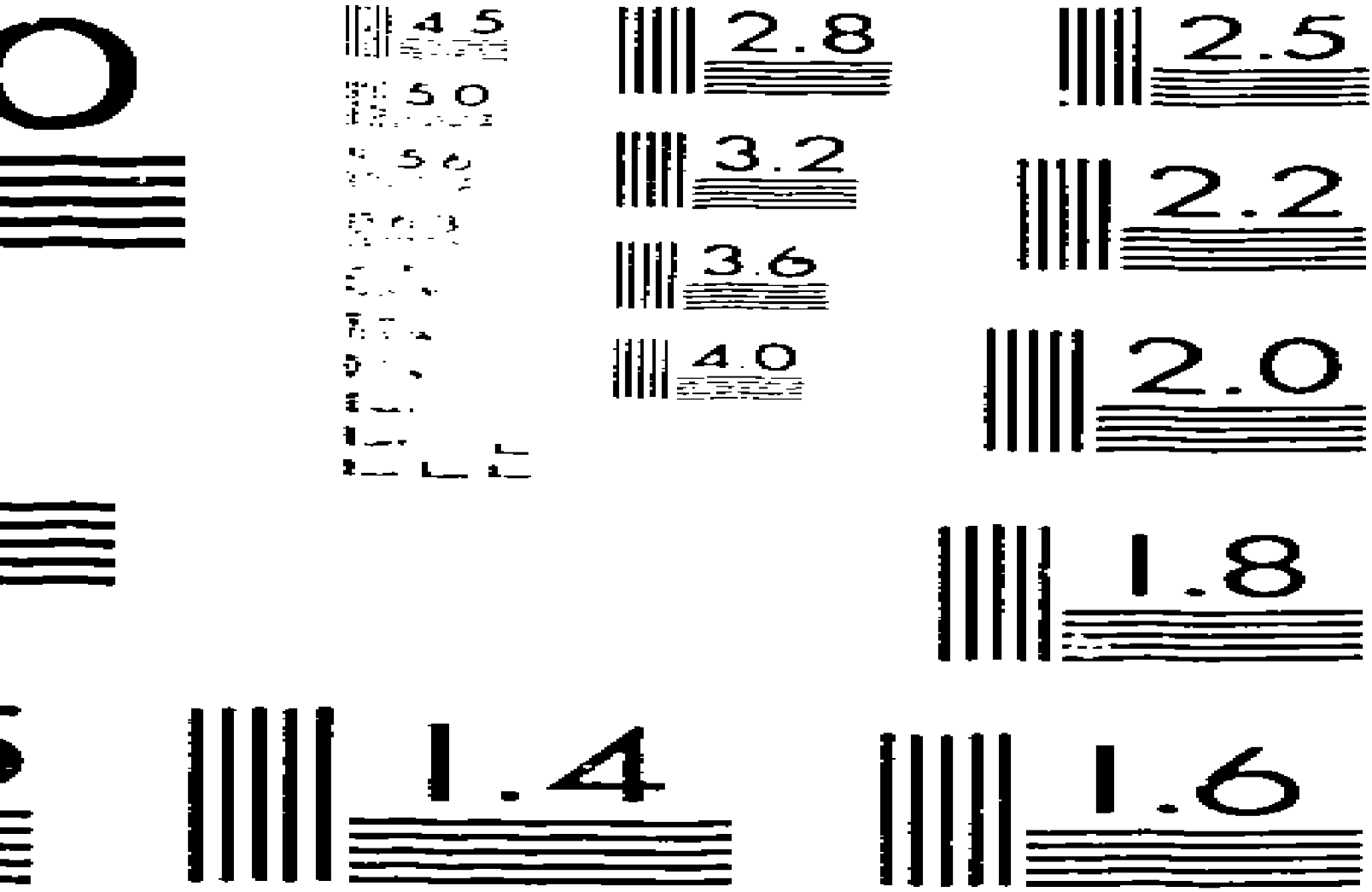

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ABSTRACT

Prepared by the U.S. Department of Health, Education, and Welfare (DHEW) for the Senate Committee on Government Operations hearings on S.10, a bill to revitalize rural and other economically distressed areas, this report relates to the impact on nonmetropolitan areas of DHEW programs. The report contains (1) an analysis of the DHEW programs which were included in title IX of the U.S. Department of Agriculture's Rural Report to Congress; (2) a summary of criteria used in determining the development, location, and construction of the DHEW facilities and services; (3) a summary f all current operating services, activities, and programs, especially grant-in-aid programs; and (4) a list of all progr. having potential for encouraging distribution of future industrial growth and expansion more evenly throughout the United States. Also included are 3 data tables on metropolitan and nonmetropolitan populations (by state) and 1970 DHEW expenditures (by agency and by state. Part 1 of the series is ED 050 874). (MJB)

92d Congress
1st Session

COMMITTEE PRINT

THE ECONOMIC AND SOCIAL CONDITION OF RURAL AMERICA IN THE 1970's

IMPACT OF DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PROGRAMS ON NONMETROPOLITAN AREAS
Fiscal 1970

PREPARED BY

OFFICE OF REGIONAL AND COMMUNITY DEVELOPMENT

OFFICE OF THE SECRETARY

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

FOR THE

COMMITTEE ON GOVERNMENT OPERATIONS

UNITED STATES SENATE

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II

FOREWORD

The Committee on Government Operations is pleased to present part II of its series on The Economic and Social Condition of Rural America in the 1970's. This study was prepared by the Department of Health, Education, and Welfare in connection with the committee's hearings on S. 10, a bill to revitalize rural and other economically distressed areas. The report relates to the impact on nonmetropolitan areas of the Department's programs.

The report addresses four particular areas: (1) an analysis of the Department of Health, Education, and Welfare programs which were included in title IX of the Department of Agriculture's Rural Report to Congress; (2) a summary of the criteria used in determining the development, location, and construction of the Department of Health, Education, and Welfare's facilities and services; (3) a summary of all current operating services, activities, and programs, especially grant-in-aid programs; and (4) a list of all programs having potential for encouraging distribution of future industrial growth and expansion more evenly throughout the United States.

This material, as well as the reports still to be received by the committee, will be of considerable benefit in the committee's study of the present economic and population disparities between our urban and rural communities.

The committee is indebted to Mrs. Nancy Wartow, Management Intern, Office of Regional and Community Development, who was responsible for overseeing this project, and for the assistance of the following Department of Health, Education, and Welfare employees: Miss Mary Lord, Raymond Carter, Barton Alexander, Miss Brenda Clarke, Miss Jan Jaffe, Okie Pierson, and Jed Carter.

JOHN L. MCCLELLAN,
Chairman, Committee on Government Operations.

LETTER OF TRANSMITTAL

U.S. DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE, OFFICE OF THE SECRETARY,
OFFICE OF REGIONAL AND COMMUNITY DEVELOPMENT,
Washington, D.C., August 6, 1971.

Hon. JOHN L. MCCLELLAN,
Chairman, Committee on Government Operations,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The attached report is in response to your request for information concerning [illegible] and their impact on nonmetropolitan areas. The report represents 2 months of diligent effort on the part of my staff to gather data from our agencies; organize, analyze, and summarize it for formal presentation.

We hope that this report will be useful to the committee. If you have any further questions, please do not hesitate to call me.

Sincerely,

PAUL L. NIEBANCK,
Deputy Assistant Secretary.

iv/v

Contents

Chapter I

A. INTRODUCTION

The attached report is the response of the Department of Health, Education, and Welfare to questions raised by Senator John L. McClellan, Chairman of the Senate Committee on Government Operations.

In preparation for its hearings on S. 10, a bill "to establish a national policy relative to the revitalization of rural and other economically distressed areas by providing incentives for a more even and practical geographical distribution of industrial growth and activity and developing manpower training programs to meet the needs of industry, and for other purposes," the committee asked the Department to furnish information relative to the impact of our programs on nonmetropolitan areas. In particular, the committee asked us to address ourselves to the following four areas:

(1) An analysis of HEW programs which were included in title IX of the Department of Agriculture's Rural Report to Congress, March 1, 1971.

(2) (a) A summary of the criteria used in determining the development, location, and construction of HEW facilities and services.

(b) The nature and extent of coordination and cooperation on the part of Federal and State officials that goes into the process of developing HEW facilities and services.

(3) A summary of all current operating services, activities and programs, especially grant-in-aid programs.

(4) Lists of all programs having potential for encouraging distribution of future industrial growth and expansion evenly throughout the United States.

The information contained in the enclosed report represents the response of the Department to these questions. This information was prepared in consultation with agency program managers and the staff of the Senate Committee on Government Operations.

B. METHODOLOGY

In order to respond to these questions in as comprehensive and accurate a manner as possible, it was necessary to undertake a number of tasks.

These tasks can be described briefly as follows:

(1) Gathering information about HEW program operations and policies.

(2) Gathering information about program obligations in metropolitan and nonmetropolitan areas.

(3) Comparing and relating data on program operations and policies to data on program obligations.

(4) Analysis of the relative impact of HEW programs on metropolitan and nonmetropolitan areas.

1. *Gathering information about HEW program operations and policies*

The Department of Health, Education and Welfare administers and/or jointly funds over 260 Federal assistance programs. Of these, about 250 have real or potential influence, either directly or indirectly, on nonmetropolitan areas. The only programs eliminated from this study were those that pertained to Foreign research and training, services to Cuban refugees, and repatriation of American nationals living abroad.

For purposes of analysis, the 250 programs were divided into six functional categories:

(1) *Planning, evaluation, and administrative support programs* (Includes all planning, evaluation, technical assistance, and informational programs, plus programs paying administrative expenses of certain State and local agencies).
(2) *Training and career development* (Includes all training, fellowship, student loan, work study, and other career advancement programs).
(3) *Research* (All research, pure and applied, medical and social).
(4) *Facilities improvement and construction* (All renovation, equipment, purchase, minor remodeling, and construction programs).
(5) *Income support* (Public assistance, income support, transfer payments including medical assistance).
(6) *Services programs*

In instances in which the activities of the program encompassed more than one of the above categories, the program was double-listed. The Office of Regional and Community Development designed a questionnaire for each of the six categories and requested the program managers of each program to fill out the questionnaire(s) appropriate to his program. Although each questionnaire requested different information depending on the type of program, many of the questions were similar. For example, issues such as Federal/State coordination of programs and projects funded in fiscal year 1970 or 1971 which are located in nonmetropolitan areas, were addressed in each questionnaire.

2. *Gathering information about program obligations in nonmetropolitan areas*

In addition to asking each Agency to outline what activities they sponsor in nonmetropolitan areas, we needed some quantitative tools to measure HEW's impact in nonmetropolitan areas: What kinds of programs (services versus income support) put the most money into nonmetropolitan areas; is the money going into these areas being used in the most beneficial way, both for the taxpayers and for the recipients of these services?

With the cooperation of the Data Management Center, Office of the Assistant Secretary Comptroller, HEW, we were able to discover the magnitude of our expenditures in nonmetropolitan areas for a given year, in this case fiscal year 1970. Defining metropolitan as all counties located in a standard metropolitan statistical area and having a population density greater than 100 persons per square mile we were able to obtain program expenditures for all HEW programs

in metropolitan and nonmetropolitan areas. (Nonmetropolitan counties are any county not meeting the definition of metropolitan.) The data obtained includes all counties in the continental United States and its trust territories. Of slightly more than 3,000 counties, only 357 qualified as metropolitan, using the above definition.[1] The county data was summarized by States, and this information, broken down by HEW agencies, is included in the appendix, table 3.

Table 1 of the appendix shows the 1970 census of population by States in metropolitan and nonmetropolitan areas. The majority of this report, however, is based on national data; program totals and agency totals divided into obligations for nonmetropolitan versus metropolitan areas throughout the country. A summary of this data appears in the appendix, table 2.

Before summarizing and evaluating the results of the program analyses, it will be necessary to give a brief explanation of the data, some of the problems and inconsistencies inherent in attempting to analyze it, and what it represents.

First, it must be noted that some of the relationships that we have tried to draw from this information is precedent-setting in the Department, and may therefore be subject to certain errors and criticisms. Although the Department publishes a semiannual program-by-program analysis of its obligations for every county in the United States,[2] data are not kept according to urban-rural areas, or metropolitan versus nonmetropolitan counties. Because of the existence of this semiannual county-by-county breakdown of program obligations, it was not difficult, however, to program the computer to separte counties. The data breakdown for this analysis is as accurate as the data which our agencies keep for their program obligations (see appendix, explanation of data).

Another problem with some of the data arises in State administered discretionary programs. Most programs of this nature are funded by the Office of Education and the Social and Rehabilitation Service. Funds are allocated to the State and are initially registered in the capital county in our accounting system. Many of these programs have formulas (based on population, income, etc.) for distribution of the money within the State. For those State-administered programs which are not required to submit an annual audit to HEW, but whose fund distribution within the State is based on a formula, Data Management Center has devised a statistical formula for recording money obligated throughout the State. There are, however, certain programs, most notably vocational education, in which no formula is used, no annual State audit is required, and no statistical distribution methods have been devised to account for the distribution of the money beyond the capital county. As a result, most vocational educational data is subject to question. Most vocational education funds appear in the

[1] The national data (appendix, table 2) is based upon a preliminary list of 358 metropolitan counties. This list contained, in error, Chittenden County, Vt., a county which has a population density greater than 100 persons per square mile, but which is not in an SMSA. Corrections have been made in the population and State data (appendix, tables 1 and 3).

[2] U.S. Department of Health, Education, and Welfare, "Financial Assistance by Geographic Area."

capital county, which is usually metropolitan. These figures, therefore, may distort the Office of Education total picture, although vocational education programs only accounted for 9 percent of all Office of Education obligations for fiscal year 1970.[3] Suffice it to say that the capital county problem in State-administered programs may skew our data somewhat.

Two general precautionary items should be mentioned for those who wish to further examine the data presented in this report. First, the money figures cited represent obligations for fiscal year 1970 rather than expenditures. (Data on the latter are usually not available until at least 2 years after the end of that particular fiscal year.)

Second, except where noted, all figures and percentages used in this report are for program obligations. For those programs which do not administer grants, we have included a few administrative expenses (salaries, expenses, and overhead) in the program analyses. We have used administrative expenses in these instances only to indicate the relative size of the program's operation. We have not included any of the programs which lack grant money in the summary data chart, appendix, table 2.

Third, both in our analyses and in our national data chart, we have eliminated almost all programs which had obligations in fiscal year 1970 but are no longer listed in the spring, 1971, OMB "Catalog of Federal Domestic Assistance" since most of the programs eliminated have no new money, and, therefore, cannot be potentially useful to nonmetropolitan areas. It was impossible to extract obligations for these programs from State totals. (Appendix, table 3.) We have, however, included in the analyses, although not in the data charts, new programs in 1970 or 1971 which had no money in fiscal year 1970 but might be of potential benefit to rural residents.

3. *Comparing and relating data on program operations and policies to data on program obligations*

The pioneer effort arose in trying to match the program titles, as listed in the OMB Catalog of Federal Domestic Assistance, with the titles of appropriation categories used in the Financial Assistance Reporting System (FARS) listings used throughout the Government. Our attempts to match up these two different kinds of listings were further hampered by the fact that the OMB program titles are those used in the spring 1971 catalog, and the data we requested carried fiscal year 1970 FARS titles. An elaborate crosswalk was finally worked out, and the program data presented are as accurate as can be expected on a first attempt at this kind of effort.[4]

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[3] Our data show 16 percent of vocational money went to nonmetropolitan areas. The timing of this report, however, did not allow us to determine the accuracy of that figure.

[4] The Data Management Center, in conjunction with the Office of Regional and Community Development, expects to continue their efforts to make the FARS system and the OMB listings more compatible, and hopes to have a uniform system within the next year. This will considerably simplify such studies as we have undertaken, and will increase the possibility of more studies of this kind. (The lack of such a system made it impossible to do an adequate analysis of the programs included in title IX. The figures included in title IX were derived from FARS data, which previously could not be made compatible with specific HEW programs.)

The results of the computer run, which used data supplied to the Federal Information System by each agency within the Department, were instructive, to say the least. We had originally planned to divide the analysis of the programs into three major categories: (1) programs having actual and direct impact on nonmetropolitan areas; (2) programs that could be of potential benefit to residents in those areas; and (3) programs with marginal or indirect influence, such as highly specialized research and training programs, the outcomes of which would be of benefit to all persons regardless of their locale, providing these services could be obtained (i.e., special treatment for cancer).

The data, however, showed some obligations in nonmetropolitan areas for almost every program administered by HEW. Therefore, the only accurate way of analyzing our programs was in terms of the relative magnitude of metropolitan versus nonmetropolitan expenditures. In this way we could also see what kinds of programs put proportionately greater amounts of money into each area.

The method of categorizing the analysis of HEW programs and of presenting the data was designed by the Presentation and Methods Branch of the Budget Division, Office of the Assistant Secretary Comptroller. It is the format for presentation of all HEW data to both Senate and House Committees on Appropriations. The programs are presented by agency, and within each agency, by categories of related programs. The summary data chart, presented in appendix, table 2, is similarly organized.

4. *Analyzing the relative impact of HEW programs on metropolitan and nonmetropolitan areas*

The analysis of the programs and their relative impact was then performed by the Office of Regional and Community Development. While the questionnaire responses formed the basis for the analyses, it was also necessary to do considerable additional research both on rural problems and on the programs themselves.

In some cases, adequate background information could not be obtained in the time available. For this reason, the quality of the analysis tends to vary.

C. SUMMARY AND CONCLUSIONS

Perhaps the most difficult task encountered in trying to assimilate the questionnaires and the data was to reconcile the magnitude of total HEW expenditures to nonmetropolitan areas with what we had assumed would be an inadequate delivery of services to those areas. The only way we could consolidate the figures with the agency responses was to look at the types of programs which accounted for the largest proportions of money going into nonmetropolitan areas. By comparing total agency expenditures we were able to make an accurate analysis.

HEW EXPENDITURES IN FY 1970

Advanced census reports for 1970 show that 34.8 percent of the Nation's population live in nonmetropolitan areas, using our definition of nonmetropolitan. Of the approximately $50.7 billion which the Department of Health, Education and Welfare obligated for fiscal

year 1970, 36 percent or about $18.2 billion was designated for nonmetropolitan areas.

It must be noted that social security transfer payments for the entire country amounted to more than $34.86 billion or approximately 68 percent of all HEW obligations. Income support programs, such as welfare, aid to the blind and disabled, and medical assistance, which are administered under the auspices of the Social and Rehabilitation Service, accounted for another $7.1 billion. In essence, about 82.5 percent of all HEW money was expended for income maintenance programs. This figure includes $9.5 billion obligated for Medicare and Medicaid, which accounted for 19 percent of our total money in that year.

Obligations for income maintenance programs in nonmetropolitan areas in fiscal year 1970 amounted to 37.6 percent of all HEW funds for income support. This percentage is slightly higher than the percentage of population in nonmetropolitan areas and does not, in itself, seem unusual, unless coupled with the fact that income support and transfer payments accounted for 86 percent of our total obligations in nonmetropolitan areas, including 22.5 percent medical payments. In financial terms, this means that $15.8 billion of the $18.2 billion that went into nonmetropolitan areas was used solely for income support or income replacement; $3.6 billion of the $15.8 billion were Medicare and Medicaid obligations.

A further conclusion is that $2.4 billion was available for all other HEW nonmetropolitan program activities (training, services, construction, etc.) for 34.8 percent of the total U.S. population. Although metropolitan areas receive $6.3 billion for all programs other than transfer payments and income maintenance (including Medicare and Medicaid), the percentage of rural versus urban obligations for these programs is 27 percent for the 34.8 percent of the total population which lives in nonmetropolitan areas.

STATE PARTICIPATION

It should be mentioned, however, that State agencies form the backbone of the service delivery system. Traditionally, education and to a lesser extent health and welfare have been the responsibility of State and local governments. Federal assistance supplements State and local programs, and provides research and demonstration money to encourage innovation in service delivery. A large majority of HEW programs are administered by State and local agencies. States and localities expend at least $3 for every $1 the Federal Government spends for education. Excluding Federal contributions for the Medicare and Medicaid programs, 49 percent of all national health care expenditures come from public sources; namely, State and local units of government.

Nevertheless, State agencies, especially those in States with large nonmetropolitan populations, do not have the capacity for adequate comprehensive statewide planning.[5] Such capability for planning would enable a State to link many nonmetropolitan needs with the distribution of services among metropolitan areas. It might also be able

[5] Hartley, David K. "State Planning" in Council of State Governments. *The Book of the States, 1968–69;* Council of State Governments, *State Progress in Planning and Budgeting Systems,* 1969.

to integrate some of the fragmented services delivered to nonmetropolitan areas and reduce some of the funding problems inherent in the allocation of scarce resources.

AGENCY EXPENDITURES

Before drawing any conclusions, a few words should be said about the $2.4 billion of services allocated by the Department of Health, Education, and Welfare to nonmetropolitan areas. We have excluded both the Medicare and Medicaid programs from the services category on the basis that these programs provide reimbursement for services rendered rather than providing services themselves. Although reimbursement for services and providing money to purchase services can be considered a service itself, for purposes of this report, it is not viewed in this manner.

Information supplied to the Data Management Center from the Office of Education (OE) show that 32 percent of all of that agency's obligations go to rural areas. The Office of Education obligated $4 billion (8 percent of total HEW funds) for all its programs in fiscal year 1970; $1.3 billion was designated for nonmetropolitan areas.

The Health Services and Mental Health Administration (HSMHA), which includes the National Institute of Mental Health, obligated $270 million or 26.7 percent of its total funds to nonmetropolitan areas in fiscal year 1970. HSMHA's total obligations amounted to slightly more than $1 billion, not quite 2 percent of all HEW obligations.

The National Institutes of Health (NIH), which focus primarily on specialized training and research, indicated in their response to our questionnaires that they have very little activity in nonmetropolitan areas. Our data shows, however, that of the $1.2 billion which is obligated for total NIH programs, $123 million or 10 percent is in nonmetropolitan areas. This figure was larger than expected, given the nature of their programs, which in most cases must be conducted at sophisticated facilities, most of which are usually located in metropolitan areas.

Including income support payments, Social and Rehabilitation Service (SRS) obligated $3.3 billion of their total $9 billion, or 37 percent of their funds to nonmetropolitan areas. Of this $3.3 billion, income support payments including medical assistance amounted to $2.7 billion; $625 million was obligated for other training and services. This latter figure represents about 32 percent of all SRS programs other than income support.

The Office of the Secretary (OS) has very little program money. Almost all of its program money is allocated for child development (which appears also under the title of Headstart and Follow Through in the Office of Education's FARS appropriations). Of $332 million obligated for OS, $144 million (43 percent) was designated for nonmetropolitan areas.

There are two major conclusions that can be drawn from the data presented in this report. First, there is a fairly equitable distribution of HEW funds to nonmetropolitan areas, based on the percentage of total U.S. population residing in those areas. Second, nonmetropolitan

areas receive proportionately more income support than services money. Compared to metropolitan areas, nonmetropolitan areas receive somewhat more than a proportionate share of income support assistance (37 percent money to 34 percent population) but less than a proportionate share of services (27 percent service money to 1 percent population).

Chapter II

PROGRAM ANALYSES BY AGENCIES

A. ENVIRONMENTAL HEALTH SERVICE

OCCUPATIONAL SAFETY AND HEALTH

The National Institute of Occupational Safety and Health administers research and training grants to support programs directed toward the control and elimination of occupational health problems.

Professional personnel training programs in techniques of controlling accidents and general improvement of work environments have important implications for nonmetropolitan areas. Most agricultural and general farmwork has little or no safety and health standards, and few union or Federal minimum regulations governing labor conditions.

Each year in the United States, more than 3,000 farmworkers are killed in accidents. This is an average of more than 10 fatalities per work day. In addition, almost a hundred times as many suffer permanent physical impairment. Data for 1961 show that there were 8,700 fatalities among farm residents from accidental causes. Of these, 3,500 involved motor vehicles, and 2,100 occurred in the farm home. Accidents at work accounted for 2,700 deaths, and public nonmotor vehicle accidents accounted for 900 fatalities.

The death rate in farmwork is third highest of all the major industries, exceeded only by the extractive and construction industries. It is six times safer to work in a factory than on a farm. Protection of migrants, general farm laborers, and coal miners from the hazards of their work should be a high priority in the work of the National Institute of Occupational Safety and Health.

Research efforts have been launched to develop protective devices for workers in beryllium and asbestos manufacturing and coal and uranium mining. A 5-year study supported by HEW revealed that 100,000 of the country's active and retired soft coal miners are affected by "black lung" disease. Research is being conducted on the cause and effect of pneumoconiosis in coal workers in Appalachia. Similar studies are being conducted on the "white lung disease" of textile workers. However, all of the nonmetropolitan studies equal about 3.6 percent of the $5.1 million spent for occupational health training and research.

