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Federal Security Agency
U. S. PUBLIC HEALTH SERVICE

FORTY-THIRD ANNUAL CONFERENCE OF THE PUBLIC HEALTH SERVICE
WITH STATE HEALTH AUTHORITIES

April 9-11, 1945
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MONDAY AFTERNOON SESSION

April 9, 1945

The opening session of the Forty-third Annual Conference of the United States Public Health Service with the State and Territorial Health Officers, held in the National Academy of Sciences Lecture Room, Washington, D. C., convened at two o'clock, Dr. Thomas Parran, the Surgeon General, presiding.

CHAIRMAN PARRAN:

The Forty-third Annual Conference of State and Territorial Health Officers with the Public Health Service is in session.

The current problems with which you and I need to deal jointly are designated by the topics for discussion listed on the program. I have asked various members of my staff to present, in detail, developments in the expanding programs of public health.

Since our last meeting, Public Law 410 has been passed. I shall not review its provisions in detail, for I hope they are familiar to all of you. This law has the great merit of bringing together, in one comprehensive statute, all of the previously existing laws relating to the Public Health Service except the Nurse Training Act--a temporary wartime law. It has given us new broad authority to act in several important areas of public health. Some of these provisions may be of great significance in the future. The new law establishes a tuberculosis control program. It strengthens the authority of the Public Health Service in administering interstate quarantine measures. Definite recognition is given to the important part to be played by nurses and scientists in our future work. These groups now are entitled to commissions in the regular corps on the same basis as our medical, dental, engineering and pharmaceutical officers. In the field of research, we have received the very important authority to allot grants-in-aid to scientific institutions, and to award fellowships in any field of medical or public health science.

This plan for cooperative activity in the quest for new knowledge has already been proved valuable in cancer research. During the War, Federally supported research under the O.S.R.D. has made very substantial contributions throughout the whole field of science. The Public Health Service hopes to develop an effective program of cooperative medical research pursuant to its authority.

Also in Public Law 410, Congress recognized the need for demonstrations, which are in effect pilot plant operations intermediate between the laboratory study and full-scale public health application.

The procedures for allocating funds to the States for public health work have been changed and, we think, improved, so as to permit greater flexibility in meeting the varying needs among the States.

Far-reaching developments in national health have already been set in motion. You are aware, of course, that hearings have been held on S.191, a bill to amend the Public Health Service Act and to authorize grants to the States for surveying their hospital and health center resources, planning the construction of additional facilities and assisting in such construction.

The hospital construction plan will be discussed in detail by Doctor Hoge. My purpose in mentioning it is to point out that this program, although similar to the cooperative health programs now in operation, involves considerably larger amounts of money. I would point out also that very few State governments have established a pattern of administration for their hospital systems, as compared with the number which have established methods of administering the traditional health programs. It should be noted that S.191 does not specify that the Health Department shall be the State Agency responsible for planning and constructing hospitals. The American Public Health Association has recommended strongly that the bill should be amended so to provide.

Before this bill is passed, the Congress is likely to consider alternate methods of administration and finance. I refer to the provisions of the Mobilization and Reconversion Act, which, by implication, gives to the Federal Works Agency the authority for planning all public works except housing, public roads, rivers and harbors, and the like. This Act further authorizes that loans to States be made for the purpose of making surveys, drawing up plans and specifications, and related activities. These loans would be repaid out of future grants by the Federal Government for the construction of such projects. S.191 provides that the Public Health Service shall utilize the facilities of the Federal Works Agency, so far as possible, in the administration of those phases of the program for which the FWA presumably has a competent staff and suitable experience.

We should like to have your ideas about this projected legislation. It would be helpful to the Public Health Service if we may know the position of the State health officers in regard to the question of the State agency appropriate to administer the hospital construction program.

Similar problems are likely to confront us in connection with other pending Federal legislation dealing with health. These several bills will be described to you by Doctor C. L. Williams. Acquaintance with the position of the State health officers towards these other proposed laws likewise will be helpful to us in formulating recommendations we may make concerning each piece of legislation.

To afford a background for your consideration, I can say that we have felt that the present pattern of Federal-State relationships in public health is a satisfactory pattern, and that it can be expanded and modified so as to serve as a structure for the accomplishment of such national health purposes as hospital construction, psychiatric services, dental hygiene--in fact so as to serve as a vehicle for any program established by the Congress for the protection of health or the provision of medical care. The fact that our current methods are satisfactory, however, should not prevent us from seeking adaptations, changes, or even new patterns, if thereby they will more effectively serve the health of the people of this country.

I shall not attempt to discuss all of the alternative methods of procedure. In fact, the pertinent considerations vary according to the particular problem and the specific means adapted for its solution. For example, an alternative to the allocation of Federal funds to the States for the construction of hospitals and health centers might be direct dealing between the Federal Government and the municipality or other subsidiary State unit concerned. Standard procedure may also be varied by the fact that the health agency in some States may not wish to assume the responsibility for hospital planning, licensing the maintenance of

standards, and other controls which are implicit in the development of an integrated State-wide system of hospital service. Likewise, in the field of neuropsychiatry, many States have a separate mental hygiene department, while in other States, these services are operated as a function of a hospital commission. In still others, the State health department has a special agency to administer neuropsychiatric programs. In traversing these varied patterns, which inter-agency lines of communication ensure the most effective operation and the best service to the people?

Nine years ago, when I came to Washington, stream pollution and its control was on the list of our discussions. Even then, bills were pending in the Congress to deal with this matter. In the intervening years, two measures were passed by the Congress: one was vetoed by the President in 1938; in 1939, companion bills were passed by the respective houses, but failed in conference. Two bills are now before the Senate, supported by identical bills in the House; also before the House is a third measure which, in general, conforms with the type of legislation recommended by the State and Territorial Health Officers in 1936.

There are several important factors involved in this important question of stream pollution which you might well consider in preparing your recommendations for Federal corrective action. First, to what extent should the Federal Government exercise its constitutional authority to regulate commerce by imposing penalties on municipalities and industries which, even with Federal assistance, after a reasonable period still fail to correct sewage pollution? Second, since the prevention of stream pollution is only one step towards effective utilization of the nation's water resources, what is the best way to integrate control of stream pollution with the broader program of national water conservation and utilization? I would mention a few of the Federal agencies which have an obvious interest in this program: the Engineer Corps of the Army, the Fish and Wild Life Service, the Bureau of Mines, the Bureau of Reclamation, the Soil Conservation Service, and the Forest Service. The military, economic, and health values inherent in this nation's water resources are of such importance that this question should be approached from the point of view of broad-scale planning.

As I said, Doctor Williams will tell you about important legislation affecting the entire field of public health now before Congress. A study of these proposed laws will require one full day of discussion. Nonetheless, it is vital that we know what legislative provisions will, in your opinion, most effectively meet the needs of the country.

You are aware of the rapidly developing program of tuberculosis control, which will be discussed in detail by Doctor Hilleboe. I would only point out to you that there are rich opportunities in this field for the coordination of all community resources to fight this old enemy of ours to the finish.

In considering venereal disease control, the rapid changes in scientific techniques have produced new problems. The nature of these new problems is not entirely clear, and will not become clear until recent scientific advances have been more accurately appraised. Eventually, standard methods of treatment will be developed as a result of these appraisals. Doctor Heller will discuss with you the goals in venereal disease control. I hope he will bring all of us up to date on the newer treatment methods in addition to explaining the anticipated shift in financing the Rapid Treatment Center program. The Centers have been an

indispensable part of the wartime program of venereal disease control. The Federal Works Agency has decided that it no longer wishes to finance the program. To my mind, it is absolutely essential that the Centers be taken over and operated under the aegis of the Public Health Service, with the same cooperation of State and local health agencies as has heretofore existed.

In recent years, we have been confronted with a number of specific interstate health problems. These have included such diverse concerns as the travel of persons who are active spreaders of venereal disease, the interstate shipment of uncooked garbage and the unregulated shipment of cheese. To prevent the recurrence of typhoid epidemics such as have been caused in a number of areas by infected cheese, there should be developed proper standards for the preparation and shipment of this food.

At this point, may I draw your attention to the fact that since, under the provisions of Public Law 410, the authority of the Public Health Service in the field of interstate quarantine has been greatly strengthened, tentative draft of new regulations has been prepared. The new regulations merit careful consideration by the committee assigned to study them. Even though the Public Health Service now possesses strong authority in the entire area of interstate commerce, it is our hope that a minimum of legal action will be required. This desirable result will be realized, however, only if each State itself keeps its own house in order.

Within the past several months the District Offices of the Public Health Service have completed re-surveys in 476 critical war areas. Of these, 88 were still without any health service whatsoever. Another substantial number had only part-time organizations. Many of these crowded communities had no milk and food sanitation programs. Garbage and refuse disposal was lacking in a number of areas. In these 476 war areas, the shortage of health manpower was still critical; some 3200 workers, in various categories, were needed to supply even minimal health services.

A large part of our discussion in the next few days will be related to the provisions of the new legislation. As I have said under Public Law 410, there has been a re-cast both of interstate quarantine and grant-in-aid regulations. In addition, there have been changes in policies governing training activities and other phases of our program.

In these days when we are in the throes of war, faced with a shortage of personnel, preoccupied with the urgent task of the day, we have little energy left for contemplating the long-range view. Nevertheless, the war will end, and, with the coming of peace, we shall have new and urgent problems. It is important that we should begin now to plan for the health and medical services which our people will require in the years ahead.

As I recall the several current and future problems which I have heretofore attempted to outline, they seem to break down into certain broad objectives:

1. An integrated system of hospitals and health centers, with adequate facilities in each State.
2. Expanded health services sufficient to reach every part of the country and carry on more intensively the preventive programs for control of venereal diseases, tuberculosis, malaria, and other mass diseases.

3. A sanitary environment for all of the people.
4. More extensive research in the medical and public health sciences.
5. Training of professional personnel to carry out these several tasks.
6. A national program of medical care maintained through a combination of insurance and tax-supported services.

In essence, these same objectives have been formulated by the American Public Health Association. There is apparent agreement in many quarters as to the broad objectives of a national health program. It is important that we formulate our goals and our programs of service, but this formulation will have value only when we are able to transmit to the rank and file of our citizens a knowledge of real health needs. We must stimulate a demand for the services which you and I know are required to raise the standard of health in this nation.

We are operating a joint enterprise, Federal-State cooperation for national health, which has proved a satisfactory practice thus far. However, we should not be blind to the fact that there are shortcomings in the present grant-in-aid program. We shall expect you to tell us about our shortcomings in connection with these grants. We, on our part, get complaints from communities which feel that they have been discriminated against, and have not received their share of Federal support from their State Agency. For example, most States have no formula for channeling Federal grants into the several communities in proportion to their needs. It is pointed out to us that the action of the State health officer is often arbitrary in the giving or withholding of funds; and that, in any event, there are no objective criteria by which to determine whether the obvious intent of the Congress is being fulfilled. In other words, there is no way to be sure that Federal funds are put to work for the benefit of all citizens for the improvement of their health in proportion to their need.

This consideration becomes even more important as we contemplate the amounts of money which would be allocated under the provisions, for example, of the hospital construction bill. We do not feel that it is desirable to attempt to regiment State policies here in Washington. However, we do feel justified in insisting that each State develop a standard practice for the distribution of Federal funds that can be justified on an objective basis. Such a practice should be designed to prevent favoritism and discrimination between communities in the State. Already a few States have done an excellent job of this kind. I would commend to the remainder a careful study of what has been accomplished.

In the next few days, we shall set our sights for another year of mutual endeavor for the nation's health. We must set them high, for the complex problems of a return to peace may be upon us before we meet again. The spirit of the times is one favoring greater achievements in service to humanity than we hitherto hoped to see in our lifetime. Many of the proposals which are now being made, and imply immediate action, actually are the dreams of public health workers made real. May we all continue to work together for their fullest realization.

We had hoped to have the Federal Security Administrator and Chairman of the War Manpower Commission here to speak to us, but unfortunately Mr. McNutt is out of the city, and he has asked the Deputy Chairman of the War Manpower Commission to be present and represent him. I have great pleasure in introducing to you the Honorable Frank L. McNamee, Deputy Chairman of the War Manpower Commission.

THE HONORABLE FRANK L. McNAMEE:

Public health has come into its own during this war. As you know, specific public health fields have gained recognition such as they have never before had. Industrial hygiene is one. Sanitary engineering is another. Health measures have gained a success that will undoubtedly bring even greater recognition in years to come. Also, it is to the credit of our public health authorities that we have experienced migrations of vast numbers of war workers and yet avoided destructive epidemics.

While visiting the battlefields in Europe recently, I learned that the War Department is putting greater emphasis than ever on public health. It is meaningful that the Army has attached to Supreme Headquarters no less an authority than Major General Warren A. Draper, Deputy Surgeon General of the United States Public Health Service.

I drew from my experience at the battlefronts the fact that our troops are finding out what public health in the United States means. The soldiers in Europe--and in the Pacific, where conditions are even worse--are learning what it means to be without proper sanitary facilities. They know what it means to be unable to drink the water that is at hand.

I also saw on the battlefields the results of our improved techniques in the field of medicine and surgery. I saw doctors giving miracle drugs. I can well understand why deaths from wounds are only 3 percent, as against 8 in the last war. These miracle drugs, improved techniques in medicine, and the experiences of physicians themselves will benefit the entire nation. Because of their experiences with mass health needs, returning physicians should have even greater understanding of the post-war health needs in America.

