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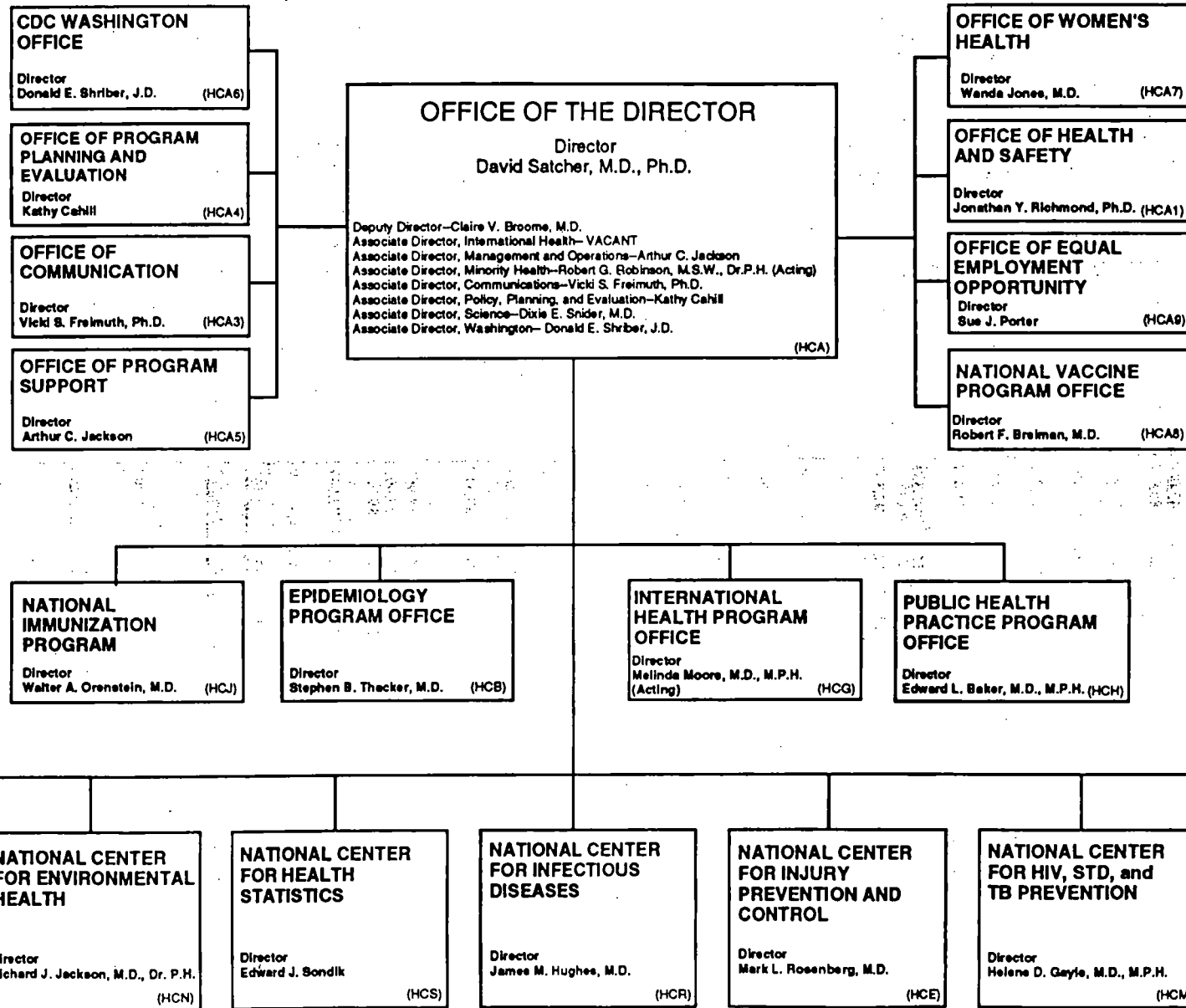
Justifications of Budget Estimates to OMB

Fiscal Year 1999

Centers for Disease Control
and Prevention

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)



Centers for Disease Control & Prevention

FY 1999 OMB Budget Submission

Budget Authority by Activity (Dollars in Thousands)

Activity	FY 1997 Appropriation		FY 1998 President's Budget		FY 1998 House Mark		FY 1998 Senate Mark		FY 1999 Estimate		Change from FY 1998 P.B.	
	FTEs	\$	FTEs	\$	FTEs	\$	FTEs	\$	FTEs	\$	FTEs	\$
Preventive Health Block Grants.....	33	\$153,994	32	\$143,940	32	\$155,000	32	\$143,940	31	\$155,581	(1)	\$11,641
Crime Bill.....	0	35,000	0	45,000	0	45,000	0	45,000	0	45,200	0	200
Subtotal	33	188,994	32	188,940	32	200,000	32	188,940	31	200,781	(1)	11,841
HIV/AIDS.....	1,063	616,790	1,029	634,266	1,029	621,790	1,029	646,790	1,008	647,090	(21)	12,824
Sexually Transmitted Diseases.....	429	106,203	415	111,171	415	111,171	415	111,171	413	132,666	(2)	21,495
Tuberculosis.....	131	119,294	127	119,236	127	119,236	127	119,236	122	119,767	(5)	531
Immunization.....	486	467,583	470	427,312	470	440,030	470	445,545	487	462,215	17	34,903
Heart Disease & Health Promotion.....	267	46,049	259	61,049	259	69,049	259	57,149	272	151,321	13	90,272
Diabetes & Other Chronic Diseases.....	110	36,333	106	46,333	106	56,333	106	52,333	115	62,539	9	16,206
Cancer Registries.....	28	22,332	27	22,332	27	25,332	27	23,082	26	22,431	(1)	99
Environmental Disease Prevention.....	328	42,685	318	41,850	318	50,850	318	51,415	346	87,536	28	45,686
Breast & Cervical Cancer Prev.....	73	139,659	71	141,897	71	145,000	71	141,897	68	142,529	(3)	632
Prevention Centers.....	0	8,099	0	8,099	0	8,099	0	8,099	0	8,135	0	36
Infectious Diseases.....	915	87,720	885	112,428	885	118,000	885	112,428	905	169,429	20	57,001
Lead Poisoning.....	35	38,181	34	38,154	34	38,200	34	38,200	33	38,324	(1)	170
Injury.....	130	40,582	126	46,433	126	52,833	126	45,263	146	66,640	20	20,207
(a) Traumatic Brain Injury.....	0	2,600	0	2,600	0	3,100	0	2,600	0	2,611	0	11
(b) Crime Bill.....	0	6,000	0	0	0	0	0	3,220	0	0	0	0
Subtotal	130	49,182	126	49,033	126	55,933	126	51,083	146	69,251	20	20,218
Occupational Safety & Health.....	1,054	141,340	1,021	148,463	1,021	148,840	1,021	148,463	987	154,124	(34)	5,661
Mine Safety and Health.....	413	31,913	413	32,000	413	32,000	413	40,000	413	32,142	0	142
Subtotal	1,467	173,253	1,434	180,463	1,434	180,840	1,434	188,463	1,400	186,266	(34)	5,803
Epidemic Services.....	303	89,083	293	89,319	293	88,797	293	88,797	283	89,717	(10)	398
Health Statistics:												
(a) Prevention Activities.....	88	37,612	85	18,963	85	37,612	85	18,033	97	41,047	12	22,084
(b) 1% Evaluation (Non-Add).....	451	48,400	451	70,063	451	48,400	451	70,063	436	70,063	(15)	0
Subtotal	539	86,012	536	89,026	536	86,012	536	88,096	533	111,110	(3)	22,084
Buildings & Facilities.....	0	30,553	0	23,007	0	20,000	0	23,007	0	63,007	0	40,000
Prevention Research.....	0	0	0	0	0	0	0	0	0	100,000	0	100,000
Program Management.....	33	2,563	33	2,465	33	2,465	33	2,465	33	2,465	0	0
Total, Budget Authority	5,919	\$2,302,168	5,744	\$2,316,317	5,744	\$2,388,737	5,744	\$2,368,133	5,785	\$2,796,516	41	\$480,199
User Fees.....	0	1,917	0	1,967	0	1,967	0	1,967	0	1,967	0	0
Superfund (EPA - ATSDR).....	406	64,000	406	64,000	406	80,000	406	68,000	427	87,000	21	23,000
Reimbursables/CLIA/Trust Fund.....	143	0	143	0	143	0	143	0	143	0	0	0
Ceiling Exempt FTEs (Non-Add).....	60	0	60	0	60	0	60	0	60	0	0	0
1% Evaluation.....	451	48,400	451	70,063	451	48,400	451	70,063	436	70,063	(15)	0
Total, Program Level	6,919	\$2,416,485	6,744	\$2,452,347	6,744	\$2,519,104	6,744	\$2,508,163	6,791	\$2,955,546	47	\$503,199

Since the new and combined vaccines will likely be recommended for the Vaccine for Children (VFC) program, it is essential that sufficient funding be available in the Section 317 grant program to purchase the same complement of vaccines being provided under VFC. Otherwise, children who are not eligible for VFC will be receiving a lower standard of care at public health clinics and participating private provider locations. This dual standard of care is unacceptable and can only be avoided if additional section 317 vaccine purchase funds are made available.

2. Develop and Address Unmet Opportunities for Prevention, Particularly Improving the Health of Disadvantaged Populations (\$136.5 million and 38 FTEs)

NATIONAL DIABETES PREVENTION AND CONTROL PROGRAM (\$16.0 MILLION AND 12 FTEs)

It is estimated that 16 million Americans have diabetes, of which only 8 million have been diagnosed with the disease. Americans with diabetes face not only shortened life spans, but also suffer from significant complications. Diabetes has become the epidemic of our time, afflicting our most vulnerable populations: minorities, the elderly, and the poor.

This initiative will fund comprehensive diabetes control programs in 29-31 states, an increase of 17-19 states from FY 1998. Comprehensive diabetes control programs include state wide coverage for diabetes control activities; reaching a much larger proportion of those with the disease. With an active national network of comprehensive diabetes control programs in every state, CDC will initiate activities related to physical activity at the community and health system levels in collaboration with state and local health departments and the evolving infrastructure of managed care. CDC will expand collaborative work with professional, private, and governmental partners to implement a National Diabetes Education Program to improve the outcome of persons with diabetes, promote early diagnosis and, ultimately, prevent the onset of this disease. A diabetes module in the Behavioral Risk Factor Surveillance System (BRFSS) will be implemented in approximately 40 states including all comprehensive states. This will provide essential data needed to better characterize and capture the true magnitude of diabetes and cardiovascular disease (CVD); risk factors data such as physical activity, nutrition, and smoking related to diabetes, and associated costs.

HARNESSING NEW TOOLS FOR HIV PREVENTION IN UNDER SERVED POPULATIONS, INCLUDING WOMEN (\$10.0 MILLION AND 12 FTEs)

From 1995 to 1996 in the U.S., AIDS cases due to heterosexual contact showed the largest proportionate increases (19%). Disadvantaged populations, especially African-Americans and socio-economically stressed youth, continue to have high rates of HIV infection despite high levels of knowledge about behavioral prevention methods. Two biomedical interventions have demonstrated possibilities in reducing the spread of this deadly disease. First, antiretroviral combination therapy lowers viral load which may translate to lower infectivity and, second, there is evidence that treatment of other STDs can reduce the spread of heterosexually transmitted HIV infection.

