
Chapter 3.

CURRENT COORDINATION ACTIVITIES

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INTRODUCTION

The U.S. Federal statistical system is decentralized and complex. Such decentralization often creates problems of fragmentation, redundancy, and user access. Furthermore, priorities for current and future data collection projects are determined largely on an ad hoc basis because major decisions regarding data collection activities usually are made or implemented by Federal agencies that administer specific programs.

Some legislative authorities, particularly the Federal Reports Act of 1942 and the Budget and Accounting Procedures Act of 1950, address the issues of health data policy and coordination. However, no single congressional mandate exists for developing health data systems in a coordinated and comprehensive fashion. In fact, a number of offices and agencies have been charged with similar health data policy, oversight, and coordination responsibilities.

There is increasing congressional and executive branch concern, however, about health data coordination and policy. In 1974, for example, Congress established a special Commission on Federal Paperwork to investigate problems associated with Federal reporting requirements, including health information requests. In addition, the 95th Congress passed legislation, Public Law 95-623, to encourage coordination among various health statistical systems.

Executive branch concern is evidenced in four executive reorganizations (March, October, and December 1977, and January 1979) that realigned many of the responsibilities of Federal agencies concerning health data policy. These organizational changes are described in this chapter; however, it is difficult to predict their effect. As part of an overall reorganization effort, the President also established the Reorganization Project for the Federal Statistical System. In December 1978, the reorganization project distributed a draft report that identifies shortcomings in Federal data systems. Final recommendations of the reorganization project are expected in **1979**.

In this chapter, administrative units responsible for coordinating health statistical systems are described according to their position within the Federal Government, beginning with major departments and agencies. * They are described in terms of their mission, accomplishments, limitations, and problems. The analysis begins with the Office of Management and Budget (OMB) and the Department of Commerce—the two executive branch units charged with statistical oversight responsibilities for the entire Federal Government. The Regulatory Policy and Reports Management Division in OMB is highlighted, as is the Office of Federal Statistical Policy and Standards (OFSPS) within the Department of Commerce. The two administrative mechanisms used for supervising sta-

*Figures 1 and 2 in chapter 2 show the organizational positions of the offices and committees described here.

tistical projects, statistical budget requests and the reports clearance process, are discussed in detail.

The rest of the chapter describes offices and committees in the Department of Health, Education, and Welfare (HEW) that have health data coordination responsibilities. The description begins at the level of the Secretary with the Offices of the Assistant Secretary for Management and Budget (ASMB) and the Assistant Secretary for Planning and Evaluation (ASPE). The functions and responsibilities of a number of offices within the two principal health-related operating components of HEW, the Health Care Financing Administration (HCFA) and the Public Health Service (PHS), are then depicted. Within HCFA, the Office of Policy, Planning, and Research (OPPR), a staff office to the Administrator, is featured.

The review of PHS coordination and planning activities focuses on the activities of the Office of Health Research, Statistics, and Technology (OHRST), the Office of Statistical Policy (OSP) in the new Office of Planning and Evaluation, and the six PHS agencies. Finally, the efforts of the three HEW Committees, the PHS Health Statistics Coordinating Committee (HSCC), the Health Data Advisory Committee (HDAC), and the National Committee on Vital and Health Statistics (NCVHS), to increase coordination of statistical activities within the Department are outlined.

THE DEPARTMENT OF COMMERCE AND THE OFFICE OF MANAGEMENT AND BUDGET

Two major pieces of legislation, the Budget and Accounting Procedures Act of 1950 and the Federal Reports Act of 1942, authorize the President to coordinate and manage Federal statistical activities. Section 103 of the Budget and Accounting Procedures Act provides authority “to develop programs and to issue regulations and orders for the improved gathering, compiling, analyzing, publishing, and disseminating of statistical information for any purpose by the various [Federal] agencies . . .”(2). The Federal Reports Act, as amended, mandates review and prior approval of Federal information requests that will sample 10 or more individuals (4).

Until October 1977, the Statistical Policy Division (SPD), located in OMB, had primary responsibility for the coordination and review functions required by legislation. As the central office responsible for the direction and coordination of Federal data activities, it had the opportunity to survey and oversee all data collection programs. Its organizational position within the Executive Office of the President permitted it to foster interagency collaboration and cooperation. However, its broadly defined responsibilities and its limited staff resources hindered its ability to comprehensively and continuously address problematic issues within any single statistical area. *

Under the President's Reorganization Plan No. 1, some of SPD'S statistical policy duties were transferred to the Commerce Department. Responsibility for section 103 of the Budget and Accounting Procedures Act was delegated to the newly created Office of Federal Statistical Policy and Standards (OFSPS) in Commerce. SPD'S successor in OMB, the Regulatory Policy and Reports Management Division, retained authority for the review and clearance of most Federal data collection forms and reporting requirements. ** It also maintained responsibility for coordinating administrative data collec-

*In 1976, 2 out of the 29 staff members assigned to SPD worked in the specific area of health statistics.