RADIOLOGICAL HEALTH

In an effort to support training of radiological health specialists and technicians, the Bureau of Radiological Health offers a 1- to 2-year formal education program. While most of these programs seem urban oriented, there is an example of the possibilities of the use of training

60-297—71—pt. 2——2

at Haskell Indian Junior College. American Indian high school graduates are provided skills to become technicians in the fields of public health, medical technology, nuclear energy, and industrial research and development institutions. Total nonmetropolitan grants, however, amount to a little more than 1.5 percent of the total funding.

FOOD AND DRUG ADMINISTRATION

The Food and Drug Administration offers training and research grants similar to the National Institute of Environmental Safety and Health and the Bureau of Radiological Health. All training grants are for masters and Ph. D. level students at colleges and universities. Less than $320,000 was spent for all FDA training grants of this nature in fiscal year 1970.

Research on food and product hazards is also primarily conducted at institutions of higher education. Although the results of these investigations would probably be beneficial to nonmetropolitan areas, where knowledge of safety hazards and precautions is limited, information usually does not reach these areas unless it is brought by metropolitan couriers.

Total FDA expenditures for fiscal year 1970 for food and product safety research equaled about $3.3 million.

For further information on the programs discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.010 Occupational Health Research Grants
13.011 Occupational Health Training
13.012 Radiological Health Research Grants
13.013 Radiological Health Training Grants
13.101 Product Safety Research Grants
13.103 Food Research Grants
13.104 Food Research Training Grants

B. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

MENTAL HEALTH

There are four broad categories of mental health programs[1] administered by the National Institute of Mental Health (NIMH) and the Health Services and Mental Health Administration: research and research support; manpower development and training; institutional support; and service activities.

RESEARCH

The mental health-hospital improvement grants program provides project grants to State mental hospitals for the support of projects which will (1) improve the quality of care, treatment, and rehabilitation of patients; (2) encourage transition to open institutions; and (3) develop relationships with community programs for mental health. Although matching funds are not required, applicants are expected to share some of the program costs. In no case may HEW pay for the entire cost of a program. Grant funds may be used for expenses directly related to projects focused on the use of current knowledge for immediate improvement of the care, treatment, and rehabilitation of the mentally ill within a State mental hospital.

Although NIMH indicated that no new research projects were funded in fiscal year 1970 or 1971, which were specifically directed to the needs and problems of nonmetropolitan areas, HEW accounting figures indicate that $900,000 was obligated in grants to facilities located in nonmetropolitan areas, as opposed to $1,500,000 granted to urban facilities. In other words, 37.5 percent of all grant money to State mental institutions participating in this program was obligated to facilities in outlying areas. Compared to the percentage of money spent for total health care services and facilities in nonmetropolitan areas (26.7 percent), this figure seems high.

It must be kept in mind, however, that until recently, most mental institutions have been located in nonmetropolitan areas. Most patients in such institutions originally come from nonmetropolitan areas; people living in rural areas tend to take care of their own. Traditionally, the philosophy of treating mental patients was to isolate them. Such practice was thought to protect normal people from having to be reminded of and subjected to the idiosyncrasies of mental patients. Prior to the 1960's, it was also thought beneficial to treat mental patients in situations in which they could be comfortable and not threatened with the problems of everyday society. Commitment was a fairly easy proc-

[1] Excluding mental retardation, which is included under the title of developmentally disabled in Social and Rehabilitation Service programs.

ess. The patient had no legal rights for redress. Consequently, State mental hospitals were stretched beyond their capacity, without adequate personnel to treat or look after the patient population. Most of the largest institutions have been located in nonmetropolitan areas, with urban facilities treating primarily short-term and acutely ill persons. It has been only recently acknowledged that patients who are not severely mentally disturbed, could and do become more seriously ill in the environment of a mental institution than if they are treated in less hostile environments, or in their own communities.

During the last decade, the trend has been toward rehabilitating as many patients as possible by sending them back into the community for at least part of the day. Such patients are allowed to return to the mental institution to sleep and for further treatment. The most successful of these efforts has occurred in metropolitan areas, where transportation permits easier access from the institution to the community. Some progress has been made in transferring patients who show rehabilitation potential from nonmetropolitan institutions to urban facilities. This factor would account for the proportion of money being spent in urban areas, since it is the hospitals in those areas which are better staffed and more capable of producing immediate results in the care, treatment, and rehabilitation of mental patients, by being able to reintegrate the latter into the community, and to meet the eligibility and objective criteria of this grant program.

Mental health research grants are given to universities affiliated with public or non-profit agencies to develop new knowledge and approaches to the causes, diagnosis, treatment, control, and prevention of mental illness through basic clinical and applied research investigations, experiments, demonstrations, and studies. Cost-sharing project grants which concentrate on alcoholism, suicide prevention, early child care, metropolitan mental health problems, crime and delinquency, and narcotics and drug abuse are given first priority.

LIMITED SCOPE OF RESEARCH PROJECTS

Although the issues involved in both the medical and social aspects of mental illness are of equal importance to urban as well as nonmetropolitan areas, and the research results are equally applicable, the tendency of mental health research to concentrate on isolated factors, such as the relationship of mental illness and crime has a negligble effect on improving the mental health of rural populations. The rate of mental illness among the national population is about 3 percent. The figure among nonmetropolitan populations is considerably higher, in some places as high as 25 percent. Many factors account for this discrepancy: malnutrition, poor general health, insecurity, isolation; all the factors which we call environment. Unless additional research is directed toward some of the broader causative factors of mental illness, any limited improvement in mental well-being of individuals living in rural areas will be negated by their surroundings.

There are a number of research projects currently concentrating on rural-urban differences and problems. A few of these projects are coupled with demonstrations, as are other research projects funded by NIMH. However, the total obligation for mental health research

in nonmetropolitan areas is only $15.5 million versus $67.3 million in urban areas. The need for fairly sophisticated resources and tools for analysis and highly trained specialized researchers, both generally located in large metropolitan medical and academic settings, would account for the majority of expenditures going to urban areas. In addition, as mentioned earlier, the type of investigations currently receiving priority seem more appropriate to metropolitan settings.

MANPOWER DEVELOPMENT AND TRAINING

Of the three mental health training and fellowship programs, two would appear to be able to generate immediate potential benefit for nonmetropolitan areas. Mental health-hospital staff development grants may be used for staff development programs at the subprofessional and professional levels by providing orientation, refresher, continuation training, and special courses for those who conduct training. This training is directed toward increasing staff effectiveness in mental hospitals and translating rapidly increasing knowledge into more effective services to patients.

Although these training grants are limited to current employees of mental hospitals, the program could benefit many subprofessional employees and potentially train them for better jobs because of the proportion of institutions located in rural areas. Nevertheless, the overall impact of this program is quite small compared to the two other training programs, which will be mentioned below. Of $116.6 million total obligations for mental health training in fiscal year 1970, only $4 million was allocated for hospital staff development grants.

The largest mental health training program is the training grants program, which obligated $107.5 million in fiscal year 1970. This program is designed to increase the number and improve the quality of people working in the areas of mental health and mental illness by training professionals for clinical service, teaching, and research; providing technical training for ancillary personnel; and by continuing education for existing mental health manpower. This program, like the former, could be of benefit in training skilled and semiskilled persons from rural areas. Most training is, however, given by academic institutions in the disciplines of psychiatry, psychology, social work, psychiatric nursing, biological and social sciences, and in other areas relevant to mental health, especially the high priority areas such as alcoholism, drug abuse, et cetera. The prerequisites for admission to such academic institutions is probably the most significant barrier to persons applying from nonmetropolitan areas, since they often lack adequate academic background for further education.

Mental health fellowships provide training for future research relating to (1) the problems of mental health and mental illness and (2) raising the level of competence and increasing the number of individuals engaged in such research through training. These project grants are limited to individuals who qualify by scholastic degree and previous training and/or have sufficient experience for the level of support sought. Primary recipients of mental health fellowships are usually predoctoral and postdoctoral candidates in fields related to mental health. All training under this program must be administered by academic institutions.

Given the nature of mental health research at this time, together with the sophisticated training required to be eligible for fellowships in this field, it can be concluded that this program has only an indirect influence on the lives of residents of nonmetropolitan areas. Nevertheless, the outcome of training of researchers and of research itself would be germane to individuals regardless of residence, providing the results would be applicable and accessible to these individuals.

Approximately 90 percent of all obligations for mental health training in fiscal year 1970 went to metropolitan areas. This figure is not surprising, since the sophisticated nature of the majority of training necessitates the utilization of larger, more complex medical and academic institutions, which tend to be located in urban areas, where both the more specialized faculties, facilities, and financial resources are located.

INSTITUTIONAL SUPPORT AND RESOURCES

All three mental health institutional support programs provide some funds for remuneration of staff involved in establishing and continuing the provision of services through or in affiliation with community mental health centers.

Community assistance grants for narcotic addiction and drug abuse authorize matching funds for construction, special projects and initial staffing of facilities offering comprehensive services for treatment of narcotic addicts. Grants are awarded on a decreasing percentage basis for a period of 8 years. If the center is located in a designated poverty area, less matching funds are required from the applicant. Due to the high incidence of narcotic addiction and drug abuse in metropolitan areas, as well as users' tendencies to concentrate in specific locations in urban areas, no money is currently being spent for this program in nonmetropolitan areas nor have any construction grants been awarded under this legislation.

The same decreasing matching formula is used in computing project grants for staffing of comprehensive alcoholism services on a temporary basis. Funds may be used as a portion of the compensation of professional and technical personnel having some experience in the prevention and control of alcoholism and who provide an element or elements of comprehensive services. A comprehensive program must include 5 essential services: inpatient, outpatient, intermediate care, 24-hour emergency services for medical, psychiatric, and social emergencies, and consultation and education services to community agencies and professionals. Although the program is not required to be located in a particular catchment area and outreach programs are provided, no money was obligated for nonmetropolitan areas in fiscal year 1970. Alcoholism is a considerable problem in many nonmetropolitan areas and is one result of the social and economic deprivation common to many outlying areas. One could only surmise that the lack of matching funds and an inability to support the required comprehensive program is preventing the implementation of this program in such areas.

A formula requiring 5–15 percent more matching funds than the two previous programs is utilized for funding project grants for the staffing of community health centers. Funds are available only for salaries of

professional and technical personnel who are providing new services within a mental health center.

Community mental health centers probably have the greatest potential capability for providing services to persons in nonmetropolitan areas, who lack access to psychiatrists and psychologists, both due to the paucity of skilled manpower in nonmetropolitan areas and the expense of treatment. Awareness of what constitutes mental illness is lacking, as well as hostility toward "meddling" in one's life—a widely held view among poor people of what psychiatrists and psychologists do. In many cases, locating mental health centers in the community has lowered the resistance of the community toward psychiatry and psychology, and treatment rendered in the community has proven to be more beneficial than commitment.

The use of community mental health centers in nonmetropolitan areas has been impeded not only by the matching requirements, but also the catchment area requirements; such a center must serve a population of no less than 75,000 but no more than 200,000 persons. Meeting even this minimum eligibility requirement has restricted the program so that slightly less than 25 percent of all mental health center staffing grants go to nonmetropolitan areas. It has been suggested that the catchment area requirement could be administratively waived to take into account nonmetropolitan population distribution as well as the possibility of allowing inpatient services to be located outside of the catchment area. Both measures would enable nonmetropolitan areas to become eligible for community mental health centers.

SERVICE ACTIVITIES

Mental health information and education activities serving both the mental health professional community and the general public are made available by the mental health scientific communications and public education program. Through a technical resource program, assistance is given in response to inquiries from individuals and organizations and to the printed and electronic media. It can be hypothesized that lack of knowledge and sophistication in nonmetropolitan areas would limit inquiries, and that public service advertising would probably be directed toward maximum impact areas, namely in large cities. Total salaries and expenses for the program were approximately $4 million in fiscal year 1970.

Direct grants for special projects in mental health are limited to initiation and development of community programs for comprehensive alcoholism services. Funds may be used to assess local needs, design programs, obtain local financial and professional support, and foster community involvement in developing these services. Funds may not be used for direct patient services or alteration and remodeling of space. These cost-sharing grants for initiation and development are restricted to $50,000 for 1 year.

Since this is a new program, there were no obligations for fiscal year 1970. However, it can be assumed that since no money is being obligated for staffing of comprehensive alcoholism services in nonmetropolitan areas, little, if any, money will be spent for special projects in alcoholism in those areas. The National Institute on Alcohol Abuse and Alcoholism has indicated that applications are not judged

by population distribution, but rather, the programs are geared to specific geographic needs. Such provisions may encourage rural areas to apply if they can bear some of the project costs.

The narcotic addict treatment program provides for civil commitment of narcotic addicts for examination and treatment, and for rehabilitation and followup services for ex-addicts. Eligible addicts are treated for periods of up to 6 months at the Federal Clinical Research Centers in either Lexington, Ky., or Fort Worth, Tex. After sufficient improvement, the addict can be placed in a rehabilitation program where he receives 2½ years of followup services and aftercare under the supervision of a social agency in his community.

Both Federal facilities are located in metropolitan counties, and most of the addicts served by the program come from urban areas. Since followup services are rendered to the individual addict in his own community, it is not surprising that 90 percent of the funds for this program go to large urban areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

RESEARCH

13.237 Mental health—Hospital improvement grants
13.242 Mental health research grants

MANPOWER DEVELOPMENT AND TRAINING

13.238 Mental health—Hospital staff development grants
13.241 Mental health fellowships
13.244 Mental health training grants

INSTITUTIONAL SUPPORT AND RESOURCES

13.235 Mental health—Community assistance grants for narcotic addiction and drug abuse.
13.240 Mental health—Staffing of community mental health centers
13.251 Mental health—Staffing of comprehensive alcoholism services

SERVICE ACTIVITIES

13.239 Mental health—Narcotic addict treatment
13.243 Mental health—Scientific communications and public education
13.252 Mental health—Direct grants for special projects

HEALTH SERVICES RESEARCH AND DEVELOPMENT

Health services research and development programs were developed to expand the base of knowledge and understanding of the forces and factors which affect the availability, organization, distribution, utilization, quality, and financing of health services and health care facilities, and to devise methods for their attainment.

Training grants and fellowships are offered to specific candidates who must be sponsored by an institution with adequate facilities for training. Grants and contracts for research are offered to States, universities, political subdivisions, and nonprofit institutions. Although research grants may be awarded to individuals, profit-making organizations are only eligible for contracts.

Since research programs are usually concentrated where health service facilities are located, nonmetropolitan areas are often excluded. Impact on nonmetropolitan areas is further hampered by the time factors involved between the discovery and implementation of health

care advances. Training is only marginally supported in rural areas. Most programs are at the masters or doctoral level which: (1) excludes rural participation because of educational deficiencies and (2) feeds personnel into metropolitan areas. Most training takes place in universities situated in metropolitan areas. The administrative, teaching, and research concerns of these institutions largely focus on metropolitan problems.

Few R. & D. programs have direct impact on nonmetropolitan health services, and less than 10 percent of all expenditures go to nonmetropolitan areas. While a few research grants place physician assistants in rural areas, most research and development takes place in and concerns manpower, services, and facilities in urban areas.

For additional information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.225 Health Services Research & Development-Fellowships and Training.
13.226 Health Services Research and Development Grants and Contracts.

COMPREHENSIVE HEALTH PLANNING

The development of the comprehensive health planning legislation, referred to as the Partnership for Health Act, grew largely out of the nationwide shortage of health manpower and facilities, and the recognition that present resources were not being used to best advantage. The distribution of the Nation's health manpower and facilities is such that some areas have more than enough hospitals and physicians, while other areas have none.

The program provides incentives for States to develop a comprehensive health plan, and provides resources to support both the planning activities and the training of personnel capable of developing such plans. Comprehensive health planning bodies are also established at the areawide level. No planning money may be used for providing or administering services.

Funds are distributed generally on a population/need basis. Approximately 15 to 20 percent of the money goes to nonmetropolitan areas. Training grants, of necessity, go to institutions which have the capability to provide quality instruction in comprehensive health planning. These institutions tend to be in metropolitan areas. There is no data available which would indicate whether the persons trained are from urban or rural areas.

Comprehensive health planning for nonmetropolitan areas tends to be done by the State agency rather than by an areawide rural health planning agency. A number of factors account for this: (1) States have traditionally assumed responsibility for health services in rural areas, because cities and urban counties have tended to have stronger public health agencies, (2) there is an acute shortage of health personnel and facilities in rural areas and, therefore, there are fewer persons to organize and push for a comprehensive health planning effort, (3) 25 to 50 percent of funds for an areawide health planning agency must come from the community. Some rural counties are too poor to even afford that amount, and (4) comprehensive health planning is a new management tool for local government, and some rural

leaders may look on planning as a low priority rather than as an essential step in the immediate solution to their problems.

Recognizing the importance of these factors, recent amendments encourage the States to undertake the responsibility of planning for nonmetropolitan areas. State planning agencies may be directly funded under section 314(b) of the legislation to perform the areawide health planning function for rural areas.

Comprehensive Health Services—Formula Grants to States (314d)

This program provides basic support to State health and mental health agencies to provide and administer services. Funds are distributed on a formula basis. The State agency spends these funds in accordance with the State plan developed by the comprehensive State Health Planning Agency discussed above. Data available indicate that States tend to expend funds proportionately to the population distribution within the State. A greater proportion of the population generally resides in urban areas.

Health Services Development—Projects Grants (314e)

Project grants may be used for the development and initial support of health services which have a goal of delivering comprehensive health services to a population not presently served. Priority has been given to model programs which improve the accessibility of health care to the poor. Less than 10 percent of these project grants have been spent in nonmetropolitan areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.206 Comprehensive Health Planning Areawide Grants
13.207 Comprehensive Health Planning—Grants to States
13.208 Comprehensive Health Planning—Training, Studies, and Demonstrations.
13.210 Comprehensive Public Health Services Formula Grants
13.224 Health Services Development—Project Grants

REGIONAL MEDICAL PROGRAMS

The regional medical program was established to strengthen and improve the Nation's health care system in order to improve the quality of care received by individuals. Regional cooperative arrangements are made among all elements of the health establishment of the established regions through interrelated research, education, demonstration, and other activities, especially for patients with heart disease, cancer, stroke, kidney, and other related diseases.

Financial and technical assistance is provided largely through project grants, with a few project contracts. Only regional medical programs may apply for grant funds, although institutions may initiate a project with the support of the regional advisory group. Technical assistance and disease control activities provide assistance in planning, development, and operation of the 56 regional medical programs. About one-eighth of total spending is in nonmetropolitan areas.

Programs such as kidney disease control often need to be located in urban centers because of the complex technical facilities needed for dialysis (DX) and transplantation (TX). These centers also serve the surrounding nonmetropolitan area as much as possible. Mississippi is considering putting specially equipped DX trailers on local hospital grounds.

The smoking and health program grew out of the 1966 report on smoking and health, which associated cigarette smoking with high death rates and death at earlier ages. Although an absolute reduction in cigarette consumption has occurred since then, death and disease associated with smoking continues to rise. In 1964 there were 46,000 deaths from lung cancer; the 1971 estimate is over 59,000. Deaths from emphysema and chronic bronchitis have doubled in 5 years. Associated coronary heart diseases have also increased.

The National Clearinghouse on Smoking and Health serves to encourage young people not to start smoking, to reduce the number of persons now smoking, and to encourage both these developments and use of less hazardous forms and ways of smoking. Sponsored activities include:

(1) Community program development
(2) Work with health professionals
(3) Program research
(4) Provision of information and education
(5) Annual reports to Congress on cigarette health consequences.

Spending for these programs occur primarily in areas of high-population density.

By coordinating health personnel around specific problem areas, this program has developed regional coordination and cooperation. Although technology limits some programs to metropolitan areas, cooperative regional arrangements among elements of the health care establishment can also greatly improve the quality of health delivery in nonmetropolitan areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.247 Regional Medical Programs—Kidney disease control
13.249 Regional Medical Programs—Operational and planning grants
13.250 Regional Medical Programs—Smoking and health

COMMUNICABLE DISEASE CONTROL

The communicable disease control programs are concentrated in four main areas: (1) nutrition, (2) venereal disease, (3) tuberculosis, and (4) general research grants. The major activities of these programs are training, advisory services and counseling, and dissemination of technical information. The program's funds are generally available to community agencies, public and private health organizations, universities, and other institutions that show competence in the requisite areas.

The nutrition program has grown in the last few years, especially since the discovery of the alarming incidence of malnutrition through-

out the lowest economic quartile of the U.S. population. The target population of the nutrition program is all persons suffering from malnutrition but especially children and pregnant and lactating women. Although resources are allocated on a priority-need basis, the more urbanized States generally receive a greater portion of funds due to the "magnitude of the prevailing problem and the possession of greater resources." There are, however, some special emphasis projects now being funded that deal with minority/rural nutrition improvement activities.

Venereal disease control and tuberculosis programs include grants for research, training, and therapy. VD is not yet a serious problem in nonmetropolitan areas, but tuberculosis rates are higher than in urban areas. The actual delivery of these programs to rural areas is marginal.

There are about seven direct research grants which focus on underlying mechanisms relating to communicable diseases and their prevention, detection, and control, located in nonmetropolitan areas. These projects account for 10 percent of the money spent on disease control research.

There have also been some training courses for public health workers in nonmetropolitan areas in fiscal years 1970 and 1971. They have been primarily geared toward disease control and prevention programing rather than emphasizing problems arising from local conditions.

We have no urban-rural breakdown on nutrition funding. Approximately $3 million was obligated for all nutrition grants and contracts in fiscal year 1970. Training for all public health workers under this program cost close to $1.6 million in fiscal year 1970. This outlay is primarily for salaries and expenses of administering the program.

For additional information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.200 Communicable disease prevention and control—consultation and technical assistance
13.201 Communicable disease—Laboratory improvement
13.202 Disease control—Research grants
13.203 Disease control—Training public health workers
13.204 Communicable disease—Tuberculosis control
13.205 Communicable disease—Venereal disease control
13.248 Center for disease control—Nutrition

HOSPITAL CONSTRUCTION

Covering the areas of grants, technical assistance, loans, and loan guarantees, hospital construction programs are designed to assist States in planning for and providing hospitals, public health centers, State health laboratories, outpatient facilities, emergency rooms, neighborhood health centers, long-term care facilities (nursing homes, chronic disease hospitals, and long-term units of hospitals), rehabilitation centers, and other related health facilities. In addition, technical assistance is offered to elevate the quality of design, construction, and operation of facilities through the provision of consultation services, including the development of guide materials.

The Hospital Survey and Construction Act (also known as Hill-Burton) of 1946 has had a very significant impact on hospital con-

struction, particularly in rural areas. The intentions of the act were twofold: (1) to assist States in surveying the needs of hospitals and assisting in comprehensive planning for hospital construction and (2) to provide assistance in financing needed construction. In 1964, the act was amended to establish a new program for the modernization or replacement of public and nonprofit hospitals and other health facilities. The 1964 Hill-Harris amendments also gave special consideration to facilities located in the more densely populated areas where the greatest need is thought to exist. This marks a shift in emphasis for the Hill-Burton program, which had previously given priority to construction of additional beds and facilities, particularly in rural and financially disadvantaged areas. This shift in emphasis has resulted in fund cutbacks for nonmetropolitan hospital construction.

Funding for the health facilities grant program is based largely on a formula determined by population, weighted by allotment percentage (representing per capita income) squared, or on the need for modernization and new construction of facilities. The Federal matching share can be as much as two-thirds of allowable total costs. Eligibility for funding is open to State and local governments, Hill-Burton State agencies, project sponsors, hospital districts or authorities, and other representatives of the hospital community.

CONSTRUCTION AND QUALITY CARE

There have been many improvements in hospital construction in nonmetropolitan areas. However, adequacy of hospital care cannot be measured by the number of beds relative to the population to be served or by the number of hospitals. Rural populations are hampered by small hospitals which are not as well staffed with technical personnel and are poorly equipped. Moreover, many hospitals in nonmetropolitan areas do not have the policies for medical staff organization which are necessary in order to meet the quality standards of the Joint Commission on Accreditation of Hospitals. In addition, a significant deficency in the provision of adequate services is the dearth of organized outpatient departments in small town hospitals. While there may be an emergency room, such a service does not meet the need for regular medical care for the rural poor.

Hospitals that serve large populations can usually afford to acquire needed equipment. If this is not possible, they can often share equipment with other hospitals in the same general area. Such an arrangement tends to lessen the financial burden to metropolitan hospitals. In nonmetropolitan areas, however, hospitals are so far apart that a hospital is forced to obtain its own equipment, or go without. This heavy capital investment coupled with low occupancy rates, which range from 70 percent to 80 percent, combine to keep rural hospitals in debt. A minimum occupancy of 90 percent is necessary to keep hospitals from losing money.