This initiative will establish 6 demonstration projects to translate a combination of new biomedical, behavioral, and sociologic findings linked to reduction of HIV transmission into effective HIV prevention practice and policy. In addition, it will evaluate the effectiveness of HIV antiretroviral therapy in decreasing the incidence of HIV infection in disadvantaged areas and the effectiveness alternative delivery models for STD treatment in reducing the spread of sexually transmitted HIV infection.

HIV Prevention

Authorizing Legislation - Section 301, 307, 310, 311, 317, 327, 352, and 1102 of the Public Health Service Act

	<u>FY 1997 Enacted</u>	<u>FY 1998 President's Budget</u>	<u>FY 1998 House</u>	<u>FY 1998 Senate</u>	<u>FY 1999 Estimate</u>
BA	\$616,790,000	\$634,266,000	\$621,790,000	\$646,790,000	\$647,090,000
FTE	1,063	1,029	1,029	1,029	1,008

1999 Authorization. Indefinite

PURPOSE AND METHOD OF OPERATION

The mission of CDC's HIV prevention program is to prevent HIV infection and to reduce associated morbidity and mortality. To achieve this mission, CDC's HIV prevention program collaborate closely with community, State, national and international partners, and other Federal agencies. Through these efforts and by providing financial assistance to State and local health and education agencies; national, regional, and local minority organizations (NRMOS); national, regional and community-based organizations (CBOs); academia, business and labor; and religious organizations, successful implementation of the program is accomplished.

Funding for HIV Prevention for the last five years:

	<u>Funding</u>	<u>FTE</u>
1994	\$543,253,000	1,002
1995	\$589,831,000	917
1996	\$584,080,000	960
1997	\$616,790,000	1,063
1998 Pres. Budget	\$634,266,000	1,029

RATIONALE FOR BUDGET REQUEST

The FY 1999 budget request of \$647,090,000 represents a net program increase of \$12,824,000 over the FY 1998 President's Budget. In addition, the FY 1999 request includes a net decrease of 21 FTEs below the FY 1998 President's Budget.

There is growing evidence that prevention programs that are carefully designed and systematically applied can change HIV-related risk behaviors. Studies have shown decreased rates of transmission among those who have been targeted for intervention. The appropriate approaches often vary from community to community. This fact increases the importance of locally designed programs for prevention, based on models that have been demonstrated and evaluated. CDC, along with other agencies in the federal government, plays a critical role in supporting those demonstrations, and in transferring the lessons learned to State and local health and education departments and community-based organizations.

HARNESSING NEW TOOLS FOR HIV PREVENTION IN UNDESERVED POPULATIONS, INCLUDING WOMEN (+\$10,000,000 AND 12 FTES)

From 1995 to 1996 in the U.S., AIDS cases due to heterosexual contact showed the largest proportionate increases (19%). In addition, AIDS deaths increased among heterosexuals and women, while decreasing among men who have sex with men and injection drug users. Disadvantaged populations, especially African-Americans and socio-economically stressed youth, continue to have high rates of HIV infection despite high levels of knowledge about behavioral prevention methods (e.g., condom use, decreased injection drug use). The proportion of African-American cases increased almost a quarter to exceed, for the first time, every other racial/ethnic group. Two biomedical interventions have demonstrated important possibilities to reduce spread of HIV in these most vulnerable of populations. First, over the last 2 years, it has been shown that anti-retroviral combination therapy lowers viral load in blood, semen, and vaginal secretions which may translate to lower infectivity. Second, there is evidence that treatment of other STDs can reduce spread of heterosexually transmitted HIV infection.

The increased funds will be used to establish six demonstration projects in the United States to translate a combination of new biomedical, behavioral, and sociologic findings linked to reduction of HIV transmission into effective HIV prevention practice and policy. These sites will evaluate two potentially complementary interventions: 1) the effectiveness of increased knowledge of HIV status and improved access and adherence to HIV anti-retroviral therapy in decreasing the incidence of HIV infection in disadvantaged neighborhoods, and 2) the effectiveness of alternative delivery models for STD treatment and related services on a community-wide basis in reducing spread of sexually transmitted HIV infection in the U.S. In addition, an STD/HIV Field Research Station will be established in the Republic of South Africa (RSA) to strengthen capacity to answer critical applied research questions.

CURRENT SERVICE REQUIREMENTS/MANDATORY COSTS (+\$2,824,000)

The FY 1999 request includes \$2,824,000 to partially fund centralized mandatory costs associated with pay costs, within-grades, GSA rent, fuel, utilities, and other related items.

OUTPUTS:

	<u>FY 1997 Enacted</u>	<u>FY 1998 President's Budget</u>	<u>FY 1998 House</u>	<u>FY 1998 Senate</u>	<u>FY 1999 Estimate</u>
Provide technical and financial assistance to cities, States, and Territories to collect HIV/AIDS surveillance data.	61 areas	61 areas	61 areas	61 areas	61 areas
Support HIV epidemiologic and behavioral intervention research to develop methods for reducing the transmission of HIV	65 projects	65 projects	65 projects	65 projects	65 areas
Provide financial and technical assistance to grantees to conduct HIV prevention activities	65 areas	65 areas	65 areas	65 areas	65 areas
Provide support to directly funded CBOs for street and community outreach, prevention case management, risk-reduction and community level interventions	94	94	94	94	94
Provide support to NRMOS to provide technical assistance to health departments and CBOs	23	23	23	23	23
Number of school personnel trained in the development, implementation, and evaluation of school-based quality HIV prevention education programs	148,000	148,000	148,000	148,000	148,000
Number of Community Planning Groups with Corrections Representation	20	35	35	35	38
Number of Community Planning Groups with CBO linkages to Corrections and Drug Treatment Facilities	12	20	20	20	25

	<u>FY 1997 Enacted</u>	<u>FY 1998 President's Budget</u>	<u>FY 1998 House</u>	<u>FY 1998 Senate</u>	<u>FY 1999 Estimate</u>
Number of HIV Demonstrations in Correctional Settings incorporating substance abuse treatment, discharge planning, and aftercare.	0	5	2	5	5
Provide Support for demonstration projects in communities to reduce the spread of HIV.	0	0	0	0	6

Infectious Diseases

Authorizing Legislation - Section 301, 307, 310, 311, 318, 327, 352, and 1102 of the Public Health Service Act

	<u>FY 1997 Enacted</u>	<u>FY 1998 President's Budget</u>	<u>FY 1998 House</u>	<u>FY 1998 Senate</u>	<u>FY 1999 Estimate</u>
BA	\$87,720,000	\$112,428,000	\$118,000,000	\$112,428,000	\$169,429,000
FTE	915	885	885	885	905

1999 Authorization.Indefinite

PURPOSE AND METHOD OF OPERATION

CDC's efforts in infectious disease prevention focus on:

- o National surveillance of infectious diseases.
- o Research to develop new or improved diagnostic tests and prevention and control strategies and techniques.
- o Work with State and local health departments and private health care providers to transfer and accelerate the general application of effective infectious disease prevention technologies.
- o Strengthening the capability to respond to outbreaks of new and reemerging infectious diseases.
- o Developing and implementing strategies to prevent the occurrence and spread of antimicrobial resistance.
- o Strengthening the capacity of the public health system at the State and local levels to provide leadership to their communities in addressing current and emerging critical health problems.
- o Developing a nationwide network for communicating information to the public health community.
- o Providing enhanced leadership, knowledge, skills, and abilities for fifty (50) federal, State, local, and international senior health officials annually through the Public Health Leadership Institute.
- o Delivering training and information to the public health workforce using a variety of methods (self-study, computer-based training, satellite teleconferences, audio conference, etc.) by the Public Health Training Network.

Funding for Infectious Diseases for the last five years:

	<u>Funding</u>	<u>FTE</u>
1994	\$47,782,000	1,008
1995	\$54,340,000	940
1996	\$62,153,000	825
1997	\$87,720,000	915
1998 Pres. Budget	\$112,428,000	885

RATIONALE FOR BUDGET REQUEST

The FY 1999 budget request of \$169,429,000 represents a net increase of \$57,001,000 and 20 FTEs over the FY 1998 President's Budget.

PREVENTING EMERGING INFECTIOUS DISEASES (\$45,500,000 AND 36 FTEs)

Over the last 50 years, significant progress has been made in the prevention and control of many infectious diseases. Today this progress has been partially reversed, due to factors which include changes in human behaviors, dramatic increases in international commerce and travel, environmental changes, and deterioration of our public health infrastructure, resulting in the emergence of drug resistance and new and resurgent bacteria, fungi, parasites and viruses. The Institute of Medicine and President Clinton have reaffirmed CDC's critical leadership role in responding to the threat of infectious diseases. This FY 1999 budget initiative continues the phased implementation of CDC's plan, "Addressing Emerging Infectious Disease Threats, A Prevention Strategy for the United States," in four areas that will help to preserve national security and protect the Nation's health:

1) Surveillance and Response (\$12,500,000)

- o Provide financial and technical support for building modern and responsive local, state, national, and global surveillance systems, and for epidemiological and laboratory response capacity for infectious disease outbreaks
- o Expand the number of regional Emerging Infections Programs in the U.S. which conduct active "early warning," population-based investigations of new agents of infectious disease
- o Develop and implement a national monitoring system for antimicrobial/antiviral use, resistance, and related risk factors

2) Applied Research (\$6,800,000)

- o Provide financial support for expanding the extramural infectious disease applied research program in critical emerging and reemerging areas such as antibiotic resistance, blood safety, health care associated infections, and waterborne diseases.
- o Expand intramural research for enhanced and improved diagnostic test development

3) Prevention and Control (\$7,400,000)

- o Implement health communication strategies for professionals and the general public to prevent the spread of emerging and re-emerging infectious diseases
- o Develop and implement educational programs to improve the appropriate use of antimicrobial drugs by health care providers and consumers

4) Laboratory Capacity (\$18,800,000)

- o Expand public health laboratory training fellowship programs to build capacity in public health microbiology at local, State and Federal public health laboratories
- o Support WHO efforts to address emerging infectious diseases globally, including enhancement of the existing WHO Collaborating Centers at CDC in carrying out reference laboratory functions

- o Provide financial and technical assistance to state and local health departments to develop capacity in areas such as molecular subtyping and other new generation diagnostics
- o Provide state-of-the-art laboratory instrumentation for expanded capacity for Biosafety Level 3 at CDC

INTERAGENCY FOOD SAFETY INITIATIVE-SURVEILLANCE AND EARLY WARNING (\$10,000,000 AND 13 FTES)

Ensuring the safety of the food supply is one of government's most enduring and important functions. It is a responsibility shared by government and the private sector. In responding to new technologies that enable food producers to grow, process, and market a growing variety of food products, the private sector and federal, state and local governments face many challenges to maintaining and improving the safety of the Nation's food supply. Disease-causing microorganisms (pathogens) continue to threaten public health as new organisms emerge as foodborne threats, and well-known organisms acquire greater potency. This increase will enable CDC to implement the following activities as part of the Interagency Food Safety Initiative:

The National Early Warning System will increase federal support to State health departments to detect foodborne diseases by increasing the number of scientists available to investigate foodborne outbreaks and by enhancing laboratory-based surveillance of important foodborne pathogens through improved diagnostic reagent availability, diagnostic and subtyping development, standardization, and training. It will improve the quality and scope of foodborne disease surveillance in the 8 FoodNet sites and in other State health departments through enhanced staffing, training, laboratory capacity/infrastructure, and coordination. And it will link federal and State public health laboratories with sophisticated computer technology that will enhance communications and data sharing, including the digitized fingerprints of foodborne pathogens.