Great credit is due to those of you who have gone to Europe and the Pacific to help win the war. But great credit is also due you who have remained at home. It is unlikely that you will receive any decorations or special recognition for your home services. But you and other members of the medical and health professions have been essential on the home front.

One of the important tasks of the War Manpower Commission, in cooperation with public health officials, has been the maintenance of a satisfactory balance between medical services for the armed forces and the home front. This problem has, indeed, been a delicate and difficult one. Too few physicians with the Army or Navy might have seriously impeded military operations, while too few physicians at certain places on the home front would have lowered morale and adversely affected the production of war materials for the armed forces. We now have an Army and Navy of more than 12 million. During peacetime years we did not graduate a number of professional personnel sufficient to meet the current needs of the armed forces. As a result, it has been necessary for the civilian population to go without some of its medical care, in order that the armed forces could have enough doctors to meet their essential needs.

You know, of course, that as a result of manpower shortages in specific areas it has been necessary to place manpower ceilings on less essential establishments in order that workers can be released into more essential industries. The ceilings become general only in the so-called "tight" labor market areas in which there are labor shortages in essential work.

Since health services are essential to a community, no unduly restrictive ceilings are likely to be placed on them. However, health offices, hospitals, and physicians can help to solve acute manpower shortages wherever they exist by being careful not to employ more help than is absolutely necessary.

In passing, I should like to pay tribute to Mr. McNutt for his deep interest in health matters. As I said, I recently had the opportunity of accompanying him to the battlefield of Europe. Because of his interest, Mr. McNutt was concerned that our troops were getting proper medical attention and that medical and health personnel itself was getting along all right.

Health protection of working men and women on the job and in their home environments continues to be a manpower "must." It is important that we plug up all the health gaps we can. The range of opportunity here is wide, but particular attention should be paid to the essential war programs. Your local War Manpower director will be glad to tell you what they are. They may occur in foundry operations, in lead production, or in any one of the highly essential war production programs.

In some instances workers have shunned foundries because of dust, fumes, and gases. Surveys by industrial hygiene specialists have been followed by improved working conditions in some foundries, but more still needs to be done. Also industrial hygiene specialists have opportunities to plug some health gaps in lead production, mining, and smelting.

Sometimes, when health hazards in an industry have been exaggerated, education to correct undue fears in the minds of workers should be undertaken. Thus production will not be delayed.

Industry itself has learned much of practical value through the work of public health men and women. From my own experience as WMC Regional Director, I know that there is still more to learn.

In spite of a limited budget, the Industrial Hygiene Division of the U. S. Public Health Service has provided leadership and much useful service. This Division has made more than 200 surveys closely related to manpower in Government-owned contractor-operated plants. This Division has also given invaluable service to war industry in making investigations and recommending remedial action in such important war industries as aluminum reduction, asbestos, and textiles. The Division has helped to solve health problems in the meat and slaughtering industry. It has aided the rubber industry.

We have witnessed the reemployment of thousands of handicapped persons, undertaken under the impact of this war. The expansion of vocational rehabilitation under the Federal Security Agency, working as a partner organization to the War Manpower Commission, has helped to meet war manpower needs. In time of stress, such rehabilitation means increasing manpower, but it also means increasing emphasis on human values. It means a new awareness that a nation's greatest resource is its people. Under FSA's rehabilitation program and WMC's selective placement program, thousands of men and women with all types of impairments have been brought into the labor force. Employers and workers have learned that a disability need not disqualify a person from useful employment and the chance to serve during the war.

The U. S. Public Health Service estimated in 1942 that there were roughly 23 million persons in the United States with chronic disease or physical impairment. Handicapped persons are today employed in jobs that range from aircraft manufacture and shipbuilding to radio repairing and all sorts of machine operations. In a study made by the Office of Vocational Rehabilitation, evidence from 117 industrial establishments employing disabled persons demonstrates that physically impaired workers have given a big manpower lift to the war effort.

Some day there will come an end to the war in Europe. We hope it will be soon. But there is a long war in the Pacific to be fought. When final victory comes, there will be new frontiers to cross in the field of manpower and public health.

We can reconvert our war skills into peacetime uses--the biggest job ahead in the post-war days. We can achieve full use of manpower. We can, the experts tell us, employ sixty million workers.

These new frontiers will offer new vistas, too, in the field of public health. There will be an opportunity to use all the technology that we possess to make this country the most healthful of all places in which to live and work. There will be the challenge to continue the expansion of our present program in the field of industrial hygiene, and to participate even more extensively in the rehabilitation program for both civilian disabled and soldier disabled.

I salute the gallant men and women of our public health services--they have helped to make it possible for the nation to produce miracles in war production and to back up our armed forces. They--every one of them--on foreign fields or on the home front--whether caring for the sick and wounded or working in hospitals or laboratories or in health offices--all are entitled to the gratitude of the nation.

The roll was called by Dr. J. O. Dean. The following were present:

Alabama	B. F. Austin, M.D.
Alaska	George Hayes, M.D.
Arizona	G. F. Manning, M.D.
Arkansas	T. T. Ross, M.D.
California	Malcolm H. Merrill, M.D.
Colorado	R. L. Cleere, M.D.
Connecticut	Stanley H. Osborn, M.D.
Delaware	Carlyle P. Knight, M.D.
Florida	Henry Hanson, M.D.
Georgia	G. G. Lunsford, M.D.
Idaho	L. J. Lull, M.D.
Illinois	Roland R. Cross, M.D.
Indiana	Thurman B. Rice, M.D.
Iowa	Walter L. Bierring, M.D.
Kansas	F. C. Beelman, M.D.
Kentucky	P. E. Blackerby, M.D.
Louisiana	David E. Brown, M.D.
Maine	Roscoe L. Mitchell, M.D.
Maryland	Robert H. Riley, M.D.
Massachusetts	V. A. Getting, M.D.
Michigan	William DeKleine, M.D.
Minnesota	A. J. Chesley, M.D.
Mississippi	Felix J. Underwood, M.D.
Missouri	John W. Williams, M.D.
Montana	B. K. Kilbourne, M.D.
Nebraska	C. A. Selby, M.D.
Nevada	Edward E. Hamer, M.D.
New Hampshire	Alfred L. Frechette, M.D.
New Jersey	J. Lynn Mahaffey, M.D.
New Mexico	C. H. Douthiry, M.D.
New York	Edward S. Godfrey, M.D.
North Carolina	Carl V. Reynolds, M.D.
North Dakota	George F. Campana, M.D.
Ohio	Roger E. Herring
Oklahoma	Grady F. Mathews, M.D.
Oregon	Harold M. Erickson, M.D.
Pennsylvania	A. H. Stewart, M.D.
Puerto Rico	A. Fernos Isern, M.D.
Rhode Island	Edward A. McLaughlin, M.D.
South Carolina	G. E. McDaniel, M.D.
South Dakota	Gilbert Cottam, M.D.
Tennessee	R. H. Hutcheson, M.D.
Texas	George W. Cox, M.D.
Utah	William M. McKay, M.D.
Vermont	C. F. Dalton, M.D.
Virginia	I. C. Riggin, M.D.
Washington	A. L. Ringle, M.D.
West Virginia	John E. Offner, M.D.
Wisconsin	Carl N. Neupert, M.D.
Wyoming	G. M. Anderson, M.D.

CHAIRMAN PARRAN:

The next item on the program is the discussion of pending legislation and anticipated funds, by Dr. C. L. Williams.

PENDING LEGISLATION AND ANTICIPATED FUNDS

DR. C. L. WILLIAMS:

Probably the most important law passed in the year since this conference last met is Public Law 410, 78th Congress, which gathers together and clarifies all of the Public Health Service authorities existing previously in numerous laws and parts of laws.

One feature of Public Law 410 is the provision for reorganization of the Public Health Service, providing for its administration in four main sections: The Surgeon General's Office, the National Institute of Health, the Bureau of Medical Services, and the Bureau of State Services. The Surgeon General's Office includes personnel, finance and similar services and comprises the Division of Nurse Education, Sanitary Engineering Division, Dental Division, Division of Public Health Methods, and the Office of International Health Relations. It also includes the Chief Medical Officer assigned to the Coast Guard, and the District Directors.

The National Institute of Health, as heretofore, administers medical research. The Cancer Institute is one of its divisions.

The Bureau of Medical Services comprises the Marine Hospital Division, the Mental Hygiene Division, and the Foreign Quarantine Division.

The Bureau of State Services, as its name implies, embraces those activities which relate directly to cooperation with the States. In it are the States Relations Division, Industrial Hygiene Division, Tuberculosis Control Division, Venereal Diseases Division, Office of Public Health Nursing, and Administrative Unit, and the District Offices. The District Office Directors, however, are responsible directly to the Surgeon General.

Under Public Law 410 the authorities are more precisely stated, and confusion that surrounded some of them in the past has been removed. For example, the Service is specifically charged with the duty of cooperating with the States on matters pertaining to public health. Its authority in interstate quarantine is clearly defined and provides, for instance, for actual detention of persons infected with certain diseases (which are to be specified from time to time by the President). The grant-in-aid provisions have been rendered more flexible, so that, for example, reallocation of funds which are not used by individual States can be made. This law will soon be in full effect when the various regulations for which it provides are promulgated.

Another enactment pertaining to public health is Public Law 457, which relates to the disposal of surplus property. This contains the provision that surplus medical supplies, equipment, and property suitable for use in public health, may be sold or leased to the States, and that the costs may be arrived at after consideration of the benefits accruing to the Government. It also provides that, for this class of property, the States shall have priority second only to that of Federal agencies. The law is to be administered by the Surplus Property Board, the status of which at present is somewhat confused but probably will be completely clarified by Congress. It seems unlikely, and probably it is not desirable, that the Public Health Service will act towards the Surplus Property Board in anything more than a consultative or advisory capacity.

In the field of proposed legislation is Senate Bill 191, introduced by Mr. Hill of Alabama, which provides by amendment to the Public Health Service Act for grants to the States (1) to survey their hospital needs and develop hospital construction programs, and (2) to actually carry out hospital construction. An important feature of the bill is the provision that to secure an allocation for planning, a State must (1) designate a single State agency for hospital survey and planning, (2) provide for a State advisory council, (3) agree to accept standards set by the Surgeon General with the approval of the advisory council (provided in the bill), (4) provide for reports as required by the Surgeon General. The Surgeon General must approve requests for allocations complying with these provisions. The appropriation authorizations in the bill are \$5,000,000 for planning, \$100,000,000 for construction, and \$5,000,000 for administrative expenses for construction.

Senate Bill 190, introduced by Mr. Murray of Montana, January 10, 1945, proposes to establish in the Public Health Service a division to be known as the National Institute of Dental Research.

Another dental bill, H.R. 2234, was introduced in the House by Mr. Traynor of Delaware, February 16, 1945. It proposes to amend the Public Health Service Act so as to provide grants to the States for developing dental health. All grants and programs under the bill would be subject to the approval of a National Dental Health Council at the Federal level and to the approval of a Dental Board at the State level. The majority of the members of the State Board must be engaged in the private practice of dentistry.

There are at least three bills in Congress proposing to provide for water pollution control. Of these, H.R. 592, introduced by Mr. Spence of Kentucky, January 3, 1945, is similar to the bill introduced by Judge Vinson at the request of the State Health Officers in 1936. It does not include any regulatory provisions. In addition, there are H.R. 587, introduced by Mr. Smith of Maine, January 6, 1945, and Senate Bill 330, introduced by Mr. White of Maine, January 18, 1945. These are companion bills which more or less combine into one bill the nonregulatory and regulatory bills which have appeared in the past.

Senate Bill 406, as introduced by Mr. Downey of California, January 25, 1945, is a companion bill to H.R. 284, introduced by Mr. Randolph of West Virginia, January 3, 1945. They provide for health programs for Federal employees.

H.R. 395, introduced by Mr. Dingell of Michigan, January 3, 1945, is the present edition of the Wagner-Murray-Dingell bill.

H.R. 525, introduced by Mrs. Norton of New Jersey, January 3, 1945, is the bill which has received some attention, I believe, from your Executive Committee. It would provide for grants-in-aid to States for safety and health control of industrial workers. It would be administered by the Department of Labor.

H.R. 1391, introduced by Mr. Miller of Nebraska, January 11, 1945, proposes to establish a Department of National Health.

H.R. 2044, introduced by Mr. Weiss of Pennsylvania, February 7, 1945, proposes to establish a United States Commission for the Promotion of Physical Fitness, and authorizes an appropriation of \$25,000,000 annually as grants-in-aid

to the States. The intent of this bill apparently is to perpetuate the present Committee on Physical Fitness of the Federal Security Agency.

H.R. 2277, introduced by Mr. May of Kentucky, February 20, 1945, is a bill to provide for the drafting of nurses. It has had a somewhat stormy passage in Congress and at the present moment there are considerable doubts as to whether it will pass.

H.R. 2550, introduced by Mr. Priest of Tennessee, March 9, 1945, provides for a National Neuropsychiatric Institute as part of the Public Health Service, and includes grants to the States in an indeterminate amount, the total for all purposes for the first year being \$10,000,000.