The problem of accessibility and acceptability directly relate to the low occupancy rate at which nonmetropolitan hospitals operate. Many are very difficult to reach, thereby discouraging people from making visits except in times of severe duress. In addition, many facilities in nonmetropolitan areas are so antiquated that potential patients will not use them. Since 1963, health care facilities which do not adhere to the provisions of title VI of the Civil Rights Act, providing equal

access for all persons regardless of race, religion, or place of national origin, are not eligible for new money from the Hill-Burton program. Nonadherence to title VI also prohibits health care facilities from participating in the Medicare and Medicaid programs. Lack of Federal construction money leads to quick obsolescence; lack of Medicare and Medicaid money raises hospital fees as well as limits access for most of the rural poor, who are not covered by private insurance and cannot afford hospital expenses.

The value of hospital construction can be increased through the development of networks of related hospitals in large geographic areas so that more and better services can be offered. Another mechanism to improve health service delivery in nonmetropolitan areas would be the development of satellite hospital centers to provide easier access to hospital and hospital-related services. Outpatient services are especially needed for treatment of patients with chronic illness in nonmetropolitan areas. Implicit in the need for improvements in health facilities construction is also the need for more equitable distribution of medical personnel.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.220 Health Facilities Construction—Grants
13.223 Health Facilities Construction—Technical assistance
13.253 Health Facilities Construction—Loans and loan guarantees

NATIONAL HEALTH STATISTICS

The health statistics training and technical assistance program provides three basic services: (1) collection, analysis, and dissemination of national and vital human statistics; (2) technical assistance and short-term training for State and local vital and human statistics personnel; and (3) advisory and counseling services for the promotion of State and local vital and human statistics training activities. Headquarters for this program is the National Center for Health Statistics located in Research Triangle Park, N.C., a nonmetropolitan area outside Raleigh.

Applications for short-term training and requests from State and local health and statistical agencies for technical assistance are honored to the extent of the Center's staffing policy.

Although almost a third of the expenditures for this program occur in nonmetropolitan areas, this primarily reflects the Center's location. Most eligible health statistics personnel work in urban areas.

For further information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.227 Health statistics training and technical assistance

MATERNAL AND CHILD HEALTH CARE PROGRAMS

The maternal and child health care program was established under title V of the Social Security Act of 1935. The provisions of the legislation are geared to enabling States to extend and improve services for: (1) promoting health programs for mothers and children and (2) locating crippled children and providing them with medical and

hospital care. In the past, rural areas were specifically emphasized. However, a 1965 amendment now requires States to orient title V programs toward making services available to children in all parts of the State by 1975.

Grants are available to State health agencies, and with their permission to local subdivisions and nonprofit organizations.

Approximately 20 percent of all grant moneys go to nonmetropolitan areas. The majority of projects require State plans and matching grants, with Federal funding up to 75 percent. State plans tend to emphasize the more concentrated urban poor, which is reflected in the marginal influence most of these programs have on rural areas.

Two of the eight maternal and child care programs still call for a special emphasis on rural areas. In response to objectives of these programs, there is a special funding procedure whereby the States must provide matching funds for one-half of the amount appropriated; the remainder is not matched and is distributed to the States on the basis of the financial need of each State for assistance in carrying out its plan. In addition, a rural child is counted twice for each urban child in keeping with the statutory emphasis on rural areas.

States may provide the following kinds of services under this program: Prenatal clinics, family planning, public health nurse, well-baby clinics, dental health clinics, special projects for high-risk mothers, and special services for crippled children.

Census figures on rural population highlight the great need for adequate maternal health care. Among white rural farm families with low incomes, the average number of births in 1960 was 48 percent higher than for the Nation as a whole. The average for poor non-white rural farm families was 156 percent greater. Infant mortality rates in isolated rural counties between 1961–65 were between 12 and 24 percent above the national average. Service projects which can respond to the lack of medical personnel and facilities and to the problems of transportation and information dissemination should help to relieve this situation.

Training grants must be applied for by public and nonprofit institutions of higher learning. Although training grants can be used for workshops, institutes, clinics, and related support items anywhere in the United States, there are no actual training programs located in rural areas or for special projects. All training is given at university medical centers and teaching hospitals and, therefore, has no medical centers and teaching hospitals and, therefore, has no specific rural problem orientation.

For further information on the programs discussed in the above summary,[1] see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.211 Crippled Children's Services [2]
13.212 Dental Health of Children
13.217 Family Planning Projects
13.218 Health Care of Children and Youth
13.220 Intensive Infant Care Projects
13.231 Maternal and Child Health Research
13.232 Maternal and Child Health Training [2]
13.233 Maternal and Child Health Training
13.234 Maternity and Infant Care Projects

[1] Carried under Social and Rehabilitation Service in 1970 appropriations bill.
[2] Special emphasis in rural areas and in areas suffering from economic distress.

EMERGENCY HEALTH

The emergency health program grew out of the concern for the ability of people to have access to medical care and equipment during times of natural or nuclear disasters and accidents or sudden illness. This concern has theoretically been intensified by studies indicating that the incidence of accidental injury mortality in rural areas is four times higher than in urban areas.

Four areas included in the emergency health program are medical self-help, community preparedness, hospital and ambulance services, and medical stockpile. The overall objective encompassing these areas is to promote higher standards of emergency medical care (including transportation, delivery of services, training, information, and equipment) as a means of better preparing people for survival in a time of sudden illness, accident, natural or nuclear disaster.

Funds are made available, without matching requirements, for the use of equipment, facilities, property, advisory services, training, and counseling. Eligibility for the receipt of Federal funds is by and large limited to Federal, State, and local agencies (such as health departments), hospitals, universities, military installations, and health professions organizations.

All Federal funds for emergency health programs went to metropolitan areas in fiscal year 1970. There are some basic reasons including the availability of other medical resources and institutions. Rural areas are sorely lacking in professional manpower, onsight medical services, and needed institutions. Nonmetropolitan residents do not have easy access to other prerequisite services and, as a result, are often without beneficial programs. Post-attack medical care is centered predominantly in urban areas. Rural area residents, when injured, must somehow be transported to the cities to receive medical care. There may also be an assumption that nuclear attacks would not likely strike in rural areas, and therefore, those areas do not need emergency precautions.

The existence of built-in barriers to service has prompted some presently existing programs to note recommendations for improvement in assistance to rural areas. Three main foci appear to be indicated. First, there is a need for federally coordinated efforts in increasing the amounts of emergency medical services and in improving the quality of these services. Second, more personnel and more funds are needed. Third, efforts should be directed at developing locally based emergency health satellite centers.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.213 Emergency Health—Civil Defense Medical Self-help
13.214 Emergency Health—Community Preparedness
13.215 Emergency Health—Hopital and Ambulance Services
13.216 Emergency Health—Medical Stockpile

MIGRANT HEALTH

The migrant health program is authorized to provide community health services and grants for improving the health of migratory agricultural workers. Grants may be used to cover part of the cost of: (1)

Developing and ...ing family health services; (2) clinics for domestic agricultu... ...ratory and seasonal workers and their families; and (3) special p... designed to improve health services for workers and their fam...

The objective ... migrant health program is to support the development and e... ...ment of high quality health care services in rural areas for m... ... and seasonal farmworkers and their families so as to raise the s... f health to that of the general population. This can be achieved ...gh providing comprehensive health services, which are made a... ...le to people as they move to and work in different places, and by ...roving the environment to assure health and safe living and working ...onditions wherever workers are located.

Project grants a... a...ailable to State and local health departments and other nonprofit private agencies, organizations, and institutions. These funds can be used to establish and operate family health services, clinincs, and other projects, such as education, training, sanitation services to upgrade heal... ...nditions, and to provide preventive and curative health services.

Although there is n... ...ixed matching ratio, the grantee is required to pay part of the cost, which varies from project to project. Many rural counties do not have enough money to cover matching payments, nor do many States consider mirgrant health a budget priority. The cost-sharing requirement limits the potential effectiveness of this program.

The migrant health program attempts to promote flexibility in locating and scheduling health services in order to make them easily accessible at times and ...laces where they will be convenient to migrant workers and their families. There is also emphasis on early detection and care of illness and injury, as well as primary preventive care, such as immunization. The family health service clinic, with additional outreach services by field nurses and aides, who visit migrant families in camps and at their homes for counseling and followup, constitutes a major innovation ... the migrant health program. As of spring, 1969, 116 single or multi...ounty projects were in operation with migrant health grant assistance in 36 States and Puerto Rico.

SPECIAL MIGRANT PROBLEMS

It cannot be ignored, however, that, despite the introduction of innovative approaches, health care services for migrants are limited and inadequate. Literally hundreds of communities with a yearly influx of migrants still lack organized programs to provide needed services. One major problem inherent in the nature of migrant workers is constant population mobility. Migrant and seasonal farm workers are in a constant state of flux and are, thus, unable to develop a sense of community. Co...mitant with a lack of communal feeling is the inability to develo... ...pe of on-going communication with local or State providers of hea... ...are.

Lack of knowledge r... ...ding migrant health needs is another reason for the dearth of servi... There has been little communication among communities, health professionals, and migrants about their health problems. Ignorance of a group's special needs often leads to exclusion and rejection of that g... ...p and its problems. This is often the case with migrant work... ... evidenced by the enforcement of State residency requirements. It ... of course, impossible for most migrants

to meet these requirements and, thus, become eligible for State and local health and welfare aid.

Perhaps the greatest problem of the migrant health program is the need for additional resources and manpower. There is also a great need for intensive efforts to examine the problems of both migrant workers and rural inhabitants, since both groups encounter similar problems. One appropriate mechanism for meeting the needs of migrant and seasonal farmworkers would be to develop more stable comprehensive health centers in high migrant-impact rural areas. These centers should have the capacity to deliver services to all segments of the population in the geographical target area, as well as the capacity to expand and contract services in accordance with the movement of migrant families.

For additional information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.246 Migrant Health Grants

INDIAN HEALTH SERVICE

The Indian Health Service is designed to meet the acute health needs of the American Indians. For an Indian to be designated eligible for health services, he must: (1) Be a member of a tribe or group of Indians recognized by the Federal Government, or for some services, the law specifies a required amount of Indian heritage; (2) live on or near a reservation; or (3) live near a trust or restricted land under the jurisdiction of the Bureau of Indian Affairs. Similar qualifications apply to Indians who file for the sanitation facilities program.

The Indian population of the United States is approximately 600,000, of which two-thirds live on land under Federal jurisdiction. Most reservations are located in sparsely settled areas, which are poor in natural resources and job opportunities. At least three-fourths of the 76,000 houses on Indian reservations and trust lands are below minimal housing standards. Attempts toward traditional economic development have failed by not taking into account Indian culture and community structure.

Health problems are aggrevated by lack of safe, available water supply and adequate waste disposal facilities. The most common infectious diseases among Indians are influenza, pneumonia, dysentary, gastroenteritis, and streptococcal infections. Trachoma, a viral disease of the eye, which has virtually disappeared in the general population, still affects many Indians. The Bureau of Indian Affairs reports that Indian life expectancy is 63.9 years compared to 70.2 years for the Nation's population.

Under the Indian sanitation program, tribal or community organizations may submit applications for modern sanitation facilities in Indian and Alaskan Native homes and communities (including Federal housing programs). The Indian health program provides direct health services through Federal facilities or under contract with community facilities and private health personnel. Both preventive and curative services are funded, including public health nurses, maternal and child care, dental and nutrition services, psychiatric care, and health education.

All service delivery of these programs occur in nonmetropolitan areas. Legislation has been proposed which would permit the use of Indian health hospitals as community hospitals providing services to non-Indians residing within an area of 50 miles of the hospital and permitting private physicians to utilize such hospitals for the care of their patients.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.228 Indian Health Services
13.229 Indian Sanitation Facilities

C. NATIONAL INSTITUTES OF HEALTH

RESEARCH AND TRAINING

Programs under the auspices of the National Institutes of Health cover wide areas of research and training. These include research and training in the areas of cancer, heart disease, arthritis and metabolic diseases, neurological disease and stroke, allergy and infectious diseases, child health and human development, studies of the eye, environmental health sciences, health manpower, dental health, general medical sciences, general research and services, construction of health facilities, and the National Libray of Medicine.

The overall objectives of NIH research programs are to conduct, assist, and foster new and improved methods of research, investigations, experiments, and studies related to the cause, prevention, methods of diagnosis, and treatment of various diseases.

Most research projects are funded through project grants and most of these project grants carry matching requirements. In many programs, current Federal legislation requires that the grantee also contribute to the cost of each research project. Cost sharing agreements are individually negotiated with each grantee. Grantee eligibility is limited to universities, colleges, hospitals, public agencies, and nonprofit research institutions, who must submit applications for support of research by a named principal investigator. In special cases, a grantee may be an individual. The fact that matching is a requirement for funding and the limited eligibility combine to make it rather difficult for rural areas to have any input in or access to NIH research programs.

In addition, the very nature of research projects do not favor rural areas. These areas have a need for basic health and health education services more than for research projects, which can only have limited and long-term relevance for nonmetropolitan areas. NIH programs are not service oriented, and the legislation authorizing them does not allow for research projects that could be specifically designed for nonmetropolitan sections of the country.

NIH training programs are intended to promote the improvement of medical and scientific research personnel through the development and enactment of research training programs. Financial assistance is rendered predominantly through project grants without any matching requirements. Eligible applicants are usually public or nonprofit institutions capable of conducting a scientifically meritorious program of training under a program director in the area of research training. An applicant may also be an individual who has received a doctoral degree or its equivalent, who has had post-doctoral experience in his line of endeavor, and who is a native born or naturalized citizen of the United States.

For the same reasons stated above regarding research programs, NIH training programs have little immediate relevance for rural areas. Some NIH research and training programs do have, however, potential relevance for nonmetropolitan areas. The National Institute of Environmental Health Services and the National Institute of Child Health and Human Development are two examples of program categories that could be important for rural areas. Programs under the National Library of Medicine, construction of health facilities, and health manpower programs are also potentially relevant. These programs are intended to closely examine, through the utilization of training and research, the possibilities for improvement in delivery of services as they relate to environmental health, maternal and child care, medical library and health related facilities, and health careers.

In nonmetropolitan areas there is a need for these kinds of programs, particularly those that relate to health careers and to child and maternal care. Nonmetropolitan areas are seriously lacking in trained health professionals. In 1962, there were 40.6 dentists per 100,000 persons in isolated semirural areas and 27.4 per 100,000 persons in isolated rural areas. There were 350.6 nurses per 100,000 persons in isolated semirural areas and 195.7 per 100,000 in isolated rural areas. Rural farm and nonfarm families, on the whole, received less free medical care in 1961 than did their urban counterparts. As of 1970, there were 185 doctors per 100,000 persons in metropolitan areas while there were 76 doctors per 100,000 persons in nonmetropolitan areas.

Maternal and child-care services are also needed in nonmetropolitan areas. The incidence of stillbirths, premature births, and infant illnesses and death are considerably higher for the rural poor than for other socio-economic groups. Women in nonmetropolitan counties, especially in rural areas, have a higher maternal mortality rate than do women in metropolitan counties. Relatively few rural families have access to information and medical advice concerning maternal and child-care services.

The aforementioned programs currently focus heavily on metropolitan areas and, therefore, nonmetropolitan areas benefit less from them. Additional financial support can directly aid rural areas, if coupled with increased attention on how research and training can improve services and service delivery.

The programs included in the preceding summary can be categorized as follows:

(A) Programs with indirect or marginal impact on nonmetropolitan areas:

(1) National Cancer Institute—Research and Training (OMB catalog numbers): 13.311, 13.312, 13.113, 13.114, 13.315, 13.372, 13.373.

(2) National Heart Institute—Research and Training (OMB catalog numbers): 13.344, 13.345, 13.346, 13.347.

(3) National Institute of Dental Research—Research and Training (OMB catalog numbers): 13.324, 13.325, 13.326.

(4) National Institute of Arthritis and Metabolic Diseases—Research and Training (OMB catalog numbers): 13.307, 13.308, 13.309.

(5) National Institute of Neurological Diseases and Stroke—Research and Training (OMB catalog numbers): 13.354, 13.355, 13.356, 13.357.

(6) National Institute of Allergy and Infectious Diseases—Research and Training (OMB catalog numbers): 13.300, 13.301, 13.302.

(7) National Eye Institute—Research and Training (OMB catalog numbers): 13.330, 13.331, 13.332.

(8) Dental Health—Research and Training (OMB catalog numbers): 13.321, 13.322, 13.323.

(9) General Research and Services—Research and Training (OMB catalog numbers): 13.306, 13.310, 13.337, 13.367, 13.368.

(10) National Institute of General Medical Sciences—Research and Training (OMB catalog numbers): 13.334, 13.335, 13.336.

(B) Programs with Potential Impact on Non-metropolitan Areas:

(1) National Institute of Child Health and Human Development—Research and Training (OMB catalog numbers):

13.316 Child Health and Human Development—Fellowships.
13.317 Child Health and Human Development—Research Grants.
13.318 Child Health and Human Development—Training Grants.

(2) National Institute of Environmental Health Services—Research and Training (OMB catalog numbers):

13.327 Environment Health Sciences—Fellowships.
13.328 Environmental Health Sciences—Research Grants.
13.329 Environmental Health Sciences—Training Grants.

(C) National Library of Medicine (OMB catalog numbers):

13.348 Medical Library Assistance—Library Resources Grants.
13.349 Biomedical Scientific Publications Grants.
13.350 Medical Library Assistance—Regional Medical Libraries.
13.351 Medical Library Assistance—Research Grants.
13.352 Medical Library Assistance—Special Scientific Project Grants.
13.353 Medical Library Assistance—Training Grants.

(D) Construction of Health Facilities (OMB catalog numbers):

13.333 General Clinical Research Centers.
13.340 Health Professions Facilities Construction.
13.369 Construction Grants for Schools of Nursing.

(E) Health Manpower (OMB catalog numbers):

1. Institutional Support

13.304 Allied Health Professions—Basic Improvement Grants.
13.305 Allied Health Professions—Special Project Grants.
13.338 Graduate Training in Public Health—Project Grants.
13.339 Health Professions Educational Improvement Grants.
13.359 Special Project Grants for Improvement in Nurse Training.
13.370 Schools of Public Health Grants—Formula Grants.

2. STUDENT SUPPORT

13.303 Allied Health Professions Traineeship Grants for Advanced Training.
13.341 Health Professions Scholarships.
13.342 Health Professions Student Loans.
13.358 Professional Nurse Traineeships.
13.360 Special Predoctoral and Postdoctoral Fellowships in Nursing Research.
13.361 Nursing Research Project Grants.
13.362 Nurse Scientist Graduate Training Grants.
13.363 Nursing Scholarships.
13.364 Nursing Student Loans.

D. OFFICE OF EDUCATION

ELEMENTARY AND SECONDARY EDUCATION

Programs administered under the Elementary and Secondary Education Act (ESEA) of 1965 have one of the greatest concentrations of Office of Education (OE) funds. A large part of the act reflects a formal policy recognition and commitment on the part of Congress and OE to children from low-income families who are educationally handicapped. The scope of the act and the size of its appropriations make it potentially one of the most far-reaching programs in education for both metropolitan and nonmetropolitan areas.

Funding for most of the programs is by formula grants. The State/Federal funding relationship is organized so that the State plan both informs the Federal Government about the State's priorities and also emphasizes comprehensive planning. Once the State Education Agency (SEA) receives its funds, it is legally required to review and approve local district plans and distribute ESEA money within the State.

EDUCATIONALLY DEPRIVED CHILDREN

Within ESEA, title I (educationally deprived children) has the largest proportion of funding. In fiscal year 1970, nonmetropolitan areas received $599 million. Title I is entirely federally financed and requires no matching funds. Approximately 15,700 out of the 26,983 school districts in the United States received title I money in 1970. The act specifies that funds are not for general usage but for supplementing expenditures for children from poor families. The money is to be concentrated in high priority areas for the specific target population, above and beyond the present use of local funds.

Title I programs include supplemental provisions of instructional materials and additional service activities such as lunch and breakfast programs, health and psychological services, cultural development, and prevocational training and counseling for urban and rural schools. Special schools for handicapped children who do not have local services available to them are also covered under title I. In addition, there are incentive projects to increase State and local funding for elementary and secondary schools and programs to improve technical assistance and general procedures within State education agencies.

Title I also has a special program for migrant children, in which funds are allocated to nine States on the basis of the number of migrant children residing there. Neither the Federal nor State Governments have reliable data on which to base the program, however, since allocations are based on the number of migrant farmworkers registered with the Department of Labor's Farm Service Bureau, and many workers are not registered.

Title I calls for a series of commitments toward better schools for low-income children on the part of the entire education system. Community participation, compliance with civil rights legislation, State and local plans are all legally required for funding. However, the size of the program and inadequate checks on procedure have often impeded enforcement.

As stated, title I funds are to be used in addition to the regular budget. Whether in fact this is the case, is not always evident from the audit of how funds are distributed within counties. In addition to improved auditing procedure, the program needs to provide technical assistance to help bridge the information gap about title I uses and procedures between community groups and local education agencies on the one hand, and State and Federal agencies, on the other.

STATE ADMINISTRATION AIDS

One possible way to provide this assistance would be through title V(A) of ESEA, which has two types of grants to serve State agencies: (1) in improving and expanding technical assistance to the local level and (2) in using experimental projects to identify and analyze State educational problems. This title could be used by a SEA to improve information and service delivery for a particular problem such as rural schools.

SUPPLEMENTAL EDUCATION CENTERS

Special project grants are available under title III, supplemental educational centers, for funds to local education agencies for innovative and/or exemplary projects designed to demonstrate solutions to critical problems common to other States. Approximately $16 million of the centers' money is in nonmetropolitan areas, and $100 million in metropolitan areas.

Program objectives in rural areas have included parental involvement, improved reading rates, student involvement, assistance to rural school boards, services to Indian and migrant pupils, and training babysitters to perform "at home" paraprofessional teaching.

Technical assistance is to be provided by the State agencies at the request of any local education agency (LEA). The State receives copies of all applications, provides recommendations to OE, assists in grant negotiations, and participates in project monitoring.

In fiscal year 1969, 37 percent of the projects under title III were rural. Budget cuts in 1970 may partially account for a drop to 12 percent in the percentage of rural funding.

BILINGUAL EDUCATION

Title VII, bilingual education, is geared to children with limited English ability. The children come from low-income families where English is not the dominant language.

Local education agencies plan and submit preliminary applications to their State education agencies for review and recommendations. During proposal development, the State acts as consultant. Once the

proposal is awarded, LEA's are authorized to hire outside experts and consultants.

Bilingual models have been developed during 1970 and 1971 with emphasis on meeting the needs of Mexican-American migrant workers. For instance, Ephrata, Wash., has a program where teachers' aides and services follow the children through the migrant stream from Washington to Texas. Other models are geared to meeting the needs of children in the nonmetropolitan Spanish-speaking areas of the Southwest. Approximately 32 percent of bilingual money is spent in rural areas.

DROPOUT PREVENTION

Title VIII provides service programs for dropout prevention. The problems of school dropouts and employment have been fairly well documented. In rural areas these problems can be magnified by the tightness of the rural job market; the majority of rural youths face a choice between underemployment on farms or in rural areas and small towns, or movement to urban areas for employment.

Because of a lack of employment opportunities on the farms or in nonfarm rural areas, the large-scale migration of youths from rural to urban areas has continued unabated. For example, in 1950, there were 9.5 million young people in the 10–19 age group in rural areas; but in 1960, when these individuals were 20–29 years old, they numbered only 6.1 million—a 36-percent decline. Among nonwhites, the migration rates are even higher. In 1950, about 1.3 million nonwhite persons aged 10–19 were living in rural areas, but in 1960 there were only 640,000 in the age group 20–29, a decline of 52 percent.

Under title VIII, special emphasis projects in rural areas accounted for approximately 3 percent of the total funds.

SCHOOL LIBRARY RESOURCES; EQUIPMENT AND MINOR REMODELING

School library resources, textbooks, and other instructional materials are also included in the Elementary and Secondary Education Act, under title II. Money is distributed to States on a formula/population basis and then to individual school boards. Because the distribution is on a population basis, rural areas tend to get less in the way of resources than do the denser areas. There are, however, some special emphasis programs for migrant farmworkers in specific areas and a reading project for an especially isolated rural area. In addition to funds available under ESEA, the National Defense Education Act has several programs for minor remodeling and instructional materials for elementary and secondary schools. The grants, which require 50 percent matching funds, go to State education agencies. After a State plan is approved by OE, local education agencies submit projects to State agencies for approval. About 10 percent of the funds are being used in nonmetropolitan areas.

