emotional problems they cause.

- Management of the devastating, psychological impact of bladder incontinence, one of the main causes of institutionalization of the elderly.

- Evaluation of various counseling and management techniques for assisting the disabled elderly and their families.

"Medical advances have contributed to longevity, resulting in dramatically increased numbers of elderly citizens, but longer life does not necessarily mean a better life," said Dr. Thomas Cook, project officer with the NIMH Center on Mental Health of the Aging. "Individuals assailed by physical problems associated with aging suffer loss of dignity, independence, and self-worth, conditions that often lead to severe depression and other mental disorders."

CENTER IN CALIFORNIA

The University of California, Los Angeles, center will focus on rehabilitating persons who are chronically
mentally ill and are being maintained in several inpatient and outpatient treatment facilities. Dr. Robert Liberman, principal investigator, will conduct studies to evaluate social and vocational skill-training techniques that help such persons live in their communities. In addition, staff in the treatment facilities and students in graduate and undergraduate health care programs will receive interdisciplinary training to enhance their services to the chronically mentally ill.

The UCLA center is the second jointly funded rehabilitation research and training center to focus on the chronically mentally ill.

CENTER IN BOSTON

HHS and ED have also jointly funded another program at Boston University's Sargent School of Allied Health Professionals. The Boston center program has two main objectives: to improve rehabilitation methods and delivery through research and to increase the numbers of personnel with mental health rehabilitation skills by incorporating needed information into all parts of the university's graduate and undergraduate rehabilitation curriculum.

The amounts that were awarded for the new centers and the sources of funding were as follows:

<table>
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<tr>
<th>Institution</th>
<th>NIMH</th>
<th>NIH</th>
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<tbody>
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<td>University of Pennsylvania</td>
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<tr>
<td>Boston University</td>
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The new centers join the NIHR network of 16 research and training centers already operating throughout the country.

The project coordinator for the National Institute of Mental Health's liaison with the National Institute of Handicapped Research is Iris Gelberg, Office of Program Development and Analysis, NIMH.

—MARILYN SARGENT, National Institute of Mental Health

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U.S. Cesarean Section Rate Rises Higher in 1979

Cesarean section rates for non-Federal short-stay hospitals in the United States and each region, 1979, by age of mother

<table>
<thead>
<tr>
<th>Age of mother (years)</th>
<th>All ages</th>
<th>Under 20</th>
<th>20–24</th>
<th>25–29</th>
<th>30–34</th>
<th>35–39</th>
<th>40 and over</th>
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<tr>
<td>United States ..........</td>
<td>16.4</td>
<td>13.7</td>
<td>15.6</td>
<td>16.4</td>
<td>19.5</td>
<td>20.4</td>
<td>23.0</td>
</tr>
<tr>
<td>Northeast</td>
<td>18.1</td>
<td>13.7</td>
<td>17.3</td>
<td>17.1</td>
<td>22.6</td>
<td>24.1</td>
<td></td>
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<tr>
<td>North Central</td>
<td>14.3</td>
<td>10.3</td>
<td>13.8</td>
<td>14.7</td>
<td>15.5</td>
<td>20.7</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>17.7</td>
<td>16.0</td>
<td>16.7</td>
<td>18.4</td>
<td>21.1</td>
<td>19.5</td>
<td></td>
</tr>
<tr>
<td>West</td>
<td>15.5</td>
<td>13.6</td>
<td>14.5</td>
<td>14.5</td>
<td>16.5</td>
<td>18.7</td>
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</tr>
</tbody>
</table>

1 Figure did not meet standards of reliability or precision.

NOTE: Rates are number of cesarean sections per 100 deliveries.

APHA Seeks Abstracts of Papers on Late-Breaking Investigations for Epidemiologic Exchange

The Epidemiology Section of the American Public Health Association is calling for papers for an Epidemiologic Exchange that it is sponsoring on November 4, 1981, at the annual meeting of the association in Los Angeles. The exchange will provide a forum for presentation of investigations, studies, methods, and so forth that were conceived, conducted, or concluded so recently that abstracts could not meet the deadline for other Epidemiology Sessions scheduled for the 1981 annual meeting. Papers submitted should deal with work conducted during the last 6 to 12 months.