There are a number of relatively minor bills in Congress, but those mentioned are the ones of material importance.

No appropriations have been made as yet for the Public Health Service for the fiscal year 1946, but estimates have been submitted to Congress by the Bureau of the Budget. The total estimate for the Public Health Service for all purposes amounts to \$127,197,600. A large part of this, \$59,957,000, is for Nurse Education, while \$14,918,400 is for the operation of hospitals and medical services. The total estimate for the Bureau of State Services amounts to \$48,716,050, split up in its larger figures as follows: States Relations Division \$25,469,000, of which \$11,000,000 is for grants to the States; Venereal Diseases Division \$16,593,000, of which \$9,428,912 is expected to be set aside for grants; Tuberculosis Control Division \$6,047,000, of which \$5,200,000 is expected to be set aside for grants; Industrial Hygiene Division \$134,000.

The principal items under States Relations Division are as follows: Assistance to State, including grants, \$11,467,000; Control of Communicable Diseases, principally typhus and plague, \$356,000; Health and Sanitation in War and Defense Areas, \$2,615,000; Control of Malaria, \$10,897,000.

In addition to this, the Bureau of the Budget has recommended that \$4,644,000 be appropriated to the Public Health Service instead of the Federal Works Agency, to finance the operation of Rapid Treatment Centers for venereal diseases.

CHAIRMAN PARRAN:

"The Objectives of Tuberculosis Control," Dr. H. E. Hilleboe, Chief of the Tuberculosis Control Division.

OBJECTIVES OF TUBERCULOSIS CONTROL IN THE UNITED STATES

DR. H. E. HILLEBOE:

For the past three years we in tuberculosis control have concerned ourselves, under the States Relations Division, primarily with problems related to the war emergency. However, since the passage of Public Law 410 in June 1944, it has been possible to do some over-all planning in tuberculosis control and to lay the groundwork for our joint efforts.

During wartime it is difficult to obtain personnel and equipment, and to bring all resources together on a nation-wide basis. But, by going out and searching in every possible place for personnel, and training individuals who have possibilities for this work, it seems reasonable to believe that a great deal of good can be accomplished even during the present emergency.

Since July 1944, as those of you in the State health departments know, our tuberculosis consultants have been working out of our District Offices to evaluate the tuberculosis control program in the States and in the larger metropolitan districts. This has been done to obtain specific current information showing the extent of the problem in each area, and to determine what could feasibly be done to control the disease at the present time.

Public Law 410 authorized us to ask for as much as ten million dollars for the present fiscal year, 1945. However, opportunities to present requests for funds did not come to the Public Health Service until September of 1944, and because of this delay, requests were cut in half. Also, after consultation with the State health officers, it was found that an immediate high-gear, nation-wide program of tuberculosis control was impossible because of the difficulties of obtaining personnel and equipment as previously mentioned. So the funds requested were considerably less than anticipated at the time of this meeting last year.

Approximately 2 million dollars were requested for the last four months of fiscal 1945. The sum of \$773,000 had been requested in December 1944, in order to set up the tuberculosis control office in the Public Health Service. This \$773,000 was not only for administrative expense but also for recruiting and training 57 regular officers, 17 reserve officers, approximately 50 public health nurses, approximately 50 technicians, and at least 200 other professional people needed in the demonstration work to be carried on in various State and city health departments. The greater part of this money was used immediately for work in connection with State programs.

Approximately \$250,000 was requested to set up a plan of research in tuberculosis control. In a modern-day attack on any chronic communicable disease, research must go hand in hand with public health service. This is particularly true in attacking tuberculosis, because there are many things that we do not know about the disease. Accordingly, a rather extensive research program has been developed, men and women have been recruited, and we have already started research on a cooperative basis in many universities and urban centers throughout the country.

You will recall that in 1944 we were concerned primarily with the matter of case-finding in some of the war production centers. During the past eighteen

months, over one-half million workers in government owned and operated plants have been examined. All cases that were discovered have been reported to local health authorities with the hope that follow-up could be carried out.

In terms of our plans for the future, it is in order to describe the common objectives of those of us working in the Tuberculosis Control Division--our district directors, our consultants in tuberculosis control, and all of the State health officers with whom it has been our privilege to work during the past fifteen years. In one state, it is very easy to think in terms of one particular phase of work, perhaps case-finding, because of the new developments that have occurred in that particular field. In another State, where there are excellent sanatorium facilities, it is very easy to emphasize the hospitalization of individuals with tuberculosis. Nevertheless, if we are going to cut down appreciably the tuberculosis mortality and morbidity rate, it is necessary that we think in terms of a very broad program. Such a program is presented for your consideration this afternoon.

In the years that have elapsed since Koch's momentous discovery of the tubercle bacillus in 1882, knowledge of tuberculosis has increased in many ways. It is significant, however, that in spite of improvements in methods of diagnosis and treatment, no real contribution has been made in the field of prevention. There is neither a specific cure nor an effective immunizing agent against the disease. Therefore, the broad objectives of tuberculosis control must be the discovery of the sources of infection and the avoidance of exposure to them.

If tuberculosis is to be eradicated, it is essential that the rate at which infectious cases develop in the population be maintained permanently below the rate at which infectious cases are isolated and prevented from spreading the disease. Furthermore, the greater the disparity in the two rates, the more quickly will this eradication be achieved. These fundamental principles, emphasized by Frost, must be constantly borne in mind in the planning of a tuberculosis control program.

The first step in the preparation of a decisive attack against tuberculosis is a careful and comprehensive evaluation of the extent and nature of the problem in each community. This should be done by reviewing the age, sex, color and geographic distribution, and the economic status of the population. These data should then be considered in connection with the community's morbidity and mortality rates for tuberculosis (before reliance is placed on these figures, the completeness and accuracy of the local vital statistics should be investigated). Detailed analyses of reliable morbidity and mortality data will quickly indicate the magnitude of the problem and clearly establish those groups most seriously affected and urgently in need of concentrated attention. Spot maps of infectious cases not isolated in hospitals and sanatoria will also be helpful in denoting the known centers of contagion, where immediate action is imperative.

There are several indices, easily derived, that are useful in measuring the force of tuberculosis mortality in a community. The ratio of the annual number of newly reported cases to the number of deaths gives some indication of case-finding activity. A low ratio suggests an inadequate program. Another index of value is the proportion of deaths from tuberculosis not previously reported as cases to the total number of tuberculosis deaths. A high ratio indicates that many new cases are not being reported until the time of death and accordingly that case-finding is poor. In areas where extensive movements of the

population of limited population data make difficult the accurate determination of current death rates, proportionate mortality percentages by age, sex, and color (i.e., the proportion of tuberculosis deaths to deaths from all causes) serve as a satisfactory measure of current mortality trends if interpreted in relation to changes in general mortality.

After the tuberculosis problem has been defined as completely as possible, careful inventory, both qualitative and quantitative, must be made of the facilities and resources being utilized for tuberculosis control in the community. With exact knowledge of the extent of the problem, including both what is, and what is not being done, it is possible to prepare a specific plan of control.

An effective program of tuberculosis control should embrace four principal phases: (1) case-finding, (2) medical care and isolation, (3) after-care and rehabilitation, and (4) protection of the tuberculous family against economic distress. A program which includes these public health measures, supported by research and well planned health education in each field of endeavor, will be certain to reduce the morbidity and mortality from tuberculosis.

1. Case-Finding

The purpose of a case-finding program is the discovery of the hidden cases of tuberculosis. In general, such a program should be directed toward those groups of the population where a high prevalence of disease is suspected and where large numbers of the people can be reached quickly and economically. Until recent years case-finding efforts were centered primarily among the family members of known infectious patients. Since tuberculosis is basically a family epidemic, a high yield of new cases was obtained by this approach. However, limited field-nursing services and clinical facilities have greatly restricted the program, except in those few communities with well developed and ample health services. Moreover, there are many tuberculous families scattered through the population in which the disease is completely unsuspected. Therefore it has been necessary to supplement and complement these family epidemiological studies with other case-finding procedures.

Since the introduction of mass radiography, case-finding has been directed on an extensive scale to large population groups without reference to specific foci of infection. This type of program has been so satisfactory that many physicians have advocated that the entire population be examined radiographically at regular intervals. Such a scheme, however, is rather difficult, and, furthermore, does not appear to be essential for the control of tuberculosis. As in the control of other communicable diseases, it is probably necessary only to reach a significant proportion of the population within a limited period of time.

There are two sizable segments of the population which may be easily reached by mass radiography. These include: (1) persons admitted to general hospitals, and (2) persons employed in the large and small industries of the nation.

Small film radiography is well suited to case-finding in general hospitals. No expense is entailed in assembling the people for study. In addition, film interpretation may be done by the staff of the department of roentgenology. Furthermore, facilities are already available for completing clinical examinations

and for providing care and treatment of ambulatory patients.

The procedure also provides several valuable by-products. Increased accuracy in the clinical diagnosis of chest disease is obtained. Nontuberculous disease is detected more quickly than before. Finally, and of particular importance, employees and nurses in contact with patients are spared unnecessary exposure to those who have tuberculosis in a communicable stage.

Hodges at the University of Michigan Hospital, Ann Arbor, Childress, et al., at Grasslands Hospital, New York, and Bloch and Tucker at the University of Chicago Clinics and Provident Hospital, Chicago, have been examining routinely the admissions to their respective institutions for some time. In Michigan, where the photofluorographic process is employed, 9.3 percent of the patients present abnormal roentgen findings; about 1.5 percent exhibit X-ray evidence of pulmonary tuberculosis. In New York, where the fluoroscopic method is used, 2.8 percent of the patients have reinfection-type tuberculosis. In Chicago where fluoroscopy and the sensitized paper method are employed, 1.3 percent of the white patients and 2.64 percent of the colored admissions have clinically active tuberculosis. From these figures the value of mass radiographic methods in the examination of admissions to general hospitals is evident.

It is hoped that soon all general hospitals will provide routine X-ray examinations of the chest just as they now are making routine serologic tests for syphilis. In 1943, over 15 million persons, not including out-patients, were admitted to general hospitals in the United States for care and treatment. The newly discovered cases of tuberculosis found among these patients can logically become the centers from which many other cases can be revealed.

Hospitals which care for the mentally ill are also ideal centers in which to develop mass radiographic methods. In the United States nearly 500,000 patients are currently hospitalized in these institutions. Chest surveys conducted in Minnesota, New York, and Illinois have shown that from 4 percent to 10 percent of these patients have X-ray evidence of reinfection tuberculosis. These people are not only likely to infect fellow patients and the institutional members with whom they come in contact, but also can disseminate their disease to the general population when released from care.

The second population group in which mass radiographic procedures may be profitably conducted consists of the millions of industrial workers. From 1942 to 1944 over one million workers in the United States were examined by eight transportable field units (35 mm. and 4 x 5 inch) of the United States Public Health Service. In this group of adults, 1.5 percent had X-ray evidence of reinfection-type tuberculosis of which approximately 65 percent were minimal, 30 percent moderately advanced, and 5 percent far advanced according to the classification of the National Tuberculosis Association. This distribution is of considerable interest in view of the fact that minimal cases comprise only 10 to 15 percent of the first admissions to tuberculosis hospitals in this country in recent years.

Other chest conditions besides tuberculosis were frequently discovered by means of these mass radiographic industrial surveys. One percent of the films exhibited evidence of nontuberculous pulmonary disease; about one-half of these were cardiac abnormalities. A number of films gave evidence of unsuspected cancer of the lungs, many of which were discovered early enough for operative intervention. Certainly no industrial hygiene program can be considered complete unless

there is included a routine chest X-ray examination of every employee prior to employment and at regular intervals thereafter.

In addition to mass radiography, several other methods are available for case-finding, and full use should be made of all of them. Carefully taken histories and physical examinations are useful in the detection of new cases having subjective symptoms or objective findings; unfortunately, however, in the early stages of pulmonary tuberculosis both symptoms and physical findings are usually absent or escape notice.

The routine use of the tuberculin test in the office of the private physician is a useful method of finding infected persons. Chest X-ray examinations of the positive reactors separate those in need of clinical study from those who do not. This method is particularly effective in the preliminary screening of household associates of infectious cases in rural areas. If the interest of the thousands of rural physicians can be aroused and translated into action, an important part of the population can be examined with gratifying results. In those areas, the family physician is usually the first to see the tuberculous individual and the one to whom the patient is returned after sanatorium care. The family physician who is conscious of the unseen presence of tuberculosis, and who suspects and properly examines everyone entering his office, will uncover surprisingly large numbers of new cases.

Following the chance occurrence of two juvenile cases of tuberculous meningitis in a small community of 450 persons in rural Minnesota, and the attendant interest aroused by the parents, Simons and Hilleboe discovered nineteen cases of reinfection tuberculosis in the community and the surrounding district in the following nine months. This was largely the result of routine tuberculin testing and X-ray examination of positive reactors of the patients coming into the office, regardless of complaint. Every private physician in the country can repeat this experience if he will apply diligently the simple methods available to him.

It is recognized that tuberculin-testing surveys among school children have great educational value. They are disappointing, however, as a means of finding considerable numbers of infectious cases and the cost per patient discovered is excessively high. It is better to concentrate those same efforts on the tuberculin testing of the family and other contacts of known cases. Tuberculin testing is similarly unsatisfactory for the examination of adult groups in which the incidence of positive reactors is high (e.g., persons in large industries). Little is gained by such testing prior to X-ray examination and valuable time is lost by repeated interruptions of work.