**Responsibilities for clearing reporting requirements mandated by certain regulatory activities are held by the General Accounting Office (GAO), not OMB.

tion and managing paperwork burden (16). Despite the reorganization, overlapping responsibilities for some statistical policy functions still remained. Consequently, a memorandum of understanding was exchanged in July 1978 between OMB and Commerce to clarify the respective functions of each office (27).

Under the authority of the Budget and Accounting Procedures Act, OFSPS is specifically responsible for the establishment of uniform statistical definitions, guidelines, and standards for conducting surveys and for publishing and releasing Federal statistics. In the past, SPD issued these standards through OMB Circular No. A-46. However, SPD never set guidelines relating solely to health statistics. SPD had only one staff person, who also was assigned other responsibilities, to develop statistical classifications and standards (24). OFSPS had requested and received additional staff positions so that its work in developing standards and guidelines can be expanded beyond that of SPD (9).

OFSPS conducts planning sessions with major statistical agencies, such as the National Center for Health Statistics (NCHS), to fulfill part of its mandate. It also manages interagency committees involved in statistical issues. OFSPS has just published **A Framework for Planning U.S. Federal Statistics for the 1980's**, the result of an interagency planning effort begun several years ago by OMB (26). The **Framework** examines the entire range of Federal statistical activities, delineates statistical problems and areas of unmet needs, and recommends general priorities and objectives for the Federal statistical system. The chapter on health statistics outlines areas in which more comparable and integrated data systems are necessary. It also recommends some methods for improving the coordination, the development, the utility, and the overall quality of health data.

OFSPS and OMB rely on two administrative mechanisms to oversee Federal statistical projects: statistical budget requests and the reports clearance process. Both budget examiners in OMB and staff in OFSPS review statistical budget requests. These requests, required under the authority of the Budget and Accounting Procedures Act for Federal agencies incurring annual obligations of **\$300,000** or more for statistical activities, are submitted to OMB (Exhibit 54 of Circular No. A-n). They consist of budget data and a short narrative statement describing each data activity supervised by an agency. * Both OFSPS and OMB may seek clarification of, or require additional information about, any budget request.

Until 1978, OMB published a yearly analysis of the principal Federal statistical programs (**Special Analysis G, Budget of the United States Government**) based on these budget requests. The special analysis displayed expenditures according to broad subject areas and noted major changes in program funding levels. These analyses provided useful information to policymakers regarding Federal resource allocation to general statistical areas (e. g., health, energy, labor) but they lacked sufficient detail to determine the appropriateness of funding levels for specific program-related data activities within a subject area. The only figure in the area of health, for example, was the total Federal obligation. Expenditures by various agencies and bureaus in HEW for specific data systems were not shown. Although OMB discontinued the special analysis of statistical programs, it plans to continue examining statistical budget requests. OFSPS plans to conduct its own analysis of statistical budgets which will be published in the **Statistical Reporter**, a monthly journal primarily designed for the exchange of information among Government employees engaged in statistical and research activities.

*As noted in chapter 2, the value of these budget requests for determining costs for Federal statistical activities is suspect because many data projects are omitted from them.

OMB'S Regulatory Policy and Reports Management Division retains responsibility for the review of reports clearance requests, the second administrative mechanism for supervising statistical projects. * Federal agencies and groups that contract with the Federal Government may not collect information from the public without prior clearance approval of the Director of OMB. Although OMB makes the final decision regarding project clearance, OFSPS offers technical advice on statistical and methodological aspects of requests and is responsible for the substantive review of all statistical surveys.

The objectives of the reports clearance procedure are to avoid duplicate or unnecessarily burdensome reports, to ensure the use of sound statistical procedures, and to improve the quality and general usefulness of the statistics obtained (11). The review and clearance process also is being used now as the primary tool for implementing a special Presidential initiative intended to reduce the Federal reporting burden on the public (13).