ANTI-TERRORISM / BIOLOGICAL AGENTS (+\$1,000,000)

Under the Anti-Terrorism and Effective Death Penalty Act of 1996, CDC is responsible for monitoring organizations that work with hazardous agents. The collection of registration fees from commercial suppliers of hazardous agents, government agencies, universities, research institutions, individuals, and private companies that transfer or use these agents only partially covers direct and indirect costs associated with administration of the program. The requested amount of \$1,000,000 will cover all remaining costs related to registering facilities and conducting inspections.

CURRENT SERVICE REQUIREMENTS/MANDATORY COSTS (+\$501,000)

The FY 1999 request includes \$501,000 to partially fund centralized mandatory costs associated with pay costs, within-grades, GSA rent, fuel, utilities, and other related items.

OUTPUTS:

	<u>FY 1997 Enacted</u>	<u>FY 1998 President's Budget</u>	<u>FY 1998 House</u>	<u>FY 1998 Senate</u>	<u>FY 1999 Estimate</u>
<u>Emerging Infections</u>					
Provide support to state health departments	22	25	27	25	30
Establish emerging infections programs	7	8	8	8	9
Implement and support extramural domestic and global surveillance networks	3	4	5	4	7
Extramural research grants awards	17	22	24	22	26
Training courses	2	3	5	3	10
Public Health Leadership Institute	1	1	1	1	1
CDC Information Network for Public Health Officials (CDC INPHO)	1	1	1	1	1
Number of Public Health laboratories receiving technical assistance and consultation on laboratory performances, and quality assurance and practice.	50	50	50	50	50
<u>Hantavirus</u>					
Cooperative agreements	4	4	4	4	4
Research and evaluation cooperative agreements	25	25	25	25	25
<u>Foodborne Illnesses</u>					
Investigations of foodborne disease outbreaks	15	20	20	20	23
Establish active foodborne surveillance or "sentinel" sites	7	8	8	8	8
State Laboratory Enhancements (Molecular Diagnostics)	0	7	7	7	11

	<u>FY 1997 Enacted</u>	<u>FY 1998 President's Budget</u>	<u>FY 1998 House</u>	<u>FY 1998 Senate</u>	<u>FY 1999 Estimate</u>
Develop, implement, and enhance surveillance to monitor antimicrobial resistance in <i>Salmonella</i>	0	0	0	0	1
National Data Bank and Subtyping Network (DNA Fingerprinting)	0	1	1	1	1
Epidemic Intelligence Service Officers (EIS)	0	5	5	5	7
Prevention Effectiveness Evaluations	0	0	0	0	5
National Laboratory Training Network Programs	0	0	0	0	1
Distance Learning Foodborne Disease Events	0	0	0	0	2

Epidemic Services

Authorizing Legislation - Section 301, 307, 310, 311, 325, 327, 352, 353, and 361 of the Public Health Service Act

	FY 1997 <u>Enacted</u>	FY 1998 President's <u>Budget</u>	FY 1998 <u>House</u>	FY 1998 <u>Senate</u>	FY 1999 <u>Estimate</u>
BA	\$89,083,000	\$89,319,000	88,797,000	88,797,000	\$89,717,000
FTE	303	293	293	293	283

1999 Authorization. Indefinite

PURPOSE AND METHOD OF OPERATION

As part of CDC's efforts to implement the Healthy People 2000 National Prevention Objectives, CDC conducts a program of scientific inquiry and applied research to solve public health problems and supports selected programs to assist States, health organizations, and others in the health field to achieve prevention goals.

Resolving public health problems rapidly will ensure cost effective health care and enhance health promotion and disease prevention. Activities involving rapid solutions range from local identification of food poisoning to national investigations, such as Legionnaires' disease and Eosinophilia Myalgia Syndrome. CDC efforts will continue to provide the United States with a trained professional staff able to investigate health problems which affect the U.S. population.

The objectives of the epidemic services activity are to:

- o Provide for the prevention and control of epidemics and protect the U.S. population from public health crises including biological and chemical emergencies.
- o Develop, operate, and maintain surveillance systems, analyze data, and respond to public health problems when indicated. Public health surveillance data are used to: estimate the incidence, prevalence, and distribution of diseases and injuries; monitor trends over time; identify subgroups at increased risk; set priorities for intervention programs; evaluate intervention programs; assess risk factors for acquiring a disease; make projections of future disease burden on society; and detect epidemics. CDC's surveillance activities involve close cooperation among federal, state, and local governments and the private medical community to provide effective public health services.
- o Train public health epidemiologists; including the Epidemic Intelligence Service (EIS) program, a 2-year post-doctoral program in applied epidemiology. Since 1951, this program has enabled public health professionals to attain proficiency in the practice of epidemiology while simultaneously providing epidemiologic service to the states and the U.S. public. More than 2,000 professionals have been trained, while playing lead roles in a variety of landmark investigations such as Legionnaires' disease, toxic-shock syndrome, and most recently hantavirus pulmonary syndrome. In 1997 a new training program, the Public Health Prevention Service (PHPS), was implemented using the EIS model, that will allow participants to develop and manage scientifically sound public health prevention programs through this three year training program that includes significant time spent at State and local levels.

- o Carry out the quarantine program as required by regulations including: (1) overseas monitoring and assessment of the quality of medical screening and treatment of refugees awaiting resettlement in the U.S. and (2) domestic inspection of all arriving refugees, review of medical records, and notification of State and local refugee programs and health departments of their arrival.
- o Reduce the importation of disease from developing countries through reduced morbidity and mortality utilizing the Global Epidemic Intelligence Service while also building partnerships with other countries.
- o Continue the publication of the *Morbidity and Mortality Weekly Report (MMWR)*, considered to be CDC's main communication mode for disease outbreaks and trends in health and health behavior. The *MMWR* is disseminated to over 700,000 people who work in the fields of public health. The *MMWR* is also available through a commercial electronic communications network to private physicians, hospitals, and other appropriate offices. Future plans include development of multi-media applications to improve dissemination and expansion of target audiences.
- o Develop, coordinate, and provide efficacious, effective, and economic prevention strategies to deliver the best possible public health programs in the context of a realistic expenditure of resources.
- o Improve and assist the development of State infrastructure by supporting State public health programs and activities through Managed Care and the development of Urban Research Centers.
- o Conduct surveillance and epidemiologic studies, provide program guidance to federal, state, and local health agencies, and conduct limited direct research targeted to the reduction of perinatal, neonatal, and postneonatal mortality and morbidity related to anemia, low birth weight, sudden infant death syndrome (SIDS), prematurity, complications of pregnancy and poor child growth.
- o Conduct ongoing surveillance, targeted epidemiologic studies, and program guidance to health agencies to reduce maternal mortality and morbidity and improve reproductive health.
- o Conduct epidemiologic and laboratory investigations of Chronic Fatigue Syndrome to define its prevalence, incidence, clinical course, and risk factors/markers; and disseminate information to educate the medical/scientific communities and the public.
- o Support national efforts to prevent teen-age pregnancy, including innovative coalition partnerships to mobilize and organize communities to conduct comprehensive programs. Teen pregnancies have declined when comprehensive community programs for youth have been applied that develop talents and skills, enhance self-esteem, inform teens about sexual development, promote prolonged abstinence, and provide ready access to health and education services.

Funding for Epidemic Services for the last five years:

	<u>Funding</u>	<u>FTE</u>
1994	\$78,204,000	446
1995	\$83,740,000	355
1996	\$77,899,000	273
1997	\$89,083,000	303
1998 Pres. Budget	\$89,319,000	293

RATIONALE FOR BUDGET REQUEST

The FY 1999 budget request of \$89,717,000 represents a net program increase of \$398,000 from the FY 1998 President's Budget. The FY 1999 FTE level also reflects a net decrease of 10 FTEs below the FY 1998 President's Budget. CDC conducts a program of scientific inquiry and research to solve public health problems and supports selected programs to assist States, health organizations, and others in the health field to achieve prevention goals.

CURRENT SERVICE REQUIREMENTS/MANDATORY COSTS (+\$398,000)

The FY 1999 request includes \$398,000 to partially fund centralized mandatory costs associated with pay costs, within-grades, GSA rent, fuel, utilities, and other related items.

Prevention Research

Authorizing Legislation - Section

	FY 1997 <u>Enacted</u>	FY 1998 President's <u>Budget</u>	FY 1998 <u>House</u>	FY 1998 <u>Senate</u>	FY 1999 <u>Estimate</u>
BA	0	0	0	0	\$100,000,000
FTE	0	0	0	0	0

1999 Authorization. Indefinite

PURPOSE AND METHOD OF OPERATION

Public health expenditures contribute significantly to longer, healthier lives. An infant born in the U.S. today has, on average, 30 more years of life expected than in 1900 -- 25 of these additional years are due to public health efforts. Many public health efforts result in considerable financial savings; others carry a net cost, but represent an important investment in saving lives and improving the quality of life. The benefits of prevention must be aggressively pursued. Yet, as the U.S. health care budget approaches \$1 trillion, only one percent of health expenditures support population-based prevention. This undervaluing of prevention not only impacts the quality of health care, but has short- and long-term consequences for health care costs. Our desire to reduce health care costs necessitates that more people-oriented, population-based prevention research be done.

Public health is driven by science, and we need to assure that scientific advances continue to be rapidly incorporated into the practice of preventive medicine and public health. The public health system of the future needs to be based on state-of the art technology, science, and ideas. Only through research will CDC be able to maintain itself at cutting-edge readiness to deal with new health problems, and to address our current problems more effectively. Examples of areas requiring prevention research include: antimicrobial resistance, the safety of the Nation's blood supply, birth defects, asthma, health problems of inner city and urban populations, and diabetes.

The Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substance Disease Registries (ATSDR) would like to lead a major effort toward generating more people-oriented, population-based prevention research to provide timely, yet scientifically sound solutions to urgent health problems. CDC, with its prevention mission, is the appropriate agency to provide leadership in the development of a new prevention research thrust. CDC along with ATSDR already conducts prevention research geared toward determining the cause of disease, injury, and disability and identifying ways--either through applying findings from basic and biomedical research, making environmental changes, or promoting behavior changes--to prevent or control these causes in people. CDC has the history, the scientific expertise, the training programs, and the partnerships with communities necessary to implement such a strategy. CDC does not conduct prevention research in isolation. We will continue to work very closely with the other agencies within DHHS, identifying the areas where we can most effectively work together and bring our best resources to bear on major public health problems.

Three forces in our nation today provide impetus for more focus on prevention research. First, Americans are more interested in how they can protect, promote, and enhance health status in their personal lives, in their families and in their communities. Yet many questions raised about the relationship among lifestyle, environment, and health remain unanswered because research has not been done.