The matching grant method is to the disadvantage of rural areas because of the difficulty in raising matching funds. A statutory change lowering the rate of matching funds required for these areas would permit greater participation. These areas also lack administrative man-

power and expertise in applying for Federal grants. A statutory change providing direct grants to LEA's in nonmetropolitan areas for administering Federal programs would stimulate greater participation. Another alternative might be to provide administrative funds to SEA's for the purpose of helping nonmetropolitan local education agencies apply for grants.

HEADSTART AND FOLLOW THROUGH

The Headstart and Follow Through programs are aimed at preparation for and support of children in elementary education. Headstart,[1] which offers a large summer program and a condensed winter program, provides preschool preparation for low-income children. The program is directed by community action groups who have the option of delegating the program to the local school board or directing it themselves. If the program is run by the schools, community councils still have final authority over its operation.

While the program requires the local level to provide 20 percent of the costs, nonmetropolitan areas can have this requirement waived. In addition, LEA's must agree to spend 10 percent of the funds on transportation to insure distribution of services to isloated areas.

Follow Through was designed to supplement the needs of Headstart children once they entered the early primary grades. The program is part of the school curriculum rather than being community originated.

Due to limited funding, the program has not been expanded nationwide, as orginally proposed, and involves only a small portion of the Headstart children. The program's focus is now on research and development of new educational models to determine successful alternatives to present education systems.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

EDUCATIONALLY DEPRIVED CHILDREN

13.427 Educationally Deprived Children—Handicapped.
13.428 Educationally Deprived Children—Local Educational Agencies.
13.429 Educationally Deprived Children—Migrants.
13.430 Educationally Deprived Children—State Administration.
13.431 Educationally Deprived Children in State Administered Institutions Serving Neglected or Delinquent Children.
13.511 Educationally Deprived Children—Special Grants for Urban and Rural Schools.
13.512 Educationally Deprived Children—Special Incentive Grants.
13.516 Preschool, Elementary and Secondary Education—Special Programs and Projects.

SUPPLEMENTAL EDUCATION CENTERS AND EQUIPMENT RESOURCES

13.479 School Equipment Loans to Nonprofit Private Schools.
13.480 School Library Resources, Textbooks, and other Instructional Materials.
13.483 Strengthening Instruction Through Equipment and Minor Remodeling.
13.519 Supplementary Education Centers and Services, Guidance, Counseling, and Testing.

[1] Headstart has been transferred from the Office of Economic Opportunity to Office of the Secretary, HEW. The appropriation for these two programs appear under OS.

SERVICES

13.403 Bilingual Education.
13.410 Dropout Prevention.
13.433 Follow Through.

STRENGTHENING STATE DEPARTMENTS OF EDUCATION

13.485 Strengthening State Departments of Education—Grants for Special Projects.
13.486 Grants to Strengthen State Departments of Education.

SCHOOL ASSISTANCE IN FEDERALLY AFFECTED AREAS (IMPACT AID)

These programs provide financial assistance to local education agencies (LEA's) upon which the Federal Government has imposed financial burdens. This includes areas where the tax base is reduced through Federal acquisition of real property or where Federal activities cause a sudden and substantial increase in school attendance; it also includes education for children residing on Federal property or whose parents are employed on Federal property. Formula grants supplement maintenance and operation expenditures for eligible school systems, regardless of need. Typically, the Federal payment is deposited in the general operating expense account together with all State and local funds available for current operating expenses. Because of the large number of Federal institutions in nonmetropolitan areas, and because their relative impact on those areas is greater than in metropolitan areas, nonmetropolitan areas receive almost as much money as metropolitan areas.

Project grants are offered for urgently needed minimum school facilities in (a) impact areas as well as (b) areas where renovation or construction is necessary because of "declared major disaster" (disaster aid). Projects under (a) must be consistent with overall State plans for school facilities construction. Applications are funded in priority order. Since most growth is occurring in metropolitan areas, and Federal enclaves in rural areas have remained stable, most project grants for new facilities go to metropolitan LEA's.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.477 School Assistance in Federally Affected Areas—Construction.
13.478 School Assistance in Federally Affected Areas—Maintenance and Operation.

EDUCATION PROFESSIONS DEVELOPMENT (EPD)

These programs were developed to meet two general needs: (1) to improve the quality of educational training programs and (2) to increase the supply of qualified education personnel. Each program also aims at a specific need. One program deals with early childhood, others deal with vocational education, preschool, elementary and secondary education, and special education for the handicapped. One grant serves the special problems of education personnel who work or will be working in recently desegregated schools, especially those personnel who have been or may be displaced as a result of the desegregation process. Another grant finances supplementary programs to

improve pupil performance in schools attended by high concentrations of underachieving students from low-income families. Other programs deal with bilingual education training models, training of media specialists, administrative training, and drug abuse education training.

Funding is primarily by project grant, typically to the State education agency (SEA) or local education agency (LEA). In some programs, institutions of higher education are also eligible for grants. Most programs stress that EPD funds should not be used to supplant existing or normal education activities. At least one program is funded with a formula grant to SEA's and LEA's, in this case, to alleviate teacher shortages by training and hiring teacher aides from the local school district. This program is important, since under the present tax structure, local school districts often cannot afford to hire more professionals. Paraprofessionals may provide a temporary solution.

Training which takes place at universities usually emphasizes urban problems, although some programs do train specialists for special rural areas. Postgraduate programs have greater urban participation due to the generally more advanced training of metropolitan professionals. Applications for programs to be conducted by or at local schools in either metropolitan or nonmetropolitan areas should be considered on the basis of need. Nonmetropolitan personnel still, however, experience difficulties in either obtaining transportation to universities, or arranging for onsite academic training from colleges which are located a great distance from nonmetropolitan sites.

For additional information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.416 Educational Classroom Personnel Training—Early Childhood.
13.417 Educational Classroom Personnel Training—Special Education.
13.420 Educational Personnel Training—Drug Abuse Education.
13.421 Educational Personnel Training Grants—Career Opportunities.
13.473 Preschool, Elementary and Secondary Personnel Development—Grants to States.
13.503 Vocational Education Personnel Development Awards.
13.504 Vocational Education Personnel Development—Professional Personnel Development for States.
13.505 Educational Personnel Development—Urban/Rural School Development.
13.506 Educational Classroom Personnel Training—Bilingual Education.
13.507 Educational Classroom Personnel Training—Teacher Development for Desegregating Schools.
13.508 Educational Personnel Development—Media Specialists.
13.509 Educational Personnel Development—Pupil Personnel Specialists.
13.514 Educational Personnel Development—Educational Leadership.

TEACHER CORPS

During the last few years of attempts to upgrade public education in the United States, it has become increasingly clear that the quality of the teaching staff and not just the materials is basic to the quality of education.

In recognition of the urgent need for better teachers, the National Teacher Corps was conceived in 1965 to recruit and train teachers for economically disadvantaged children. The training emphasis has been on sensitizing teachers to the culture and life style of poor families.

Equally important to this program is the goal of changing existing patterns of teacher training. The public schools and the college or university involved must agree in a contract to innovate within their teaching program. With few exceptions, schools cannot be served when the percentage of pupils from low-income homes falls below the poverty average for the Nation, the State, or the school district as a whole.

The Teacher Corps is a matching program requiring 10 percent of the funds to be from non-Federal sources. The university/school plan is submitted to the State education agency, which, on approval, sends it to Washington, where a panel of education consultants and Teacher Corps staff members evaluate all proposals to see if they are in accord with the letter and spirit of the Teacher Corps legislation and guidelines.

There is very little money for the program. In fiscal year 1970, about 25 percent of total program funds were spent on nonmetropolitan university/school Teacher Corps programs.

For further information on the program discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.489 Teacher Corps—Operations and Training

HIGHER EDUCATION

Enrollment in institutions of higher education in the United States has increased each year since the early 1950's, rising from 2.1 million in 1951 to an estimated 7.6 million in 1970. Along with greatly expanded college enrollment, there has been a concomitant increase in the number of faculty members, in the number of degrees conferred, and in expenditures for higher education.

Since tuition and fees cover less than half of classroom instructional costs, the need for other funds has grown with the increase in enrollment. State government subsidies, endowments, and gifts have made up most of this "instructional deficit," but many schools need additional assistance, some of which may be obtained through the following Office of Education programs.

PROGRAM ASSISTANCE

Several programs are available to assist colleges to improve or maintain the quality of their instruction.

A program for land-grant colleges distributes funds on a formula basis to each State, which in turn makes awards directly to its land-grant college(s). About one-fourth of the money is proportioned among the States on the basis of population; the remainder is distributed equally among them. Colleges can use funds to support instruction in the mechanical arts, agriculture, English language, and science, or for equipment and training for such instruction. Rigorous use restrictions, however, include a ban on extension work, thereby potentially restricting rural agricultural curriculums.

Another program, entitled "Strengthening Developing Institutions," assists colleges in bolstering their academic, administrative, and student service programs so that these institutions may participate adequately in the higher education community. Project grants are avail-

able for cooperative arrangements whereby developing institutions and other institutions or agencies share resources. National financing fellowships are given to outstanding graduate students and to junior faculty members to teach at developing institutions. Support is also available for professors retired from established colleges to teach and to conduct research in developing institutions. Projects usually include demonstration and innovation and are developed on the basis of specific needs of the applicant institution. About 15 percent of total funds go to colleges in nonmetropolitan areas.

CONSTRUCTION

The financial squeeze also affects the ability of colleges and universities to finance capital outlays for new facilities for growing student bodies. Sound planning for statewide needs on a long-range basis is necessary, if Federal funds for facilities are to be used effectively. Financial resources can then be made available for insuring construction of the needed facilities.

Project grants are offered to State commissions on higher education for comprehensive planning to determine the construction needs of institutions of higher learning. Grants are also offered to these commissions for administering the State plans required under title I of the Higher Education Facilities Act. Grants which are allocated to the States on the basis of a formula cover full cost of facilities planning projects.

Formula grants also provide the major funding for actual construction costs. Grants may be made for up to 50 percent of the eligible costs, with applicant institutions providing the difference.

A program for interest subsidization provides annual interest grants to colleges and universities to reduce the costs of construction loans. At least 15 percent of the development cost of the facility must be financed from non-Federal sources. Although many rapidly expanding institutions are located in rural areas, only one-third of Federal expenditures for educational facilities construction and interest subsidization goes to nonmetropolitan areas.

STUDENT AID

Although students actually pay only a fraction of the total cost of their education, in recent years they have been paying more and more in actual dollar amounts. An Office of Education survey conducted in 1961–62, reported the average tuition and fees for all public institutions of higher education as $218 and $906 for private schools. The 1971–72 estimate is $383 (public) and $1,830 (private). Room and board have almost doubled during the same period. Federal job, scholarship, and loan programs aid some students who cannot afford these costs. Most of these programs are project grants to institutions, which then provide students with financial assistance.

Educational opportunity grants (EOG's) enable students of exceptional financial need to pursue higher education. Generally, every eligible institution that applies under the EOG program is funded. The institution must provide additional aid to recipients and not reduce its total expenditures for student aid.

The National Defense Education Act (NDEA) direct loan program has established loan funds at eligible institutions. Students may become eligible for partial cancellation of their loan through teaching or service in the Armed Forces. Moneys are distributed among institutions according to a formula. The institution must provide $1 for each $9 of Federal moneys. Institutions may apply for a loan to cover their share, if necessary. At most institutions, NDEA funds are scarce, as demand exceeds supply.

The guaranteed student loan program insures loans for educational expenses. Loans are available from nearly 20,000 leading banks in the country. Most are, however, located in urban areas. Loans may be used only to pay costs of obtaining postsecondary education. Other loan programs include a loan fund for Cuban nationals.

To encourage the part-time employment of students, particularly those from low-income families, the work-study program gives project grants to colleges and universities. Students who need earnings from employment to continue their education are employed by the college or an off-campus agency. The employer pays 20 percent of the student's salary; the Federal grant pays the rest. Recent cutbacks in Federal allocations have raised the minimum criteria for student eligibility under this program.

A related program, cooperative education, provides students with alternate periods of full-time academic study with periods of full-time public or private employment. Money appropriated under this program may not be used for student's salaries, but to pay for salaries and administrative expenses incurred in the planning, implementation, strengthening, or expansion of such programs.

UPWARD MOBILITY

Another set of programs aims to bring disadvantaged students into institutions of higher education and assist them in successful completion of their academic programs. Upward Bound awards funds to institutions to establish precollege preparatory programs designed for high school students from low-income families, who lack adequate secondary school preparation. The program, funded up to 80 percent with Federal project grants, stresses indepth counseling with parents and students and development of academic skills. Projects must limit Federal expenditures to $1,490 per student. Rural institutions applying for Upward Bound funds are generally unable to meet the 20 percent matching requirement. An added strain is the high costs of transporting nonmetropolitan students and personnel to institutions where Upward Bound programs are offered.

Talent Search has no matching requirements, but the applicant is encouraged to seek partial project support from non-Federal sources. This program is aimed at young people from grade 7 up who are "of financial or cultural need with an exceptional potential" for postsecondary education. Funds are awarded to institutions and agencies which identify qualified youths and encourage them to continue with their schooling. No instruction, tutoring, student financial aid, or other student support may be funded by this program, although publicizing of existing forms of aid is encouraged. Current rural-oriented projects deal with American Indians, migrants, and Chicanos.

The Special Services for Disadvantaged Students program assists low-income and physically handicapped students on college campuses. Project grants are given to educational institutions to fund counseling, tutoring, and other educational services.

Generally, student aid has been limited by insufficient appropriations. Individual student grants or loans are usually too small to meet the needs of disadvantaged students.

PERSONNEL DEVELOPMENT

In 1959–60, institutions of higher education employed 418,788 professional staff members. By 1969–70, the Office of Education estimated the number had almost doubled to 806,000. Several Federal programs, including NDEA, offer fellowships and short-term grants to increase the supply of well-prepared teachers, administrators, and educational specialists for both community colleges and 4-year colleges and universities.

Fellowships are offered through institutions of higher education, which have high quality graduate level programs to prepare personnel for work in higher education. Most of the training is done at a college or university. In some cases, however, part of the training is done off-campus in the community. Project grants to institutions also fund short-term training programs of a graduate-level quality. Emphasis is given to training educational personnel of junior colleges, developing institutions, and higher education personnel working with low-income and minority students. Between a quarter and a third of all funding for these programs goes to institutions which are either located in nonmetropolitan areas or are geared to the needs of such areas.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

PROGRAM ASSISTANCE

13.453 Higher Education—Land Grant Colleges and Universities.
13.454 Higher Education—Strengthening Developing Institutions.

CONSTRUCTION

13.455 Higher Education Academic Facilities—State Administration.
13.457 Higher Education Academic Facilities Construction—Interest Subsidization.
13.459 Higher Education Academic Facilities Construction—Public Community Colleges and Technical Institutes.

STUDENT AID

13.407 College Teacher Graduate Fellowships.
13.418 Educational Opportunity Grants.
13.460 Higher Education—Insured Loans.
13.463 Higher Education—Work Study.
13.469 National Defense Education Act—Loans to Institutions.
13.471 National Defense Student Loans—Direct Loan Contributions.
13.482 Special Services for Disadvantaged Students in Institutions of Higher Education.
13.488 Talent Search.
13.492 Upward Bound.
13.510 Higher Education—Cooperative Education.

PERSONNEL DEVELOPMENT

13.461 Higher Education Personnel Development—Institutes, Short-Term Training, and Special Projects.
13.462 Higher Education Personnel Fellowships.

VOCATIONAL EDUCATION

Vocational education programs are intended to assist States in developing and conducting vocational programs for all persons who desire and need them. Different areas covered by vocational education programs include basic grants to States, consumer and homemaking education, cooperative education, curriculum development, research, special needs, State advisory councils, work study, and innovation (exemplary programs and projects).

Funding is predominantly determined by formula. Eligibility is mostly limited to State boards of vocational education. (The figure shown in appendix table 2 for vocational education programs represent funds allocated to State boards.) The boards, in turn, distribute the money to the various counties, including metropolitan and nonmetropolitan areas. For the most part, the data show that the capital counties in the States receive a disproportionately large amount of money for vocational education. Unfortunately, the Office of Education has no system of tracking how the money is distributed within the State.

There are currently some exemplary vocational education projects that are supported and operate within nonmetropolitan areas. No such projects are adequately funded however.

There is room for increased emphasis on vocational guidance and counseling in rural areas. The funding of part E of the vocational amendments of 1968 would result in providing vocational education programs in rural areas where bussing is not feasible. Equally important is the need for the Office of Education to actively stress the development and expansion of mobile classroom/lab facilities to meet nonmetropolitan needs.

This same program has, under the auspices of the State boards for vocational education, developed area vocational education schools to serve nonmetropolitan areas. Most of these facilities are located on or near intersections of the interstate road system and can serve several rural areas. Many local school districts are able to contribute to the area schools, thus enabling them to acquire needed equipment for specialized vocational programs. In turn, local districts are able to make use of the area schools as supplements to their own schools. Currently, 95 to 100 percent of rural sections of the country are covered geographically by area vocational education schools. Some of these schools, however, are so far from some sections that many youths are still not able to become actively involved in the programs. What is needed is the construction and development of additional area vocational education schools to insure easier access for more youths in nonmetropolitan areas. Underlying these needed improvements is additional funding.

For further information on the programs discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.493 Vocational Education—Basic Grants to States.
13.494 Vocational Education—Consumer and Homemaking.
13.495 Vocational Education—Cooperative Education.
13.496 Vocational Education—Curriculum Development.
13.498 Vocational Education—Research.
13.499 Vocational Education—Special Needs.
13.500 Vocational Education—State Advisory Councils.
13.501 Vocational Education—Work Study.
13.502 Vocational Education—Innovation.
13.517 Vocational Education—Project Research Grants.

LIBRARIES AND COMMUNITY SERVICES

The various areas covered by programs under the category of library and community services include library training grants, adult education, teacher education, college resources, library services to the physically handicapped, library services—State institutional library services, library services—interlibrary cooperation, library services—grants for public libraries, construction of public libraries, university community service, adult education, and educational broadcasting facilities.

The overall objectives of those programs dealing with library services are to establish and improve library services through grants for construction, through the provision for systematic and effective coordination of special, academic and school libraries, and through the extension of public services to areas without service or with inadequate service. Additional objectives include the extension of library services to the physically handicapped, assistance to colleges and universities for the development of their library facilities and training of library staffs.

University community service programs are intended to encourage colleges and universities to help combat community problems by strengthening those community services and continuing education programs specifically designed to provide communities with problem-solving assistance. The hope is to strengthen existing mechanisms or create new ones to focus resources of colleges and universities on the process of building problem-solving competence in local communities.

The adult education programs are designed to assist in the establishment and growth of adult education programs through training personnel, providing financial assistance, and experimenting with new and different teaching methods. The other program in this category is educational broadcasting facilities, which provides for the acquisition and installation of electronic equipment for noncommercial broadcasting to serve the educational and informational needs of people in the community.

FUNDING

With the exception of three projects, libraries and community services programs are funded through formula grants. These grants also carry a matching requirement of 34 to 67 percent in some cases, 50 percent in others, and 33⅓ percent in others. These requirements often make it difficult for poor rural areas to make use of these programs.

Regarding the use of funds, under the grants program for public libraries, money may not be used for law, medical school, or academic libraries as these are organized to serve a specialized clientele. Funds may, however, be used for books and other library materials, library equipment, salaries and other operating expenses and for administration of the State plan for services.

In line with the use restrictions listed above, eligibility for funding for the majority of the programs is open to institutions of higher education, State educational agencies, or other appropriate public or private agencies or organizations.

Libraries and community service programs hold a high degree of relevance for rural communities. These communities, usually lacking

library resources which are necessary to educational achievement, can especially benefit from programs that are intended to provide services to areas without the facilities to develop services. One such program is university community service—grants to States, which is designed to encourage colleges and universities to help strengthen communities to solve their problems. This program is, however, mandated by law to place special emphasis on urban and suburban areas. Thus, there is a built-in shortchanging of nonmetropolitan areas. Approximately 61 percent of the funds for this program went to exclusively urban and suburban areas in fiscal year 1970, while only 10 percent went exclusively to rural areas. The remaining 29 percent was utilized in projects covering both rural and urban or suburban areas.

Similarly, under the college library resources program, the majority of the grant awards were given to institutions located in urban and suburban communities in fiscal year 1970, the assumption being that the program is directed to reflect the needs of economically disadvantaged students. Implicit in this assumption is the belief that economically disadvantaged students do not constitute a significant part of the rural population.

Under the adult education—special projects program, in fiscal year 1970, grants of $2,820,000 were made for special projects located in metropolitan areas or projects which emphasized the needs of people in metropolitan areas. Grants totaling $1,751,000 were made for such projects in nonmetropolitan areas. The remaining $3,329,000 from the $7,900,000 total money for adult education was for grants to be utilized by either metropolitan or nonmetropolitan programs under the State basic grants for adult education program.

Such an imbalance of money for rural areas for programs for which there is a substantial need might be corrected through the allocation of additional funds to insure funding and services that meet the needs of rural as well as urban areas. Some programs have suggested changes in legislation to eliminate such phrases as "with particular emphasis on urban and suburban problems." This may indeed be necessary. Under the program for construction of public libraries, a new 5-year program has just been passed and goes into effect beginning in fiscal year 1972. This program is designed to serve all localities with inadequate facilities.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.400 Adult Education—Grants to States.
13.401 Adult Education—Special Projects.
13.402 Adult Education—Teacher Education.
13.406 College Library Resources.
13.408 Construction of Public Libraries.
13.413 Educational Broadcasting Facilities.
13.464 Library Services—Grants for Public Libraries.
13.465 Library Services—Interlibrary Cooperation.
13.466 Library Services—State Institutional Library Services.
13.467 Library Services to the Physically Handicapped.
13.491 University Community Service—Grants to States.

HANDICAPPED EDUCATION

Education of the Handicapped Act, title VI, offers a variety of services, training, and research programs.

Under the service category, early school education receives the most emphasis. Handicapped preschool and school programs require State plans and have matching requirements. Under the State plan, some schools have established rural areas as their priority target. According to the Bureau of Education for the Handicapped, a majority of the children receiving direct services live in areas with a population under 50,000. During fiscal year 1969, 31 percent of the 155,000 handicapped children receiving direct services lived in rural areas having less than 2,500 population, 38 percent in populations between 2,500 to 50,000 and 31 percent in urban areas.

Programs for children with special learning disabilities offer service, research, and teacher training project grants. There are four special emphasis projects for fiscal year 1971–72 in nonmetropolitan areas. They all seem to concentrate their efforts on providing resource units throughout the State and developing in-service teacher training programs.

RESEARCH AND TRAINING

A little over a quarter of the model programs in early childhood assistance are located in nonmetropolitan areas. These exemplary services are for handicapped children between 0–8 years and their families. The program has a 10-percent non-Federal matching requirement.

The rural projects respond to certain specific needs of handicapped children in relatively isolated areas that are removed from the consolidated service centers of the State. The most important factor in the service of very young handicapped children is the inclusion of training with the parents. Week-long intensive training sessions, as well as individual counseling, are emphasized in many of the programs where parents and children work in groups, and then are seen in follow-ups at home.

Teacher education and recruitment has always been a problem for rural States, where there is a shortage of regular teaching assistance, as well as special educators. Project grants for handicapped teacher education go directly to universities and institutions of higher learning, which are encouraged to make their programs relevant to local needs. In an attempt to make this requirement more responsive to the needs of the States, all institutions, as of fiscal year 1972, will be required to include a statement from the appropriate State education agency official as to the extent to which the proposed plan addresses itself to State and local manpower needs.

The kinds of special needs that should be built into a program for a rural area have been addressed in several special emphasis projects. Because rural areas have a shortage of teaching staff on all levels, a training model is being developed to prepare a multidisciplinary teacher who will be able to intervene successfully with learning and

behavior problems of both regular and special education children. Plans for special education coordination to share staff on a statewide basis and assess needs to develop joint manpower training programs are also in the project stage.

The organization of data is such that it is difficult to determine exactly how much money is actually spent on nonmetropolitan projects. Of the $30.4 million in the program, $8.6 million is sent to universities with nonurban campuses.

Information dissemination projects are part of several programs. Information for the parents of handicapped children in rural areas and recruitment of rural local personnel are two examples of a few special emphasis projects. Technical assistance to educators can be established through a regional resource centers project and/or a university.

Research and innovation programs include deaf/blind centers, and physical education and recreation research and training. About 18 percent of research and innovation money is spent in rural areas.

A media service, including captioned films for the deaf, is available to schools and agencies. The program funds two rural programs: one providing media services for mentally retarded Indians, and the other, a preschool program for "highest risk" Spanish-American children.

In summary, the primary needs for the rural handicapped seem to lie in the areas of in-service training, development of a statewide paraprofessional program, parent involvement in training, and various outreach service programs.