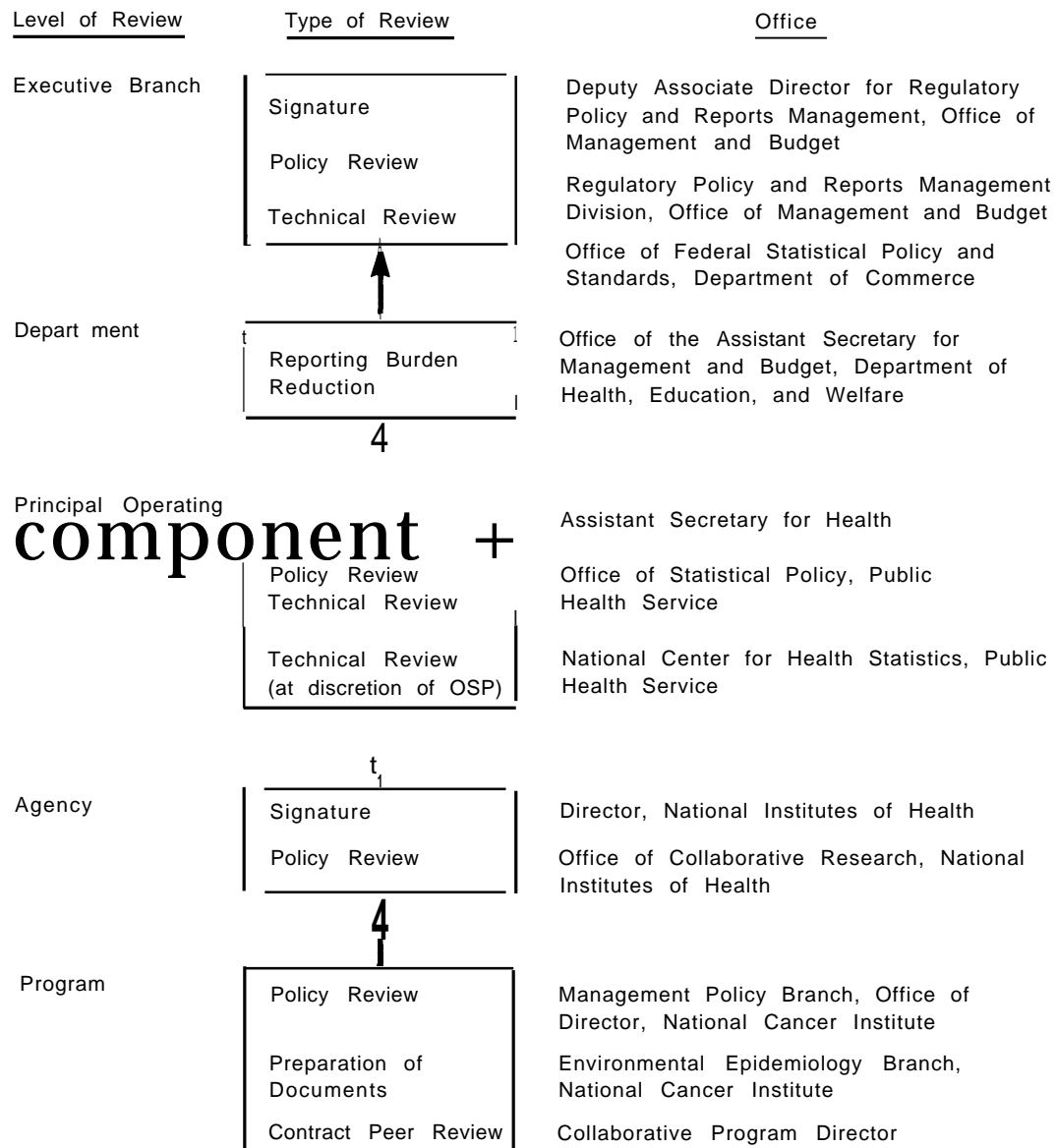
Forms or reporting plan requests are submitted to the OMB clearance office (Standard Form 83), and contain fairly comprehensive information about projected statistical activities. OMB maintains and periodically circulates a list of approved projects that are currently in use. The OMB files containing the clearance requests and sample forms or reports are open to the public; however, no attempt has been made to computerize them, nor are they available for use outside OMB offices. Currently, OMB is testing the feasibility of a computerized keyword system to retrieve information on projects approved by the clearance office.

The clearance process has been partially effective in preventing data collection activities of obviously inadequate quality and design. However, this process has a number of limitations. First, certain reports are exempted from the process, including clinical trials, data projects conducted under grants, and data collection projects mandated under the Health Professions Educational Assistance Act of 1976. In fact, the Commission on Federal Paperwork estimated that fewer than 50 percent of the reports requested by the Federal Government are reviewed by OMB (23). Second, the clearance process is extremely slow. Each level of the bureaucracy, from originating office to OMB, reviews every proposed project (see figure 3). Third, the clearance procedure does not set priorities for choosing reports to review, and the result is a backlog of requests which vary in significance. Finally, although agencies' clearance procedures vary, review by OMB begins at the final stage of an agency's planning process. Delaying an active review of a project until its final planning stages is untimely and inappropriate, given the large investment of resources already made in the project. Until the clearance and planning processes are linked, little improvement in coordination can be expected.

OMB also has authority, under the Federal Reports Act, to determine the necessity for collecting information, to designate a central collection agency if doing so would more efficiently serve the needs of two or more agencies, and to require the cooperation of Federal agencies in exchanging and sharing information. In practice, OMB has rarely exercised this broad authority for coordinating statistical activities in the health area. One of the few OMB attempts to provide coordinating leadership in this area met with mixed success. In 1975, OMB ruled that, in order to reduce the burden on respondents, a Bureau of Labor Statistics (BLS) survey, which focused on employees in hospitals working in nonhealth occupations, should be incorporated into a joint survey of hospital staff conducted by NCHS and supported by the Bureau of Health Manpower (BHM) (35). A survey of nursing personnel, normally conducted by a professional society, was also in-

● Requests to conduct statistical activities may also go through other clearance mechanisms, including those for grants and contracts and internal evaluation reviews.