Second, our health care system is changing from an individual curative approach to a more population-based prevention approach. This is due to both the role of managed care and the concern in this country that we must focus more on prevention to curtail our enormous expenditures for treatment. Third, academic health centers are trying to adapt to changes in society and the health care arena. While we have made excellent progress in stimulating basic biomedical research in the academic medical community, we have done very little to enable that same community to look at the populations they serve and enhance their health status through population-based research. In order to adapt to changes taking place in the health care arena, academic health centers need to be able to expand their faculties to include more people who are engaged in population-based prevention-oriented research, to increase the involvement of their faculties in communities where more health care is being provided, and increase the exposure of their students to faculty members who have expertise in population-based research. Ninety percent of CDC's Prevention Research Initiative would go to extramural research programs at academic medical centers, schools of public health and others. This research would be geared to determining the cause of disease, injury, and disability and identifying ways to prevent or control these causes in people.

In summary, the undervaluing of prevention not only impacts the quality of health care in this country but also has and will continue to have a short- and long-term adverse impact on health care costs. Without the type of investment in population-based prevention research we are recommending, we will never shift the current health care paradigm in this country toward more prevention, which results in the need for less treatment.

Funding for Prevention Research for the last five years:

	<u>Funding</u>	<u>FTE</u>
1994	\$0	0
1995	\$0	0
1996	\$0	0
1997	\$0	0
1998 Pres. Budget	\$0	0

RATIONALE FOR BUDGET REQUEST

The FY 1999 budget request of \$100,000,000 represents a net program increase of \$100,000,000 over the FY 1998 President's Budget to support prevention based research. Of this amount, 90% will be used to support extramural activities.

This initiative proposes a broad-based research program that will encompass subject matter in the full range of CDC's mission. For example:

Using Emerging Technology to Obtain and Act on Health Information

CDC and its partners are applying emerging information technology to disease surveillance, monitoring of health status, analyzing health care trends, and identifying health needs. The surveys, epidemiologic studies, and disease surveillance conducted by the CDC are important national health research resources, and this initiative will enhance the ability of CDC researchers to develop new methods and to investigate this data in greater depth than is now possible. Advances in communication technology mean that knowledge can be shared rapidly, and that public health interventions can be based on a sound information base.

Transitioning from Research Bench to Medical and Public Health Practice

Biomedical research is producing a steady stream of results identifying new risk factors for disease and new environmental detriments to health. To apply these results to practice means finding practical and cost-effective ways of using these results. For example, about 120,000 children each year are born in this country with a serious birth defect -- the cause of 75% of these remain unknown. One type of serious birth defect, neural tube defects (spina bifida and anencephaly), is found in 4,000 newborns each year in the U.S. The cost to society of treating and caring for an individual affected by neural tube defects is about \$118,000, resulting in a total annual cost to society of \$709 million. Epidemiologic research has suggested that the vitamin folic acid could prevent about 50% of the U.S. cases of neural tube defects. Thus, 2,000 cases of neural tube defects could be prevented each year by consumption of adequate folic acid by women of childbearing age. CDC's Prevention Research Initiative will help us answer the following questions: how can we prevent costly and devastating birth defects; how do we increase women's consumption of folic acid in order to prevent neural tube defects; what other preventable risk factors contribute to these and other birth defects; and what are the most appropriate communication channels and community partnerships to use in reaching increasingly diverse populations?

Developing State-of-the-Art Laboratory Methods

Laboratory research plays a critical role in helping CDC accomplish its mission both nationally and internationally, and CDC has a strong intramural program on which to build. CDC must participate in the development of new, efficient diagnostic methods, and novel uses of existing methods, to rapidly and accurately diagnose infectious, environmental, and occupational diseases in order to evaluate their impact on public health and to facilitate the early recognition of emerging and reemerging problems of public health importance. Infectious diseases may reemerge because bacteria become resistant to antimicrobial drugs, which usually occurs as a consequence of widespread use and misuse of antimicrobial drugs. This development, and the spread of resistant strains of bacteria, causes suffering in millions of Americans each year at a cost of billions of dollars. For instance, each year bacteria cause 7 million cases of acute middle-ear infections and 500,000 cases of pneumococcal pneumonia. Until recently, these bacteria were treated with penicillin, which was both effective and inexpensive. Since the early 1990s, however, penicillin has become ineffective in many cases of serious illness. In one city, one out of three (33%) pneumococcal strains are resistant to penicillin, but more importantly, one out of seven (15%) are resistant to even the most expensive and most potent antibiotics. Yearly costs incurred from antimicrobial resistance are estimated to be \$4 billion and increasing. CDC's Prevention Research Initiative will develop laboratory methods and surveillance that will help us determine the magnitude of the problem and what factors contribute to antimicrobial resistance. Our Nation will then be better equipped to minimize or eliminate antimicrobial resistance.

In addition to addressing our ability to respond to antimicrobial resistance, continued vigilance is needed to ensure the safety of the Nation's blood supply. Each year millions of Americans undergo blood transfusions. Because blood is a human tissue, it is a natural vehicle for transmission of infectious diseases. The experience with HIV in the 1980s illustrates the need for vigilance regarding new threats to the blood supply. Our experience with HIV provided a basis for screening programs to prevent transmission of hepatitis B and more recently hepatitis C, but it would be foolish to assume that new infectious threats to the blood supply will not emerge. CDC's Prevention Research Initiative will expand laboratory methods and surveillance to better enable us to answer the following questions: how do we continue to protect the safety of the blood supply; how do we monitor the blood supply to detect the occurrence of known pathogens; how do we determine risk of transmission; and how do we evaluate the risk of newly recognized pathogens being transmitted through the blood supply?

Analyzing Occupational Safety and Health

Disease and injury and their interplay with work, environment, and workforce are priority areas of research identified in the National Occupational Research Agenda (NORA). Developed by NIOSH and partners in both public and private sectors, NORA provides a framework as well as research tools and approaches to guide occupational safety and health research in the United States over the next decade, not only for CDC, but for the entire occupational safety and health community.

Bridging the Gap Between Discrete Subject Areas and Disciplines

The initiative will support broad-based public health research covering the full range of the CDC mission, such as violence prevention, health problems of special population groups, infectious diseases, chronic disease risk factors and their modification, and environmental influences on health. Developing approaches that build on the strengths of multiple disciplines - epidemiology, behavioral sciences, health services research, information sciences, communications, medicine, and laboratory approaches - leads to new approaches to implementing effective public health programs. This interdisciplinary approach is critical to improving health; For example, the health of children is influenced in multiple ways - through a variety of health threats. For instance, asthma is one of the nation's most common and costly diseases, estimated to affect between 14 and 15 million people. Asthma is the leading cause of chronic disease in children, affecting 4.8 million youth. In 1990, the cost of asthma was estimated to be \$6.2 billion. Many of the causes of and ways to prevent asthma attacks are known. Research has demonstrated that a comprehensive, practical intervention program based on findings from biomedical, behavioral, and environmental research can result in decreases in hospitalization rates, emergency room visits, and school absenteeism. A common-sense, cost-effective national prevention strategy to reduce the human and financial toll of asthma is needed. CDC's Prevention Research Initiative will help us answer the following questions: what can we do to protect children from the complications of this deadly disease; what factors influence the onset and complications of asthma; and what environmental and community-based interventions will improve the health of children with asthma?

Broad-based public health research will allow us to tackle the full burden of one of the Nation's costliest diseases, like diabetes. Sixteen million people have diabetes, a leading cause of blindness, kidney failure, and lower limb amputations. The American Diabetes Association estimates that diabetes costs the Nation \$91.8 billion in 1992, including \$45.2 billion in direct medical expenditure and \$46.6 billion in indirect cost. This devastating health and economic burden particularly affects disadvantaged populations, and yet need not exist. Effective preventive measures have been proven to reduce significantly the disabling and costly effects of the complications of diabetes. CDC's Prevention Research Initiative will help us to answer the following questions: how can the health and economic burden of diabetes be reduced; what populations are at highest risk of complications of diabetes; what lifestyle factors help to reduce the consequences of diabetes; what is an appropriate standard of care for diabetes to prevent disease complications; and what are the most appropriate communication channels and community partnerships to use in reaching increasingly diverse populations? The scientific approach to diabetes will involve epidemiologic, behavioral and health services research.

PROCESS FOR IMPLEMENTING THE RESEARCH INITIATIVE

Implementing an enhanced research program to build public health science will be a multi-year effort undertaken in partnership with the public health practice and research communities. CDC has learned from the highly successful model used by NIOSH for developing NORA to set future CDC research priorities. More than 500 organizations and individuals outside NIOSH provided input to the development of the agenda which will focus research on those areas determined to be important

for preventing future work-related illness, injuries, and death. CDC will seek broad community involvement in identifying problems, research needs and opportunities. By involving researchers, public health officials, community leaders, and private sector organizations in setting a research agenda, CDC can assure a direct link between research, development, and application. CDC also will lay the groundwork for future research efforts by encouraging partnerships, building infrastructure at the local level, and encouraging joint grant applications from collaborating partners at the community level. Applications for funds under this initiative will be subject to rigorous peer review.

Extramural Research

CDC will develop new partnerships and build on existing mechanisms to support quality extramural science. Approaches include:

- Developing Community Capacity

CDC will support the development of cross-cutting community research by building on CDC's Prevention Centers and Urban Research Centers Program. These programs are uniquely suited to pool the resources of academic researchers; Federal, State and local governmental agencies; community-based organizations; and health practitioners thus expanding the capacity of diverse professionals to conduct prevention research and apply the results. For example, people living in inner cities suffer a disproportionate burden of illness and injuries. In particular, they suffer from traditional public health problems such as STDs, TB, adolescent pregnancy, and low immunization rates, as well as more recently recognized public health problems such as HIV/AIDS, chronic disease, elevated blood lead levels, and violence. Common factors such as poverty, social class, crowding, pollution, and urban stress contribute to a wide spectrum of health problems such as these. Common risk and social factors call for cross-cutting community interventions. Strictly categorical programs are unlikely to be successful in addressing multi-faceted problems. Coordinated multidisciplinary public health research will facilitate the development, implementation, and evaluation of prevention programs to address these complex social problems. CDC's Prevention Research Initiative will better enable us to answer the following questions: what are the causes of the disproportionate health burden in inner cities; who is most at risk; what's the disease burden within the community; what interventions are appropriate; how can interventions be done most efficiently; and what are the best designs for integrating cross-disciplinary interventions for diverse communities?

- Supporting Investigator-initiated Research

CDC will expand on its reliance on externally-initiated research, as a way of assuring that new directions, ideas, and innovations meet the Nation's needs. Communities need to be centrally involved in the continuing search for innovative public health approaches and medicine, minority health professions schools, and managed care organizations will be used. Existing categorical mechanisms such as the Injury Centers, Centers for Birth Defects Prevention and Research, NIOSH Centers and the Injury Research Grants program may also be utilized.

Intramural Research

The current CDC research capacity effectively complements the contributions in biomedical research made by NIH and health services research made by AHCPR, the research advances made by academic centers, industry, and CDC scientists themselves through practical applications of novel advances. CDC researchers are among the world's leaders in addressing the growing threat of antimicrobial resistance, developing applications such as polymerase chain reaction (PCR) tests to identify specific infectious agents, diagnosing the cause of outbreaks (such

as the Ebola virus outbreak in Zaire), measuring exposure to environmental agents (such as lead and cotinine), conducting occupational safety research, and forecasting influenza trends and developing the most appropriate protective vaccine.