For further information on the programs discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.443 Handicapped—Research and Demonstration.
13.444 Handicapped Early Childhood Assistance.
13.445 Handicapped Innovative Programs—Deaf-Blind Centers.
13.446 Handicapped Media Services and Captioned Films.
13.447 Handicapped Physical Education and Recreation Research.
13.448 Handicapped Physical Education and Recreation Training.
13.449 Handicapped Preschool and School Programs.
13.450 Handicapped Regional Resource Centers.
13.451 Handicapped Teacher Education.
13.452 Handicapped Teacher Recruitment and Information.
13.520 Special Program for Children with Specific Learning Disabilities.

RESEARCH AND TRAINING

Research and training programs in the Office of Education cover the areas of civil defense education, educational research training, training of teacher trainers, and educational staff training for volunteers in education.

The objective of the civil defense education program is to incorporate civil defense instruction into school curriculums, develop effective disaster preparedness plans, and train radiological monitors and shelter managers. Research and training programs are intended to increase the supply of competent and professionally trained educational research, development, dissemination, evaluation, and training personnel through support of graduate, in-service, and other training activities; and to develop more effective training programs and other resources for carrying out the research and training functions needed to improve education.

Federal support for research and training programs is primarily through project grants. Eligibility for funding is open to State education agencies, local education agencies, colleges and universities, and public and private nonprofit organizations. Coordination between State and Federal authorities in determining the characteristics of programs is required, in most instances. In the civil defense education programs, there is a coordinated effort from the time a State is requested to submit a proposed State plan and budget until the amount of funding is determined by negotiation between both parties and a contract has been executed. A close working relationship is maintained during postcontract periods, including visits to the State agencies to monitor contract compliance and program effectiveness and to provide advice and guidance to State staff. Some training programs (training of teacher trainers, education research training) require coordination between institutions of higher education, local education agencies, and State education agencies.

Theoretically, all research and training programs are intended to emphasize metropolitan and nonmetropolitan areas on an equal basis. More emphasis is on urban areas, however, mainly due to limited funding of the program and the fact that urban areas do have great need of services. Upon the receipt of additional financial support, an extension of the program's policy to include rural as well as urban areas should be enacted. The training of teacher trainers program presently emphasizes urban more than rural areas in its operations. Needless to say, this program is extremely relevant to the needs of rural areas, especially since there is an overwhelming tendency for rural areas to attract those teachers who are less experienced and less well educated than those working in urban areas.

This latter program and other related programs could be better utilized in rural areas if additional funding were provided. Concomitant with this should be an increased emphasis on the upgrading of teachers at the elementary and secondary levels, especially those who will teach in nonmetropolitan areas, where teacher training programs have most often been inadequate.

For further information on the programs discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.404 Civil Defense Education
13.424 Educational Research Training
13.490 Training of Teacher Trainers
13.515 Educational Staff Training—Volunteers in Education

CIVIL RIGHTS TECHNICAL ASSISTANCE AND TRAINING

Established by the Civil Rights Act of 1964, the civil rights technical assistance and training program is designed to facilitate the desegregation process by providing technical and training support to desegregating school districts.

Grants are made to local school boards to help them prepare and carry out desegregation plans, to give school personnel special inservice training, and to employ specialists in school desegregation problems.

Training institutes are authorized to improve the ability of school personnel to deal with special educational problems. Teachers, school

administrators, and sometimes school board members have participated in these institutes. In addition, funds have been used to establish a series of school desegregation consultative centers at colleges and universities to make available trained personnel to help school districts with problems stemming from desegregation.

Although the focus is clearly at the local level, the program also provides for support of State education agencies in order to facilitate their assistance to local school districts. This State support includes advice and assistance regarding preparation, adoption, and implementation of desegregation plans, information about the most effective methods of dealing with the special problems of desegregating schools, and provision of qualified personnel from the Office of Education or outside sources for on-site assistance.

The program provides project grants to local education agencies and both grants and contracts to institutions of higher education for training institutes. During fiscal year 1970, 68,444 school personnel and advisory specialists were trained; 500 teachers and administrators were involved in institutes; and 138 school districts received grants.

There are no restrictions or guidelines which would necessarily make assistance more relevant to metropolitan or nonmetropolitan areas. In terms of numbers, however, school districts served tend to be more nonmetropolitan in nature because the districts required by law to desegregate are more often located in such areas. In terms of actual dollars, however, there are more resources applied in metropolitan areas. In fiscal year 1970, expenditures in metropolitan areas totaled $10.8 million, whereas the comparable figure for nonmetropolitan areas was $4.6 million. This fact may be attributed to the greater concentration of colleges and universities in metropolitan areas.

For further information on the program discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.405 Civil Rights Technical Assistance and Training

RESEARCH AND DEVELOPMENT

Research and development programs seek to improve the educational system through various kinds of studies and demonstrations.

Research and development centers bring together resources and interdisciplinary talent to focus on broad problem areas which, although not yet at the crisis stage, require continuous attention. Most of the centers are located at major universities where they receive considerable sustaining support from the parent institution. Many also receive foundation support for special aspects of their programs.

Centers work closely with educational laboratories which are more concerned with the final development, adaptation, and actual delivery of services. There are now 11 of these autonomous, nonprofit corporations.

General education (project) research provides funds to colleges, universities, State education agencies, or other private or public agencies and individuals to: (1) carry out basic and applied activities and (2) mount systematic development activities necessary to resolve a few of the most pressing problems in education. Special

emphasis is on improving student and parent options in obtaining educational services. Current efforts focus on providing appropriate career education to resolve the unemployability problem of dropouts.

Two other programs, library research and arts and humanities, carry out research and development activities within a single discipline. Funded activities must show promise of improving education in settings other than those in which they are carried out.

The experimental schools program serves as a bridge from research, demonstration, and experimentation to actual school practice. These large-scale experiments, limited in number, have a major focus on documentation and evaluation.

Most of the above programs are carried out with project grants. The general education research program requires some cost-sharing of grants, but also can work through contracts without matching requirements. The amount of matching funds available is not a determining factor in selection of activities to be funded.

Most projects do not investigate factors which are related to demographic areas. (An exception is the regional research program, which offers small project grants for regional study.) Since most research facilities are located in metropolitan areas, only about 7 percent of total money is spent in nonmetropolitan areas. Programs thus tend to focus more around urban problems. Some exceptions include—

(*a*) rural sharing services;
(*b*) interdisciplinary evaluation of summer programs, for rural disadvantaged youth;
(*c*) development of home/community-based career education, which may be particularly appropriate for nonmetropolitan areas; and
(*d*) the Appalachia Educational Laboratory, which has been particularly concerned with educational cooperatives.

Good education is not a matter of region, or demographic area, and major problems needing development attention are common to both metropolitan and nonmetropolitan parts of the country. Still, service delivery in each area presents unique problems and challenges.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.411 Educational Research and Development Centers
13.412 Educational Research and Development—Regional Education Laboratories.
13.422 Educational Research and Development—General Education (Project) Research.
13.474 Research and Development—Arts and Humanities
13.475 Research and Development—Library Research
13.476 Research and Development—Regional Research
13.521 Experimental Schools

E. OFFICE OF THE SECRETARY

OFFICE OF CHILD DEVELOPMENT (OCD)

The Office of Child Development funds research and demonstration grants, technical assistance, and the Headstart program. Grantees for research and demonstration projects are required to share in the cost of projects and must make actual cash outlay or have funds deducted from the indirect cost. Eligible applicants are public or nonprofit institutions of higher learning and public and nonprofit agencies or organizations, including State or local public agencies responsible for administering or supervising the child welfare services plan.

Prior to fiscal year 1971, grants were to be used in projects: (1) of regional or national significance; (2) to demonstrate new methods or facilities; and (3) to demonstrate research in the field of child welfare in order to encourage experimental and special types of services.

In past years, HEW money in new child development research has been tied into a Social and Rehabilitation Service services integration project to develop a more consolidated method of social service delivery.

While the Headstart program is now under OCD, a description of the program has been included in the OE/ESEA analysis above (page 35) for the purpose of continuity.

Technical assistance is available on a contract basis for any component of the Headstart program: education, health, volunteer services, administration, etc. In fiscal year 1972 direct local purchase of technical assistance services will be offered in some local communities on an experimental basis.

The need for Headstart programs in rural areas presents different problems than those in cities. Transportation and methods of outreach are crucial.

A project in West Virginia, "Headstart at Home," attempts to meet some of these specialized rural needs.

In the area of research and development, little has been done in rural areas in the past. Hopefully, the services integration project will be able to develop ways of meeting the child service delivery problems on a regional as well as local level.

For further information on these programs, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.600 Child Development—Headstart.
13.601 Child Development—Technical Assistance.
13.607 Child Welfare Research and Demonstration Grants.
13.608 Child Development—Child Welfare Research and Demonstration Grants.

CIVIL RIGHTS COMPLIANCE ACTIVITIES

Title VI of the Civil Rights Act of 1964 says that no person shall be discriminated against because of his or her race, color, or national origin in any program or activity that receives Federal financial assistance. It also says that no Federal assistance can be extended to any activity in which there is discrimination on the grounds of race, color, or national origin.

Title VI is administered by the Office of Civil Rights, which is located in the Office of the Secretary. In terms of the amount of financial assistance under Federal grant and loan programs, HEW is the major agency affected by title VI. It administers three of the largest Federal programs—public assistance, aid to education, and public health research and services.

Agencies receiving assistance must submit written assurances that they will comply with the law and the regulations the Department issues. If a recipient reneges on this commitment of compliance or refuses to make a commitment, Federal assistance may be discontinued.

The Office of Civil Rights has also been delegated certain responsibilities from the Department of Labor for enforcing an Executive order that bans discrimination in employment by Federal contractors and on federally assisted construction projects. Executive Order 11246 applies to discrimination on the basis of religion and sex in addition to the grounds of race, color, or national origin.

Much of the activity of the Office of Civil Rights has been concentrated on colleges, hospitals, nursing homes, and elementary schools. These services are vital to the functioning of programs in nonmetropolitan areas as well as in urban areas.

For additional information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.602 Civil Rights Compliance Activities.

MENTAL RETARDATION COORDINATION AND INFORMATION

The Secretary's Committee on Mental Retardation coordinates the Department's mental retardation programs and advises the Secretary on related issues. The Committee provides information to the public and technical assistance to any organization concerned with mental retardation.

During fiscal year 1970, nearly $40 million was obligated by HEW for mental retardation programs, which cover most aspects of the retardate's life. (See SRS/Developmentally Disabled.) Many agencies of the Department administer programs which affect the mentally retarded: it is extremely important that their efforts be focused on specific goals, so as to prevent duplication and gaps in program services for the mentally retarded.

The Secretary's Committee often establishes priority areas for special emphasis: e.g., poverty, model cities, institutional care, voluntary activities. There is no particular focus on rural areas at the present time.

For further information on this program, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.603 Mental Retardation Coordination and Information.

HUMAN RESOURCES DEVELOPMENT PLANNING

The Office of Regional and Community Development (formerly Center for Community Planning) serves the 10 HEW regional offices and clients of the Department. It provides a single focus for information dissemination and technical assistance especially in the areas of:

(1) Intergovernmental relations, with special emphasis on general purpose government;
(2) Joint programs, particularly model cities; and
(3) Activities not covered by other agencies of the Department.

States, cities, counties, public and private organizations, and individuals requiring assistance in a program area covered by the operations of the Office may apply for assistance through the regional directors or directly to the Deputy Assistant Secretary for Regional and Community Development. In fiscal year 1970, fund reservations were obtained from 44 HEW programs earmarked for Model Cities projects. Assistance was provided to 250 localities in other HEW funding areas.

The Office includes a rural development staff, which focuses on the special problems of human resources development in nonmetropolitan areas.

For further information on the program discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.604 Planning for Human Resources Development.

SURPLUS PROPERTY UTILIZATION

Every year, as program requirements or operations change, agencies and departments of the Federal Government find they own unnecessary or obsolete real or personal property. Many categories of obsolete property must be reported to the General Services Administration, which then exercises disposal jurisdiction. Other property is screened for utilization by other Federal agencies. Eventually, all unneeded property is deemed "surplus."

Surplus personal properties are donated to public or tax-exempt nonprofit private medical institutions, schools or school systems, colleges and universities, schools for the mentally retarded and physically handicapped, licensed educational radio and television stations, and public libraries. Real property can go to States, their political subdivisions and instrumentalities, tax-supported or nonprofit tax-exempt educational and medical institutions, and hospitals or similar institutions.

HEW carries out a clearinghouse effort through 53 State agencies (including the District of Columbia, Puerto Rico, and the Virgin Islands) and the regional and headquarters offices of the surplus property utilization program. These offices issue catalogs, bulletins, and newsletters to keep potential recipients up to date on what is avail-

able. State agencies must submit a State plan and comply with HEW standards of operation.

"Supermarket" distribution centers allow representatives of eligible institutions to look over available materials. Once an institution indicates a desire for a surplus item, it must only pay the moving and service costs which may be involved in acquisition.

Sometimes a surplus item or parcel can fill a need "as is." Hospital and health facilities, computers and electronic equipment only need a change of ownership to be put to use. Where surplus property cannot be used in its original form, a very simple metamorphosis can often make it the raw material of community development. Little needs to be done to make a classroom out of a quonset hut, or a college dormitory out of an Army barracks building. About 90 percent of the Federal property labeled "surplus" comes from the Department of Defense; the remaining 10 percent comes largely from the Veterans' Administration, the Departments of Agriculture, Interior, and Treasury, and the General Services Administration.

Between 1946 and June 30, 1968, almost $6.6 billion of real and personal property were made available to eligible institutions. Property is allocated to States on a per capita wealth and State population index. Urbanized communities participate less than rural and more needy areas. Nonmetropolitan areas lack the funds to buy resources through commercial channels and, thus, have a greater need for surplus property.

The surplus property program encourages local initiative and improved cooperation among levels of government.

The system of surplus property distribution is an additional channel for Federal aid, a channel with a tremendous potential impact on rural areas.

For further information on this program, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.606 Surplus Property Utilization (Federal Property Donation Program).

FACILITIES ENGINEERING AND CONSTRUCTION AGENCY (FECA)

At present, there are about 40 health and education construction programs within HEW, expending annually about $1 billion, thereby generating a total construction expenditure of about $4 billion. Through a network of regional and district offices, the Facilities Engineering and Construction Agency provides architectural and engineering services to State agencies, which are required to submit a State plan. The services furnished by FECA do not conflict with the services of a grantee's private architect/engineer. A few of these projects are in nonmetropolitan areas. FECA has four primary concerns:

(1) Improvement of health and education facilities design and construction;
(2) Development of HEW Departmentwide design standards;
(3) Reduction of costs and improved flexibility as made possible by advanced building techniques; and

(4) Adherence to Federal requirements such as competitive bidding.

Toward these goals, FECA has established a facilities management system, initiated a "deep look" study of HEW property, developed the concept of "valve engineering" (organized effort to achieve the required function at the lowest total cost), and planned professional workshops in relevant program areas.

For further information on the program discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.607 Facilities Engineering and Construction Activities—Technical Assistance.

F. SOCIAL AND REHABILITATION SERVICE

GRANTS TO STATES FOR PUBLIC ASSISTANCE

Even though absolute poverty has declined over 35 percent in the last 10 years, about 25.4 million persons or 12.8 percent of the U.S. population were still living in poverty in December 1968. To meet this need, public assistance expenditures, Federal, State, and local, amounted to $13.6 billion in 1969. About 40 percent of these expenditures represent payments to providers of medical care, and 60 percent represent cash payments to public assistance recipients.

MAINTENANCE PAYMENTS

These programs provide State welfare agencies with partial money based upon the State's quarterly estimates of total funds needed. Under an HEW-approved State plan, money payments are then made to the eligible beneficiary by the State or local welfare agency.

The Old-Age Assistance (OAA) program, established in all States, pays needy people, 65 years or older, cash benefits for food, shelter, and clothing. In some States, OAA also pays for homemaker services so that elderly recipients may remain in their own homes, although incapable of completely caring for themselves. The average monthly benefit among the more than 2 million OAA recipients was $74.95 in January 1970. Benefits ranged, however, from $46.30 in Mississippi, to $155.20 in New Hampshire. Each State determines its own payment, based upon its ability and willingness to finance the non-Federal share of payments. Since the fiscal ability and tax resources of rural States tend to be more limited than urban States, payments are usually lower in those States which consist primarily of nonmetropolitan areas. Assistance payments represent 70 percent of an individual's total income in nonmetropolitan areas, compared to 50 percent in urban areas.

All States also have an aid to the blind program for needy blind persons. The statutory requirements are similar to those for OAA, except there is no age requirement. The States have the responsibility for defining blindness, which is usually interpreted as visual impairment preventing a person from earning a living. Payments in January 1971 ranged from $54.40 in Mississippi to $178.75 in Alaska. The matching requirement for this program also limits its potential in rural areas.

All States except Nevada had an aid to the permanently and totally disabled program in 1970. States establish their own definition of eligibility, taking age, training, experience, and social setting into consideration. Generally, there must be a physical or mental impairment which is expected to continue indefinitely and substantially prevents a person from engaging in any useful occupation. Alaska had the high-

est average monthly payment in January 1971—$175.25; Louisiana was lowest—$55.60. This program is also limited in rural areas due to the matching requirement.

Aid to families with dependent children (AFDC), which is directed toward encouraging the care of needy dependent children, is the largest maintenance payment program. Federal funds pay for part of both maintenance payments and administrative costs. The program must be in effect statewide, and Federal requirements for individual eligibility must be met in the required State plan. One of the biggest problems in the AFDC program is that each State still determines its own payments and eligibility requirements within the broad Federal requirements. Some States put no limitation on the value of an applicant's home while others limit it to less than $3,000. Some allow applicants less than $500 worth of other personal property and other States permit more than $1,000. Cohabitation with a man other than a lawful spouse is grounds for automatic incligibility in some States, but not in others. Average payments vary from $12.05 per child per month in Mississippi to $76.35 in New York (January 1971 figures). As a report to the Social and Rehabilitation Service, HEW, points out, "These variations are not matters of trivial consequence; they bear on questions of both physical and mental health, life chances, human dignity, and some would maintain even life itself." [1]

Programs in nonmetropolitan areas are especially weak due to the matching requirement. Appropriations by the State legislature affect total funds available for payments, since the Federal Government only matches the amount the State is willing to appropriate. The State finds it is unable to provide the non-Federal money it has originally estimated, the Federal share is reduced accordingly, as are payments to recipients.

Emergency welfare assistance is supposed to provide financial aid to States for emergency family assistance in crisis situations. Families of migratory workers are included in this category. Federal funds pay for 50 percent of the program cost under a HEW approved State plan. Often, because of inadequate funding, State definitions of "emergency" are too narrow to fill the gaps left in other assistance programs.

The impact of these programs on nonmetropolitan areas is tremendous, since nonmetropolitan personal incomes are low. In general, the proportion of persons receiving some form of public assistance is higher in States with greater rural populations. For example, a typical 10-county region in southern Oklahoma [2] reports that 42 percent of the total per capita income of the area is derived from HEW public assistance and transfer payments.

MEDICAL ASSISTANCE PROGRAMS

Authorized by title XIX of the Social Security Amendments of 1965, the medical assistance program, commonly referred to as Medicaid, aims to make quality medical care available to low-income groups by coupling Federal requirements for program coverage and quality of care with Federal financial participation.

[1] "Welfare Policy and Its Consequences for the Recipient Population", a study of the AFDC program by Bureau of Social Science Research, Inc., to SRS/HEW.
[2] Southern Oklahoma Development Association.

In order to qualify for participation in the Medicaid program, States must meet certain specified Federal requirements which guarantee minimum standards of quality of services as well as equal treatment and access to services for all eligible beneficiaries of the program. In addition, as of March 1971, the following basic services were mandatory for States participating in the Medicaid program: inpatient hospital care, outpatient hospital services, laboratory and X-ray services, skilled nursing home services for persons 21 or older, home health services for any eligible individual who is entitled to skilled nursing home services, screening and treatment for individuals under 21 as may be provided in regulations of the Secretary of HEW, physicians services, and transportation. It should be noted, however, that definitions and limitations of these benefits vary greatly from State to State. States also have the option of providing any other medical and remedial services recognized under State law.

Payments to a State are made on a matching basis as long as the State's plan and operation are in compliance with the requirements of title XIX of the Social Security Act and title VI of the Civil Rights Act of 1964. The proportion of Federal matching is based on a Federal medical assistance percentage formula, which is computed according to the per capita income of a State. The amount of Federal matching varies from State to State and ranges from 50 to 83 percent. In terms of the costs incurred by the States to finance Medicaid, the Federal share of the program is 54 percent on the average, with the remaining 46 percent derived from State and local funds. States with large nonmetropolitan populations need and receive more Federal funds with lower matching requirements, and States with greater population concentrations in metropolitan areas have greater matching requirements.

All participating States (only Alaska and Arizona have not applied for participation) are required to provide basic Medicaid benefits to all categorically needy recipients (all public assistance recipients—the aged, blind, disabled, and families with dependent children). In addition, States have the option to provide benefits to the medically indigent—those families and individuals who are ineligible for public assistance, but whose incomes are insufficient to obtain necessary medical care, and all children under 21 whose parents cannot afford medical care. Due to the variations of State standards for eligibility in the categorical programs, and the fact that Medicaid has no nationally uniform income levels for eligibility, each of the 52 States and jurisdictions operate 52 distinct and different Medicaid programs. Income eligibility levels for the medically needy are tied to cash assistance payment levels (they can range from 100 to 133 percent of payment levels) and, thus, also vary from State to State.

Of the 25 States which do not have programs for the medically indigent, the range in income eligibility for a family of four varies from $2,376 a year for the lowest State, South Carolina, to $4,188 for Maine, the highest State. Among the 27 States and jurisdictions with medically needy programs, the comparable range for income eligibility is $2,600 in Oklahoma and $5,000 in New York State.

Total Federal obligations for the Medicaid program in fiscal year 1970 were close to $2.8 billion, of which approximately 37 percent went to nonmetropolitan areas. This relatively high percentage, compared to other proportions for service programs, reflects the large number of

people in rural areas who are eligible for public assistance, and concomitantly, Medicaid. This percentage most likely also reflects the fact that the proportion of Federal funds to nonmetropolitan areas is significantly greater than in metropolitan areas. If more States with large numbers of nonmetropolitan residents were able to support programs for the medically indigent, the percentage figure might be even higher.

BARRIERS TO PARTICIPATION

It must be remembered, however, that the inability of many of the more rural States to provide significant matching funds limits their capability to provide any but the minimal required services necessary to participate in the program. Although these services have begun to make some marginal impact on the health status of the rural poor, there are still some significant problems in reaching potential beneficiaries.

Since Medicaid services must be provided through certified providers, and since many physicians and hospitals located in nonmetropolitan areas are unwilling to participate in the program because of bureaucratic redtape and the delay in reimbursement for services, Medicaid eligibles may have to travel long distances to receive services. Although the patient's transportation may be covered under the program, the patient may not consider the hardship of travel worth the value of services.

Another problem exists in beneficiary eligibility. Although the program is available to all recipients of public assistance, there is some resistance to receiving welfare assistance, especially in the backwoods areas of Appalachia. Not only pride prevents these people from accepting charity, but the State and Federal requirements attached to welfare money, such as being forced to send children to school (book-learning education is not a value in many rural areas), and house investigations discourage the more rural populations from signing up for welfare. These people are automatically excluded from the Medicaid program if the State adheres strictly to the categorical needs program.

Much can be said about the exclusion of the medically indigent in many State programs, as well as the definition of medically indigent which is applied across the board in each State. Suffice it to say that the exclusion of the medically indigent, especially in States which are predominantely nonmetropolitan and, concomitantly, tend to have lower levels of income eligibility for assistance payments, occurs most often in the States where a "medically needy" category would have most impact. Support of such a program, however, is hindered by the States' inability to provide matching funds and the rapidly increasing costs of medical care.

SOCIAL SERVICES, ADMINISTRATION, TRAINING, AND DEMONSTRATION PROJECTS

Social services programs are funded by formula grants to States based upon their estimates of requirements for matching Federal funds at the 3 to 1 Federal-State ratio. The purpose of the grants is to provide social services to needy individuals, specifically those covered under public assistance programs.

Federal funds may be used for the operation of social service programs to provide legal services, family planning, family counseling, child care, housing improvements, and information or referral services. Each State plan must be approved by HEW. Despite the great need for these services in rural areas, matching requirements limit nonmetropolitan participation. Programs for transportation for staff and recipients aggravate the situation because of greater distances between service centers and recipients.

Administrative assistance provides formula grant moneys to States. The Federal Government pays 50 percent of the cost of administering the five income maintenance programs. Because of higher overhead, operating costs, and larger staffs, urban States receive more funds than rural States.