Figure 3.—Reports Clearance Process for a Cancer Epidemiology Study Conducted Under Contract and Requiring Household or Telephone Interviews



corporate. The response rate to this survey, conducted by NCHS in 1976, was only 50 percent. The volume of data the survey instrument attempted to capture caused the unacceptably low response rate. Other factors, such as lack of support from professional groups, may also have contributed to the low response rate. This example illustrates that coordinating data collection activities solely to achieve maximum efficiency and minimal respondent burden may not always provide necessary data of adequate quality for the community of users.

The implications of the 1977 reorganization that transferred certain responsibilities for statistical policy from OMB to Commerce are unclear. Under the reorganization,

OMB'S Regulatory Policy and Reports Management Division was assigned 24 positions and Commerce's OFSPS, 15 (17). * Core staff of the new Commerce office, including the Director, are former members of the OMB Statistical Policy Division. Both this transfer of staff and the active commitment of the Commerce Department to fulfill a Government-wide statistical policy function could result in the improved planning and coordination of Federal statistical activities. The fact that OMB retains sufficient authority to resolve any interagency differences that cannot be handled by Commerce increases the likelihood of success (14). However, the division of oversight responsibilities, all of which were formerly administered by OMB, between OMB and a Federal agency that itself collects data, could reduce the intended effectiveness of the reorganization. The President's Reorganization Project for the Federal Statistical System indicated in its preliminary report that it would recommend reunifying statistical policy functions in a strengthened central office (16).

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Department of Health, Education, and Welfare (HEW) has a number of offices with responsibilities relating to health data policy and coordination. Authority to coordinate data projects has, for the most part, been delegated to the Health Care Financing Administration (HCFA) and the Public Health Service (PHS). However, two staff offices at the level of the Secretary, ASMB and ASPE, maintain some oversight responsibilities for health data activities throughout the Department.

The Assistant Secretary for Management and Budget (ASMB) is responsible for the implementation of reports clearance procedures throughout HEW. ASMB has delegated this authority to the Assistant Secretary for Health and to the Administrator of HCFA. This office also has overall responsibility for the development of policies and standards concerning public use of reports and reviews departmental statistical budget requests as part of its budgeting function. In 1976, ASMB instituted a special review of large new data projects (those requiring 20,000 or more reporting hours) to comply with the Presidential directive to reduce reporting burden on the public.

The Assistant Secretary for Planning and Evaluation (ASPE) provides guidance for the planning activities of the Department. The ASPE staff also conducts several large surveys in conjunction with their planning and evaluation responsibilities, and are involved in basic research on statistical methodologies. Presently, ASPE is one of several participants preparing a departmentwide health statistics plan for FY 1978.

Health Care Financing Administration

Each of the three major HCFA divisions, the Medicare Bureau, the Medicaid Bureau, and the Health Standards and Quality Bureau (HSQB), maintains large ongoing health data collection activities. The Office of Policy, Planning, and Research (OPPR), a staff office to the HCFA Administrator, has primary responsibility for data policy and coordination of statistical activities throughout the agency. However, the final reports clearance unit before transmittal to OMB is in the HCFA Office of Management and Budget, another staff office to the Administrator. OPPR has recently established the HCFA Health Data Policy Committee to serve as a forum for discussing internal data policy

*As mentioned previously, OFSPS has subsequently received additional staff members.

issues, including coordination. Representatives from each of the HCFA bureaus will serve on the Committee, which has not yet met to discuss its plans and functions.

OPPR is already leading efforts to develop common statistical reporting requirements for Medicare and Medicaid. Uniform billing and discharge data requirements were mandated by section 19 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. Duplicative collection of discharge data by several agencies in HCFA and by other programs in PHS has been a source of problems for a number of years. In 1978, the Secretary of HEW delegated responsibility for development and collection of uniform billing and discharge data to HCFA. Two internal task forces, one on uniform billing and another on discharge data, have been formed by OPPR. The agency is now in the process of drafting proposed regulations concerning the implementation of the task forces' recommendations.

OPPR and NCHS, a PHS agency, are collaborating on another important statistical activity. They have proposed a joint, expanded survey to replace both the former Current Medicare Survey of the Medicare program and the Medical Care Expenditures Survey, a single-time survey conducted by NCHS and the National Center for Health Services Research (NCHSR). The expanded survey, the Medical Utilization and Expenditures Survey, will be initiated in FY 1980. HCFA and NCHS will both provide funding for the new survey; NCHS will administer its data collection activities.