Research as a Component of GPRA

As one of its GPRA goals, CDC is committed to assuring that science is translated into action. A research program such as this is one of the strategies identified to bring effective prevention programs to communities. Strategy 4.1 calls for collaboration with diverse partners. The Department also is committed to creating new forms of collaboration in research and has identified in its strategic plan a goal of "investing in the Nation's capacity for new scientific knowledge." As stated in the April 1 draft document, "Expansion in research investments across a broad front of scientific disciplines and operating divisions within the Department will do more than anything else to ensure improvements in health status and in the kinds and quality of services we sponsor."

CDC Prevention Research: A Component of the Secretary's National Health Research Initiative

CDC's Prevention Research Initiative will be a critical part of the Secretary's "National Health Research Initiative" that seeks to provide \$25 billion over 5 years to expand research in CDC, NIH and AHCPR. CDC research will complement NIH and AHCPR research. While CDC is involved in all levels of research from the most basic biomedical research at the cellular level to more population-based research investigating the effects of disease, disability, and injury on the health status of large groups of people, NIH concentrates on biomedical research, AHCPR focuses on health services research, and CDC supports primarily prevention research. Currently 85 percent of the CDC budget is devoted to applications with approximately 15 percent devoted to research. The history of science has shown that there is no substitute for investigator-initiated research as a source of new directions, new ideas, and innovations. Some of our most difficult problems in addressing the health problems of the Nation's under-served can benefit from coupling researchers with community leaders. Prevention research is essential for protecting our citizens from the ravages of disease, injury, disability, and premature death. CDC, the Nation's prevention agency, has the vision, the mission and the entrepreneurial spirit to meet this research challenge.

Program Management

Authorizing Legislation - Titles III, Section 794 of Title VII, XV, XVII, XIX, XXVI, XXVII, and section 1102 of the Public Health Service Act, sections 101, 102, 103, 201, 202, and 203 of the Federal Mine Safety and Health Act of 1977, [Public Law 101-354] and sections 20, 21, and 22 of the Occupational Safety and Health Act of 1970.

	<u>FY 1997 Enacted</u>	<u>FY 1998 President's Budget</u>	<u>FY 1998 House</u>	<u>FY 1998 Senate</u>	<u>FY 1999 Estimate</u>
BA	\$2,563,000	\$2,465,000	\$2,465,000	\$2,465,000	\$2,465,000
FTE	33	33	33	33	33

1999 Authorization Indefinite

PURPOSE AND METHOD OF OPERATION

Effective and efficient administrative management is provided to all the Centers, Institute, Offices, and staff elements of CDC.

Other goals are to:

- o Ensure an effective and coordinated prevention approach throughout the country and to plan for meeting the Year 2000 Prevention Objectives for the Nation.
- o Maintain liaison within and outside the federal government in matters relating to prevention and occupational safety and health.
- o Maintain a focal point to provide national leadership in prevention and occupational safety and health.
- o Ensure that the programs of the agency are efficiently managed and internally and externally coordinated.
- o Continue safety management and other activities to ensure the safest and most effective use of the Centers' laboratories.
- o Provide safe and adequate facilities for the operations of CDC.

Funding for Program Management for the last five years:

	<u>Funding</u>	<u>FTE</u>
1994	\$3,131,000	70
1995	\$3,058,000	65
1996	\$2,637,000	65
1997	\$2,563,000	33
1998 Pres. Budget	\$2,465,000	33

RATIONALE FOR THE BUDGET REQUEST

The FY 1999 budget request of \$2,465,000 represents no change from the FY 1998 President's Budget. This activity supports the overall direction and management of the Centers for Disease Control and Prevention. This includes both the science, management and legislative policy and direction for the agency in domestic and international public health prevention activities. In addition to this overall administrative direction, the Office of the Director provides leadership activities to ensure the delivery of excellent preventive health services to the Nation.

The FY 1999 request will support skills of many differing disciplines and the valuable resources required to carry out the missions assigned the Centers for Disease Control and Prevention. The specific objective of this activity is to coordinate these disciplines and resources in a manner that focuses on both the missions of the CDC and responsible stewardship of the resources appropriated for those missions.

productive lives for all Americans. CDC collaborates with the National Highway and Traffic Safety Administration for accident related data; Health Resources and Services Administration for maternal and child health related data; and the Department of Justice for rape prevention data.

Program Activity - HIV/AIDS

Program Description

The epidemic of HIV and AIDS presents unique social, economic, and public health challenges to governments and individuals in the United States and around the world. While significant progress has been made in understanding the disease and developing treatments since the first case was reported in the U.S. in June 1981, HIV remains a deadly infection for which there is no vaccine, no cure, and for which there is an expanding, but still limited, inventory of available treatments. An average of 100 Americans are diagnosed with AIDS every day and 100 to 150 men, women, and children become infected with HIV every 24 hours. Globally, 8,500 people become infected each day, including nearly 1,000 children.

As of September 30, 1996, reports of 566,002 cases of AIDS among persons in the U.S. had been reported to the CDC, and more than 343,000 of these persons have been reported to have died as a result of complications related to HIV. Since 1987, AIDS has risen from being the 15th leading cause of death among all Americans to the 8th. AIDS is now the leading cause of death among Americans aged 25 to 44. CDC estimates that between 40,000 and 60,000 Americans are becoming newly infected with HIV each year, and that between 650,00 and 900,000 Americans are currently living with HIV.

HIV is transmitted in a limited number of ways--most commonly sexually, parenterally, and perinatally. Transmission of HIV infection can be prevented. Prevention efforts should be guided by the best available scientific knowledge. Behaviors are major determinants of the transmission of HIV infection. Prevention or modification of high-risk behaviors is an effective intervention to prevent HIV transmission. Prevention is an important cost-effective component of the control of HIV infection. Successful prevention of HIV transmission requires individual effort as well as the collective participation of federal, State, and local governmental, nongovernmental, and international organizations.

The federal government should continue providing assistance to State and local health agencies and community-based organizations to implement effective HIV risk reduction and prevention programs, surveillance of the incidence of HIV and AIDS, research, evaluation, training, and technology transfer of effective interventions, prevention programs, and evaluation activities.

External factors that affect accomplishing goals and objectives for the HIV program:

- HIV incidence reporting is not conducted in all states.
- The ability of state and local health departments to implement needle exchange programs is limited.
- It is difficult for CDC and its partners to ask explicit questions about adolescents' sexual behaviors.
- There is a lack of sufficient funding for behavioral research, technology transfer, behavioral surveillance, evaluation activities of interventions and prevention programs, training and education programs, etc.
- For prevention education programs, sensitive issues exist such as abstinence vs. condom use.

Performance Objectives and Measures

Objective 1:

Improve the national HIV/AIDS surveillance system's ability to identify incidence and prevalence of HIV infection. Surveys and demonstrations for revising the national HIV/AIDS surveillance system will be conducted in FY 1999.

Performance Measures:

- Confidentiality standards for reporting will be defined.
- Baselines will be established for measuring incidence in selected sentinel high-risk populations.
- Trends in long-term survival and rates of transmission of new infections will be measured.

Objective 2:

Reduce the rate of heterosexually- and perinatally-acquired HIV/AIDS cases, as well as AIDS cases related to injecting drug use and male homosexual contact, through the implementation of HIV prevention programs as part of a community planning process.

Performance Measures:

- The number of heterosexually-acquired HIV/AIDS cases will be decreased by 10% from the 1995 base of 9300 AIDS cases diagnosed.
- The number of perinatally-acquired HIV/AIDS will be decreased by 50% from the 1993 base of 525 cases diagnosed.
- The number of AIDS cases related to injecting drug use will be decreased by 15% from the 1995 base of 17,800 cases diagnosed.
- The number of AIDS cases related to male homosexual contact will be decreased by 20% from the 1995 base of 28,600 cases diagnosed.

Objective 3:

Reduce the incidence of HIV/AIDS through the dissemination of HIV prevention education programs.

Performance Measure:

Increase from 86% in 1995 to at least 90% of the students in grades 9 - 12 who will be taught about HIV/AIDS prevention education in school.

Verification/Validation of Performance Measures: The number of AIDS cases diagnosed will be monitored using the National AIDS reporting system. The system is routinely evaluated for data quality and has very high rates of reporting completeness and timeliness.

Resources

Funds: \$437,235,000

FTE's: 266

Information Technology Needs: In order to effectively monitor HIV infection rather than the morbidity data of AIDS, a total revamping of the HIV/AIDS surveillance system will be necessary. To accomplish this task, the latest in information technology, both hardware and software, will be needed. Technical assistance will be needed by most states in implementation of this technology. Advanced technology will be needed to expand on behavioral surveillance activities which is currently being funded in only a few states.

Links to CDC and DHHS Strategic Plans

These objectives measure the performance of CDC Assessment and Assurance Goals 2 and 4 and relate to the DHHS Goal 1: To promote health and reduce the major threats to healthy and productive lives for all Americans. Regarding perinatal transmission, CDC is working closely with the Health Resources and Services Administration to implement the language in the recently passed Ryan White legislation. CDC is collaborating with the Substance Abuse and Mental Health Services Administration and the National Institute for Drug Abuse on issues related to transmission of HIV/AIDS in the injecting drug using population. A

working group has also been established to address health care issues in correctional institutions.

Program Activity: Sexually Transmitted Diseases

Program Description

A recent CDC report documented that over 85% of the most common infectious diseases in the U.S. are sexually transmitted. The immediate and long-term disease burden and costs associated with STDs globally and in the U.S. are immense. STDs are one of the most critical challenges in the nation today because of their severe and costly consequences for women and infants, their tremendous impact on the health of adolescents and young adults (especially among minority populations), and the integral role other STDs play in the transmission of HIV infection. Conversely, an investment in STD prevention is leveraged several ways--it improves the health of women, infants, and young people, and slows down the spread of HIV infection in our most vulnerable and disadvantaged populations. In addition to the human costs, STDs other than AIDS add \$10 billion dollars to the nation's health care costs each year.

Compared to the U.S. (which has among the highest STD rates in the industrialized world), Canada and some countries in Western Europe have nearly eliminated infectious syphilis. U.S. rates of gonorrhea are 50 to 100 times higher than rates in Sweden. In the U.S., large-scale regional screening demonstration programs have rapidly, dramatically, and reproducibly reduced chlamydia prevalence in women.

While STD prevention is technically feasible today in the U.S., an effective national system for STD prevention currently does not exist. Among the problems are 1) profound cultural and social barriers to adoption of healthy sexual behaviors; 2) a fragmented system of informational and educational services that leads to inadequate awareness of STDs and misperceptions of risk among high risk individuals; 3) a fragmented system of STD-related clinical services manifested by inadequate training of health care providers, the under recognition of the importance of private sector providers in STD prevention, and the absence of innovative services targeted to youth and disenfranchised populations that lead to inadequate diagnosis and treatment of STDs or missed clinical opportunities; 4) inadequate integration and coordination of STD, HIV, unintended pregnancy, and cancer prevention programs at the local level despite the strong interrelationships between these programs; and 5) inadequate human and financial resources in both the public and private sectors to meet recognized need for behavioral and biomedical solutions.

Performance Objectives and Measures:

Objective 1:

Reduce STD rates by providing chlamydia and gonorrhea screening, treatment, and partner treatment to 50% of women in publicly funded family planning and STD clinics nationally.