Training programs are more expensive in nonmetropolitan areas. The statewide requirement, however, encourages more even distribution of training funds. These programs train personnel employed or preparing for employment in State and local agencies administering public assistance plans.

Demonstration grants fund experimental pilot projects to develop and improve public assistance administration. Because these project grants require no matching requirement, more nonmetropolitan areas can take advantage of them. Examples of rural-oriented programs include:

(1) Services integration in rural and suburban areas;
(2) Prepaid medical/dental plans for rural areas; and
(3) Housing improvements in four rural counties.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

MAINTENANCE PAYMENTS

13.703 Aid to Families with Dependent Children
13.704 Aid to the Blind
13.705 Aid to the Permanently and Totally Disabled
13.709 Emergency Welfare Assistance
13.722 Old-Age Assistance

MEDICAL ASSISTANCE

13.714 Medical Assistance Program

SOCIAL SERVICES, ADMINISTRATION, TRAINING AND DEMONSTRATION PROJECTS

13.723 Public Assistance Demonstration Grants
13.724 Public Assistance—State and Local Training
13.741 State and Local Administration of Public Assistance
13.754 Public Assistance—Social Services

SOCIAL WORK—MANPOWER TRAINING

Training grants for the development of personnel for social work are given to colleges, universities, and associations of such schools to meet part of the costs of development, expansion, or improvement of undergraduate programs in social work and programs for graduate training of professional social work personnel. Grants for graduate training are limited to faculty, their supporting personnel, and minor improvements to existing facilities.

Project grants for social work manpower training require matching funds equal to 10 percent of the project. State welfare agencies that

are prospective employers review project applications for appropriateness of the proposal to agency employee needs.

In fiscal year 1970 and 1971, one-sixth of the projects funded were especially relevant to nonmetropolitan areas. Another one-eighth were awarded to colleges who draw large portions of their student bodies from nonmetropolitan areas.

The primary factor preventing additional moneys from going into nonmetropolitan areas is the capacity of educational institutions in such areas to incorporate social work training into their curricula. Total program obligations for fiscal year 1970 amounted to $3 million, which limits the amount of the average grant, especially considering that funding is only available for one out of three applicants.

For additional information on the program discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.740 Social Work Manpower—Training Grants

WORK INCENTIVE PROGRAM—CHILD CARE

The work incentive program (WIN) is administered by the Department of Labor in cooperation with HEW. Its objective is to help persons receiving AFDC become self-supporting. HEW funded $85.8 million for the training and allowances parts of WIN, which are administered solely by the Department of Labor. HEW also contributes social services and support to the program through the regular maintenance payments programs. Also under WIN, and administered by HEW, State and local welfare agencies provide necessary child care for persons referred to them by State public employment offices for training. Persons employed as a result of WIN programs continue to receive financial help with child care until other satisfactory child care arrangements can be made.

All care outside the child's own home must be in facilities that meet Federal interagency day-care requirements, in addition to meeting State and local licensing requirements. Because of the unavailability of day-care centers to WIN referees, most eligible families must make other arrangements. For example, in Allegheny County, Pa., 1,319 children are receiving day care. Of these, 1,051 remain in their own homes; 89 are cared for in relatives' homes; 105 are in nonrelatives' homes. Only 77 are enrolled in approved day-care centers.

WIN child care programs are funded with the Federal Government providing $3 for each $1 State and local funds. So far, enough Federal funds have been appropriated to match State funds, despite a close-ended appropriation. State appropriations have been small, however, often too limited to establish programs which (1) allow all WIN applicants to be refunded, and (2) develop the needed child care spaces.

WIN is basically an urban program with localities for projects chosen by the Department of Labor. Nonmetropolitan areas do not usually have day-care facilities outside of in-home care. Rural States also have more trouble meeting the 25 percent matching requirement.

For additional information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.748 Work Incentive Program—Child Care
17.226 Work Incentive Program—Training and Allowances (DOL)

VOCATIONAL REHABILITATION

Vocational rehabilitation concentrates on programs to prepare handicapped individuals for gainful employment. The definition of handicapped has expanded in the past decade to include physically, emotionally, and mentally disabled individuals. Recently, vocational rehabilitation budget justifications have included the "socially disabled" as part of the handicapped employable category.

Rural areas present certain problems for rehabilitation programs. Centers for training must have adequate facilities for transportation and client followup. Employment placement is difficult in nonindustrialized areas. Innovation services must be developed to meet the needs of these areas. Money for vocational rehabilitation is allocated directly by the State by a formula grant with 20 percent matching requirement.

SERVICES

Most of the service programs are either operated directly by the State vocational rehabilitation agency or depend on the agency to refer applicants.

Services for social security disability beneficiaries are operated by the State and deal with the individual regardless of his geographic location. Basic support grants in vocational rehabilitation place the handicapped in employment after referral from State agencies. The isolation of most rural people from centralized services such as State vocational rehabilitation, plus the transportation problem, which might be aggravated in the case of a handicapped individual, prevents the nonmetropolitan population from fully benefiting from employment referral services.

In a few rural areas, programs try to serve the local needs through mobile evaluation units and placement of counselors for handicapped clients in rural hospitals.

Some grants are aimed at expanding or developing innovative vocational rehabilitation services in specific geographic areas within States. Project plans which call for the expansion of services to nonmetropolitan areas are to be given priority consideration according to the legislation. Project expansion in rural areas has included the use of mobile evaluation units and the establishment of outreach stations scattered throughout the State.

Employment projects have been established with industry and business enterprises. The State vocational rehabilitation agency determines which individuals are eligible. Since most large industry is located in urban areas, the program has had little impact in nonmetropolitan areas.

The most recent project development has been in new career opportunities. New career programs attempt to help both the underemployed and the unemployed.

Handicapped and nonhandicapped individuals are trained to work in rehabilitation and other public service agencies. Hopefully, the availability of human service agencies on a decentralized statewide basis will encourage full-time placement of new trainees equally distributed in urban and rural areas.

FACILITIES AND TRAINING

Facility improvement grants are awarded on the basis of State plans outlining facilities needs. Priority in facilities and construction is to be given to plans for regional services to nonmetropolitan areas. Programs for technical assistance for innovation and initial staffing of new facilities are also available.

Very little research and demonstration is going on in nonmetropolitan areas. There are a few projects concerned with methods of comprehensive health care in rural areas. Use of a "hotline" among professionals, medical students in isolated areas, and a method of systematic followup of out-patients are now being tried in a few States.

Training rehabilitation personnel and keeping them up to date is a part of vocational rehabilitation grant programs. Most of the training is on a professional level, and refresher courses deal mainly with new concepts of "handicapped" and how to treat them.

In fiscal year 1970, a special grant was made for the preparation of a training guide on "Rehabilitating the Disadvantaged Disabled in Rural Settings."

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.728 Rehabilitation Research and Demonstration Grants
13.729 Rehabilitation Research and Training Centers
13.730 Rehabilitation Services Projects—Projects with Industry
13.731 Rehabilitation Service Projects—Expansion Grants
13.732 Rehabilitation Service Projects—Innovation Grants
13.733 Rehabilitation Training
13.742 Rehabilitation Facilities Projects—Improvement Grants
13.743 Rehabilitation Service Projects—Initial Staffing
13.744 Rehabilitation Facilities Improvement Grants—Technical Assistance.
13.745 Rehabilitation Services Training Grants
13.746 Rehabilitation Services and Facilities—Basic Support
13.747 Vocational Rehabilitation Services for Social Security Disability Beneficiaries.
13.749 Rehabilitation Service Projects—New Career Opportunities
13.755 Vocational Rehabilitation—Construction Grants

SOCIAL WELFARE COOPERATIVE RESEARCH AND DEMONSTRATION GRANTS

Social welfare cooperative research and demonstration grants provide support for research on problems relating to the prevention and redirection of dependency, and to improve the administration and effectiveness of programs carried on under the Social Security Act,

This program also includes contracts for cooperative arrangements with States and nonprofit organizations for the conduct of research and demonstration projects relating to such studies.

The purpose of the program is to evaluate and add to existing knowledge new approaches to such matters as (1) the prevention and reduction of economic dependency; (2) more effective organization, coordination, and administration of social welfare and social security programs; and (3) the provision of medical and social services authorized by the Social Security Act.

Federal funding is through project grants with a matching requirement of 5 percent. Grants are limited to States, public and other nonprofit organizations. Contracts may be executed with nonprofit or profitmaking organizations.

In fiscal years 1970 and 1971, SRS funded research programs which included demonstration, innovation, or special projects components. One such project, conducted in Cincinnati, Ohio, studied the effect on families and individuals when public relief was exhausted in a rural community. Another study, conducted in Boston, examined welfare aide positions in social and health services for an American Indian community. Others included a field survey of migratory farm labor in Wisconsin, a study of withdrawals from active occupational roles by certain occupational groups in a rural area, and a study of the identification of poverty in a rural area.

Given the fact that [illegible] ntage of nonmetropolitan residents are on some kind [illegible] ance, social welfare cooperative research and demo [illegible] rograms do have relevance. Additionally, they ha [illegible] ial ability to effect changes in [illegible] vice delivery with respec[illegible] ural area residents, particularly those receiving some form of public assistance.

For further information on the program discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.739 Social Welfare Cooperation Research and Demonstration Grants.

MENTAL RETARDATION—DEVELOPMENTALLY DISABLED

Mental retardation programs are going through a change that is being experienced throughout the health service fields. Until recently, the objective behind programs for mentally retarded children relied heavily on a consolidation of the population into institutions. Due to the social stigma behind institutionalization, most facilities are found in rural isolated areas, and are not designed to serve the mentally retarded according to their individual needs. There is, hopefully, a movement away from this kind of institutionalism toward community facilities, which are more oriented toward individual and local needs.

In urban areas, sheltered workshops, day-care, and rehabilitation centers are becoming more common. As yet, there are few facilities for areas with dispersed populations. It has been difficult for people to estimate what proportion of the 3 percent mentally retarded in this country are rural. Because the mentally retarded in the city are easier to locate and, therefore, seem to present the largest number of the retarded population, they have received the most care.

The 1960 White House Conference on Children and Youth recommended:

> That community facilities for diagnosis and identification be readily accessible to anyone suspected of a mental handicap . . . direct special attention to the needs of rural areas.

In the past decade it has become more apparent that the number of mentally retarded in rural areas is at least equal to those in urban areas.

Technological influences on rural areas have resulted in changes in life style, which demand new approaches to mental retardation. Increased mobility, including access to neighboring small towns, has influenced family treatment of mentally retarded children. Diagnostic facilities have made farm families more aware of what mental retardation is and have begun to break through the myth of the "different" child. The consolidation of schools with better screening, but without special education classes, has eliminated the mentally retarded child from community education facilities.

The older notion that the family cared for its own is being subjected to the same pressures urban families had experienced years ago. Mobility, lack of education opportunity, danger, and economic usefulness all play a part in changing some rather fundamental values of rural farm life. This, of course, has been complicated by the greater life expectancy for profoundly and severely retarded children.

As sophistication on the part of rural families increases concerning the nature and treatment of mental retardation, so will demands increase not only for institutions but for better home care facilities, special classes, sheltered workshops, day-care centers, etc.

SRS programs are primarily service oriented. The hospital improvement program has always been oriented toward models of new and improved techniques of care and treatment of an identified group of residents within State institutions for the mentally retarded. As of fiscal year 1972 the emphasis will be altered to demonstrations of techniques for providing alternatives to institutional care through development of community resources.

There is also a program for initial staffing of community service facilities. Funds for the initial cost of staffing in new community facilities or new services in already existing facilities are available to public or nonprofit agencies. About 2 percent of the money is presently spent in nonmetropolitan areas.

The rehabilitation service projects program is for the mentally retarded who do not fall under vocational rehabilitation services. There is an emphasis on providing services in community facilities. While priority is put on rural and urban poverty, most of the program (98 percent of the money) is concentrated in urban areas.

A basic support grant is available to State agencies to encourage and develop a comprehensive plan for treatment of the developmentally disabled. Assistance is by formula grant with matching requirements, which vary between regular areas (75 percent) and poverty areas (90 percent).

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.715 Developmentally Disabled—Community Service Facility Initial Staffing
13.717 Developmentally Disabled—Hospital Improvement Program
13.718 Developmentally Disabled—Rehabilitation Service Projects
13.753 Developmentally Disabled—Basic Support

CHILD WELFARE

Child welfare services work to establish, strengthen, and extend child welfare to protect and care for homeless, dependent, and neglected children, and children in danger of becoming delinquent.

A uniform grant of $70,000 is made to each State, as well as an additional grant which varies directly with child population under 21 and, inversely, with per capita income. The formula half of the grant allows for a greater portion of the money to go to more populated States.

While child welfare encourages innovative projects (rural and urban), the central office has no mechanism for receiving and recording such programs even for general information purposes.

Research and demonstration projects can be operated by public or nonprofit institutions, universities, or public agencies. These kinds of demonstrations relate to some aspect of child welfare delivery such as service centers for families of children who are neglected or abused, services to young mothers, day care for working women, and other child care services. About 2 percent of the money allocated to research and demonstration is spent in rural areas.

Training programs are contracted through universities, mainly with social work schools. There are three different types of grants used to strengthen resources for training personnel: traineeships for students, project grants for teaching, and short-term training projects.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.706 Child Welfare Research and Demonstration Grants
13.707 Child Welfare Services
13.708 Child Welfare Training

DEVELOPMENT OF PROGRAMS FOR THE AGING

There are 1.5 million individuals over 65 who live on less than $600 a year. Millions of others live in poverty as couples. In 1900, there were fewer than 4 million Americans over 65; today there are more than 20 million. In 1920, more than 30 percent of the aged were working; today only 20 percent are in this category. Science is increasing longevity, but it is taking away jobs, making the elderly obsolete. Through the Administration on Aging and other SRS offices, HEW is trying to meet the needs of older people in their home communities.

There are major fund allocations to State aging agencies to help them provide local community services and opportunities for their older residents. Under these programs, more than 1,000 communities have established services related to health, housing, transportation, nutrition, education, and recreation for the aging.

PLANNING AND EVALUATION

Formula grants provide Federal money for statewide planning coordination, evaluation, and administration. Funds are also made available to assist local communities to carry out service and training programs. The formula takes into consideration the number of persons aged 65 and over in the State. The States with larger aged populations (which are usually the larger, more urbanized States) receive more funds. State agencies may then use funds to pay part of the cost of community projects on a decreasing matching basis (75 percent first year; 65 percent second year; 50 percent subsequent years). Nonmetropolitan areas do not always have the leadership and financial resources to meet these requirements. If legislation permitted different or special matching ratios, the programs would likely be more accessible to nonmetropolitan areas.

VOLUNTEER SERVICES

Two programs provide the opportunity for volunteer service for persons 60 years of age and over. The retired senior volunteers program places persons in their own or nearby community agencies. Although the program presently operates at the same level in metropolitan and nonmetropolitan areas, the scarcity of resources in non-SMSA's plus the physical and social isolation of rural America makes potential nonmetropolitan impact tremendous. The foster grandparent program provides services to children with special needs in institutional settings. The criteria to become a foster grandparent is an adult of retirement age who is classified as low income and "is considerate and understanding" of children. The foster grandparent receives a stipend, transportation, meals, and physical exams.

There is little money in these programs and the Administration on Aging has discouraged potential applicants from submitting applications during the last several years, since no funds were available for new projects. Of the few programs in existence, approximately one-third are located in nonmetropolitan areas. Several of the programs located in metropolitan areas draw foster grandparents from nonmetropolitan areas as well. Sixty-eight percent of the foster grandparent programs are located in SMSA's, and approximately 64 percent of older persons reside in SMSA's.

RESEARCH AND DEVELOPMENT

Projects operate under direct project grants with 10 percent non-Federal matching requirements. Programs are submitted by State agencies and private nonprofit agencies. If the agencies were to develop a specific strategy for nonmetropolitan areas that selected program settings and arranged transportation, the programs could have more application in rural areas.

Research and development grants fund projects which test creative ways to improve the lives of the elderly and gain reliable information about their status and needs. The number of grant projects in urban or suburban areas exceeds those in nonmetropolitan areas. One reason for this appears to be the large number of projects in Model City neighborhoods subject to earmarking requirements; there could be earmarking of funds for projects in nonmetropolitan areas, analogous to Model City earmarking. Another reason may be the 10 percent matching requirement.

Training grants provide funds for three areas of study:

(1) Planning and administration of programs for the elderly;
(2) Teaching and research in aging; and
(3) Providing direct services to older people.

Funding is by project grants to institutions. Most funds (88 percent) go to metropolitan areas where research facilities are located.

For further information on the programs discussed above, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.700 Aging—Grants to States for Community Programs.
13.701 Aging—Research and Development Grants.
13.702 Aging—Training Grants.
13.710 Aging—Foster Grandparents.
13.750 Aging—Grants to States for Areawide Model Projects.
13.751 Aging—Grants to States for Statewide Planning, Coordination, Evaluation, and Administration.
13.752 Aging—Retired Senior Volunteers.

JUVENILE DELINQUENCY

Many people think juvenile delinquency is solely an urban problem. Statistics indicate, however, that juvenile delinquency is also a serious problem in nonmetropolitan areas. In 1964, for example, the rate of delinquency court cases per 1,000 child population was 33.9 in strictly urban areas, 23.6 in semiurban areas, and 10.6 in rural areas. These statistics are somewhat skewed, nevertheless, since potential rural delinquents are often handled through extra-official channels. Offenses often go undiscovered. While the problem may seem more acute in metropolitan America, it is extremely serious in nonmetropolitan areas.

"Juvenile delinquency" refers to youths who have engaged in some behavior which has resulted in their being processed by juvenile authorities. Efforts in the past have aimed largely at changing individual personalities in order to eliminate delinquency. Recent theory has indicated that changing the social situation may be more strategic in the prevention or elimination of delinquency. The goals of the program are twofold and must be pursued concomitantly:

(1) To eliminate social conditions which obstruct conforming behavior by modifying present arrangements and creating new ones for vulnerable youth.

(2) To improve the social skills of youth so that they may grasp the opportunities which do exist.

Most Federal juvenile expenditures (almost 70 percent) are in metropolitan areas. Planning, prevention, and rehabilitation programs help States and communities to:

(1) Prepare comprehensive plans for controlling delinquency.

(2) Provide diagnosis, treatment, rehabilitative, and preventive services.

(3) Develop community based alternatives to institutionalizing youths.

Resources are allocated by project grants, according to priority needs. The Federal share for planning may not exceed 75 percent, and for rehabilitation programs the Federal share may not exceed 60 percent. Poor rural areas may have trouble meeting these requirements.

Training programs, designed to increase the number and upgrade the quality of youth service personnel, are focused, primarily, in the metropolitan region. The agency reports that in order to increase program training, more funds are needed for grantees.

Model programs aid projects that will develop and improve techniques and practices in the delinquency field. Expert technical assistance is also offered. All local applicants must submit copies of their application to the clearinghouse and the designated State agency. The Federal Government may finance up to 100 percent of program costs. A system project specifically designed for rural areas is currently being developed in Montana.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.711 Juvenile Delinquency Prevention and Rehabilitation.
13.712 Juvenile Delinquency Prevention and Control—Model Programs and Technical Assistance.
13.713 Juvenile Delinquency Prevention and Control—Training of Youth Service Personnel.

G. SOCIAL SECURITY ADMINISTRATION

SOCIAL SECURITY

Social Security benefits cover all but 7 percent of the Nation's workers. Of those 7 percent 3 to 4 percent are Federal employees and State and local civil servants. Each State can determine whether to put its public workers under social security. The remaining 3 or 4 percent not covered are domestic workers who make less than $50 in a calendar quarter, self-employed individuals who earn less than $400 a year, ministers who take a poverty oath, and certain farm laborers.

Agriculture laborers have been covered by social security since 1950. Social Security attempts to reach as many as possible of the rural population. Probably one of the most difficult groups to cover has been the migrant worker. According to social security legislation, farm laborers are only entitled to social security if they meet two criteria: first, if their pay is more than $150 for a given year; and second, if they have worked 20 days a year on an hourly basis. Those workers who follow the migrant stream have difficulty meeting these social security standards.

Another problem for migrants trying to qualify for social security has been the inadequate methods of withholding money. Too often social security is taken out of the [illegible] in the pockets of crew managers.

Social security benefits include retirement and survivors benefits, special benefits for persons over 72, and disability insurance.

Benefits are paid only to persons who gain "insured status," which depends on the number of quarters of coverage on their social security earnings record. A quarter is considered covered if the individual receives at least $50 of wages or is credited with $100 of self-employment income in that quarter.

The basic old-age benefit is paid to workers retiring at age 65 or over. It varies from a minimum of $55 to a maximum of $218 per month, depending on the individual's average monthly wage when he was working. A transitionally insured status, set up under the 1965 law, provides a special minimum benefit to otherwise ineligible persons who reached the age of 72 prior to 1969.

Based on overall sources of income, social security benefits represent some 25 percent of the income of all individuals over 65. There are no data available that distinguishes between urban and rural recipients.

Disability insurance is paid to workers who are totally disabled after 6 months from the onset of the disability. Disability benefits are computed in the same way as old-age benefits, but disability payments tend to be larger, on the average, because the stricter qualification requirements eliminate low-paid, irregularly employed workers. The disability must be so severe that the individual is unable to engage in any kind of substantial work that exists in the national economy, re-

gardless of whether such work exists in the immediate area in which he lives, whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

Determinations of disability are generally made by State agencies (usually the State vocational rehabilitation agencies) under agreements with the Federal Government and on a reimbursable basis.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

Of special significance to nonmetropolitan areas are the 1969 Social Security Amendments that provide special benefits to miners who are totally disabled by black lung disease or to their widows.

Pneumoconiosis is a chronic lung disease caused by breathing dust in underground coal mines. This debilitating disease causes shortness of breath and is eventually fatal.

The miner or his widow must prove that pneumoconiosis was the sole cause of disability and that it arose out of employment in an underground coal mine. The "total disability" clause, however, prevents many miners from receiving compensation and forces them to either continue mining (if they are healthy enough), try to find other work in mining towns (which is extremely difficult), or go on public assistance.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.802 Social Security—Disability Insurance
13.803 Social Security—Retirement Insurance
13.804 Social Security—Special Benefits for Persons Aged 72 and Over
13.805 Social Security—Survivors Insurance
13.806 Special Benefits for Disabled Coal Miners

HOSPITAL INSURANCE FOR THE AGED

The tremendous increase in medical knowledge in the last 40 years, leading to the lengthening of the average lifespan of all Americans, and concomitantly, the increased number of retired persons over 65 living primarily on social security benefits, pointed to a significant need to finance health care for the 8 percent of the population over 65. Since the elimination of many previously threatening short-term acute illnesses, the more serious chronic diseases have become the primary causes of sickness and death in our society. These diseases often originate earlier in one's life, but the lack of proper preventive measures, complicated by the degenerative processes accompanying old age, force symptoms and manifestations of these illnesses to become more acute in later years. It is in these years, the years after retirement when income is limited, that illness is most devastating, both physically and financially.

The need for financing health care and ensuring that quality health care would be available to older people, both within a hospital and outside, became a right for all Americans over 65, who are entitled to social security benefits, under title XVIII of the Social Security Amendments of 1965. The Health Insurance for the Aged program, commonly called Medicare, was implemented in July of the following year.

HOSPITAL INSURANCE

There are two distinct parts of the Medicare program. One is hospital insurance (part A). The other is supplementary medical insurance (part B). Hospital insurance provides insurance protection for covered hospital services to any person 65 or over who is entitled to social security or railroad retirement benefits. The objective of the program is to help the aged meet the costs of most services ordinarily furnished in hospitals, extended-care facilities, and by home health agencies, through a program of prepaid hospital insurance. Excluded from hospital insurance coverage are personal comfort and convenience items, private duty nurses, private rooms unless medically necessary, physicians' services, and custodial care. This insurance is financed by social security deductions, paid by employers, employees, and self-employed individuals.

All persons 65 years or over, who are entitled to social security benefits or their dependents, are automatically covered. Many people who were not eligible for social security or railroad retirement benefits, but who became 65 before 1968, qualified for hospital benefits by filing under certain transitional provisions included in the law. Although these provisions are still in force, they have been restricted by the addition of certain work requirements in the last few years.

For each benefit period during which a patient is hospitalized, the program pays the provider (health institution) the costs of up to 90 days of inpatient hospital services, 100 days of extended care, and 100 home health visits. The beneficiary is responsible for the first $60 of inpatient hospital care for each benefit period, $15 per day for the 61st through 90th day of inpatient hospital care, and $7.50 per day after 20 days of care in an extended-care facility. In addition, the 1967 Amendments to the Social Security Act provide each Medicare beneficiary with a lifetime reserve of 60 days of hospital care if the 90 days covered for one illness have been exhausted. Beneficiaries pay $30 a day for each day of lifetime reserve used. Once the beneficiary meets each deductible as noted, the program pays the full reasonable costs (including both direct and indirect costs) of covered services.