Public Health Service: Office of Health Research, Statistics, and Technology

The Office of Health Research, Statistics, and Technology (OHRST) was created by a January 1979 reorganization of the Office of the Assistant Secretary for Health (OASH) to replace the Office of Health Policy, Research, and Statistics (OHPRS). This new Office will supervise the activities of NCHS, NCHSR, and the National Center for Health Care Technology (NCHCT). The Office was established to augment PHS'S ability to foster and assess technological developments in health and to strengthen the relationship between health statistics, health services research, and health technology assessment.

The 1979 reorganization transferred the Office of Statistical Policy (OSP), which was located in OHPRS before the reorganization, to another new office, the Office of Planning and Evaluation (OPE). The responsibilities of OPE and the ongoing activities of OSP will be discussed in a later section.

The National Center for Health Statistics is the only Federal agency expressly established to collect and distribute information describing the health of Americans. NCHS was created statutorily* by the Health Services Research, Health Statistics, and Medical Libraries Act of 1974, Public Law 93-353. This Act directed the Secretary of HEW to use NCHS to coordinate, to the maximum extent possible, all health statistical activities begun and supported by HEW. The law also authorized NCHS to design and implement a cooperative health statistics system to produce comparable and uniform health data and statistics at the Federal, State, and local levels.

NCHS'S latest enabling legislation, the Health Services Research, Health Statistics, and Health Care Technology Act of 1978, Public Law 95-623, mandated the establishment of standardized means for collecting all health information and statistics that are authorized by laws administered by HEW. It also directed the review of all health data collections that are subject to the reports clearance process to insure their *conformance*

*As noted in chapter 2, NCHS was first created in 1960 by the merger of the National Health Survey with the National Office of Vital Statistics.

not only to promulgated standards, but also to the minimum data sets that have been established for several substantive areas. NCHS began conducting technical reviews for some proposed health data collections as part of the reports clearance process in 1978.

It is too early to predict NCHS'S effectiveness in fulfilling its new responsibilities. The Secretary has not yet formally delegated authority for Public Law 95-623, but it could be interpreted as considerably strengthening NCHS'S role within the Department for coordinating health statistics. In addition, this legislation may create the statutory base for NCHS participation in the reports clearance process and provide authority for taking corrective action should data projects fail to conform to the standards.

Public Law **95-623** also authorized NCHS to expand its epidemiological activities and to coordinate the development of a Government-wide statistical program on the health effects of the environment. However, no additional funds were appropriated to NCHS in FY 1979 for these tasks.

NCHS administers two programs that are designed expressly to improve the efficiency and coordination of health statistics. These programs, the Cooperative Health Statistics System (CHSS) and the Reimbursable Work Program (RWP), were created to fulfill the Agency's legislative mandate to produce comparable and uniform health information and statistics. Despite NCHS'S latest enabling legislation, both CHSS and RWP are likely to continue to be the primary NCHS programs for coordination.

CHSS is an organizational mechanism for the development of health data systems that can be shared by data producers and users at the local, State, and Federal levels. The conceptual basis of the program is that data should be collected and processed by the level of government or by the agency best equipped to collect them, and that the data should be shared with all other levels and users in machine-readable form. The long-range strategy of this hierarchical and linked data collection approach is to reduce cost and respondent burden while meeting informational needs of users at all levels of government.

When fully developed, CHSS will include seven components, each of which will provide a different type of health-related data: vital statistics, health manpower, health facilities, hospital care, ambulatory care, long-term care, and health survey data. Within each component, standard definitions, comparable methods, and a core data set will be established to ensure the quality and comparability of data across States. Operationally, the system will work through either a State center for health statistics or a consortia of data users and producers within a State. NCHS provides contracts to these State agencies or data consortia for the development of statistical components, conducts technical assistance and training programs, and pays the appropriate Federal share of the costs. NCHS also is coordinating efforts among Federal agencies so they will link their data needs to CHSS. This program may be unable to fulfill its intended purpose, however, because participation by these various data users and producers is voluntary.

Although receiving a statutory base in Public Law **95-623** and high priority from NCHS, CHSS is developing slowly. By the end of FY **1978**, **44** States had contracts for the vital statistics component, and **36** States had contracts for both the health manpower and the health facilities components. Hospital discharge data systems, the fourth active CHSS component, were being implemented in 9 States (19). Even if CHSS were completely implemented in all the States, national data would not be available for at least 4 to 5 years, and time series data would take even longer to develop. In addition, within the data components that are operational in some States, many problems of comparabil-

ity, completeness, data element uniformity, and periodicity of data collection are evident (21, 35).

NCHS is seeking additional Federal funds to accelerate the implementation of CHSS. In FY 1978, Federal expenditures for CHSS totaled \$14.3 million (25). If additional funds are allocated to the program, NCHS plans to implement the vital statistics, health manpower, and health facilities components in all States by **1979** and all seven CHSS components by 1983 (34). OSP has awarded a contract to fully evaluate CHSS, including its concept, organization, and costs. A preliminary report is anticipated in 1979 and a full report in 1980.