The laboratory demonstration of tubercle bacilli continues to be the most exact method of diagnosis of tuberculosis. Unfortunately, many people with hidden tuberculosis do not raise sputum. In recent years, the examination of the fasting stomach contents obtained by simple gastric lavage has been employed extensively for the detection of virulent acid-fast organisms. This technique is especially useful with persons having minimal lesions but no expectoration. Pharyngeal swabs have been used for the detection of tubercle bacilli in Europe but have not been well accepted or used extensively in this country.

The practicing physician will do well to request routine laboratory examinations of the sputum of each of his patients with pulmonary symptoms. A number of these persons will be found to have tuberculosis. Most States provide free laboratory service for such tests.

When funds for tuberculosis control are limited in a given community, great care must be exercised in the choice of case-finding procedures. Those methods should be selected which will reach the greatest number of people in the shortest possible time, within the limits of available facilities and personnel. It is interesting to note the comparative results obtained at identical cost by small and large film methods in mass case-finding. It is conservatively estimated that 100,000 persons can be examined by 35 mm. or 70 mm. photofluorography at the same cost as that for the examination of 10,000 or 20,000 persons by 14 x 17 inch roentgenography. It may be argued that several minimal cases of tuberculosis will be overlooked by the former technique. However, even if this method of mass radiography fails to detect 15 percent of these lesions, it will still uncover a considerably greater number of cases than the large film technique due to its inherent economy. Even under the most favorable conditions, 14 x 17 inch celluloid films detect a total of only 329 cases of reinfection-type tuberculosis in all stages of the disease, as compared with 1,500 cases by the small film method. The latter technique detects five times as many moderately and far advanced cases as well as an additional 751 minimal cases.

The evaluation of the case-finding methods to be used in tuberculosis control must take into consideration quantitative as well as qualitative factors. From the public health point of view the choice between 14 x 17 inch celluloid and small film techniques is overwhelmingly in favor of the latter when large numbers of persons are to be examined.

When a person is found to have evidence of tuberculosis by one of the various case-finding methods, clinical and laboratory studies must be made to confirm or refute the diagnosis. Then one may proceed with the plan for medical care and isolation.

2. Medical Care and Isolation

From a public health viewpoint, the primary purpose of sanatorium care is isolation of the patient to prevent spread of the disease. In addition, there is the opportunity to arrest the disease if it is not too advanced, and to provide general physical restoration of the individual.

The full benefits of early diagnosis of pulmonary tuberculosis can be realized only if an adequate number of hospital or sanatorium beds are readily available for treatment of those with remediable disease and for isolation of the infectious patients. These institutions must be supplemented by well-located chest clinics, generous public health nursing services, accessible laboratory facilities and the active participation of family physicians.

It is short-sighted to concentrate on case-finding, if treatment is to be delayed because of a shortage of sanatorium beds. Once a program is started in a community, immediate plans must be made for providing a sufficient number of beds. Temporary facilities including beds in general hospitals should be utilized until tuberculosis hospitals are available. Mass radiography may be employed to advantage in communities with no clinical facilities, to arouse the public to demand the construction and maintenance of the necessary hospitals. These are strong measures but they are at times necessary.

At present, long periods of hospitalization are usually necessary for the care and treatment of tuberculous patients. However, as mass radiography reaches larger numbers of the population, shorter periods of care will frequently be the rule since many of the patients will have less extensive disease. If sufficient clinical facilities are established throughout the country, such persons, including those on collapse therapy, may often be transferred to the chest clinic for treatment and supervision. Others need only enter local convalescent homes.

The family physician, with the advice and counsel of the specialists at local chest clinics, can often supervise the care of the many patients with arrested disease. Many private practitioners have become skillful in the administration of pneumothorax treatments. Others have become adept in the interpretation of chest films. Chest clinics should promote and assist in the postgraduate training of interested private physicians.

In those unfortunately situated communities where no sanatoria or tuberculosis clinics are established, an attempt should be made to isolate known open cases in the home until such time as hospital facilities become available. The public health nurse can plan an important role by demonstrating simple methods of isolation and disinfection, and by attempting to obtain examination of household contacts at frequent intervals.

3. After-Care and Rehabilitation

Tuberculosis often causes considerable disability and, accordingly, many persons who contract the disease must make an adjustment in their way of living when released from sanatorium care. This adjustment is not an easy one to make, and any guidance which can be given during the period of hospitalization will prepare the way for effective rehabilitation.

Soon after the tuberculous patient has entered the sanatorium, he should have an opportunity to discuss with his physician the medical problems of his particular case, so that an understanding of his condition may be acquired at an early date. As time goes on, further conferences will permit the establishment of an acceptable regime, which may be followed not only during the days of hospitalization but in the period thereafter. During these discussions, the question of the type of work which will be most suitable for the patient to follow will arise. In these conferences, the services of social workers, educational psychologists, and employment officers are essential in reaching a satisfactory choice. It is desirable that facilities be provided for instruction and training in the selected vocation as soon as the patient is medically and emotionally prepared.

Persons with arrested disease should be returned gradually to full-time activity through increasing part-time or modified employment. The Altro Workshops in New York are good examples of this type of sheltered work. It is necessary to subsidize these workers during the period of partial employment in order to provide the family with sufficient income to subsist. Soviet Russia and Great Britain have also carried out successful schemes for sheltered work, particularly during the critical first two years after discharge from hospital care.

The disposition of persons with infectious tuberculosis of a chronic character presents a special problem. Such individuals can be ambulatory and do some work, yet they must remain segregated because of the communicability of their disease. The English have arrived at a partial solution through the Papworth and

Preston Hall Village Settlements. In Soviet Russia, so-called night sanatoria provide partial medical supervision and regulated rest periods for these persons. Segregated sections of factories have been designated sometime for the employment of persons with chronically active disease. Small local workshops in connection with well-established, large sanatoria have also been utilized. These patients, of course, require subsidy to supplement their limited income.

There is still another large group of tuberculous persons which requires assistance for after-care. These include individuals who have received maximum benefits from modern therapy but who still have active disease, and therefore must remain isolated. These persons can well be segregated in local institutions and rest homes where care can be given at a minimum cost for the protection of the health of the community.

Fundamentally the after-care and rehabilitation of the tuberculous patient constitutes low cost insurance on the tremendous investment of hospitalization. They are essential parts of a tuberculosis control program and without them such a program falls short of its goal.

4. Protection of the Tuberculous Family Against Economic Distress

Tuberculosis is a community disease which is important not only in terms of public health but also from the viewpoint of national economy. Once the disease becomes advanced, the affected person is often disabled for life and dies a premature death. The family, broken up by long periods of disability or death of the breadwinner, almost inevitably is thrown upon public resources for its support. Accordingly, a sound medical program must be complemented by a generous plan of public assistance, particularly for the families of the tuberculous poor. If this is not done, full benefits will not be realized from the other phases of the program and especially from sanatorium care.

It is no simple matter to provide institutional isolation and treatment for all known infectious cases. The problem of inducing these individuals to enter sanatoria and to remain there long enough to arrest their disease, or prevent spread of their disease to others, is a difficult one. If the breadwinner is the afflicted person, his first concern is for the welfare of his family. Unless some provision is made to avoid economic disaster for dependents, physical disaster will eventually befall the affected individual who refuses to continue hospitalization while his family is in want. A national plan to provide adequate protection against loss of wages during treatment, and for several years after arrest of the disease, is the only logical answer to this problem.

In achieving the four principal objectives of tuberculosis control, great assistance can be given by a carefully planned program of research in each of the fields of operation. Careful studies and investigations are indicated in the evaluation of present-day public health methods. Frequent inventories must be taken by State and local health departments to determine whether or not measures employed are actually decreasing mortality from the disease.

The application of new technical developments in mass radiography should greatly simplify the problem of case-finding among the population groups now difficult to reach. Mass radiography will make possible the epidemiological investigation of entire communities where only a small number of families could be

studied before. This will give the epidemiologist an opportunity to study fundamental relationships in the evolution of pulmonary tuberculosis on an extensive scale.

An intensive search must be made on a broad scale for chemo-therapeutic and biologic agents to prevent the disease or to increase an individual's resistance to tubercle bacilli. When a drug or biologic product which will destroy tubercle bacilli in the human body is found, immediate efforts should be made to use the new agent prophylactically, before irreversible pathological processes have developed. Infected household contacts of known infectious cases or nurses exposed to unsuspected tuberculous patients in general hospitals would offer a fertile field for a broad program of prevention of pulmonary tuberculosis.

Careful studies of social and economic problems in the field of after-care and rehabilitation are also needed. Among these, an evaluation of the economic loss due to tuberculosis in the family and community is indicated. On the basis of such an investigation the social security laws may be amended to protect the tuberculous family against loss of wages.

These are only a few of the urgent problems that must be solved. Scientific research must proceed hand in hand with public health services if tuberculosis is to be brought under control.

Another important tool that effectively aids in accomplishing the principal objectives of tuberculosis control is health education. This includes health education for the public, instruction of the tuberculous and their families, and special training from professional groups. Full use of the resources of voluntary tuberculosis associations greatly simplifies this part of the broad program.

Initially, it is necessary to impress the public with the importance of tuberculosis as a community problem. This can best be done by giving people an opportunity to participate in local programs of health education. Such education should be informative in a propaganda sense, in order to attract attention, and at the same time hold it. Special consideration should be given to the instruction of tuberculous persons and their families, for whom, of course, health education should be especially meaningful. For professional groups, extensive post-graduate training and refresher courses should be developed to increase their opportunities for acquiring knowledge in the new methods of tuberculosis control.

During the past few decades, the National Tuberculosis Association and its affiliated societies have carried on an extensive and continuous program of health education, including demonstrations and services in communities where medical care for the tuberculous has not been available.

Health education programs based upon a careful analysis of the needs of individual communities can encompass the entire field of tuberculosis control. As opportunities present themselves, attention can be focussed on (1) case-finding, (2) medical care and isolation, (3) after-care and rehabilitation, (4) protection of the tuberculous family against economic distress. Thereby, the cardinal objectives of a complete program will be clearly set forth. Stimulated by this new knowledge, the public should be aroused to follow the recommendations of health leaders in the provision of personnel and facilities for a well-planned and carefully executed attack against tuberculosis.

On the basis of the decline in the mortality of tuberculosis in the United States--the crude rate in 1940 was one quarter of the rate in 1900--several workers have intimated that tuberculosis is no longer a serious problem and have viewed the situation with complacency. However, even a casual perusal of the mortality and morbidity tables will quickly demonstrate to the critical observer that tuberculosis remains in the foreground as a public health problem. Approximately 60,000 tuberculosis deaths were reported yearly by State health departments in the five-year period, 1939 to 1943. Furthermore, tuberculosis is the principal cause of death of persons 15 to 35 years of age. Indeed in the age group, 20 to 34 years, one in every six deaths in the white population and one in every three deaths in the colored is due to tuberculosis.

Industrialization appears to be assuming a prominent role as a causal factor of high tuberculosis mortality rates. In 1939 to 1941 these rates were higher in cities than in rural areas for all age groups, and for all races. It is interesting to note, however, that whereas tuberculosis mortality increased with increasing size of community for adult males of both white and colored extraction, it decreased for adult white females, and remained practically the same in communities of all sizes for adult negro females.

During the present war emergency, special problems have appeared to demonstrate again the close relationship between war and tuberculosis. The rate of decline, which in the years just prior to World War II had become quite rapid, is for the first time in two decades beginning to decrease. Indeed in several large industrial areas, tuberculosis mortality rates have actually increased. During the period 1939 to 1943, an average of 110,000 new cases of tuberculosis have been reported to State and local health departments annually. In the surveys made by the Public Health Service, most of the newly discovered cases were not known to local health officials. Accordingly, the number of hidden cases must be up in the hundreds of thousands.

The Selective Service System found over 150,000 tuberculous young men whose disease was discovered by routine chest X-ray examination at the examining and induction stations. This important segment of the population must be given careful clinical attention so that the infectious cases may be isolated and their contacts examined for additional sources of infection. When demobilization occurs members of the armed forces will be re-examined roentgenographically to discover the cases of tuberculosis that have developed in line of duty or that have been overlooked during induction examinations. From the foregoing it is evident that war brings its own problems of tuberculosis control, which will require careful consideration in the over-all planning.

On July 1, 1944, the 78th Congress of the United States passed a law which made possible the establishment of a new Tuberculosis Control Division in the United States Public Health Service. Section 314 (b) of Public Law 410, 78th Congress reads as follows:

"To enable the Surgeon General.....to developing more effective measures for the prevention, treatment, and control of tuberculosis, and to assist, through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate measures for the prevention, treatment and control of such disease, including the provision of appropriate facilities for care and

treatment, and including the training of personnel for State and local health work, and to enable him to prevent and control the spread of tuberculosis in interstate traffic, and to meet the cost of pay allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist in carrying out the purposes of this section with respect to tuberculosis, and to administer this section with respect to such disease, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1945, the sum of \$10,000,000 and for each fiscal year thereafter a sum sufficient to carry out the purposes of this subsection."