Performance Measures:

- The prevalence of *chlamydia trachomatis* among high risk women under 25 will be reduced from 11.6% (1995) to less than 8%.
- The prevalence of *chlamydia trachomatis* among women under the age of 25 in publicly funded family planning clinics will be reduced from 9% (1996) to less than 6%.
- The incidence for gonorrhea in women aged 15-44 will be reduced from 300 per 100,000 (1995) to less than 200 per 100,000.
- The incidence of PID, as measured by a reduction in hospitalizations for PID, will be reduced from 162 per 100,000 (1995) to less than 125 per 100,000 women aged 15-44 and the number of initial visits to physicians

for PID will be reduced from 245,000 (1995) to less than 225,000.

Objective 2:

Reduce the incidence of congenital syphilis through the following strategies:

- More than 95% of women attending publicly funded prenatal clinics will be screened for syphilis (subject to development of state and local surveillance).
- More than 80% of women attending publicly funded prenatal clinics who have untreated or inadequately treated syphilis will be treated within 2 weeks of their initial prenatal visit (subject to development of state and local surveillance).
- More than 95% of pregnant women in counties with syphilis rate greater than 4 per 100,000 will be screened for syphilis in hospitals at the time of delivery (subject to development of state and local surveillance).

Performance Measure:

The incidence of congenital syphilis in the general population will be reduced from 39 per 100,000 live births (1995) to less than 30 per 100,000 live births.

Objective 3:

Reduce the incidence of primary and secondary syphilis through the development of syphilis elimination action plans for each state that had a primary and secondary syphilis rate in 1995 of greater than or equal to 4 per 100,000 population and an HIV prevalence in childbearing women of greater than 1 per 1,000.

Performance Measure:

At least 85% of U.S. counties will have an incidence of primary and secondary syphilis in the general population of less than or equal to 4 per 100,000. This is an increase from 81% in 1995.

Verification/Validation of Performance Measures: Data will be collected through the National STD Surveillance System. Data will be verified through the National STD Accelerated Prevention Campaign and the National Infertility Prevention Program.

Resources:

Funds: \$103,700,000

FTE's: 358

Information Technology Needs: Existing systems are in place to measure this objective with the exception of monitoring the number of pregnancies in which a mother has a curable or manageable STD. Additional systems must be developed at the state and local levels to monitor service delivery.

Links to CDC and DHHS Strategic Plans

These performance measures relate to the CDC Assurance Goal 4 and to the DHHS Goal 1: To promote health and reduce the major threats to healthy and productive lives for all Americans.

Program Activity: Tuberculosis

Program Description

Achievement of the reduction in the case rate of tuberculosis will put the Nation back on track toward the elimination of TB from the U.S. - a goal articulated by the Secretary of the Department of Health and Human Services in 1989: "It is time to commit to a tuberculosis-free society."

In the 1970's and 1980's many areas around the country redirected TB control

funds to other activities and key elements of some TB control programs were dismantled. Progress toward the U.S. goal of TB elimination stopped when the downward TB trend reversed in the years 1985 to 1992 and there was a 20 percent increase in TB cases, along with outbreaks of multidrug-resistant tuberculosis (MDR-TB) and deaths among health care workers. This resurgence was associated with a deterioration of the public health infrastructure complicated by the AIDS epidemic, increased numbers of cases among the foreign born, and transmission of tuberculosis in institutions, particularly in hospitals and prisons. In 1992-1993, additional resources helped to rebuild the public health TB infrastructure permitting health departments to address these problems and TB declined again from 1993-1996. Achievement of this long term strategic objective requires a continued commitment of resources to prevent additional deterioration of the necessary infrastructure at the local, state, and/or federal levels.

Performance Objectives and Measures

Objectives:

Reduce the tuberculosis case rate through the following strategies:

- Collect TB morbidity data from states and define surveillance variables.
- Fund states/locals for implementing CDC treatment/control recommendations, community outreach, conducting TB patient cohort reviews; expanding contact examination; screening and preventive treatment for high risk groups and implementing state-of-the-art TB lab services.
- Collect/analyze and disseminate TB program evaluation data.
- Complete TB outbreak investigations and issue recommendations where applicable within 30 days.
- Provide TB diagnostic, treatment and process training for civil surgeons and panel physicians responsible for screening refugees and immigrants.
- Develop a national TB training strategic plan and support and report on TB related applied and operational research.
- Develop the Tuberculosis Information Management System for state and local health departments for surveillance and case management.

Performance Measures:

- At least 85% of TB patients will complete a course of curative TB treatment within 12 months of initiation of treatment (some patients require more than 12 months treatment). Baseline data for the number of patients who complete TB treatment within 12 months is 66.8% in 1993.
- At least 92% of TB patients with initial positive cultures will also have drug susceptibility results. Baseline data for this measure is 87.4% in 1994.
- At least 75% of contacts of infectious cases and 70% of other high risk infected persons will be placed on preventive therapy will complete a regimen. Baseline measures are 68.4% and 64.8% respectively from 1993 data.
- States will report information to CDC for at least 90% of defined variables. No baseline data is available as CDC has not yet defined variables.

Verification/Validation of Performance Measures: All confirmed cases of TB are regularly listed in the Report of Verified Case of Tuberculosis (RVCT) and follow-up information is submitted electronically to CDC via Tuberculosis Information Management System (TIMS) software. Verification of performance will be conducted through a review of data collected by these two systems. Additionally for the third measure listed above, state and metropolitan area health departments will assist with performance verification.

Resources

Funds: \$120,930,000

FTE's: 122

Information Technology Needs: Performance will be assessed based on information

that will be available from program management reports submitted by state and territorial health departments with software available beginning in 1998.

Links to CDC and DHHS Strategic Plans

These performance measures relate to the CDC Assurance Goal 4 and to the DHHS Goal 1: To promote health and reduce the major threats to healthy and productive lives for all Americans. In addition to state and major city health departments, the Division of Tuberculosis Elimination also works with the Advisory Committee for the Elimination of TB, the National TB Controllers Association, and the American Lung Association/American Thoracic Society to set guidelines, recommendations and policies related to TB prevention and control.

Program Activity: Immunization

Program Description

The mission of the National Immunization Program (NIP) at CDC is to prevent disease, disability and death from vaccine-preventable diseases in children and adults. NIP focuses on several major programmatic areas to achieve these goals. These include childhood immunization, adult immunization and global polio eradication.

Appropriate administration of safe and effective vaccines remains the most cost-effective method of preventing human suffering and reducing economic costs resulting from vaccine-preventable diseases. For every dollar spent on DTP vaccination \$29 is saved, and for every dollar spent on MMR vaccination \$21 is saved.

Although NIP has assistance from many partners, State and local health agencies play a primary role in helping NIP carry out its mission in the United States. State and local health agencies use CDC grant funds for a wide range of activities including hiring staff, conducting surveillance, assessing immunization levels, developing immunization registries, conducting education and outreach, and establishing partnerships with community groups and private sector organizations.

There are two primary sources to measure attainment of performance goals. The NNDSS is the data source for tracking cases of vaccine-preventable disease. Interim data from this system are routinely published in the Morbidity and Mortality Weekly Report (MMWR). Final data are published in the Annual Summary of Notifiable Diseases.

CDC collects vaccination coverage data at the National, State, and local levels through the NIS. With these data, the impact of National, State, and local policies and programs can be evaluated and monitored and the results will provide the primary means of monitoring progress toward the goals of the performance plan. These surveys measure antigen-specific and series complete coverage by selected age categories, with detailed analyses for race/ethnicity and by poverty groups also being presented. Such surveys are necessary to monitor the improvement of immunization coverage levels in the target populations of 78 State and local areas receiving funds to implement Immunization Action Plans. Information in the NIS is supplemented with data from the NHIS. The surveys of immunization coverage levels cost approximately \$15 million annually. The following objective also encompass the Vaccines for Children Program.

Performance Objectives and Measures

Annual Objective:

Reduce the number of cases of most vaccine-preventable diseases by ensuring that 2 year olds are vaccinated, and by increasing pneumococcal pneumonia and

Program Activity - Prevention Centers

Program Description

CDC's Prevention Centers program provides grants to academic institutions--schools of medicine, public health, or osteopathy--to fund applied research designed to yield tangible results in health promotion and disease prevention. The primary goals of the program are to make communities more accessible and amenable to prevention interventions; increase collaboration among agencies and nontraditional partners; and train public health professionals to seek creative ways to prevent chronic diseases. The network of collaborating academic research centers works to fill the knowledge gaps that block achievement of priority prevention goals. The Prevention Centers work with state and local health departments and other agencies to research findings.

Many of the research projects are specific areas of importance to meeting the Healthy People 2000 Objectives. Centers focus on one or more of the following: disease prevention and health promotion among children and youth, older adults and disabled persons; health behaviors among African American, Asian and Hispanic, Native American and rural populations; applied prevention research to serve urban and rural areas that result in improved public health practice at the State, local, and community level; training at the local, state, and regional level to use health data to develop, refine, and implement public health programs.

Performance Objectives and Measures

Objective:

Increase collaboration efforts among research universities and community-based organizations to more effectively implement chronic disease and teen pregnancy prevention research and demonstration projects that focus on new intervention methods and provide results to states and local organizations.

Performance Measure:

- The 14 university-based Prevention Research Centers will conduct at least two educational sessions per year for public health practitioners and community leaders, focusing on core disciplines in public health, intervention methods, translation or evaluation. Currently, Prevention Research Centers are not conducting any comparable educational sessions.
- At least two interventions will be conducted in each of the thirteen demonstration projects to reduce teen pregnancy in their target community. Interventions will be selected by a needs assessment and field test of the program. In FY 1997, one of the thirteen demonstration projects conducted two interventions.

Verification/Validation of Performance Measures: Both performance measures will be verified through site visits, progress reports and other publications, and depend a great deal on successful collaboration with the universities and community coalitions.

Resources

Funds: \$8,214,000

FTE's: 0

Information Technology Costs: \$0

Links to CDC and DHHS Strategic Plans

This performance measure is related to the CDC Science Goal 1 and the DHHS strategic plan Goal 6: Strengthen the nation's science base for health and human services.

Program Activity - Infectious Diseases

Program Description

Over the last 50 years, significant progress has been made in the prevention and control of many infectious diseases. Today this progress has been partially reversed, due to factors which include changes in human behaviors, dramatic increases in international commerce and travel, environmental changes, and deterioration of our public health infrastructure, resulting in the emergence of drug resistance and new and resurgent bacteria, fungi, parasites and viruses. In responding to the threat of infectious diseases, CDC continues to work in the areas of surveillance and response, applied research, prevention and control, and laboratory capacity and training.

Ensuring the safety of the food supply is one of government's most enduring and important functions. Disease-causing microorganisms continue to threaten public health as new organisms emerge as food borne threats, and well-known organisms acquire greater potency. Existing surveillance systems reveal many gaps in our knowledge of food borne and waterborne pathogens. A large number of different pathogens and toxins cause food borne disease. Sources of contamination are more numerous and varied as the pathogens themselves. For many emerging pathogens, available diagnostic assays for detection of these pathogens in patients and in food and water have severe limitations.