RWP allows NCHS, with its superior technical capabilities and expertise, to be reimbursed for performing statistical activities that supply data to other Federal agencies. For example, RWP derived estimates of "problem drinkers" by States for the National Institute on Alcoholism and Alcohol Abuse (NIAAA). These estimates were used by NIAAA in decisions concerning the allocation of Federal funds to alcoholism treatment centers. Through the Health Interview Survey (HIS), NCHS also collected data for the Office of Smoking and Health (OSH). NCHS views the RWP as an important mechanism for increasing the reliability and validity of data, eliminating overlap, and reducing overall Federal costs (34). Its statistical services include not only methodology design, technical assistance, and data analysis but also the actual data collection for other Federal programs.

NCHS established the RWP in FY 1976 under the authority provided by section 601 of the Economy Act of 1932. Staff restrictions on NCHS, however, have limited its growth and hindered the performance of its duties. In RWP'S first year, NCHS allotted 25 positions for the program. This allocation increased the total number of staff positions to 34. Previously, NCHS had informally delegated nine positions to the program in order to begin responding to Federal agencies' requests for technical assistance. Since 1976, no new staff positions have been created.

Public Health Service: Office of Planning and Evaluation

The Office of Planning and Evaluation (OPE), as mentioned previously, was created as part of the January 1979 reorganization of OASH. The health policy, evaluative, and legislative development responsibilities of the Office of Health Policy, Research and Statistics (OHPRS), now OHRST, were transferred to the Office of Planning and Evaluation. The Office of Statistical Policy (OSP), the focal point within PHS of efforts to develop and coordinate health data and statistical policy, was also transferred from OHPRS to the new office. Statutory authority for the activities of OSP derives from section **301** of the Public Health Service Act which requires the Surgeon General to promote the conduct and coordination of data collection activities.

The Office of Statistical Policy (OSP) has responsibilities for coordinating and standardizing all health data policy for PHS and acts as a liaison for statistical policy with other Federal agencies concerned with health issues. OSP reviews and makes recommendations on PHS statistical budgets, plans, evaluation studies, and legislative proposals, and is responsible for the final reports clearance within PHS. It reviews and comments upon reports, papers, and studies relative to statistical policy issues for the Surgeon General and provides a statistical perspective to the PHS policy development process. OSP was instrumental in the development of, and now provides staff support for, both the PHS Health Statistics Coordinating Committee (HSCC) and the Health

Data Advisory Committee (HDAC). The direction, coordination, and much of the work of the HEW annual inventory of health data projects are being conducted by OSP.

OSP was established by a December **1977** reorganization of OASH that gave special attention to data policy. Before 1977, OSP was part of the Office of Policy Development and Planning (OPDP), a predecessor of OHPRS. Despite subsequent reorganizations, OSP has retained many of the same broad responsibilities, delegated by the Secretary for statistical coordination and planning, as OPDP (**43**). Thus, the accomplishments and problems of OSP can best be viewed in an historical context.

OPDP concentrated its staff resources on final clearance activities, and its efforts were successful in reducing Federal reporting burden. Approximately 340 data projects were initially reviewed by the Office in FY 1974, the number of projects submitted for review in FY **1977** had decreased to approximately 170. In FY 1978, OSP reported the submittal of 156 projects (48).

The reports clearance process, which reviews projects for technical, substantive, and policy concerns, has improved the technical quality of surveys and other data collection activities conducted by PHS. To further enhance technical quality, OSP initiated a procedure by which any project submitted for clearance that contains complex methodological or sampling designs is routed to statisticians in NCHS for technical review. OSP also routes data projects involving surveys of hospitals or health manpower to NCHS, which then checks samples to assure they do not duplicate selection of the same health professionals or hospitals responding to current data projects.

OSP'S successes in planning and coordinating data projects are less clear than its achievements in reducing reporting burden. Limited authority and insufficient staff in both OPDP and OSP have prevented aggressive planning for the majority of health data systems and projects. Presently, there is little indication that OSP will provide greater leadership in health data policy matters than its predecessor.

Public Health Service Agencies

The six agencies of the Public Health Service independently and jointly conduct some activities related to the coordination of health data. A representative of each agency is a member of PHS'S HSCC. Each agency has its own clearance officer who reviews agency forms, reports, and data systems before their transmittal to OSP. In addition, several agencies have made substantial efforts toward improving the coordination and compatibility of their own data systems.