On December 22, 1944, \$773,000 of the amount authorized was appropriated by Congress to enable the Tuberculosis Control Division to set up its organization and to procure and train medical officers and other professional personnel and to obtain necessary equipment and supplies to assist the States in extending and expanding their programs of tuberculosis.

Additional funds were requested of the new Congress now in session for grants-in-aid to States for the remainder of the fiscal year 1945. This program of the United States Public Health Service together with that of the voluntary groups of the National Tuberculosis Association offer great hopes of more rapidly reducing the morbidity and mortality from tuberculosis in the United States.

When the broad objectives of tuberculosis control are considered, it becomes apparent that preventive measures should be centered increasingly on infectious cases in the community. These persons and their contacts should be singled out for special attention, including rigid isolation and medical and social supervision. When these problems have been accepted as a community responsibility it is hoped that public opinion will then demand that the program of tuberculosis control become a campaign which will lead to the eradication of the disease.

DISCUSSION

CHAIRMAN PARRAN: This is a new program, and, although some of us discussed it briefly at our interim meeting in New York last autumn, I think it merits further discussion here today because of its importance.

DR. REYNOLDS (North Carolina): What is the intent of the program after we have found known open cases that are at home with no hospital facilities from lack of hospital beds, in the one instance, and from poverty in the other instance? Is it contemplated in the present bill, for instance, that there will be means to establish new hospital beds?

DR. HILLEBOE: The bill, as you know, provides not only for making available hospital beds but also, if necessary, their maintenance and operation. However, if you were to attempt to take some of the small appropriation that will be available during 1946 (which, as Dr. Williams pointed out, will be approximately 6 million dollars), it would not go very far in the construction or maintenance and operation of hospital beds.

At the present time in this country there are approximately 86,000 hospital beds which are maintained at an annual cost of between 86 and 100 million dollars. We would not know where to draw the line in the expenditure for hospital construction and care of any part of our 6 million dollars.

We contemplate, Dr. Reynolds, in the immediate future, a careful survey of the proposed expenditures and the proposals for constructing additional hospital beds jointly made by our people in district offices and you people in the State offices. We will determine together what amount the State is going to contribute, what amount the community will contribute, and what might be expected of the Federal Government. It is quite essential for the State and the local community to assume their fair burden of the care of residents of the State.

DR. ROBERT H. RILEY (Maryland): Dr. Hilleboe, where would the funds come from for the care of nonresident patients in a State? In Maryland we will have some. Will it come out of our allotment or out of your allotment?

DR. HILLEBOE: In the three months ending June 30, 1945, the Public Health Service requested \$262,000 for the care of nonresidents during that period; and in the budget for 1946 estimates were drawn up for something in excess of \$500,000. In the course of hearings before the budget bureau of the Executive Office of the President these items were deleted from the budget. For that reason, there are no funds that have been earmarked for the States to meet these particular problems. We hope to present again the need for such appropriations, but at present there are no funds, either in the grants to the States or in the amount available to the Public Health Service, for the care of nonresidents.

CHAIRMAN PARRAN: Dr. Hilleboe, may I supplement Dr. Reynolds' question? I am not sure I understand the answer completely. You say the law authorizes the provision of facilities for the treatment of tuberculosis. That means the building or leasing of sanatorium beds or the maintenance of patients in those beds. Will it be your purpose to seek such funds in subsequent fiscal years, or will you expect the States themselves to carry this burden?

DR. HILLEBOE: The soundest course to follow from a public health point of view would be for the States themselves to make provision for funds for the care of resident patients. The States have been carrying that burden and it is a reasonable responsibility for the State to take care of its own residents. If new hospital beds are to be provided, provision for the maintenance and operation of these new hospitals or new hospital beds would be made through Federal funds only until the State can assume that responsibility.

DR. REYNOLDS: The State institutions house only those cases that have a reasonable chance of arrestment. The case that is doing the damage is the open case beyond recovery which, in its chronic condition, remains outside as a carrier. That is the case for which I want to see what we can do.

DR. HENRY HANSON (Florida): The advanced case is the one responsible for the spread of tuberculosis.

DR. HILLEBOE: I think that is quite true. Yet, the positive sputum case would be just as much a responsibility of the local community, in the protection of the public health, as the patient requiring care. As a matter of fact, about 50 percent of patients in sanatoria, would not only spread disease if released, but also require care and special treatment.

It was our understanding, on the basis of conferences last year, that in the initial phases of the problem we would not get into the maintenance of sanatoria, the use of general hospital beds, or the payment for care in sanatorium beds already available. In one instance a State requested the expenditure of, perhaps, half a million dollars, to take over the responsibility of the county welfare department, which assumed that responsibility was already being carried by the State. That seems to be merely a shifting of the load from the county to the Federal Government, and does not seem sound.

DR. RILEY: Dr. Hilleboe, how many States refuse to take the open cases? I don't think Maryland makes any distinction, I think we take them all. The fact is, we rather encourage the open cases to come in out of the community.

DR. REYNOLDS: We have 1,000 cases in our three institutions, and we have twenty-two county sanatoria in the State. Most of the cases in those institutions are open cases, but they are not beyond recovery.

DR. P. E. BLACKERBY (Kentucky): Isn't there authorization in the bill for maintenance?

DR. HILLEBOE: Yes, there is under the heading, "Provision of Appropriate Facilities for Care and Treatment."

DR. BLACKERBY: I assumed it was the intent of Congress to provide for maintenance.

DR. HILLEBOE: It may have been the intent of Congress, but on the basis of our projected plans for the development of the new program, we made no immediate requests for funds of that nature. If we give money for maintenance to one State, why not give an equal amount to another State? If we did that, our program would conceivably run into a maintenance budget of 60 or 70 million dollars annually.

The initial problem facing us now in the beginning of the program is the building up of health department facilities. Twenty-six States have no tuberculosis control officer. It seems more important to obtain the services of needed health officers even if we have to go out and commission a man, train him, and lend him to a State, than to pay the hospital maintenance of cases that are otherwise given care by the State if we do not make the money available.

DR. WILLIAM M. MCKAY (Utah): Are the provisions of Senate Bill 191 sufficiently broad, assuming the bill is passed, to give us some relief on additional hospital beds for our tuberculous patients?

CHAIRMAN PARRAN: Yes, although, as I read Public Law 410, Section 314, even broader authority is therein already contained in existing law.

Again without intending to pursue the question of providing buildings or maintenance, or buildings and maintenance for care of patients, I revert to Dr. Hilleboe's remark that no States have asked for funds for this purpose. Dr. McKay's question implies that his State would seek assistance for getting additional tuberculosis beds. I am not arguing for or against Federal aid for these purposes. Is the situation such that no States needed to ask for funds for building additional sanatorium beds, or did they fail to ask for funds because we indicated we did not intend to ask for them?

DR. HILLEBOE: The latter is entirely correct, and results from the agreement we had last fall. I, too, have no conviction either for or against Federal participation in the provision of beds. However, at the present time, it is not easy to obtain the necessary priorities or the materials to build sanatorium beds. That is one factor.

A second factor is this: Starting April 15th the tuberculosis consultants in the District Offices are going out into the States to compile their annual inventory for the District Directors. We do contemplate getting thereby detailed information on the extent of the problem. We can then determine specifically what should be done, and when; we can find out what our part might be and what the State's part might be. When we have that information, then we will be ready to go ahead on a building program.

CHAIRMAN PARRAN: In light of this part of the discussion, Dr. Hilleboe, can't we assume that this question of Federal funds for either buildings or maintenance is one that should be considered by the Committee which will make recommendations concerning this program?

DR. WILLIAM DEKLEINE (Michigan): For those States that have reasonably adequate hospital facilities, it would be unfair to allocate this money largely for hospital construction, because it would interfere with their developing the services that you speak of. It seems to me that it would be far better to stick to the policy of providing funds to supplement State budgets for such services and to leave the question of hospital construction open for a future date. We might look forward to requesting separate appropriations for hospital construction and thus not confuse the issue at this time.

CHAIRMAN PARRAN: This question was pursued by several of the Senators in the course of hearings on S. 191. We will have a discussion of it a little later, but the question boils down to this: Does not the provision of Section 314 of the Public Health Law inevitably penalize the State which has done the most in

the construction of hospitals heretofore? The answer inevitably is that as the States tend to meet 100 percent of their needs in any sphere, such States would be penalized in favor of the States which heretofore, because of poverty or inaction, have done less.

DR. EDWARD S. GODFREY, JR. (New York): As one of the States that has pretty good facilities, I don't feel we are being penalized if we provide some construction for other States that don't provide it. I think, just as with the venereal disease program, considering the migratory population we have, that one part of the country ought to help out another.

I think, however, that you have been very wise in not considering a hospital construction program up to this time. There is more to it than simply building a hospital and having the walls and bricks and a few facilities. We ought also to think of tuberculosis as some day, within a generation, I hope, disappearing as a major public health problem. These hospitals ought to be built so that they can be converted to other uses, of which there will be plenty. Perhaps they should be tied up with the teaching hospitals, in some such scheme as that in the Pepper Bill.

DR. HILLEBOE: I want to point out this one fact. On the advice of many of the health officers in session, and on the advice of the Budget Bureau, and of our own advisers in the Public Health Service, it has seemed wise to approach this program on a step-by-step basis. For the first time, perhaps, we have begun a grant-in-aid program without being rushed to death. We have had a chance to think and to plan, and to get counsel, and to take one thing at a time. I hope you will go along with us on this, because I think we will reach our ultimate goal more quickly if we proceed this way.

CHAIRMAN PARRAN: The next subject is "Goals in Venereal Disease Control," by Dr. J. R. Heller, Chief of the Division.

GOALS IN VENEREAL DISEASE CONTROL

DR. J. R. HELLER:

Reasonably adequate venereal disease control programs have been projected during the last seven years and measurable progress has been made, but during wartime, rapid advances in chemotherapy and a constant transition of program planning necessitate reexamination of methods. The state of flux of venereal disease control methods brings out the deficiencies in the mechanisms used in executing these programs. It is these deficiencies that I should like to discuss this afternoon, and by scrutiny and analysis point out before us two goals susceptible of attainment.

On February 24th there was sent to each of you a set of charts depicting certain aspects of the venereal disease problem and the way in which it has been met during the war period. Along with this material was sent a request for replies to several questions concerning your needs and plans for the coming year. These questions were designed to obtain information which would enable the Public Health Service to approach the Congress with an accurate estimate of your need for funds and a justification of such expenditures.

I should like to discuss your replies, and the conclusions which we were able to draw from them. In order to refresh your memories, slides will be shown of the charts which you received.

The first chart showed that during the past four years, although Congress has made available much larger sums for the control of venereal disease, there has not been the hoped-for increase in cases of early syphilis admitted to clinics. Nor has there been any increase in the comparative number of early cases admitted. However, the number of cases of gonorrhea has increased significantly.

The second chart indicated that the lack of increase in syphilis admissions was not due to any increased tendency for patients to seek private care, since there has been little change in the number of cases reported by private physicians.

The third chart showed that, although admissions for gonorrhea increased, changes in therapy led to little increase in the number of clinic visits by gonorrhea patients. Only about 5 percent of all visits during the year were made by persons seeking treatment for gonorrhea: a proportion which has not changed appreciably during the past four years. The slight increase in the admissions for gonorrhea, then, can account for but little of the increased expenditures.

It seems clear from these slides that the increased funds appropriated during this period have not increased case-finding efficiency in a like degree. And we all know that success in the control of any infectious disease depends on finding cases and rendering them noninfectious before they have had a chance to spread their disease to other individuals. Therefore, you were asked to say whether or not you planned to increase the amount of funds budgeted to case-finding agencies, and to propose other plans which you might have for improved case-finding.

There was general agreement on several points. One such is the need for greater utilization in the program of the private practitioner and greater cooperation on his part. One particular plan was outlined several times, namely: when a blood specimen submitted to the State Laboratory by a private practitioner proves to be positive, the report of the result should be followed by a letter to the doctor calling to his attention the services offered by the Health Department. Others of you agreed in proposing that penicillin be made available without cost to those physicians who will allow their patients to be interviewed for contact information by a trained epidemiologic investigator.

The need for expanded and more inclusive programs of education was mentioned in a number of replies. As a matter of fact, plans for an educational program are already under way, and the Public Health Service can now make available such facilities and consultative services as may be individually requested.

The replies also generally agreed that the personnel in the regular clinics might be better utilized if emphasis were shifted from treatment to diagnostic and case-finding activities. Many expressed a need for trained personnel: lay follow-up workers, male investigators, and public health nurses trained for full-time venereal disease work. It was repeatedly stated that unfilled vacancies already existed, and, although training facilities have been established, that suitable candidates could not be found. As you have recently been informed, a number of servicemen trained in the venereal disease field, such as Pharmacist's Mates in the Navy and Noncommissioned Venereal Disease Control Officers in the Army, are now being separated from the armed forces. When requested, the Public Health Service can, in many instances, find the trained workers needed.

Solution of these personnel difficulties will be possible only if suitable staff recognition and adequate salaries are provided. In those States in which lay investigators have been most successful, personnel of a high educational level have been employed and salaries comparable to other positions of equal responsibility in the State have been paid.