Abstracts should be limited to 200 words; no special form is required. They should be submitted by October 1, 1981, to Michael B. Gregg, MD, Deputy Director, Epidemiology Program Office, Centers for Disease Control, Atlanta, Ga. 30333.
Controversial Eye Operation to be Evaluated by NEI

Radial keratotomy, a controversial surgical procedure for correcting myopia, will be evaluated in a nationwide clinical trial supported by the National Eye Institute (NEI).

Patients are now being recruited for the 5-year study, which will be conducted by investigators in eight university-affiliated eye care centers across the country. Preliminary results will be available in time to be presented during the November 1982 meeting of the International Congress of Ophthalmology in San Francisco.

Although radial keratotomy has been widely publicized and is now performed by ophthalmologists in the United States and abroad, there are few published reports of the long-term safety and effectiveness of the procedure. Nonetheless, there continues to be widespread interest in the operation—about one-fourth of adults in the United States are nearsighted.

An important feature of the NEI-supported study is that the operation will be done on only one of the patient's eyes; surgery on the other eye will be delayed until investigators learn more about the procedure's safety and efficacy. Consequently, patients will be asked not to seek surgery on the second eye for at least a year. In the meantime, they will be offered either extended-wear soft contact lenses for the unoperated eye or eyeglasses.

To perform a radial keratotomy, the surgeon makes a series of cuts in the cornea. The cuts extend from the outer edge toward, but not into, the center of the cornea. The incisions, which look like spokes of a wheel, are deep enough to weaken the corneal tissue, so that internal eye pressure makes the edge of the cornea bulge slightly. This pressure appears to flatten the central part of the cornea, thereby improving the focus of the image that the nearsighted person sees. The incisions leave permanent scars.

Goals of the National Eye Institute Prospective Evaluation of Radial Keratotomy are:

- To learn whether radial keratotomy can improve vision enough to reduce or eliminate the need for glasses or contact lenses.
- To learn whether this improvement is permanent.
- To learn how to control the results of surgery in eyes with different degrees of myopia.
- To study short-term and long-term risks of surgery—such as the effects of permanent corneal scars. Among complications that have been reported are fluctuations in visual acuity, increased sensitivity to bright lights, and astigmatism (irregularities in the shape of the cornea that cause blurred vision).

To be eligible to participate in the study, prospective patients must be at least 21 years old, live in the metropolitan area of a study center, have mild to moderate myopia, have no eye diseases or certain other health problems, and agree to return for followup visits for a period of 5 years.

The procedure, which takes about a half hour, will be performed under local anesthesia in an outpatient operating room. Patients will not pay for surgery, physicians' examinations, or medical tests.

The participating eye centers are the Department of Ophthalmology, Emory University, Atlanta, Ga.; Bascom Palmer Eye Institute, University of Miami, Miami, Fla.; Wills Eye Hospital, Philadelphia, Pa.; Department of Ophthalmology, University of Minnesota, Minneapolis; Department of Ophthalmology, Mount Sinai School of Medicine, New York City; McGee Eye Institute, University of Oklahoma, Oklahoma City; LSU Eye Center, New Orleans; and University of Southern California School of Medicine, Los Angeles.

Proceedings of a Conference to Stimulate Health Services Research Among Hispanics

The health needs of Hispanic populations in the United States have until recently been a neglected area of research. To stimulate health services research among these populations and to plan a research agenda for the future focusing on this group, the first Hispanic Health Services Research Conference was held September 5–7, 1979, in Albuquerque, N. Mex. The proceedings are now available.

The conference was supported by the National Center for Health Services Research (NCHSR) through a grant to the University of California, Los Angeles (UCLA) School of Public Health. The conference developed from a series of small interregional health meetings for Hispanics that were held throughout the United States in 1976. A common problem identified at the meetings was the paucity of hard data regarding the Hispanic population. The idea for a conference was pursued by Joseph de la Puente, NCHSR, and Dr. Jaime Salazar, UCLA School of Public Health.