The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) is planning to establish a new data-related committee to replace the recently abolished Program Data Coordinating Committee (PDCC). During its existence, PDCC examined the conceptual and definitional compatibility of data elements used in the client-oriented data systems of ADAMHA's three institutes. Goals of the PDCC included determining minimum data sets and, while not combining Federal-level data systems, encouraging individual States to develop an integrated data system for all programs administered by ADAMHA. As part of a mental health statistics improvement program in the National Institute of Mental Health (NIMH), one of the three ADAMHA institutes, uniform data sets for mental health facilities, manpower, and client data are being developed. To ensure consistency with CHSS, a memorandum of understanding was exchanged between NIMH and NCHS and an interbureau committee was established to maintain coordination.

The Center for Disease Control (CDC) has a staff activity that evaluates current national surveillance systems in an effort to coordinate them. Currently, a number of surveillance systems obtain data from various sources, including city and county health departments, State health departments and vital registrars, hospitals, physicians, and clinical laboratories. The CDC staff activity, organized in early 1978, has initiated several studies to determine the best methods for obtaining unduplicated counts of different health conditions. Results of the studies, which are expected within 3 years, are meant to indicate which surveillance systems should be combined or eliminated.

The Health Services Administration (HSA) maintains no formal data coordinating committee for its three major divisions, the Indian Health Service (IHS), the Bureau of Medical Services (BMS), and the Bureau of Community Health Services (BCHS). However, BCHS has successfully consolidated the requirements for its health services programs into a common program management reporting system. The new data system, the BCHS Common Reporting Requirements (BCRR), became operational in early 1977, replacing six diverse program data systems.

The Health Resources Administration (HRA) and two of its bureaus, the Bureau of Health Planning (BHP) and the Bureau of Health Manpower (BHM), work closely with NCHS to determine and meet the data needs of their programs. Enabling legislation for BHP, Public Law 93-641, and for BHM, Public Law 94-484, mandated this cooperation with NCHS. Currently, NCHS is assisting BHP in the preparation of manuals about data resources for local and State planning agencies; and BHM and NCHS are jointly developing methods to gather data for extensive manpower-related requirements. Successful coordination may have been facilitated by NCHS'S former location within HRA.

The National Institutes of Health (NIH) has customarily allowed each of the 11 individual institutes to assume responsibilities for their own data needs. In **1977**, NIH formed an inter-Institute coordinating committee of epidemiologists to encourage the efficient use of funds in meeting the data needs of the 11 institutes and to respond to the increase in epidemiological research. The committee, which also has representatives from other PHS agencies, serves as a forum for discussing major epidemiological research projects during the early stages of planning. A second committee, the Cost of Illness Coordinating Group, was formed at NIH to investigate methods for developing data on the incidence, prevalence, and cost of diseases.

Advisory Committees

The PHS Health Statistics Coordinating Committee (HSCC) was established in mid-1978 to ensure greater technical and operational coordination of statistical activities within PHS. It acts as an internal forum for information exchange and operational and technical coordination. Representatives from each of the six PHS agencies serve on the Committee. The Director of NCHS chairs the Committee, and OSP serves as executive secretariat.

HSCC meets on a monthly basis and has formed several task forces. One task force, concerned with comparability and standards, has just completed guidelines for standard definitions and minimum categories for data collection for eight data items. HSCC will serve as the conduit for agency comments on the guidelines as well as for their promulgation through PHS reports clearance channels. Another task force is reviewing the NIMH Mental Health Demographic Profile System in terms of its ability to fulfill various PHS agency needs.

The Health Data Advisory Committee (HDAC) was formed to ensure that the health statistical systems of HEW are coordinated, produce complementary statistics, and minimize the impact of Federal reporting requirements on health care institutions. HDAC is responsible for evaluating data policies and systems, encouraging the coordination of statistical activities between HEW and other Federal agencies, recommending requirements and reviewing proposals for uniform data sets and for standard definitions of data elements, and advising the Secretary on cross-cutting issues relative to health statistical systems (28).

HDAC is a newly established committee; its charter was signed by the Secretary on February 3, 1979. HDAC was created to replace and augment the work of its predecessor, the Health Data Policy Committee (HDPC). In light of the recent signing of the charter, it is premature to assess the new Committee's impact. The accomplishments and limitations of HDPC are instructive in understanding HDAC'S anticipated role.

The Assistant Secretary for Health established HDPC in March 1974 to provide policy guidance and coordination for HEW health data activities. Identified as the focal organization within HEW for health data policy, the HDPC charter assigned the Committee major responsibilities that were very similar to those now delegated to the new HDAC (29). Until mid-1977, HDPC met on a monthly basis. HDPC ceased functioning at that time, pending the reorganization of OASH.

HDPC essentially served a reactive function because its activities centered around general and specific statistical issues brought to its attention. Its major accomplishment was the sponsorship of an annual health statistics plan for HEW. The initial health statistics plan, issued in 1976, represents the first inventory of HEW health data projects. The second and final HDPC plan was issued in 1977 and included a descriptive framework for health statistics. It also inventoried HEW health data collection projects and described health data systems operated by VA and DOD.