It has been suggested that the Public Health Service sponsor a training course of nine months for Venereal Disease Investigators, those eligible to be individuals who have had two years of college work and one year of employment experience. Provision would be made to confer college credit for this course if the individual meets the scholastic requirements of the institution. Efforts might be made through existing means to contact the Army and Navy, so that men being released, who are interested in this type of work, could be offered the special training outlined.

We should like your collective opinion on such a proposal. Would the State and Territorial Health Officers request that former servicemen trained in this field be assigned to the States for a trial period, with the understanding that, if they meet the requirements of the State merit system, they will subsequently be employed in the venereal disease program? If this proposal meets with your approval, we will need an estimate of the number of these men that will be needed.

The replies, as a whole, contained many worth while, forward-looking suggestions. Some of them we hope to be able to act upon promptly. Frankly, however, your replies still leave remaining a difficult task in attempting to justify the continuation of the present budget, as well as six million dollars

additional for in-patient care of venereal disease cases. It is fully realized, that, with the draining off of eleven millions of men into the armed forces, where they will be treated and cared for, your time is being spent largely in tracking down the disease in females. It is a well-known medical fact that the venereal diseases are much harder to find in a female population than in a male. This undoubtedly accounts, in part, for the lower score of the civilian health authorities. But, even taking this into account, performance has not seemed to be commensurate with funds expended.

With the widespread introduction of rapid treatment facilities, a re-evaluation of the place of the routine treatment center and clinic in the overall venereal disease program becomes necessary. It seems likely that a large proportion both of infectious syphilis and of potentially complicated syphilis will be given in-patient care.

For some time it has been quite apparent that a not inconsiderable portion of the funds appropriated for the control of venereal diseases is being expended in many out-patient clinics in the prolonged treatment of latent syphilis. Much of this treatment is administered to patients with positive blood tests solely. Therefore, we should like to recommend that in these latent cases treatment be terminated when 30 arsenicals and 40 bismuth injections have been administered.

Taking these things into consideration, it seems that much of the time in the clinics now being taken up with treatment will be converted to case-finding, interviewing, and diagnosis, in the near future. Of course there will always be patients for whom rapid treatment is contraindicated, or impracticable for various reasons, but the bulk of time now spent on treatment will certainly be otherwise used.

It becomes apparent that an estimate of the operational cost of routine venereal disease clinics has become necessary. The cost analysis forms sent you were preliminary, and invited discussion. Your replies have been extremely helpful. Almost without exception, you felt that the forms were too complicated and detailed to be completed in the clinics. A simpler form has been drafted, and will be presented to the Committee on Venereal Disease Control. In the near future we will have a representative from the District Office visit your health department to explain the forms in detail to those assigned by you to collect the data.

The next four slides relate to the Rapid Treatment Center program, and illustrate what is perhaps the most encouraging phase of the whole venereal disease picture. Slide IV shows the cost per patient day for each of the various rapid treatment centers. Slide V compares the percentage of treatments completed among patients receiving rapid therapy and that among patients receiving routine therapy. Slide VI shows the steadily increasing number of early syphilis cases admitted to rapid treatment centers during the last half of 1944 and the steadily decreasing length of stay for such patients. And Slide VII shows the same trends for patients with gonorrhea.

From these slides it can be seen that many more patients complete their treatment under rapid than under routine therapy. That program will probably operate with even greater efficiency as further experience is gained. There was considerable variation in costs as shown in Slide IV. A number of centers, even those not engaged in research, exceed the National Hospital rate of \$5.00 a day.

It was proposed that, in addition to a continuance of the regular rapid treatment center program, other funds be requested for the rental of beds in already existing hospitals wherever the provision of a rapid treatment center would prove too expensive, or would be impracticable on other counts.

You definitely agreed. Acting on this mandate, we requested that six million dollars be appropriated for the in-patient care of patients with venereal disease, such funds to be used either for the maintenance and operation of rapid treatment centers or for rental of beds in already existing institutions. The choice will be made on the basis of your requests and the needs of the area to be served. The Bureau of the Budget has recommended to Congress an appropriation of $4\frac{1}{2}$ million dollars rather than the requested 6 million. This Bureau feels that the penicillin treatment of gonorrhoea will revert to the clinic or private physician.

Slide No. VIII shows the potential national manpower and the dollars that could be saved had it been possible to treat, in the asymptomatic stage, those persons who were subsequently admitted to mental institutions with paresis and other late forms of neurosyphilis. Some of the methods of treatment which are most effective with this type of syphilis can be administered only under hospital procedures. The question put to you was, "When it is determined that the infected person is considered potentially responsive to intensive therapy, should he be given in-patient care regardless of the stage of syphilis?" Among all those whose replies were received, only three did not wish to provide in-patient care for this type of case.

In several instances the authority of health institutions to treat cases that are not communicable was questioned, but it was generally felt that this course of action could be properly said to lie in the field of preventive medicine. As it now stands, we should like to be able to extend in-patient care whenever requested by you to all syphilis patients who are considered potentially responsive to intensive therapy. However, we cannot lessen our attention to the major problem, that is, the reduction of infectious venereal disease through finding and treating early cases.

We would like to have your collective approval on the plans for the future administration of venereal disease control as I have outlined them to you.

CHAIRMAN PARRAN: Thank you, Dr. Heller. Are there questions or comments?

DR. RILEY: I would like to know more about the program for training personnel. Is it Dr. Heller's notion that persons who are not medical men, or nurses, would be trained and sent out through the States? I want to go on record as opposed to that.

DR. HELLER: Dr. Riley, on the basis of many requests from State and local health officers and on the basis of experience, nonmedical personnel have been found very effective where nurses and doctors have not been available. In several States, notably Oklahoma, lay investigators have been used with remarkable success. More than half of all Army contacts are being found in Oklahoma (irrespective of the data submitted by the Army), through lay investigators, with, of course, the help of some public health nurses.

DR. HANSON: I just want to report on our success down in Florida. We started out using the heat box and we had very creditable success. Then, we changed to penicillin. I believe Dr. Jones thinks that he gets results just about as good with the heat box, in some cases. So far, we are not quite ready to say which of the two treatments we prefer.

CHAIRMAN PARRAN: Are there further comments or questions? Did you want to comment upon the Oklahoma scheme, Dr. Mathews?

DR. GRADY F. MATHEWS: I understand Dr. Riley's conviction about the use of nonmedical men, and the loss in not using trained nurses and doctors, but we didn't have them. We employed men 45 and 50 years old. We trained them, put them on the job, and we have had excellent results. They have had both in-service training and training at St. Louis. I think it would be a good idea to start planning to continue the best of these men in their present capacity.

DR. GODFREY: What is the salary range contemplated?

DR. HELLER: The salary contemplated, Dr. Godfrey, is from perhaps a beginning salary of \$1800 upward to \$3600 or more depending upon qualifications and the positions established in the State health department.

DR. GODFREY: What would these positions be comparable to?

DR. HELLER: There is probably no category of personnel in State health departments to which they might be compared, other than sanitarians who are not sanitary engineers in the engineering department. In the Public Health Service we have a group called public health representatives to which classification these individuals might be in some respects compared.

DR. GODFREY: What is their salary range?

DR. HELLER: Their salary ranges from \$2000 upwards to about \$3800.

DR. MERRILL (California): We have been working with these men investigators for seven years or so in California. Until the last three or four years we had only half a dozen or so on the staff, assigned, for the most part, to local health departments. Now we have about thirty of them in various areas of the State.

In our Civil Service system they are called Venereal Disease Investigators. Their base salary range is \$170 to \$210 a month. Added is \$25 a month for war emergency adjustment, so they begin now at \$195.

We have come to believe that, as a permanent fixture in the larger health departments, these male investigators serve a very useful purpose. They can carry on tasks, evening work and rather difficult police contact work to which the public health nurse is not well adapted.

The prior training of these men varies almost as much as the men who occupy the positions. For the most part, however, those on our staff are college graduates or near college graduates, who, with a few exceptions, have had Navy pharmacist mate training some time in the past.

DR. GODFREY: Are your men older men, as are Dr. Mathews'?

DR. MERRILL: With two or three exceptions, all of our men are now over 37. Most are in their 40's. We have had men in their late 20's who have worked out all right, but we have lost all those to the armed services.

DR. R. H. HUTCHESON (Tennessee): We are using these men in our State now. A few of them are doing a good job. I think it depends entirely on the personality of the individual. But I have had the feeling all the time that we were doing something that really wasn't just exactly in the public health field, and that is, putting out unofficial policemen.

It is true that these men can go into places where nurses can't, into the honky-tonks and juke joints, or wherever they go; places where doctors wouldn't be willing to go and nurses couldn't go; but that, after all, is a job for the police and not for the health department. I think that we are letting the bars down a bit if we plan on this as a permanent organization within the State and county health departments. In some places there will always be a use for a few investigators, but I don't believe there is anything you can find to replace the nurse. I think that we ought to plan that in our future programs.

DR. A. L. RINGLE (Washington): Dr. Parran, we have a few investigators in Washington. We have found that they worked very successfully. At the present time we have a colored investigator, and we find his services have been extremely valuable.

DR. DeKLEINE: It seems to me that the time has come when we must approach the venereal disease problem a little differently than in the past. We must apprehend the spreader. There is only one way to do it. That is to go out and find him. We approach our communicable disease problems in that way; we don't hesitate to use police power for quarantining smallpox or any other communicable disease. Why should we not do the same in dealing with venereal diseases? If we refer this back to the police department, nothing will be done except occasionally. We must assume that responsibility ourselves, and we must do it unhesitatingly, provided the State law gives us the authority so to do.

In Michigan, we would welcome lay workers, not as police officers, but to use them for apprehending spreaders. Using the newer methods of treatment (we now treat gonorrhea in Michigan in twenty-four hours at our rapid treatment center), I can see the possibility of controlling venereal disease, particularly gonorrhea. But that means we must find the spreaders, and if we haven't the courage to find them, then we will not do the job. Lay workers, well trained of course, are better adapted to that work than physicians and nurses.

CHAIRMAN PARRAN: Are there other comments? If not, thank you very much, Dr. Heller.

We come to the closing item on our program, "State-wide Hospital and Health Center Surveys," Dr. Vane M. Hoge.

HOSPITALS AND HEALTH CENTERS IN THE FIELD OF PUBLIC HEALTH

DR. VANE M. HOGE:

I will discuss some recent developments which may have an important bearing on all public health programs in the postwar years.

The public interest in all matters pertaining to health is now at an all-time high. It is noteworthy, too, that a new concept of public health is developing throughout the country. The old lines of demarcation between so-called preventive and curative medicine are fast disappearing. Good public health is a result -- the end product of many factors, including preventive medicine, hospitalization and medical care.

Each of these three fields of endeavor has been, and doubtless will continue to be, under more or less separate auspices. To the more than 12 million men and women in uniform, however, there is only one field of health care. (When the soldier is inducted into service he is given all the necessary immunizations; his food and water supplies are protected and his environment kept as sanitary as conditions will permit; when he is sick or wounded he is attended by medical officers and, if necessary, is given hospitalization.) This universality of health care in the armed services is certain to exert an influence on civilian health care in the postwar years. It is quite likely, therefore, that segregation of services will become progressively less well defined and that more integration and coordination of these fields will be brought about. State departments of health are the logical agencies to effect this coordination.

It is to be expected in time of war that a nation should give much more attention to health matters than in peacetime, and that both Federal and State Governments should play leading parts. This expectation has been borne out to a remarkable degree during the present war. The splendid and well-publicized medical services of the army and navy have brought to millions, both in and out of the services, a concrete realization of the effectiveness of good medical care. This effectiveness has been further enhanced by the Emergency Maternity and Infant-Care Program whereby hospital delivery service has been provided the wives of servicemen. The U. S. Cadet Nurse Corps Training Program started by the Public Health Service in July 1943 has done much to popularize the nursing profession and lend it glamor. This program will provide thousands of additional nurses to meet the larger public health and hospital needs after the war.

The Lanham Act Program, providing community facilities in war-congested areas, has made possible some notable achievements in the field of civilian health. For almost the first time, venereal disease has been subject to large-scale hospitalization. In more than 60 rapid treatment centers, operated by or in cooperation with State health departments, nearly 100,000 patients have been hospitalized and given intensive treatment.

"Lanham Act funds have also been utilized in conjunction with the Cadet Nurse Corps Program to provide housing and training facilities. Without regard to war areas, about 240 projects providing more than 12,000 student accommodations have been obtained from this source."

Of all the health facilities constructed under the Lanham Act Program, hospitals and health centers are probably the most significant, from several standpoints. The Federal Government for the first time recognizes the principle that

voluntary hospitals are quasi-public institutions in function, and has made financial grants for their construction. Under pending legislation this principle would be extended into the postwar years.

Health centers constructed under the Lanham Act, although relatively few in number, are a permanent and valuable development in the public health field. At the beginning of the war, the term "health center" was rarely heard. Few existed, in fact, except as branch centers in some of the larger cities. State health officers, better than anyone else, know the unsatisfactory conditions under which many local health departments have been forced to work. Under the war program, more than one hundred of these local units have been built, and, for the first time, these health organizations have modern quarters for their own exclusive use. The effect of these new health centers on the morale, community standing, and efficiency of local health units has been extraordinary. A modern facility, to be either independent or a part of a local hospital, should be the immediate postwar goal of every local public health department.