In fiscal year 1970, total national expenditures for health and medical care were $67.2 billion, of which Medicare accounted for 10 percent. Of total national health expenditures, 7.1 percent were paid under the hospital insurance program. Of the total national outlays ($67.2 billion), $24.9 billion was paid from public sources. Medicare represented 28.6 percent of all public spending. Over 90 percent of the total spending for hospital care for the aged came from various public sources, and more than 65 percent of those public expenditures came from Medicare.

State health departments determine whether the institution, agencies, and laboratories within the State that wish to participate in the program meet the requirements for participation. State health departments also resurvey participating institutions periodically, consult with them in establishing and maintaining utilization review standards and procedures, and assist them in attempts to improve their services. The Medicare program in turn reimburses State health departments for the costs of performing such services and for a share of

the costs of planning the coordination of their Medicare activities with related activities in the health field.

One important criterion for a hospital to participate in the Medicare program is compliance with the Civil Rights Act, particularly title VI, which prohibits participating hospitals and extended-care facilities from practicing any policy of racial segregation in rendering services. Another requirement for participation in the program is accreditation by the Joint Commission on Hospital Accreditation. To be accredited, an institution must meet certain standards, such as adequate nursing staff, accessible fire escapes, etc. Approximately 95 percent of the licensed general hospitals in the country are certified for participation in the program, but those that have not applied or are not certified are primarily located in the predominately rural States. As a result, many aged persons in these areas, both black and white, are being denied access to facilities for hospital care to which they are legally entitled.

Lack of transportation to facilities also makes it difficult for elderly rural residents to receive medical services, whether or not under the Medicare program.

Another problem faced by the elderly in nonmetropolitan areas is the inability to meet the various deductibles and cost-sharing requirements. Since the aged in nonmetropolitan areas generally receive lower social security benefits than the aged in urban areas (because their original earnings base was lower), they are less able to afford even the initial deductible and coinsurance required by the program.

SUPPLEMENTARY MEDICAL INSURANCE

Supplementary medical insurance, part B of Medicare, covers physicians' services, out-patient hospital services, medical services and supplies, out-patient physicial therapy, and drugs and biologicals that cannot be self-administered. The objective of this part of the program is to help beneficiaries pay bills for physicians' services and certain other medical services and supplies which are necessary but are not covered under the hospital insurance program (part A).

Supplementary medical insurance is funded through a voluntary program of medical insurance financed by beneficiary premium payments and matching payments from the Federal Treasury. Benefits are paid for covered services on the basis of reasonable charges for necessary services furnished by providers, such as doctors, hospitals, and extended-care facilities. Services not covered include routine physical checkups, routine foot care, orthopedic shoes, eye examinations, hearing examinations, immunizations, routine dental care, cosmetic surgery, personal comfort and convenience items, and services not reasonable or necessary for diagnosis or treatment.

All persons 65 years or older may apply for supplementary medical insurance. Applicants who wish to participate in this program are encouraged to sign up during the 3 months prior to their 65th birthday. Each enrollee currently pays a monthly premium ranging from $5.60 to $7.30, depending on when he signed up for the program. The Federal Government matches this premium. After the enrollee meets an

annual deductible of $50, the program pays 80 percent of the reasonable charges for covered services. "Reasonable charges" are based on the charge a provider (physician, hospital, etc.) customarily makes for a given service and the prevailing charges among doctors and hospitals in the same area for a similar service.

Total Medicare obligations for fiscal year 1970 amounted to $6.8 billion. Supplementary medical insurance amounted to $2 billion. Of total expenditures for physicians' services for the aged, 80.1 percent came from various public sources. Medicare accounted for more than 71 percent of these public expenditures.

The Medicare law mandates that a uniform reimbursement formula be applied throughout the country. The formula itself provides for no State to State variation in either the level of covered services or the amount paid for those services.

Since the formula requires, however, that Medicare reimbursement for a given service not exceed prevailing charges in an area, there may be variations from locality to locality within a given State in the amount paid for services, depending upon the level of prevailing charges among physicians in an area. The overall effect of this may be that prevailing charges may be generally lower or higher in one State than another, and that the amount of reimbursement may vary from State to State.

As mentioned earlier, the supplementary medical insurance program is based on voluntary enrollment by the individual. A large majority of the aged in metropolitan areas have enrolled in this program. In 1967, 93 percent of all persons in the United States over 65 had enrolled in part B. In the 10 most urban States, the rate of enrollment was higher than the national average. Among the aged living in nonmetropolitan areas enrollment was significantly less. Only three of the 10 most rural States had more than 93 percent of the aged population enrolled in the supplementary insurance program.

It can be assumed that many elderly residents in nonmetropolitan areas are not easily able to afford to pay the deductible or monthly premiums. This fact would account for the lower rate of enrollment in nonmetropolitan areas. Another factor mentioned earlier, which would also account for low enrollment, is the unavailability and inaccessibility of physicians and other services. There is less reason or motivation for nonmetropolitan residents to enroll, since, in many cases, they are unable to reap the full benefits of the programs.

The Medicare program has had considerable impact in nonmetropolitan areas in terms of improving the quality of medical care provided to the aged. It has also enabled the aged to receive services that they previously could not afford. One feature of the Medicare amendments provides for improved services for the indigent, both old and young, under the Medicaid program. These services are largely limited to certain categories of the poor, but the law does permit Federal matching of State funds for medically indigent persons,[1] even if they

[1] For further explanation of medically indigent persons under the Medicare program, see part F, Social and Rehabilitation Service, Grants to States for Public Assistance, Medical Assistance Programs, pp. 56-58.

are not receiving cash assistance. Under the Medicaid program, States may agree to pay the monthly premiums of needy and low-income Medicare beneficiaries who are eligible for Medicaid. All persons 65 and over, who become medically needy after the agreement is signed, are automatically covered. However, it is still necessary for the States to put up approximately half the cost of medical care for the poor, and this keeps the economic potential of rural States considerably lower than that of urban States.

It is to the problems stated above that Medicare should address itself to enhance the delivery of medical care services to elderly persons in rural as well as urban sections of the country.

For further information on the programs discussed in the above summary, see OMB, *Catalog of Federal Domestic Assistance*, June 1971.

13.800 Health Insurance for the Aged—Hospital Insurance.
13.801 Health Insurance for the Aged—Supplementary Medical Insurance.

H. PROGRAMS JOINTLY FUNDED OR ADMINISTERED BY HEW

MANPOWER DEVELOPMENT

Two programs in manpower development are cooperative ventures involving several Federal agencies as well as local leaders and organizations. Concerted services in training and education (CSTE) is an approach to rural community development. Programs under the Manpower Development Training Act tend to emphasize urban development problems.

CONCERTED SERVICES IN TRAINING AND EDUCATION

CSTE is a pilot effort to improve smaller communities and rural areas by demonstrating that education and occupational training, in conjunction with other development activities, can significantly help to increase employment opportunities. It is especially concerned with the 3 million rural residents aged 25 and over who have less than 5 years of schooling, and the 19 million who have not completed high school. Only about half as many rural eligible youth, compared with urban youth, go to college.

A major CSTE function is to plan and coordinate pilot projects at the Federal level. Local, State, and Federal representatives meet to identify manpower needs and bring available resources together. The project coordinators are well-trained local residents with a good knowledge of the people and their problems. Coordinators are kept abreast of changes in Federal education and training programs in semiannual conferences, in which representatives of the cooperating Federal agencies participate. The experience gained in the pilot projects has encouraged Government agencies to place greater emphasis on interagency approaches to manpower problems.

Several of the Federal agencies take turns in paying the salaries, secretarial costs, and travel expenses of local coordinators. For example, in Arkansas, local administrative costs are underwritten by the Manpower Administration of the Department of Labor, while in Kentucky, the cost of local coordination is shared by the Tennessee Valley Authority, the State Division of Vocational and Technical Education, and the State Extension Service. Each year, these administrative costs have averaged about $25,000 per area. HEW funds are used primarily to fund coordinated projects from regular grant moneys.

MANPOWER DEVELOPMENT AND TRAINING

Manpower Development and Training Administration (MDTA) programs are jointly administered by the Departments of Labor and HEW. These programs provide classroom occupational training and related support services for unemployed and underemployed persons who cannot obtain appropriate full-time employment. Brief refresher training for unemployed professionals is also offered.

The Department of Labor carries out labor market surveys to locate concentrations of individuals who are without employment or who are underemployed. Through State employment agencies, eligible persons are counseled and referred to an MDTA program. HEW is required to fund all instructional and classroom training. Some programs are established by joint agreement between the State employment and educational agencies. Other programs are arranged by special joint contracts between DOL and HEW and the sponsoring organization (for example, the Marine Cooks and Stewards Union training program). After training is completed, DOL is responsible for placement and followup.

All HEW funds come through DOL appropriations; the fiscal year 1970 figure was $157,311,985. Unlike most HEW programs, MDTA grants are cost-reimbursable, i.e., payments to sponsors for services offered. Lack of a matching requirement should make these programs especially relevant to nonmetropolitan areas. Still, they focus primarily on the visible urban unemployed. Only about 10 to 15 percent of the trainees are rural residents, and approximately one-eighth of the total funds go to projects located in nonmetropolitan areas.

APPALACHIAN REGIONAL COMMISSION (ARC)

Appalachia, a nonmetropolitan region which stretches across parts of 13 States, is an area of economic and human distress. Income, employment, and educational achievement are far below the rest of the Nation. Infant mortality, adult illiteracy, and dilapidated housing are all far more widespread in Appalachia than in the rest of the Nation.

The Appalachian Regional Commission was established to combine the resources of the 13 Appalachian States and 10 Federal departments and agencies. Two goals have been enunciated: (1) providing the people of Appalachia with the health and skills they require to compete for opportunity wherever they choose to live; and (2) developing a self-sustaining Appalachian economy, capable of supporting the people with rising incomes, improving the standard of living, and increasing employment opportunities.

ARC has five ways of approaching these goals. First, working with State and local agencies, ARC develops comprehensive and coordinated plans and programs for the development of the region. Second, the plans are then implemented through financial assistance for specific ARC programs and projects. Third, technical assistance is provided to the State and local development districts in implementing the Appalachian program. Fourth, grants and contracts finance research on problems facing the region. Finally, ARC serves as the focal point for coordination of Federal and State efforts in Appalachia.

HEW works with ARC in the areas of human resource development. Besides developing its own projects, ARC encourages HEW to fund additional projects in the region, especially in the categories of vocational education, health, and early childhood education.

Often, Appalachian States and localities are unable to meet Federal matching requirements for these programs. ARC can provide partial relief by funding up to 30 percent of the project cost, contributing to the non-Federal portion. This opens up many more programs to the region.

Appendix

DATA TABLES

EXPLANATION OF THE DATA

DEFINITION

To be included as metropolitan under this study, a county had to meet two qualifications:

(1) the county is located in a Standard Metropolitan Statistical Area (SMSA), and

(2) the county has a population density of 100 persons per square mile, or greater.

Nonmetropolitan counties did not meet both of these qualifications.

ARRANGEMENT OF THE DATA

Population data are listed by State. The U.S. total does not include trust territories.

Expenditure data are arranged in two schedules: National and State. The national schedule shows metropolitan versus nonmetropolitan spending for program categories within each HEW agency. The State schedule lists metropolitan versus nonmetropolitan agency totals.

SPECIAL DATA CHARACTERISTICS

Most national data have been rounded to the nearest $0.1 million (table 2). Listings include only programs which were continuous throughout fiscal year 1970, except as noted. Figures include HEW program expenditures but not administrative expenses.

The national data (table 2) are based upon a preliminary list of 358 metropolitan counties, including in error, Chittendon County, Vt. This county has the required population density, but is not in a SMSA. It has been reclassified as nonmetropolitan, and corrections have been made in the population and State data (tables 1 and 3, respectively).

The data for the Social and Rehabilitation Service (SRS) and for the Social Security Administration (SSA) trust fund items are based on Federal funds obligated during the period of the report and do not represent actual expenditures of Federal funds. The Federal funds obligated may apply to other periods as well as to the period of this report.

Some funds go directly to State agencies. The distribution of certain of these funds is the result of statistical methods used by the agency. In the case of some of the Office of Education programs, statistical allocations are not available. Expenditures thus appear under the county in which the State capital is located. This problem is discussed more fully under Methodology and within the analyses of the relevant program categories. The figures in the data schedules therefore represent an estimated apportionment of HEW expenditures in metropolitan and nonmetropolitan areas.

TABLE 1.—*Population of the United States, 1970: Metropolitan and nonmetropolitan populations by State*

State	Total	Metropolitan	Nonmetropolitan
Alabama	3, 444, 165	1, 410, 073	[illegible]4, 092
Alaska	302, 173	0	[illegible]2, 173
Arizona	1, 722, 482	967, 522	[illegible]4, 960
Arkansas	1, 923, 295	366, 426	[illegible]6, 869
California	19, 953, 134	15, 931, 156	[illegible]1, 978
Colorado	2, 207, 259	1, 463, 501	[illegible]3, 758
Connecticut	3, 032, 217	2, 584, 847	[illegible]7, 370
Delaware	548, 104	385, 856	[illegible]2, 248
District of Columbia	756, 510	756, 510	0
Florida	6, 789, 443	4, 619, 252	[illegible]140, 123
Georgia	4, 589, 575	2, 280, 230	2, 309, 354
Hawaii	769, 913	629, 176	140, 737
Idaho	713, 008	112, 230	600, 778
Illinois	11, 113, 976	8, 692, 007	2, 421, 969
Indiana	5, 193, 669	2, 991, 928	2, 201, 741
Iowa	2, 825, 041	918, 578	1, 956, 463
Kansas	2, 249, 071	910, 523	1, 338, 458
Kentucky	3, 219, 311	1, 251, 993	1, 967, 318
Louisiana	3, 643, 180	1, 816, 908	1, 526, 272
Maine	993, 663	283, 807	709, 856
Massachusetts	5, 689, 170	5, 523, 413	165, 757
Maryland	3, 922, 399	3, 307, 337	685, 062
Michigan	8, 875, 083	6, 705, 342	2, 169, 741
Minnesota	3, 805, 069	1, 897, 751	1, 907, 318
Mississippi	2, 216, 912	349, 555	1, 876, 357
Missouri	4, 677, 399	3, 870, 426	806, 973
Montana	694, 409	0	694, 409
Nebraska	1, 483, 791	621, 123	862, 668
Nevada	488, 738	0	488, 738
New Hampshire	737, 681	323, 941	413, 740
New Jersey	7, 168, 164	5, 511, 330	1, 656, 834
New Mexico	1, 016, 000	315, 774	700, 226
New York	18, 190, 740	15, 457, 901	2, 732, 839
North Carolina	5, 082, 059	1, 716, 529	3, 365, 530
North Dakota	617, 761	0	617, 761
Ohio	10, 652, 017	8, 094, 486	2, 557, 531
Oklahoma	2, 559, 253	1, 010, 307	1, 548, 946
Oregon	2, 091, 385	865, 896	1, 225, 489
Pennsylvania	11, 793, 909	9, 226, 556	2, 567, 353
Rhode Island	949, 723	768, 580	181, 143
South Carolina	2, 590, 516	870, 032	1, 720, 484
South Dakota	666, 257	95, 209	571, 048
Tennessee	3, 924, 164	1, 880, 570	2, 043, 594
Texas	11, 196, 730	7, 141, 994	4, 054, 736
Utah	1, 059, 273	683, 913	375, 360
Virginia	4, 648, 494	2, 654, 986	1, 993, 508
Vermont	444, 732	0	444, 732
Washington	3, 409, 169	2, 248, 837	1, 160, 332
Wisconsin	4, 417, 933	2, 470, 714	1, 947, 219
West Virginia	1, 744, 237	507, 662	1, 236, 575
Wyoming	332, 416	0	332, 416
Total, United States	203, 184, 722	132, 392, 678	70, 792, 044
Percent	100	65. 2	34. 8

TABLE 2.—*Department of Health, Education, and Welfare expenditures in metropolitan and nonmetropolitan areas, fiscal year 1970*

	Nonmetropolitan areas	Metropolitan areas
Environmental Health Service	$846, 000	$8, 600, 000
Health Services and Mental Health Administration	247, 336, 000	752, 770, 000
National Institutes of Health	96, 110, 500	911, 295, 000
Total, health agencies	344, 292, 500	1, 672, 665, 000
Office of Education	1, 256, 472, 000	2, 496, 325, 000
Office of the Secretary	167, 000, 000	239, 000, 000
Social and Rehabilitation Service	3, 339, 865, 000	5, 387, 726, 000
Social Security Administration	13, 055, 360, 000	21, 751, 700, 000
Total, DHEW	18, 162, 929, 500	31, 541, 416, 000
ENVIRONMENTAL HEALTH SERVICE		
Occupational Health Training and Research Grants	188, 000	5, 100, 000
Radiological Health Training and Research Grants	658, 000	3, 500, 000
Food and Drug Administration	0	61, 700, 000
Total	846, 000	70, 300, 000
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION		
Mental health:		
1. Support and conduct of research:		
Research grants	15, 500, 000	67, 300, 000
Hospital improvement grants	900, 000	1, 500, 000
2. Manpower development: Training and fellowship grants	12, 700, 000	103, 900, 000
3. Support of institutions and resources:		
Staffing of community mental health centers	12, 000, 000	35, 500, 000
Narcotic addiction and alcoholism community assistance	0	3, 000, 000
4. Service activities: Narcotic addict treatment	1, 100, 000	19, 500, 000
5. Construction: Community mental health centers [1]	2, 900, 000	9, 200, 000
Total, mental health	45, 100, 000	239, 900, 000
Health services, research and development:		
Fellowships and training	2, 000, 000	17, 700, 00
Research grants	559, 000	6, 000, 000
Research contracts	918, 000	10, 700, 000
Total	3, 477, 000	34, 400, 000

Footnote at end of table.

TABLE 2.—*Department of Health, Education, and Welfare expenditures in metropolitan and nonmetropolitan areas, fiscal year 1970*—Continued

	Nonmetropolitan areas	Metropolitan areas
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION—Continued		
Comprehensive health planning and services:		
Partnership for health grants:		
Areawide planning	$1, 700, 000	$7, 700, 000
Grants to States for planning	5, 400, 000	34, 000, 000
Planning grants for training, studies, and demonstrations	491, 000	3, 600, 000
Formula grants to States for public health services	10, 900, 000	63, 000, 000
Project grants for health services	4, 500, 000	60, 000, 000
Total, comprehensive health planning grants	22, 991, 000	108, 300, 000
Regional medical programs:		
Operating and planning grants	10, 200, 000	70, 700, 000
Kidney disease control and smoking and health	260, 000	6, 000, 000
Total	10, 460, 000	76, 700, 000
Communicable diseases: Research grants	188, 000	1, 900, 000
Hospital construction: Health facilities construction grants	116, 700, 000	116, 900, 000
National health statistics: Training and technical assistance	85, 000	170, 000
Maternal and child health: (carried under S.R.S. in 1970 appropriations bill):		
Maternal and child health services	19, 800, 000	30, 100, 000
Crippled children's services	23, 600, 000	34, 500, 000
Maternity and infant care and family planning	3, 700, 000	57, 700, 000
Health of school and preschool children	3, 300, 000	36, 700, 000
Training	0	9, 100, 000
Research	335, 000	5, 600, 000
Total, maternal and child health	50, 735, 000	173, 700, 000
Emergency health (listed as administrative expenses).		
Migrant health grants	6, 000, 000	8, 000, 000
Indian Health Service:		
Health,[2] total	108, 800, 000	
Sanitation facilities,[2] total	20, 000, 000	
Total, Health Services and Mental Health Administration	247, 336, 000	752, 770, 000

Footnote at end of table.

TABLE 2.—*Department of Health, Education, and Welfare expenditures in metropolitan and nonmetropolitan areas, fiscal year 1970*—Continued

	Nonmetropolitan areas	Metropolitan areas
NATIONAL INSTITUTES OF HEALTH		
National Cancer Institute:		
Training	$1, 900, 000	$11, 400, 000
Research	4, 000, 000	67, 000, 000
National Heart Institute:		
Training	3, 400, 000	20, 100, 000
Research	5, 500, 000	80, 200, 000
National Institute of Dental Research:		
Training	1, 142, 000	5, 600, 000
Research	827, 000	12, 400, 000
National Institute of Arthritis and Metabolic Diseases:		
Training	2, 400, 000	18, 000, 000
Research	7, 000, 000	69, 700, 000
National Institute of Neurological Diseases and Stroke:		
Training	4, 000, 000	12, 800, 000
Research	4, 300, 000	10, 800, 000
National Institute of Allergy and Infectious Diseases:		
Training	1, 972, 000	10, 400, 000
Research	5, 000, 000	44, 600, 000
National Institute of Child Health and Human Development:		
Training	2, 000, 000	10, 900, 000
Research	4, 700, 000	35, 100, 000
National Eye Institute:		
Training	568, 000	3, 300, 000
Research	1, 800, 000	2, 800, 000
National Institute of Environmental Health Sciences:		
Training	1, 115, 000	2, 700, 000
Research	1, 700, 000	5, 700, 000
Health Manpower:		
Institutional support	18, 600, 000	112, 300, 000
Student assistance	3, 700, 000	27, 800, 000
Dental Health:		
Training grants	0	4, 933, 000
Research grants	135, 000	500, 000
National Institute of General Medical Sciences:		
Training	10, 500, 000	51, 400, 000
Research	3, 700, 000	55, 000, 000
General research and services:		
Animal resources, training	108, 500	362, 000
Support grants	4, 500, 000	86, 600, 000
Construction of health facilities	1, [illegible]00, 000	145, 700, 000
National Library of Medicine	443, 000	3, 200, 000
Total, National Institutes of Health	96, 110, 500	911, 295, 000

60-297—71—pt. 2——7

TABLE 2.—*Department of Health, Education, and Welfare expenditures in metropolitan and nonmetropolitan areas, fiscal year 1970*—Continued

	Nonmetropolitan areas	Metropolitan areas
OFFICE OF EDUCATION		
Elementary and secondary education:		
Educationally deprived children	$599,000,000	$727,100,000
Dropout prevention	1,300,000	4,300,000
Bilingual education	7,200,000	15,400,000
Supplementary educational centers	16,400,000	100,000,000
Library resources	4,100,000	38,400,000
Guidance, counseling, and testing	1,400,000	13,100,000
Equipment and minor remodeling	3,700,000	33,100,000
Strengthening State departments of education	4,700,000	25,100,000
Total	637,800,000	956,500,000
School assistance in Federally affected areas (Impact aid):		
Maintenance and operation	212,100,000	295,600,000
Construction	1,300,000	8,900,000
Total	213,400,000	304,500,000
Education professions development: Preschool, elementary, and secondary	19,150,000	75,000,000
Teacher corps	5,500,000	16,100,000
Higher education:		
1. Program assistance:		
Strenghening developing institutions	13,500,000	16,500,000
Land grant colleges	3,800,000	18,300,000
2. Construction:		
Facilities construction and interest subsidization	27,000,000	55,400,000
State administration	149,000	9,900,000
3. Student aid:		
Educational opportunity grants	65,300,000	102,500,000
Direct loans (NDEA)	72,600,000	121,700,000
Insured loans	1,900,000	103,000,000
Work study programs	63,000,000	86,000,000
Special programs for disadvantaged students	14,700,000	28,400,000
Total, student aid	221,149,000	539,900,000
4. Personnel development	17,300,000	41,400,000
Total, higher education	278,449,000	581,300,000
Vocational education:		
Basic grants	43,000,000	288,000,000
State advisory councils	0	900,000
Consumer and homemaking education	2,000,000	13,000,000
Cooperative education	3,800,000	10,200,000
Innovation	2,500,000	6,700,000
Curriculum development	99,000	775,000
Total	51,399,000	319,575,000

TABLE 2.—*Department of Health, Education, and Welfare expenditures in metropolitan and nonmetropolitan areas, fiscal year 1970*—Continued

	Nonmetropolitan areas	Metropolitan areas
OFFICE OF EDUCATION—Continued		
Libraries and community services:		
Library services	$5, 000, 000	$30, 000, 000
Construction of public libraries	1, 300, 000	3, 700, 000
College library resources	4, 100, 000	5, 900, 000
Librarian training	866, 000	3, 100, 000
University community services	2, 800, 000	6, 700, 000
Adult basic education	6, 200, 000	43, 600, 000
Educational broadcasting facilities	300, 000	1, 800, 000
Total	20, 566, 000	94, 800, 000
Education for the handicapped:		
Preschool and school programs	3, 600, 000	225, 600, 000
Early childhood programs	800, 000	2, 200, 000
Teacher education and recruitment	8, 600, 000	21, 800, 000
Research and innovation	2, 400, 000	14, 600, 000
Media services and captioned films	719, 000	4, 000, 000
Total	16, 119, 000	68, 200, 000
Research and training:		
Dissemination	1, 400, 000	5, 100, 000
Training	2, 100, 000	4, 600, 000
Civil defense education	392, 000	1, 400, 000
Total	3, 892, 000	11, 100, 000
Civil rights education	5, 600, 000	10, 800, 000
Research and demonstration:		
Total	4, 600, 000	60, 400, 000
Total, Office of Education	1, 256, 472, 000	2, 496, 325, 000
OFFICE OF THE SECRETARY [3]		
Child development: Follow Through, Head-start	167, 000, 000	239, 000, 000
SOCIAL AND REHABILITATION SERVICE		
Grants to States for public assistance:		
1. Maintenance payments:		
Old-age assistance	737, 000, 000	628, 000, 000
Aid to the blind	26, 200, 000	32, 900, 000
Aid to permanently and totally disabled	229, 300, 000	319, 300, 000
Aid to families with dependent children	681, 800, 000	1, 646, 300, 000
Emergency welfare assistance	2, 300, 000	6, 300, 000
Subtotal, maintenance assistance	1, 676, 600, 000	2, 632, 800, 000
2. Medical assistance	1, 061, 300, 000	1, 762, 100, 000
3. Social Services, Administration:		
Training and demonstration projects	312, 400, 000	652, 700, 000
Social work manpower training	764, 000	2, 000, 000
Total	3, 051, 064, 000	5, 019, 800, 000

Footnote at end of table.