Lack of appropriate diagnostic tests compromises our public health efforts to prevent and control outbreaks. With improvements in our ability to recognize these diseases and improved "early warning" surveillance systems, there will initially be an increase in the number of reported cases before there is a downward trend resulting from effective prevention programs.

Performance Objectives and Measures

Objective 1:

Strengthen the capacity of local, state, and federal agencies to prevent and control emerging, reemerging, and antimicrobial resistant infectious diseases by supporting epidemiologic and laboratory surveillance and response, research, education and training at all levels of government. To achieve this objective, in FY 1999, within local, state, and federal agencies and with other partners, CDC will:

- Increase national surveillance and response
- Increase laboratory testing capability
- Provide public health training
- Define core capacity
- Increase personnel

Performance Measure:

- Increase from 22 in 1997 to 38 states that will receive financial and technical assistance for enhanced surveillance and response systems, including electronic laboratory-based reporting and molecular epidemiology, in order to strengthen national capacity for detecting and responding to infectious threats.
- Increase from 7 in 1997 to 10 regional population-based Emerging Infections Programs that will conduct early warning investigation of agents of infectious diseases.
- Increase from 3 in 1997 to 15 extramural domestic and global surveillance networks that will be implemented to monitor conditions including: antimicrobial resistance, threats from transfusion of blood and blood products; infectious diseases among travelers, immunosuppressed, and under served populations.
- New and improved diagnostic tests will be made available for areas such as blood safety, antimicrobial resistance, sexually transmitted diseases,

malaria, and health-care associated infections through the provision of 32 extramural awards for enhanced research programs. In 1997, 17 awards were given.

- Increase from 20 in 1997 to 40 public health microbiology laboratory fellows that will be trained and available for local, state, and federal laboratories.
- Core capacity and needs of state health departments will be defined by surveying all states.

Objective 2:

Reduce the incidence of food borne illness to the greatest extent feasible by enhancing local, state, and federal ability to conduct epidemiologic and laboratory surveillance and response, research, prevention and control activities, and training. To achieve this objective in FY 1999, within local, state, and federal agencies and with other partners, CDC will:

- Increase national surveillance and response for food borne illness
- Increase laboratory testing capability, including subtyping methods for pathogens
- Provide public health training
- Evaluate cost-effectiveness of prevention strategies

Performance Measure:

- The scope of active surveillance network (FoodNet) will be expanded from 7 in 1997 to 8 regional Emerging Infections Programs.
- Enhanced basic food borne disease surveillance and control activities, including standard molecular subtyping methodologies for bacterial food borne pathogens, beginning with *E. coli* O157:H7, will be available in 16 states. Currently no states have enhanced surveillance.
- Increase from 0 in 1997 to 10 prevention effectiveness evaluations that will be conducted.
- The National Data Bank and Subtyping Network (DNA Fingerprinting) will be developed.

Verification/Validation of Performance Measures: Original data is collected from grantee reporting. Performance will be verified through on sight technical assistance and periodic visits and progress reviews.

Resources

Funds: \$203,825,000

FTEs: 936

Information Technology Needs: National standards for electronic reporting of infectious diseases (including food borne diseases) must be developed and strengthened by CDC in collaboration with state and local health departments.

Links to CDC and DHHS Strategic Plans

These performance measures are related to the CDC Science and Assessment goals 1 and 2 and the DHHS strategic Goal 5: Improve public health and safety systems and Goal 6: Strengthen the Nation's science base for health and human services. CDC collaborates with the Food and Drug Administration and the U. S. Department of Agriculture in accomplishing these objectives.

Program Activity - Lead Poisoning

Program Description

Childhood lead poisoning is a major preventable environmental health problem in the United States that is estimated to cost society billions of dollars. Progress continues to be made in reducing childhood lead poisoning, but many children nationwide, especially those who live in large central cities with older housing, continue to be heavily exposed to lead from lead-based paint, dust, and

**CDC AIDS PREVENTION - EXTRAMURAL/
 INTRAMURAL PROGRAMS -- SUMMARY**
 (Dollars in Millions)

AIDS Prevention	FY 1996	FY 1997	FY 1998	FY 1999
CDC Extramural Programs:				
State/Local Health Dept.....	296.9	308.6	326.1	326.1
Community-Based (Direct).....	17.6	17.0	17.0	17.0
National/Regional Org.....	23.1	28.0	28.0	28.0
State/Local Educ. Agencies.....	20.2	20.2	20.2	20.2
Nat'l Public Information	23.6	23.4	23.4	23.4
Other (non-govt, universities, hospitals, private business).....	51.9	53.2	53.2	53.2
Subtotal, Extramural	433.3	450.4	467.9	467.9
CDC Intramural	150.8	166.4	166.4	166.4
HIV Investment*	0	0	0	12.8
Total, CDC AIDS Prevention	584.1	616.8	634.3	647.1

* FY 1999 figures do not include the extramural/intramural breakdown of the \$13 million increase requested. At this time, there has been no determination as to how much funding will be provided to the various types of organizations listed above.

CDC FINANCING BY PROGRAM AND ORGANIZATION -- FY 1999

Exhibit P

(Dollars in Thousands)

Activity	Program Support/ Services	EPO	PHPP0	NIP	NCEH	NCCDHP	NCID	NCHSTP	NCHS	NIOSH	NCIPC	TOTAL
Prev. Health Services Block Gran	1,934	1,639	340	0	10	195,746	209	0	403	0	500	200,781
AIDS/HIV.....	45,104	100	8,241	0	217	51,336	41,510	493,009	3,162	4,411	0	647,090
STDs.....	3,200	0	1,802	0	0	1,500	3,954	122,210	0	0	0	132,666
Immunization.....	26,750	500	2,307	410,722	0	600	21,236	0	100	0	0	462,215
Tuberculosis.....	2,923	0	969	0	0	0	12,821	101,370	0	1,684	0	119,767
Infectious Diseases.....	8,319	4,360	12,569	0	2,760	1,380	136,141	3,900	0	0	0	169,429
Epidemic Services.....	9,484	20,647	0	0	2,799	33,126	19,474	3,783	404	0	0	89,717
Breast and Cervical Cancer.....	2,901	0	0	0	0	139,628	0	0	0	0	0	142,529
Lead Poisoning.....	669	0	0	0	37,655	0	0	0	0	0	0	38,324
Cancer Registries.....	520	0	0	0	0	21,911	0	0	0	0	0	22,431
Heart Disease & Health Promot....	12,767	0	2,700	0	3,500	130,254	0	0	1,000	1,100	0	151,321
Diabetes & Other Chronic Dis.....	1,105	0	0	0	500	60,934	0	0	0	0	0	62,539
Environmental Health Activities..	430	200	1,300	100	81,679	1,593	600	200	1,000	200	234	87,536
Injury Control.....	2,693	0	0	0	0	0	0	0	0	0	66,558	69,251
Occupational Safety & Health.....	5,597	0	0	0	79	0	0	0	79	180,511	0	186,266
Statistics.....	5,872	93	0	0	0	0	0	0	35,082	0	0	41,047
Prevention Centers.....	54	0	0	0	0	8,081	0	0	0	0	0	8,135
Program Management.....	2,465	0	0	0	0	0	0	0	0	0	0	2,465
Prevention Research.....	100,000	0	0	0	0	0	0	0	0	0	0	100,000
Buildings & Facilities.....	23,007	0	0	0	0	0	40,000	0	0	0	0	63,007
Total, Budget Authority	255,794	27,539	30,228	410,822	129,199	646,089	275,945	724,472	41,230	187,906	67,292	2,796,516
User Fees.....	71	0	26	0	690	0	95	0	915	170	0	1,967
1% Evaluation Statistics.....	0	0	0	0	0	0	0	0	70,063	0	0	70,063
Subtotal, Other Resources	71	0	26	0	690	0	95	0	70,978	170	0	72,030
Total, Program Level **	255,865	27,539	30,254	410,822	129,889	646,089	276,040	724,472	112,208	188,076	67,292	2,868,546

** Excludes funding request for ATSDR (\$87,000,000).

CDC FINANCING BY PROGRAM AND ORGANIZATION -- FY 1997
(Dollars in Thousands)

Exhibit P

Activity	Program Support/ Services	EPO	PHPPPO	NIP	NCEH	NCCDPHP	NCID	NCHSTP	NCHS	NIOSH	NCIPC	TOTAL
Prev. Health Services Block Gran	1,147	1,639	340		10	184,746	209					
AIDS/HIV.....	44,804	100	8,241		217	51,336	40,710	463,809	403		500	188,994
STDs.....	2,737		302				3,354	99,810	3,162	4,411		616,790
Immunization.....	26,118		1,107	421,522			18,836					106,203
Tuberculosis.....	2,450		969				12,821	101,370		1,684		467,583
Infectious Diseases.....	7,610		9,409				70,701					119,294
Epidemic Services.....	9,372	20,125			2,799	33,126	19,474	3,783	404			87,720
Breast and Cervical Cancer.....	2,361					137,298						89,083
Lead Poisoning.....	526				37,655							139,659
Cancer Registries.....	421					21,911						38,181
Heart Disease & Health Promot....	12,495					33,554						22,332
Diabetes & Other Chronic Dis.....	899					35,434						46,049
Environmental Health Activities..	1,079				41,179	193						36,333
Injury Control.....	2,624										234	42,685
Occupational Safety & Health.....	4,684				79						46,558	49,182
Statistics.....	6,104	93							79	168,411		173,253
Prevention Centers.....	18								31,415			37,612
Program Management.....	2,563					8,081						8,099
Prevention Research.....												2,563
Buildings & Facilities *.....	30,553											0
Total, Budget Authority	158,565	21,957	20,368	421,522	81,939	505,679	166,105	668,772	35,463	174,506	47,292	2,302,168
User Fees.....	71		26		690		45		915	170		1,917
1% Evaluation Statistics.....	0								48,400			48,400
Subtotal, Other Resources	71	0	26	0	690	0	45	0	49,315	170	0	50,317
Total, Program Level**	158,636	21,957	20,394	421,522	82,629	505,679	166,150	668,772	84,778	174,676	47,292	2,352,485

* Includes one-time funding (Phase I) for security enhancements/emergency funding (\$23,100,000).