The operation of the Lanham Act in the health field deserves careful study by all health officers, hospital administrators, and others concerned with the administration of medical care. It should be stated at the outset that as an emergency war program, the Lanham Act seems to have worked exceptionally well. Our concern now is whether this program, or any part of it, should be retained as a pattern for future Federal relationships with State and local governments.

It will be recalled that the Lanham Act and its several amendments since 1941 has authorized the appropriation of \$520,000,000 for the provision of community facilities in war areas. These community facilities have included practically all types of health facilities: hospitals, nurses' homes, health centers, sanitary facilities and others. In contradistinction to most of the previously established Federal grant-in-aid programs, this Act authorized the Federal Works Agency to deal directly with local sponsors and, in all cases, placed upon the administrator of the program the final responsibility for determining need. A nominal responsibility for determining need was delegated to the Public Health Service. We had no authority, however, either to assure or to prevent construction, nor to insure the quality of any construction. "It is understood that the state health officers had even less to say in these matters."

As time went on, it became more and more apparent that this emergency program was not a desirable pattern for peacetime operation. State health officers were often and, perhaps, unavoidably by-passed in matters in which they had a direct concern; there was little uniformity of either standards or quality of construction in hospitals and health centers; nor could little, if any, consideration be given beyond the needs of the immediate community concerned. From observation of the difficulties encountered in this program, there gradually emerged the broad outlines of a pattern of postwar operation which would eliminate many of the difficulties of the emergency program.

In an address last April 13, before the Pennsylvania branch of the American Hospital Association, we outlined six points thought to be essential in the formulation of any postwar program involving health facility construction. These points are:

1. A State health planning committee representing the hospitals, the State public health services, the medical profession, the

architectural profession, and such representatives of the general public as may be deemed necessary to assist the State agency in determining needs and formulating a construction program.

2. Based on a comprehensive survey, a program of hospital and health center construction and improvement directed to the end that all parts of the State shall be adequately served.
3. An estimate of the total capital cost of the program and the probable allocation of costs.
4. Plans whereby the standards of small hospitals can be maintained through service connections with larger hospitals.
5. A single State agency to administer grants-in-aid and other Federal programs concerned with hospitals, and to carry out the program of the State planning committee.
6. A State advisory council with representation similar to that of the planning committee to assist the State agency in carrying out its program.

During the past year, Nation-wide interest has developed in setting up programs more or less along the lines mentioned above. More than 30 States have taken some steps to organize State-wide health and hospital surveys and several others have indicated their intention of doing so.

The administrative organization of these surveys seems to fall into about four general patterns:

- 1) Hospital survey committees working under official State planning commissions.
- 2) Special governor's commissions to study hospital and health services.
- 3) State health department surveys with widely representative advisory councils.
- 4) Survey groups formed by State legislative action.

In a number of other States, hospital associations have appointed committees to formulate survey programs by one or another of the four patterns mentioned.

There is, of course, a great deal of similarity among the four general methods of procedure. One feature they all appear to have in common is wide representation. It is significant that the so-called consumer groups are beginning to demand a voice in the administration of medical affairs. Therefore, in addition to public health officials, hospital officials, and organized medicine, most of the advisory councils and survey groups have representation from labor, industry, agriculture, etc.

Since nearly all the States have had legislative sessions during the past winter, a very large number of bills bearing on public health and public health departments have been under consideration. Four classes of proposed State legislation are especially germane to this discussion:

- 1) Legislation authorizing State health departments to conduct hospital and public health surveys.
- 2) Legislation authorizing State health departments to administer hospital and health center construction programs in addition to surveys of need.
- 3) Legislation creating survey commissions.
- 4) Legislation for the licensing of hospitals.

Legislation authorizing State surveys has resulted from a growing conviction on the part of health and hospital officials that we face the postwar period with our health facilities poorly distributed and in bad physical condition. It has been felt that sound future programs could not be built until a more complete knowledge of facility and service needs was obtained. Consequently, last summer, Mr. Frank Bane, Chairman of the Council of State Governments, came to the Public Health Service and requested our assistance in drawing up a model bill to be presented to the State assemblies. In cooperation with the Council of State Governments and the Department of Justice, such a bill was prepared. In brief, it contained the following provisions:

- Sec. (1) Authorized the State health departments to conduct State-wide surveys of all hospital and health center facilities; to appraise the sufficiency of such facilities to serve all the States; and to formulate a program for the construction of necessary additional hospitals and health centers.
- Sec. (2) Authorized the State health departments to apply for and accept on behalf of the State any funds which might become available from the Federal Government to help defray the cost of these surveys.
- Sec. (3) Provided that after the enactment of Federal grant-in-aid legislation the State health department should submit a concrete program for new construction and improvement of health and hospital facilities in order of priority of need.
- Sec. (4) Provided that the health department should approve individual projects both as to need and as to adequacy of design.
- Sec. (5) Provided that the State health department was authorized to accept Federal funds either on behalf of the State or any other eligible applicant within the State for construction surveys and administration of construction.
- Sec. (7) Provided that with the approval of the State health department, any two or more counties, or other political subdivisions, could enter into an agreement for the joint acquisition and maintenance of a hospital or health center.

- Sec. (8) Provided that the State health departments should have authority to supervise the awarding of contracts and inspect the performance of construction work.
- Sec. (9) Provided for the licensing of hospitals by the health departments. (With this authority, unnecessary and inadequate construction of hospitals could be prevented.)
- Sec. (10) Provided for a State advisory council to assist the State health departments in the administration of this act, including surveys, construction and administration.

Before this model bill could be submitted by the Council of State Governments to the several State officials, it had to be approved by all the Federal agencies in any way concerned. This procedure applies to all legislation sponsored by the Council. One agency objected to all but the survey features of the bill and, as a result, only the first two sections were released to the States. The survey part of this original bill was introduced into a number of State legislatures and in some States has been enacted.

Insofar as we can determine, only two States prior to this year had over-all licensing authority over all hospitals. These were Massachusetts and Minnesota. In both States this authority is vested in the health department. During the past winter, a large number of States have considered hospital licensure bills similar to those in effect in Minnesota and Massachusetts and at least two, Maryland and Indiana, have enacted such legislation. In the Maryland law the authority is vested in the State health department. The Indiana law places the authority in the State health department also, but, in addition, provides an advisory council. It is probable that several more licensure laws will be passed during the current sessions. California has since enacted a hospital licensing law.

There is no doubt that a good hospital licensure law is one of the most valuable and most needed weapons in the fight for a higher standard of public health. All three of the national hospital organizations are in strong support of this control. (Opposition comes largely from the small substandard hospitals, of which there are about as many as registered institutions.) Certainly, any support which the State and local health organizations can give to the State hospital associations in their efforts to obtain such laws will be a step in the right direction. Within the past month, the American Hospital Association has organized a Committee to develop an up-to-date model licensing bill for submission to State legislatures. We have been asked to serve as a member of this Committee.

During the past year, while new developments in the health and hospital fields have been going on in the States, somewhat parallel action has been developing at the national level. The American Hospital Association, which represents most of the registered voluntary and public hospitals throughout the country, is an old, conservative organization. Yet, it has long recognized the fact that the hospitals were facing a future which would require new duties and new responsibilities. They recognized, too, that the economic circumstances upon which the voluntary hospital system had been built were changing, and that private contributions could no longer be relied upon to perpetuate the system. Accordingly, in October 1943, the house of Delegates of the American Hospital Association went on record as favoring a Federal grant-in-aid program to the States for the construction of needed hospitals.

Early in the year prior to this resolution, the American Hospital Association set up a postwar planning committee to develop a long-range plan aimed at improvement of the hospital system and a better coordination of hospital and other health services. In October 1942, this committee recommended the organization of a Commission on Hospital Care, to be financed privately and to operate entirely independent of the Hospital Association. The function of the Commission was to conduct a Nation-wide study of hospital and related health needs.

During the ensuing year, that is, 1943, the planning committee was successful in obtaining financial support for the Study Commission. The Kellogg Foundation, the Commonwealth Fund and the National Foundation for Infantile Paralysis, each contributed \$35,000 to cover the expenses of the Commission over a period of two years.

After funds were secured, twenty nationally known men and women were selected to make up the membership of the Commission on Hospital Care. Mr. Thomas S. Gates, President of the University of Pennsylvania, is the Chairman. Dr. Arthur C. Bachmeyer, Medical Director, University of Chicago Hospital, was appointed to direct the national study. The Public Health Service is cooperating through the loan of a medical officer as assistant director.

Shortly after the appointment of the Study Director last August, the Commission announced the objectives of its proposed study. These objectives are six in number:

1. To obtain a census of present hospital and public health facilities.
2. To appraise their capacity for service.
3. To establish standards or criteria relative to physical facilities, organization, and management of hospitals.
4. To determine the over-all need for additional facilities and services.
5. To formulate a national coordinated hospital plan.
6. To suggest methods by which the national plan can be realized.

Because of limitations of time and money, the Commission will be unable to direct detailed studies in each State. It is, however, conducting a detailed pilot out for use or adaptation by the other States. As mentioned before, more than 30 States have taken some steps towards organizing a State-wide survey. Now about 40 States are planning or conducting hospital surveys. The Commission hopes to obtain the cooperation of each of these State groups, so that the facts obtained may be comparable throughout the country.

The Commission has published two booklets setting forth the general outline and scope recommended for State studies. It has also prepared two survey schedules; one for hospitals and one for public health facilities. While the hospital schedule in particular is rather lengthy, it was the consensus of both the Director and his technical advisory committee that a shorter schedule would not elicit all the detailed information necessary.

As now planned, these schedules will be completed in duplicate. One copy will be sent to the Chicago Office of the Commission, where certain items will be coded and punched on cards. This copy will then be returned to the hospital or health department, as the case may be, for permanent reference. The second copy of the schedule will be retained by the State health department or other agency which has conducted the study. This detailed information on each hospital will be of the utmost value to the State agency which may now or later have responsibility for any program dealing with hospitals in any way.

A question that naturally arises is the relationship between the surveys being fostered by the Commission on Hospital Care and by State legislatures, and pending Federal legislation, specifically, the Hill-Burton Bill, S. 191, and the companion Patrick Bill, H.R. 2755. Since these are only pending Bills, it is difficult to answer this question as intelligently as one should like. It is, of course, impossible to say at this time what amendments may be made before final enactment. I think, however, that certain assumptions may be made and certain steps taken with reasonable safety.

I believe you have all seen copies of S. 191 and are familiar with its provisions. As you know, one of the major provisions is the allotment of \$5,000,000 to the States to finance State-wide surveys and develop programs for construction of health centers, public, and voluntary nonprofit hospitals. There is little chance, I think, that any grant-in-aid construction program will be instituted which does not require a thorough survey. Any study carried out along the lines suggested by the Commission should yield sufficiently comprehensive data to meet the requirements of any future legislation.

A requirement of S. 191 is that a State plan must be developed before any Federal funds will be allotted. This plan would doubtless be built on the basis of existing facilities as determined by survey, plus other factors as may be required by legislation. Until legislation is enacted, it will not be possible to develop any official standards as to the content of an acceptable State plan. Certain general requirements may be anticipated, however, and it may be well to have these in mind while a survey is in progress:

1. Total needs: The plan should show the total existing health facilities, including broadly, general, tuberculosis, and mental hospitals, public health facilities, chronic disease facilities, etc. Measured against desirable standards of adequacy, the plan should show the total need for new facilities in all the categories, for extensions and for replacements.
2. Location of facilities: Determination of location of new facilities would be a major part of a State plan. It is probable that in the case of mental and tuberculosis hospitals, location will be second in importance to adequate quantity. In the case of general hospitals, distribution should be fully as important as quantity. It is important that hospitals be placed near to the people if they are to serve effectively. To do this will require, in many instances, hospitals too small to operate as an independent unit. To safeguard the quality of care in these small units, they must be organized with a service association with larger, better equipped, and better staffed institutions. The smaller the new unit may be, the more intimate the association with the larger

institution should be. The ideal plan, of course, would be a complete coordination of services all the way from the large teaching medical center down through the medium-sized district hospitals to the rural hospitals and health centers. Such a plan will doubtless be a slow evolutionary process even under a program such as S. 191. The immediate problem is how to prevent the establishment of small hospital units with no outside associations.

Health centers also should be near the people. It is probable that almost every local health unit will need at least one. In the State plan, the need for health centers should be supported by the current or projected public health programs.

3. Priority of Construction: S. 191 would authorize the appropriation of 100 or more millions per year for construction. Local contributions would perhaps amount to about an equal amount. While this seems like a lot of money, it is small in relation to the accumulated need. The capital investment, or at least the replacement cost, of existing non-Federal hospitals is in excess of 5 billion dollars. The depreciation cost alone, at the low rate of 2 percent per year, is more than one hundred million. It will be necessary, therefore, for the plan to show the priority of need from year to year.
4. Cost and distribution of cost: S. 191 provides that non-Federal funds must be provided to the extent of 25 to 75 percent depending upon the financial status of the State. The State plan would, therefore, show total costs and the fact that these non-Federal funds were available for the projects scheduled from year to year.

These four points are general requirements that may be anticipated any program similar to that proposed under S. 191. They should be kept in mind during the current surveys. Should S-191 be enacted in substantially its present form, some additional requirements for a State plan would be those mentioned specifically in Section 622 of the Bill.