TABLE 2.—*Department of Health, Education, and Welfare expenditures in metropolitan and nonmetropolitan areas, fiscal year 1970*—Continued

	Nonmetropolitan areas	Metropolitan areas
SOCIAL AND REHABILITATION SERVICE—Con.		
Work incentives:		
Training and incentives (program administered by Department of Labor) ($86,000,000 total).		
Child care, total	$3, 200, 000	$12, 300, 000
Rehabilitation:		
1. Vocational rehabilitation service:		
Basic services	225, 500, 000	210, 500, 000
Innovation	1, 500, 000	1, 800, 000
Expansion of services	2, 000, 000	8, 900, 000
2. Rehabilitation facilities:		
Planning and construction	508, 000	930, 000
Initial staffing	243, 000	595, 000
Facility improvement	1, 700, 000	8, 200, 000
3. Rehabilitation research and training:		
Research and demonstration	2, 100, 000	18, 700, 000
Training	4, 900, 000	22, 500, 000
Special center program	400, 000	9, 300, 000
Total	238, 851, 000	281, 425, 000
Mental retardation:		
Hospital improvement	4, 700, 000	3, 700, 000
Rehabilitation service projects	968, 000	3, 200, 000
Community service facilities	6, 000, 000	21, 500, 000
Total	11, 668, 000	28, 400, 000
Child welfare:		
Child welfare services	19, 700, 000	26, 300, 000
Training	833, 000	5, 000, 000
Research and demonstration	535, 000	3, 600, 000
Total	21, 068, 000	34, 900, 000
Development of programs for the aging:		
Grants to States for community services	6, 900, 000	6, 100, 000
Foster grandparents program	3, 100, 000	5, 700, 000
Research and demonstration	588, 000	2, 300, 000
Training	326, 000	2, 300, 000
Total	10, 914, 000	16, 400, 000

TABLE 2.—*Department of Health, Education, and Welfare expenditures in metropolitan and nonmetropolitan areas, fiscal year 1970*—Continued

	Nonmetropolitan areas	Metropolitan areas
SOCIAL AND REHABILITATION SERVICE—Con.		
Juvenile delinquency prevention and control:		
Planning, prevention, and rehabilitation	$2, 500, 000	$4, 800, 000
Training	435, 000	1, 300, 000
Model programs and technical assistance	165, 000	701, 000
Total	3, 100, 000	6, 801, 000
Total, Social and Rehabilitation Service	3, 339, 865, 000	5, 387, 726, 000
SOCIAL SECURITY ADMINISTRATION		
Trust funds:		
Old-age survivors, insurance	9, 394, 100, 000	15, 921, 900, 000
Disability insurance	1, 158, 800, 000	1, 607, 800, 000
Hospital insurance	1, 774, 600, 000	2, 978, 500, 000
Supplementary medical insurance	723, 900, 000	1, 240, 300, 000
Total, trust funds	13, 051, 400, 000	21, 748, 500, 000
Federal funds: Special benefits for disabled coal miners	3, 900, 000	3, 200, 000
Total, Social Security Administration	13, 055, 300, 000	21, 751, 700, 000

[1] This program not included in analysis because no new money available.
[2] No geographic breakdown available.
[3] Most Office of the Secretary programs do not administer grants-in-aid. Therefore, these programs are not included in this data table.

TABLE 3.—*Program Expenditures, By State*

METROPOLITAN AND NONMETROPOLITAN AREAS; AGENCY TOTALS

Agency abbreviations

OE—Office of Education.
FDA—Food and Drug Administration.
HSMHA—Health Services and Mental Health Association.
NIH—National Institutes of Health.
SSA—Social Security Administration.
SRS—Social and Rehabilitation Service.
OS—Office of the Secretary.
SI—Special Institutions.

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
Alabama:		
OE	$49, 333, 906	$48, 020, 221
FDA		
HSMHA	9, 790, 058	7, 373, 044
NIH	12, 398, 324	2, 169, 141
SSA	212, 670, 688	289, 607, 197
SRS	51, 971, 254	131, 369, 392
OS	3, 133, 105	6, 411, 180
Total	339, 297, 335	484, 950, 175
Alaska:		
OE		22, 041, 935
FDA		
HSMHA		1, 717, 521
NIH		528, 940
SSA		14, 047, 806
SRS		7, 611, 927
OS		1, 464, 623
SI		
Total		47, 734, 225
Arizona:		
OE	19, 719, 893	24, 583, 183
FDA		
HSMHA	6, 935 598	[illegible], 057, 848
NIH	2, 142, 260	792, 257
SSA	128, 734, 778	164, 770, 681
SRS	26, 513, 100	26, 238, 889
OS	4, 805, 259	1, 273, 716
SI		
Total	220, 763, 877	188, 563, 859

TABLE 3.—*Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
Arkansas:		
OE	$33, 499, 731	$17, 792, 508
FDA		
HSMHA	3, 696, 729	7, 135, 935
NIH	81, 752	2, 482, 904
SSA	277, 589, 758	54, 899, 226
SRS	79, 702, 144	11, 073, 628
OS	4, 124, 237	878, 829
SI		
Total	398, 694, 351	94, 271, 846
California:		
OE	302, 111, 896	64, 054, 303
FDA	2, 583, 140	
HSMHA	76, 678, 927	9, 236, 084
NIH	116, 913, 774	13, 131, 568
SSA	2, 659, 354, 413	771, 918, 902
SRS	1, 224, 099, 411	455, 856, 317
OS	18, 841, 248	6, 603, 593
SI		
Total	4, 403, 257, 546	1, 320, 966, 577
Colorado:		
OE	38, 465, 066	13, 417, 193
FDA	785, 700	
HSMHA	16, 223, 558	2, 528, 873
NIH	11, 818, 834	2, 097, 510
SSA	193, 401, 215	128, 841, 168
SRS	50, 750, 091	46, 139, 962
OS	2, 729, 629	2, 357, 808
SI		
Total	314, 270, 056	195, 390, 864
Connecticut:		
OE	35, 763, 444	5, 125, 890
FDA		
HSMHA	12, 417, 333	2, 192, 247
NIH	16, 641, 609	1, 793, 584
SSA	455, 709, 589	75, 381, 821
SRS	103, 242, 457	14, 081, 196
OS	1, 790, 592	185, 112
SI		
Total	625, 770, 829	98, 759, 850
Delaware:		
OE	3, 268, 755	8, 500, 313
FDA		
HSMHA	852, 173	1, 689, 361
NIH	249, 697	
SSA	55, 758, 455	26, 641, 087
SRS	8, 864, 232	4, 039, 358
OS	663, 069	306, 162
SI		
Total	69, 670, 197	41, 176, 281

TABLE 3.—*Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
District of Columbia:		
OE	$175, 327, 111	
FDA	39, 098, 191	
HSMHA	42, 294, 776	
NIH	46, 854, 605	
SSA	136, 623, 389	
SRS	145, 697, 631	
OS	6, 224, 888	
SI	42, 429, 908	
Total	681, 033, 762	
Florida:		
OE	99, 368, 234	$26, 034, 317
FDA		
HSMHA	23, 189, 814	7, 370, 950
NIH	41, 995, 338	4, 073
SSA	1, 057, 195, 736	519, 525, 246
SRS	130, 882, 551	63, 616, 715
OS	9, 668, 910	2, 659, 640
SI		
Total	1, 362, 682, 760	619, 210, 941
Georgia:		
OE	64, 030, 447	43, 434, 832
FDA	1, 170, 500	
HSMHA	12, 887, 753	5, 118, 842
NIH	14, 551, 555	1, 637, 842
SSA	257, 141, 864	310, 962, 569
SRS	76, 779, 717	141, 460, 247
OS	2, 743, 553	3, 243, 106
SI		
Total	492, 552, 133	505, 907, 473
Hawaii:		
OE	20, 789, 080	765, 171
FDA		
HSMHA	5, 200, 008	469, 882
NIH	3, 387, 710	480, 212
SSA	59, 576, 529	25, 818, 034
SRS	19, 502, 993	5, 943, 682
OS	580, 789	506, 400
SI		
Total	109, 112, 163	33, 983, 381
Idaho:		
OE	7, 665, 861	7, 579, 946
FDA		
HSMHA	1, 788, 310	1, 465, 251
NIH	48, 000	372, 538
SSA	18, 496, 860	98, 272, 839
SRS	3, 440, 239	18, 378, 437
OS	144, 969	1, 042, 855
SI		
Total	31, 598, 055	127, 111, 866

TABLE 3.—*Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
Illinois:		
OE	$131, 364, 976	$23, 023, 777
FDA	1, 432, 300	----------
HSMHA	36, 443, 488	5, 168, 779
NIH	48, 028, 877	559, 279
SSA	1, 410, 529, 533	511, 595, 381
SRS	337, 674, 308	101, 110, 104
OS	13, 310, 362	1, 716, 379
SI	----------	----------
Total	1, 979, 351, 998	643, 173, 699
Indiana:		
OE	44, 900, 105	20, 110, 178
FDA	----------	----------
HSMHA	9, 183, 007	8, 907, 115
NIH	6, 242, 075	9, 972, 066
SSA	474, 878, 422	398, 701, 241
SRS	41, 344, 232	27, 404, 207
OS	3, 340, 490	1, 553, 716
SI	----------	----------
Total	580, 010, 032	466, 648, 523
Iowa:		
OE	22, 324, 743	23, 381, 787
FDA	----------	----------
HSMHA	4, 399, 064	4, 763, 325
NIH	1, 126, 818	11, 191, 754
SSA	156, 393, 811	395, 604, 860
SRS	24, 225, 901	49, 302, 671
OS	1, 175, 687	1, 827, 308
SI	----------	----------
Total	209, 646, 024	486, 091, 705
Kansas:		
OE	23, 549, 488	20, 970, 281
FDA	----------	----------
HSMHA	4, 752, 679	3, 712, 967
NIH	4, 072, 874	3, 578, 184
SSA	127, 889, 817	280, 009, 237
SRS	26, 466, 804	48, 967, 018
OS	972, 565	1, 147, 111
SI	----------	----------
Total	187, 759, 942	358, 384, 798
Kentucky:		
OE	15, 791, 827	66, 451, 034
FDA	----------	----------
HSMHA	4, 640, 851	13, 690, 884
NIH	7, 376, 908	104, 092
SSA	191, 394, 699	332, 114, 177
SRS	30, 045, 977	114, 011, 472
OS	1, 912, 442	5, 994, 682
SI	1, 404, 000	----------
Total	252, 609, 525	532, 366, 341

TABLE 3.—*Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
Louisiana:		
OE	$51, 217, 711	$32, 511, [illegible]
FDA	1, 002, 490	[illegible]
HSMHA	12, 136, 265	5, 081, [illegible]
NIH	13, 643, 765	259, [illegible]
SSA	242, 627, 864	226, 467, [illegible]
SRS	80, 539, 760	121, 740, [illegible]
OS	4, 420, 339	3, 860, [illegible]
SI	[illegible]	[illegible]
Total	405, 696, 119	389, 92[illegible]
Maine:		
OE	2, 680, 167	14, 444, 7[illegible]
FDA	[illegible]	[illegible]
HSMHA	426, 530	4, 203, [illegible]
NIH	120, 995	1, 695, [illegible]
SSA	57, 84[illegible] 563	132, 462, [illegible]
SRS	13, 231, 371	36, 424, [illegible]
OS	342, 837	1, 348, 472
SI	[illegible]	[illegible]
Total	74, 677, 498	190, 599, 875
Maryland:		
OE	41, 007, 514	34, 091, 427
FDA	1, 205, 450	[illegible]
HSMHA	14, 428, 879	5, 428, 635
NIH	28, 409, 808	27, 061, 337
SSA	279, 760, 223	200, 304, 159
SRS	94, 994, 166	40, 979, 158
OS	960, 449	2, 650, 105
SI	[illegible]	[illegible]
Total	460, 788, 359	310, 669, 106
Massachusetts:		
OE	90, 566, 354	2, 450, 482
FDA	1, 074, 220	[illegible]
HSMHA	38, 618, 444	125, 682
NIH	95, 359, 632	421, 919
SSA	1, 066, 882, 019	45, 228, 427
SRS	302, 695, 109	7, 109, 098
OS	6, 409, 357	329, 915
SI	[illegible]	[illegible]
Total	1, 602, 437, 849	55, 665, 523
Michigan:		
OE	104, 261, 911	18, 061, 986
FDA	1, 440, 400	[illegible]
HSMHA	28, 290, 618	5, 018, 258
NIH	30, 018, 169	578, 759
SSA	1, 098, 207, 023	430, 754, 383
SRS	212, 045, 781	90, 956, 465
OS	5, 851, 900	2, 852, 226
SI	[illegible]	[illegible]
Total	1, 480, 884, 173	548, 477, 585

TABLE 3.—*Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
Minnesota:		
OE	$37, 797, 365	$25, 524, 097
FDA	1, 139, 880	
HSMHA	12, 284, 253	5, 933, 747
NIH	25, 118, 745	228, 533
SS	290, 034, 110	386, 514, 664
SI	71, 278, 218	81, 060, 384
O	825, 360	3, 542, 297
SI		
Total	438, 494, 312	502, 803, 722
Mississippi:		
OE	29, 506, 434	52, 798, 297
FDA		
HSMHA	5, 416, 116	7, 764, 217
NIH	3, 201, 923	404, 617
SSA	45, 195, 732	268, 148, 309
SRS	9, 098, 050	88, 934, 557
OS	17, 000, 422	17, 527, 105
SI		
Total	109, 366, 169	435, 577, 102
Missouri:		
OE	37, 887, 332	46, 984, 994
FDA	1, 519, 475	
HSMHA	22, 880, 106	8, 687. 808
NIH	28, 708, 568	995, 691
SSA	499, 923, 350	401, 633, 505
SRS	70, 102, 042	109, 284, 861
OS	4, 341, 023	4, 375, 796
SI		
Total	665, 523, 491	571, 962, 658
Montana:		
OE		20, 413, 509
FDA		
HSMHA		3, 341, 099
NIH		996, 207
SSA		120, 162, 941
SRS		22, 583, 305
OS		1, 925, 192
SI		
Total		169, 402, 222
Nebraska:		
OE	19, 623, 350	9, 219, 527
FDA		
HSMHA	5, 102, 503	1, 809, 119
NIH	7, 303, 787	113, 191
SSA	91, 979, 474	183, 188, 778
SRS	16, 446, 843	26, 357, 398
OS	1, 156, 627	725, 403
SI		
Total	141, 638, 997	221, 413, 416

TABLE 3.—*Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
Nevada:		
OE		
FDA		$10, 353, 028
HSMHA		
NIH		2, 316, 026
SSA		213, 491
SRS		60, 704, 203
OS		11, 183, 506
SI		605, 658
Total		85, 400, 524
New Hampshire:		
OE	$1, 937, 611	10, 208, 070
FDA		
HSMHA	375, 619	2, 714, 023
NIH	104, 174	3, 136, 643
SSA	41, 133, 426	94, 282, 236
SRS	3, 565, 236	7, 876, 086
OS	106, 065	753, 537
SI		
Total	47, 235, 947	188, 970, 595
New Jersey:		
OE	84, 692, 008	13, 542, 142
FDA		
HSMHA	16, 820, 047	7, 475, 041
NIH	8, 025, 841	3, 170, 833
SSA	995, 023, 125	280, 896, 735
SRS	158, 155, 389	27, 965, 626
OS	7, 972, 447	1, 282, 887
SI		
Total	11, 207, 819, 429	334, 345, 846
New Mexico:		
OE	9, 523, 573	30, 594, 546
FDA		
HSMHA	2, 520, 691	2, 537, 759
NIH	2, 175, 989	193, 310
SSA	36, 044, 487	84, 828, 383
SRS	11, 218, 802	33, 586, 335
OS	413, 975	2, 939, 659
SI		
Total	1, 913, 391	154, 759, 758
New York:		
OE	348, 858, 201	31, 681, 855
FDA	4, 292, 201	
HSMHA	88, 082, 776	8, 521, 175
NIH	132, 460, 745	7, 606, 491
SSA	3, 114, 747, 942	570, 179, 716
SRS	1, 059, 282, 659	111, 093, 179
OS	19, 192, 851	3, 116, 428
SI	3, 605, 538	
Total	4, 772, 021, 752	732, 218, 576

TABLE 3.—*Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
North Carolina:		
OE	$64, 640, 949	$63, 811, 840
FDA		
HSMHA	17, 202, 000	10, 928, 162
NIH	40, 160, 437	724, 505
SSA	214, 982, 675	448, 936, 832
SRS	47, 597, 886	106, 219, 151
OS	3, 285, 475	6, 504, 068
SI		
Total	401, 898, 635	637, 124, 558
North Dakota:		
OE		18, 029, 613
FDA		
HSMHA		3, 824, 056
NIH		990, 811
SSA		107, 778, 767
SRS		22, 655, 723
OS		1, 113, 224
SI		
Total		154, 404, 760
Ohio:		
OE	120, 600, 377	17, 400, 701
FDA	1, 270, 150	
HSMHA	32, 088, 068	9, 630, 375
NIH	83, 843, 925	327, 661
SSA	1, 318, 065, 001	438, 676, 525
SRS	212, 842, 155	76, 207, 839
OS	7, 526, 673	2, 848, 615
SI		
Total	1, 776, 785, 728	545, 091, 716
Oklahoma:		
OE	21, 049, 854	38, 982, 215
FDA		
HSMHA	6, 202, 169	5, 318, 408
NIH	6, 115, 655	1, 417, 973
SSA	147, 476, 002	303, 760, 374
SRS	28, 393, 226	101, 579, 331
OS	1, 397, 457	4, 300, 773
SI		
Total	210, 673, 106	455, 359, 074
Oregon:		
OE	22, 296, 203	19, 220, 958
FDA		
HSMHA	2, 320, 496	6, 500, 521
NIH	8, 911, 179	4, 128, 222
SSA	183, 008, 609	221, 290, 268
SRS	37, 576, 100	36, 662, 544
OS	247, 820	1, 479, 044
SI		
Total	254, 404, 926	289, 370, 373

TABLE 3.—*Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
Pennsylvania:		
OE	$152, 361, 640	$23, 961, 840
FDA	1, 342, 450	
HSMHA	44, 671, 739	12, 371, 393
NIH	66, 092, 602	3, 233, 320
SSA	1, 738, 632, 138	518, 860, 133
SRS	370, 996, 246	112, 041, 193
OS	9, 044, 358	2, 094, 942
SI		
Total	2, 384, 803, 959	672, 598, 736
Rhode Island:		
OE	14, 764, 797	4, 227, 236
FDA		
HSMHA	3, 560, 079	973, 354
NIH	2, 653, 942	406, 541
SSA	165, 174, 716	23, 424, 180
SRS	46, 757, 202	4, 372, 535
OS	827, 147	132, 735
SI		
Total	233, 752, 104	33, 536, 581
South Carolina:		
OE	32, 952, 997	38, 870, 956
FDA		
HSMHA	7, 560, 189	9, 463, 782
NIH	2, 443, 463	23, 967
SSA	97, 783, 391	217, 655, 936
SRS	17, 634, 502	54, 672, 667
OS	1, 353, 529	4, 219, 977
SI		
Total	159, 784, 392	324, 907, 285
South Dakota:		
OE	980, 875	19, 541, 713
FDA		
HSMHA	56, 363	2, 032, 489
NIH	36, 187	721, 160
SSA	17, 011, 194	105, 617, 133
SRS	2, 900, 945	23, 475, 974
OS	37, 139	1, 642, 224
SI		
Total	21, 035, 674	153, 043, 664
Tennessee:		
OE	54, 486, 372	37, 344, 122
FDA		
HSMHA	20, 774, 885	6, 373, 280
NIH	21, 376, 672	136, 377
SSA	267, 927, 150	318, 866, 07[illegible]
SRS	58, 129, 749	81, 995, 092
OS	2, 869, 058	4, 864, 033
SI		
Total	425, 727, 231	449, 578, 982

TABLE — *Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
Texas:		
OE	$154, 055, 843	$56, 417, 618
FDA	1, 248, 650	
HSMHA	36, 134, 498	11, 055, 048
NIH	37, 341, 760	1, 263, 588
SSA	850, 612, 764	714, 464, 212
SRS	210, 946, 292	221, 909, 864
OS	10, 428, 562	5, 007, 171
SI		
Total	1, 301, 595, 619	1, 010, 149, 095
Utah:		
OE	20, 304, 643	6, 823, 007
FDA		
HSMHA	10, 226, 315	555, 462
NIH	7, 416, 102	735, 304
SSA	81, 786, 779	50, 306, 452
SRS	22, 888, 701	16, 352, 588
OS	778, 671	504, 916
SI		
Total	143, 524, 092	75, 277, 729
Vermont:		
OE		9, 778, 045
FDA		
HSMHA		3, 437, 405
NIH		2, 815, 104
SSA		80, 689, 353
SRS		26, 809, 834
OS		1, 053, 072
SI		
Total		124, 327, 783
Virginia:		
OE	76, 149, 435	35, 331, 038
FDA		
HSMHA	9, 495, 474	6, 038, 705
NIH	17, 493, 012	6, 464, 949
SSA	218, 153, 250	315, 357, 747
SRS	63, 057, 998	57, 730, 258
OS	2, 490, 447	2, 787, 459
SI		
Total	450, 024, 746	423, 782, 103
Washington:		
OE	28, 110, 254	31, 401, 526
FDA	1, 098, 400	
HSMHA	10, 777, 074	4, 498, 155
NIH	31, 612, 266	1, 759, 249
SSA	359, 635, 927	216, 459, 263
SRS	77, 319, 778	58, 712, 718
OS	2, 711, 380	1, 419, 307
SI		
Total	511, 324, 854	314, 3[illegible], 218

TABLE 3.—*Program Expenditures, By State*—Continued

[Leaders signify zero]

State	Metropolitan	Nonmetropolitan
West Virginia:		
OE	$20, 178, 728	$25, 543, 821
FDA		
HSMHA	2, 591, 187	7, 218, 457
NIH	, 656	3, 218, 751
SSA	100, 131, 023	260, 991, 298
SRS	16, 524, 059	57, 145, 857
OS	1, 492, 799	2, 668, 216
SI		
Total	140, 933, 969	356, 810, 078
Wisconsin:		
OE	38, 560, 010	23, 771, 865
FDA		
HSMHA	10, 590, 710	7, 630, 229
NIH	22, 062, 074	1, 286, 777
SSA	420, 855, 817	401, 239, 895
SRS	73, 168, 116	88, 116, 959
OS	2, 995, 610	1, 008, 831
SI		
Total	568, 232, 337	523, 054, 556
Wyoming:		
OE		9, 023, 979
FDA		
HSMHA		3, 194, 351
NIH		191, 556
SSA		49, 917, 096
SRS		7, 552, 072
OS		708, 932
SI		
Total		70, 587, 986
Trust Territories:		
American Samoa		2, 504, 478
Canal Zone		294, 753
Canton and Enderbury I		374
Caroline Islands		42, 235
Guam		6, 875, 880
Mariana Islands		1, 371, 199
Marshall Islands		2, 460
Midway Islands		17, 181
Puerto Rico	39, 871, 206	337, 846, 941
Ryukyo Islands		581, 036
Tokelav Islands		65, 744
Virgin Islands		8, 717, 200

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(Part 3 to follow)