** Excludes funding request for ATSDR (\$64,000,000).

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Centers For Disease Control And Prevention

HIV
Historical Funding Table
(Dollars in Thousands)

	<u>FY 1989</u> Actual	<u>FY 1990</u> Actual	<u>FY 1991</u> Actual	<u>FY 1992</u> Actual	<u>FY 1993</u> Actual	<u>FY 1994</u> Actual	<u>FY 1995</u> Actual	<u>FY 1996</u> Actual	<u>FY 1997</u> Enacted	<u>FY 1998</u> President's Budget	<u>FY 1998</u> House	<u>FY 1998</u> Senate	<u>FY 1999</u> Estimate
CDC	377,592	442,826	496,960	477,120	498,253	543,253	589,831	584,080	616,790	634,266	621,790	646,790	647,090

Centers for Disease Control and Prevention
Funding For Children
Dollars in Thousands)

<u>Program/Activity</u>	FY 1997 Enacted	FY 1998 President's Budget	FY 1998 House	FY 1998 Senate	FY 1999 Estimate
<u>Direct Programs:</u>					
<u>Childhood Immunization (NIP)</u>	<u>840,117</u>	<u>773,477</u>	<u>877,134</u>	<u>882,649</u>	<u>924,717</u>
Childhood Immunization	467,583	427,312	440,030	445,545	462,215
Vaccines For Children	372,534	346,165	437,104	437,104	462,502
<u>Infectious Diseases (NCID)</u>	<u>6,974</u>	<u>9,484</u>	<u>10,002</u>	<u>9,484</u>	<u>15,213</u>
Prev/Control Infant Diarrhea	1,681	1,681	1,681	1,681	1,681
Other Infectious Diseases	5,293	7,803	8,321	7,803	13,532
<u>Environmental Disease Prevention (NCEH)</u>	<u>21,895</u>	<u>21,895</u>	<u>25,060</u>	<u>30,303</u>	<u>37,895</u>
Birth Defects	7,079	7,079	10,244	14,487	7,079
Developmental Disability	1,745	1,745	1,745	1,745	1,745
Spina Bifida	2,213	2,213	2,213	3,213	9,213
Fetal Alcohol Syndrome	6,344	6,344	6,344	6,344	9,344
Mental Retardation	4,514	4,514	4,514	4,514	4,514
Asthma	0	0	0	0	3,000
Universal Newborn Hearing Screening	0	0	0	0	3,000
<u>Heart Disease & Health Promotion (NCCDPHP)</u>	<u>29,168</u>	<u>42,654</u>	<u>42,654</u>	<u>35,454</u>	<u>123,654</u>
Adolescent & School Hlth	9,881	9,881	9,881	9,881	9,881
Tobacco Prev/Control	19,287	32,773	32,773	25,573	113,773
<u>Childhood Lead Paint Poisoning (NCEH)</u>	<u>38,181</u>	<u>38,154</u>	<u>38,154</u>	<u>38,154</u>	<u>38,334</u>
<u>Injury Prevention & Control (NCIP&C)</u>	<u>11,552</u>	<u>11,552</u>	<u>11,552</u>	<u>11,552</u>	<u>14,552</u>
<u>Epidemic Services (NCCDPHP)</u>	<u>26,901</u>	<u>26,901</u>	<u>26,901</u>	<u>26,901</u>	<u>26,901</u>
MCH Epi Program	1,160	1,160	1,160	1,160	1,160
Teen Pregnancy Prevention	13,690	13,690	13,690	13,690	13,690
Prevention Surv. Efforts	8,937	8,937	8,937	8,937	8,937
Prenatal Smoking Cessation	892	892	892	892	892
Research Black White Gap	2,222	2,222	2,222	2,222	2,222
<u>HIV</u>	<u>65,136</u>	<u>65,136</u>	<u>65,136</u>	<u>65,136</u>	<u>65,423</u>
Subtotal, Direct	1,039,924	989,253	1,096,593	1,099,633	1,246,689
<u>Indirect Programs:</u>					
<u>Sexually Transmitted Diseases (NCHSTP)</u>	<u>61,680</u>	<u>62,700</u>	<u>62,700</u>	<u>62,700</u>	<u>62,700</u>
Prev. of Congenital Syphilis	33,970	33,129	33,129	33,129	33,129
Adolescent STD	27,710	29,571	29,571	29,571	29,571
<u>Environmental Disease Prevention (NCEH)</u>					
Disabilities Prevention Program	518	518	518	518	518
<u>Injury Prevention & Control (NCIP&C)</u>	<u>1,700</u>	<u>1,700</u>	<u>1,700</u>	<u>1,700</u>	<u>1,700</u>
<u>Health Statistics (NCHS)</u>	<u>13,354</u>	<u>13,354</u>	<u>13,354</u>	<u>13,354</u>	<u>14,104</u>
<u>HIV</u>	<u>27,583</u>	<u>28,457</u>	<u>27,833</u>	<u>29,033</u>	<u>29,123</u>
Subtotal, Indirect	104,835	106,729	106,105	107,305	108,145
Total CDC	1,144,759	1,095,982	1,202,698	1,206,938	1,354,834

Centers for Disease Control and Prevention

Minority Health
(Dollars in Thousands)

<u>Programs Directly</u> <u>Benefiting Minorities:</u>	FY 1997 Enacted	FY 1998 President's Budget	FY 1998 House	FY 1998 Senate	FY 1999 Estimate
Office of Minority Health (OMH)	1,906	1,906	1,906	1,906	1,906
Minority Populations (NCEH)	14,668	14,668	14,668	14,668	14,668
Minority Health Grants (NCHS)	886	886	886	886	886
Injury Prevention					
Youth Violence (NCIPC)	7,448	7,428	7,428	7,428	7,428
Safe America (NCIPC)	0	0	0	0	2,300
HIV/AIDS (HIV)	58,282	58,282	58,282	58,282	58,541
Total	83,190	83,170	83,170	83,170	85,729

Minority Health - HIV Subset

(Dollars in Thousands)

<u>HIV Programs Directly</u> <u>Benefiting Minorities:</u>	FY 1997 Enacted	FY 1998 President's Budget	FY 1998 House	FY 1998 Senate	FY 1999 Estimate
	11,300	11,300	11,300	11,300	11,348
National/Regional Activities	23,868	23,868	23,868	23,868	23,976
State/Local Projects*	19,554	19,554	19,554	19,554	19,641
Minority CBO's	3,560	3,560	3,560	3,560	3,576
Other Minority Activities	58,282	58,282	58,282	58,282	58,541
Subtotal HIV					

* Includes high risk infected persons

Centers For Disease Control And Prevention

Pediatric AIDS

	Fy 1997 Enacted	FY 1998 President's Budget	FY 1998 House	FY 1998 Senate	FY 1999 Estimate
<u>CDC:</u>					
Perinatal Infections	8,551	8,551	8,551	8,551	8,589
Childbearing Studies	13,292	13,292	13,292	13,292	13,351
Mothers and Infants	<u>30,294</u>	<u>30,294</u>	<u>30,294</u>	<u>30,294</u>	<u>35,812</u>
Total CDC	<u>52,137</u>	<u>52,137</u>	<u>52,137</u>	<u>52,137</u>	<u>57,752</u>

**LEADING CAUSES OF DEATH IN AMERICA
FY 1997**

	Deaths*	YPLL	Hospital Discharge*	Prevalence
		In thousands	In thousands	
Heart Diseases	724,125	1,384	4,168	14,028,000
Cancer (Malignant Neoplasms)	556,245	1,888	1,316	7,400,000
Stroke (Cerebrovascular diseases)	156,735	250	898	4,031,000
Chronic Obstructive Pulmonary Diseases	110,030	151	1,111	(2)
Unintentional Injuries	90,385	1,827	2,493	(3)
Pneumonia/Influenza	84,936	164	1,333	(2)
Diabetes Mellitus	64,000	187	494	8,764,000
HIV Infection(1)	46,431	1,318	305	
Infant Mortality	27,597	1,833	N/A	
Suicide	31,187	704	N/A	(3)
Homicide	24,256	897	N/A	(3)
Liver Disease/Cirrhosis	24,801	215	80	(2)

Note: Prevalence figures are estimates of the number of persons in the United States who have a particular disease some time during the given year.

* Projected by linear regression.

(1) Beginning in 1987, category numbers *042-*044 were introduced for classifying HIV infection.

(2) Prevalence data is not available for this category.

(3) Prevalence data is not applicable to this category because occurrence is usually characterized by an acute event with a short duration of illness.

Number of Deaths for Selected Causes of Death by Year Data are based on the National Vital Statistics System						
		(1)	(2)	(2)	(2)	(2)
	1995 final	1996	1997	1998	1999	2000
Cause of Death						
All causes	2,312,132	2,322,421	2,338,742	2,361,832	2,384,922	2,408,012
Diseases of heart	737,563	733,834	724,125	721,870	719,615	717,360
Cerebrovascular diseases	157,991	160,431	156,735	157,976	159,217	160,458
Malignant neoplasms	538,455	544,278	556,245	563,824	571,402	578,981
Chronic obstructive pulmonary diseases	102,899	106,146	110,030	113,188	116,347	119,505
Pneumonia and influenza	82,923	82,579	84,936	86,083	87,230	88,377
Chronic liver disease and cirrhosis	25,222	25,135	24,801	24,641	24,482	24,322
Diabetes mellitus	59,254	61,559	64,000	66,476	68,952	71,428
Unintentional injuries	93,320	93,874	90,385	90,011	89,637	89,263
Suicide	31,284	30,862	31,187	31,257	31,327	31,397
Homicide and legal intervention	22,895	20,738	24,256	24,347	24,438	24,530
Infant mortality (3)	29,203	28,237	27,597	26,273	24,949	23,625
HIV infection (4)	43,115	32,655	46,431	49,475	52,520	55,565

(1) Preliminary data (Pre-publication data - not to be released to the public until (at least) August 27, 1997.

(2) Projected by linear regression.

(3) Infant deaths are also included in cause-specific calculations.

(4) Beginning in 1987, category numbers *042 - *044 were introduced for classifying HIV infection.

Years of Potential Life Lost before Age 65 for Selected Causes of Death by Year							
Data are based on the National Vital Statistics System							
			(1)	(1)	(1)	(1)	(1)
	1994	1995	1996	1997	1998	1999	2000
	Years Lost in Thousands						
Cause of Death							
All causes	12,317	12,204	12,266	12,273	12,280	12,287	12,294
Diseases of heart	1,429	1,440	1,392	1,384	1,377	1,370	1,362
Cerebrovascular diseases	252	255	249	250	251	252	252
Malignant neoplasms	1,870	1,865	1,882	1,888	1,895	1,902	1,908
Chronic obstructive pulmonary diseases	147	149	148	151	153	155	157
Pneumonia and influenza	170	164	165	164	162	160	159
Chronic liver disease and cirrhosis	224	223	217	215	213	211	209
Diabetes mellitus	170	176	181	187	193	199	205
Unintentional injuries	2,000	2,004	1,875	1,827	1,780	1,732	1,685
Suicide	702	698	700	704	708	712	716
Homicide and legal intervention	833	758	879	897	915	934	952
Infant mortality (2)	2,045	1,908	1,912	1,833	1,755	1,676	1,598
HIV infection (3)	1,065	1,077	1,224	1,318	1,412	1,507	1,601

(1) Projected by linear regression.

(2) Infant deaths are also included in cause-specific calculations.

(3) Beginning in 1987, category numbers *042 - *044 were introduced for classifying HIV infection.

Number of Hospital Discharges Data from the National Hospital Discharge Survey						
		(1)	(1)	(1)	(1)	(1)
	1995	1996	1997	1998	1999	2000
Estimate in Thousands						
Diagnoses						
Diseases of heart	4,050	4,105	4,168	4,230	4,293	4,355
Cerebrovascular diseases	926	889	898	907	916	925
Malignant neoplasms	1,414	1,356	1,316	1,276	1,235	1,195
Chronic obstructive pulmonary diseases	1,064	1,068	1,111	1,154	1,197	1,240
Pneumonia and influenza	1,266	1,296	1,333	1,370	1,408	1,445
Chronic liver disease and cirrhosis	77	79	80	82	83	85
Diabetes mellitus	493	488	494	499	505	510
Human immunodeficiency virus infection	249	282	305	327	350	373
Injury and poisoning	2,591	2,537	2,493	2,450	2,406	2,362

(1) Projected by linear regression.