A fundamental problem of HDPC was its lack of authority to force decisionmaking or implement policies, especially those decisions involving agencies outside PHS. Although composed of agency representatives from throughout the Department, the Committee was dominated, in terms of the composition of its membership and its organizational placement, by PHS. Consequently, each member functioned as a peer within HDPC, usually without relinquishing agency viewpoints. In addition, the anticipated role of HDPC in setting priorities for remedial actions in data projects was not realized; it did not function as a policymaking body (5). This shortcoming was recognized by members of HDPC. In interviews with the Office of Technology Assessment (OTA), one member expressed the view that, although the Committee was a useful forum for expressing agency interests, the group was not successful in reaching consensus. Other members expressed frustrations with the lack of Committee progress.

HDAC was formed to correct some of the more fundamental shortcomings of HDPC. Therefore, HDAC'S members are more broadly representative of the entire Department and less representative of PHS. The Committee will be chaired, on an annual rotating basis, by the Deputy Assistant Secretary for OHRST in PHS and the Associate Administrator for OPPI in HCFA. The Director of OSP will serve as the executive director of the Committee and provide the necessary staff. The new Committee will have members from ASPE, ASMB, the Office of the Assistant Secretary for Human Development, the Office of Inspector General, HCFA, PHS, and NCHS. In addition, representatives of OFSPS in Commerce, VA, and DOD will be invited as nonvoting members to participate in the Committee's meetings. The Assistant Secretary for

Management and Budget will arbitrate issues that cut across agency jurisdictions when they cannot be resolved within the Committee (28).

The need for a departmentwide committee is partially demonstrated by the absence of an inventory of health data systems during the year no committee existed. PHS did publish a statistics report for FY 1977, but it included only PHS data systems. A statistical plan for FY 1978 is now being prepared under the auspices of HDAC. The plan includes an inventory of the health data activities of PHS, HCFA, ASPE, and the Office of Human Development Services.

The National Committee on Vital and Health Statistics (NCVHS) was mandated by the Health Services Research, Health Statistics, and Medical Libraries Act of 1974, Public Law 93-353, to serve as an external public advisory committee on health statistical matters to the Secretary of HEW. NCVHS was originally chartered, at the request of the World Health Organization, in the late 1940's to represent the United States at international meetings. Although NCVHS still continues to serve in an advisory role for international statistical and classification activities, its statutory authority considerably expanded the role of the 15-member advisory committee (30). Its membership, selected by the Assistant Secretary for Health, is composed of nongovernmental experts representing several health-related disciplines.

To assist and advise the Secretary, NCVHS is charged by legislation with three primary functions: to delineate statistical problems bearing on health and health status and to stimulate studies of such problems whenever possible; to determine, approve, and revise the terms, definitions, classifications, and guidelines for assessing health status, health services, and health service distribution and cost; and to counsel on the design and approval of health information systems concerned with the collection, processing, and tabulation of health statistics within HEW. Legislation passed in **1978**, Public Law **95-623**, added advisory responsibilities relating to both CHSS and the formulation of standardized means for the collection of health information and statistics. This Committee's ability to fulfill such a large mandate is limited, however, because it meets only three times a year and has few staff resources.

NCVHS reviews and comments upon the various documents concerning health data prepared by HEW and OMB. It is briefed on the health data activities of various agencies within HEW and makes suggestions for their improved coordination with NCHS. Finally, it examines specific problem areas brought to its attention, including the need for promulgating and implementing the uniform hospital discharge data set throughout HEW and the lack of a single departmentwide policy on confidentiality. NCVHS has made strong recommendations for the solution of these data problems. It has also suggested several HEW reorganization plans that would facilitate coordinating and monitoring health data systems.

Substantive contributions are made primarily through its subcommittees. A number of subcommittees are currently designing uniform data sets for basic categories of health data that can be used by various Federal agencies. The subcommittee on hospital discharge data has completed its work and serves as a model for other NCVHS subcommittees concerned with uniform data sets for ambulatory care, long-term care, manpower, and facilities. Four other subcommittees are also active: One is evaluating the NCHS Health Interview Survey (HIS); another is considering needs for health information under national health insurance; a third is advising on issues related to CHSS; and the fourth is examining the needs for mental health statistics and the best methods to meet these needs.

A problem confronted by NCVHS is its traditional association with PHS, despite the fact that its enabling legislation established it in the Office of the Secretary. The Assistant Secretary for Health appoints its members and staff support is provided by NCHS. Furthermore, the Committee spends a majority of its time inspecting programs of NCHS (26). NCVHS has not been assigned clear responsibility for monitoring statistical activities outside PHS. In particular, it has not exercised oversight responsibilities for the data collection activities of HCFA, although HCFA maintains large data collection programs in the area of health cost and expenditure data. In early 1978, the NCVHS charter was rewritten to explicitly state that the Committee must report to the Secretary and must act as an advisor to the Department on all health statistical matters. The Secretary has not yet acted upon this new charter.