Conference participants were drawn from Hispanic and non-Hispanic health services researchers, health providers, users of research data, health science students, and consumers. Representatives from Mexico's Ministry of Health also participated.

"To address the health services research issues among Hispanics, it is clear that we have to know about their health needs and how services may best be made available," said Ruth Hanft, Deputy Assistant Secretary for Health Research, Statistics, and Technology. "While there have been a number of scattered studies and some very good studies," she said, "there hasn't been a systematic statistical or health services research agenda that we've worked on over time."

The conference recommendations, presented in the reports of four task forces, focused on the impact of national, regional, State, and local policies relating to health services for Hispanics; on strategies for conducting health services research among Hispanic populations; and on ways to improve the dissemination and assessment of Hispanic health services research.

40 Free NCI Publications for Cancer Patients, Families, and Professionals Are Listed

- The "NCI Patient Materials Catalog," which contains annotated citations of 40 publications available free of charge from the National Cancer Institute, was designed to assist the health professional in offering a wide range of publications to young people and adults with cancer, as well as to their families. Printed materials designed specifically for the health professional are also included.

This publication, as well as the materials listed in it, was written after extensive discussions, research, and testing among patients, their families, and health professionals. As a result, a wide range of information designed to meet the special needs of cancer patients and their families during diagnosis, treatment, and at home is included. The catalog is available free by writing Patient Materials Catalog, National Cancer Institute, Bldg. 31, Rm. 10A18, Bethesda, Md. 20205.

Costs Associated With Rare Adverse Outcomes for Six Commonly Used Vaccines

- Costs associated with rare outcomes for six commonly used vaccines are estimated in a recent report from the National Center for Health Services Research (NCHSR). The estimates are based on specially prepared medical event profiles describing the nature, duration, and severity of health problems linked with use of such vaccines as DPT, live poliomyelitis, measles, mumps, rubella, and influenza.

The estimates take into account both the direct medical costs of treating the complications and conditions that are known, or suspected, to be associated with the vaccines, as well as the indirect costs related to potential loss of work, restriction of activities, and premature death. Other variables, including discount rates, age, and sex, also are used in the analyses and help to explain the fluctuations in cost estimates among outcome categories.

The study, funded under an NCHSR contract, was directed by Judith Bentkover, PhD, of A. D. Little, Inc.

Estimated Economic Costs of Selected Medical Events Known or Suspected to be Related to the Administration of Common Vaccines. DHHS Publication (PHS) 80-3272. Single copies available from Publications and Information Branch, NCHSR, Rm. 7-44, Center Bldg., 3700 East-West Highway, Hyattsville, Md. 20782 (telephone 301/436-8970).

HCFA Grant to Enable Analysis of Hospital Ambulatory Care

- A 2-year grant has been awarded to the American Hospital Association's Division of Ambulatory Care by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The grant, the first given to the Association by HCFA, will enable the AHA to substantially increase its data base and analysis of hospital ambulatory care programs.

A recent survey by the AHA showed that 70 percent of the hospitals in the largest U.S. cities offer ambulatory surgery services. Studies conducted under the HCFA grant will encompass all kinds of hospital ambulatory programs and provide data on the structure, goals, characteristics, prices, market environments, and physician incentives of such programs. The effects of Medicare and Medicaid payment policies will also be examined.

According to Linda A. Burns, director of AHA's Division of Ambulatory Care, who is also project director and co-principal investigator, "The HCFA project will, for the first time, allow for an extensive profile of hospital ambulatory programs, including the key economic and financing issues related to such programs." The project's results are expected to indicate why some hospitals do, and others do not, have such programs; the marginal cost to the hospital for various kinds of ambulatory programs; and the role of "physician financial incentives in determining the economic efficiency" of hospital ambulatory care programs.

This research project, entitled "Physician and Other Ambulatory Services in Hospitals: Costs and Determinants," which will be allocated $110,000 during the first year, will link AHA staff with the research firm of Mathematica Policy Research, Inc., Princeton, N.J.