It is, of course, impossible to even summarize very well in 20 minutes the broad subject I have tried to cover here today. If there are any questions, I shall try to answer them if I can.

CHAIRMAN PARRAN: Thank you, Dr. Hoge. Are there questions?

DR. GETTING: Mr. Chairman, there are two parts of this fund: the 5 millions for survey and the 100 millions for construction. I understand that both parts have to be matched. I am wondering what the attitude of the United States Public Health Service might be regarding that 5 million dollars for survey purposes; how, in your opinion, do you think the States could match that?

DR. HOGE: The 5 million dollars provided for surveys would have to be matched; I assume from State funds, or any other funds that are available.

CHAIRMAN PARRAN: I don't think you could match one Federal fund against another.

DR. GETTING: Would it be possible to suggest to Congress that that 5 million dollars not be matched?

CHAIRMAN PARRAN: It is quite reasonable for the State health officers or other groups to suggest any amendments to S. 191 which they think would make it a better bill. Dr. Getting has a point here that involves time more than anything else, that is, getting one State to match the funds. Also, the 5 million dollars is available until expended. That point has been criticized.

DR. THURMAN B. RICE (Indiana): Dr. Parran, inasmuch as many of the legislatures have adjourned and may not convene in special session after VE-Day, it appears very important that this requirement for matching should be removed; otherwise, we won't have any opportunity to take advantage of the funds for perhaps two years.

CHAIRMAN PARRAN: I assume that one of the committees is considering this matter, and may wish to make recommendations. In my own remarks, I referred to the recommendation made by the American Public Health Association. Would Dr. Atwater wish to speak on that point, since he represents that Association?

DR. ATWATER: It was simply that we felt, after studying the bill for some time, that there was an unnecessary confusion between a separate planning agency and an administering agency, and that the two might well be combined. Also, as Dr. Parran has said, we felt that there was doubt about the desirability of the provision leaving for indefinite expenditure, with no certain time limit, the 5 million dollars so authorized.

DR. F. C. BEELMAN (Kansas): There will be States that won't have agencies authorized to participate and to administer such programs. Will this bill permit the direct channeling of funds to local units, for expenditure in hospital construction?

DR. HOGE: Not in the way I think you mean, Dr. Beelman. The bill will permit direct channeling of funds to local communities or sponsors in case the State is not able, on account of statutory or constitutional prohibitions, to make an allotment to a nongovernmental hospital, such as a church hospital. In that case, the Federal Government could deal directly with the local community, but only after the local community's project had been found by the State survey to be needed, and so certified by the State agency handling the program.

DR. BEELMAN: Some State agencies have no authority to make surveys of that nature or to expend money for that program.

DR. HOGE: That is true, and provision for such authority was the purpose, of course, of legislation that was drawn up last fall and introduced in quite a number of State legislatures. Whether or not, in the absence of such recent legislation, the States would have sufficient authority, I couldn't say. I think the situation would vary in different States, and that it would be a matter only the Attorney General could decide. It has been my impression that under the basic public health laws of the State they might handle it.

CHAIRMAN PARRAN: The basic provision of S. 191 is that the State must designate a single State agency to administer the provisions of the Act within the State.

DR. WALTER L. BLERRING (Iowa): In Iowa we developed a plan, not by approaching the Legislature, but by forming a committee, in conjunction with the Commission on Hospital Care. This committee is composed of ten members, and the Commissioner of Health is the Chairman. It represents the University Hospital, the President of the Hospital Association, the Superintendent of the largest voluntary hospital, of the largest county hospital, the State Medical Society, the State Nurses' Association, the Blue Cross Association, the State Board of Control, and the State Catholic Charities.

This Committee was appointed by the Governor, and was made a part of the State Department of Health. Lapsed funds were used for the expenses of the survey. The State Department of Health lent one of its directors, clerical assistance was provided, and the necessary equipment has been bought. Arrangements have been made with the Commission on Hospital Care for the Director to spend several days in their office, and subsequently for him to go to Michigan, to observe the programs there.

A preliminary list of hospitals, nursing homes, maternity homes, and health centers, is now being prepared. Meetings are held once a month, and it is hoped that within a month's time, the actual survey of the institutions may be begun. We have found that our listing, based on all possible sources, almost triples the number of hospitals recorded in the Hospital Number of the American Medical Association Journal.

We are going ahead without any thought of asking for Federal participation, until we can demonstrate the need. We will be ready when that time comes.

DR. RILEY: I think we will meet the expense of a survey somehow. I don't believe we have passed any legislation, but we do have an Advisory Committee on Hospital Inspection which could very well be used for this purpose. Just how we will raise the money, I don't know. I want you to come to Maryland, sit down with some of the people there, and talk it over with us.

DR. GODFREY: Do the moneys used for matching have to be appropriated for this specific purpose?

DR. HOGE: No, I shouldn't think so, Dr. Godfrey.

DR. GODFREY: So long as they can be used for that purpose and are used on whatever ratio of Federal funds are expended, is that O.K.?

DR. HOGE: I should think the only limitation would be that, as Dr. Parran said, you couldn't match Federal money with Federal money.

CHAIRMAN PARRAN: However, I think we made it clear that the State health officers may propose budgets contemplating the use of what they used to call Title VI funds for purposes of survey. If you have any lapsed funds which are being accumulated because of failure to fill vacancies, or other reasons, and you wish to set up a budget for planning in this field, we shall be glad to entertain such proposals.

DR. FELIX UNDERWOOD (Mississippi): Would you state definitely just what a health center is?

DR. HOGE: A health center is primarily a concept rather than a building. The health center is something merely to house the program that you are able and willing to undertake.

DR. UNDERWOOD: The right kind of building is very important.

DR. HOGE: That is extremely important, but it is secondary, of course, to your program. Once your program is crystallized, it is relatively easy to develop a good physical facility to accommodate it.

DR. UNDERWOOD: I was thinking about diagnostic facilities.

DR. HOGE: Any health center worthy of the name should have diagnostic facilities in it, but it would seem like a waste of money to build a facility for something that could not be gone ahead with.

DR. UNDERWOOD: In the minds of those who created this bill, those who wrote this bill, and the Congressmen who will act on it, how was the health center to tie in with the hospital?

DR. HOGE: In two ways. First, I think we are going to see better coordination of ordinary, routine public health measures with hospital measures, utilizing facilities of the hospital or the health center to best advantage without duplication.

Second, the health center may become a hospital facility to meet the needs of isolated areas which could not support a voluntary hospital. Such an area might be too small to need even a county hospital, but there might be a health center for clinic and diagnostic purposes, and there might be need for a few beds for obstetrics.

DR. BIERRING: Could a health center and the facilities of the local practitioners be combined? In addition to facilities for the health personnel, local doctors might have their offices there, and clinical and X-ray laboratories might be established. Thus preventive and curative medicine could be brought together. With a few maternity and emergency beds, there could be combined the interests of both the health personnel and the practitioners. We will get farther in a great many communities if we have some such plan as that.

DR. HOGE: That is true, Dr. Bierring, and one of the plans we have available does contemplate that very thing. As a matter of fact, it will be published in next month's issue of the Hospital Journal.

(Following the announcement of committee meetings, the meeting adjourned at 5:30 o'clock.)

TUESDAY AFTERNOON SESSION

April 10, 1945

The meeting convened at 2 o'clock, Dr. C. L. Williams presiding.

CHAIRMAN WILLIAMS: Gentlemen, the meeting will come to order.

The first order of business on this afternoon's session is, "Administrative Policies for Malaria Control," to be presented by Mr. Hollis, Dr. Gilliam, and Dr. Boyd, each taking up a portion of the time. Mr. Hollis.

ADMINISTRATIVE POLICIES FOR MALARIA CONTROL

MR. M. D. HOLLIS:

I believe you are all familiar with the general organizational and operational policies that govern the several activities carried on through the office of Malaria Control in War Areas. On the surface it may seem that this program departs from our traditional lines of approach, but in reality it does not. The terms of the appropriations, and the fact that they are made in the interest of the war effort, require the Public Health Service to carry on more than the usual degree of activity. However, in putting the plan into effect, actual operations are conducted through the existing structure of State and local health departments.

To provide time for discussion, this paper is limited to a statement of major activities, with some comment on the pertinent question of returning malaria carriers.

Extra-Cantonment Malaria Control.

This is the fourth season of anti-malarial operations in the extra-cantonment areas of military and war industry establishments. From the 1942 coverage of 900 such establishments in 17 States, activity by 1944 had expanded to include 2,000 such installations, located in 500 counties of 35 States, the District of Columbia, Puerto Rico, and Jamaica. Of these 2,000, about 500 were general hospitals and prisoner-of-war camps. Inclusion of these latter types of establishments marked the first shift in emphasis from the original concept of protecting military personnel from the civilian reservoir of infection to protecting the civilian population from imported reservoirs of the disease. Operations in 1944 required a total Federal expenditure of slightly over \$8,000,000, of which 82 percent was for employment of a personnel complement of 3,500.

In 1945 there will be a reduction in the total number of military establishments, although some increase is expected in general hospitals and POW camps. These changes, together with accrued benefits from anti-malarial drainage, will reduce control expenditures about 20 percent. This work, coordinated with the excellent control programs of the Army and Navy within reservations, has as its primary objective the protection from malaria of essential war personnel. The malaria rate for continental troops in 1944 was less than one-fourth of the 1941 rate, and the insignificant number of cases that did occur were well scattered throughout the country. During the same period, several significant outbreaks occurred in the civilian population.

Aedes Aegypti Control

Anti-aegypti measures, as a precaution against dengue and yellow fever, are carried out in 15 cities in the 7 southeastern States for a twofold purpose: (1) to control production of the Aedes aegypti mosquito in the 15 more important air- and seaports of entry and (2) to provide a small nucleus of well trained mobile personnel, who, with necessary equipment, can converge on any point if yellow fever is introduced. (This was done during the recent outbreak of dengue fever in Hawaii.) This activity is now being integrated with the general sanitation program of the city-county health departments, on a fifty-fifty personnel basis and will operate this year in the continental United States on a Federal budget of approximately \$180,000. The Hawaiian program is carried out jointly with the Army through the Territorial Health Department.

Extended Malaria Control

In October at your New York meeting, Dr. Louis L. Williams and two of our Atlanta staff presented a proposal to extend malaria control operations to selected civilian areas where malaria was still of significance as an endemic disease. This proposal included (1) removing the hazard of malaria transmission in the more important endemic foci; (2) providing mobile control units to take care of possible explosive outbreaks; (3) preventing the creation of extensive new breeding areas of the malaria vector. With your endorsement, and the support of the military authorities, the proposal was submitted to Congress and a supplemental appropriation secured to inaugurate work this spring. A budget of about \$5,000,000 to continue operations in the fiscal year 1946 is now pending in the Congress.

The first objective of this program is control of the mosquitoes most likely to be infectious. To accomplish this, DDT residual house spraying will be done in about 400,000 dwellings in the most malarious rural sections of the South. Larvicidal and drainage operations will be carried out in urban centers. Delineation of the areas to be covered has been worked out by the Medical Division in Atlanta, in close cooperation with the State Health Departments. For 1945, the work will include all or portions of 115 counties in 14 southeastern States. Actual spraying began in March and the entire program will be in operation by the middle of April. War shortages continue to hamper operations, but the required 500 additional automotive vehicles have been procured, equipped, and distributed to States. The necessary tonnage of the chemical DDT, together with xylene (a solvent), and triton (an emulsifier), have been placed in the hands of States. Mixing machinery and spray equipment have been designed, built, and distributed. The availability of labor, questionable three months ago, is working out reasonably well in most areas.

To deviate a moment on DDT, a year's exhaustive tests have confirmed the earlier optimism regarding its value as a residual house spray. This season our Savannah laboratory is delineating its use as a larvicide under field conditions, and preliminary work has already demonstrated its limitations. DDT is still better than good, but like the sulfa drugs, is not the total answer.

The second objective of the extended program is to maintain emergency surveillance and control units in marginal areas. To this end, 14 mobile units fully equipped, with trained crews, are in operation on a "circuit-riding" basis. Although these units are not bound by State lines and hence are attached to Public Health Service District Offices, their itineraries are worked out with the respective State Health Departments. A reporting system is maintained to keep the States apprised of operations. At the moment, the units service general hospitals and prisoner-of-war camps.

The third objective is to apply sound malaria control principles to the location and construction of artificial lakes and reservoirs. For this purpose administrative machinery has been established with the Army Engineer group and other Federal and State agencies interested in water impoundment developments.

Importation of Diseases

The significance to public health of the importation of insect-borne and related infectious diseases by returning military and other personnel is being discussed rather widely in professional circles. As for malaria, there is general agreement that the return of vivax-infected persons to their home communities will

be of some importance, although estimates as to the probable number of such carriers vary widely. There is also divergence of opinion both as to the effect these carriers will produce and as to the defense techniques that should be marshalled.

On analysis, the following factors appear pertinent:

1. The present mortality rate for malaria in the continental United States is the lowest on record. Highly endemic areas continue to recede, and there remains only one known hyperendemic focus. However, from these smoldering endemic areas malaria has resurged before and may, with an increase in carriers, resurge again. The estimate of 350,000 indigenous carriers in southeastern United States presented to you last year has gained support from other authorities.

2. The probable number of carriers that will infiltrate with returning military and other personnel is indeterminate. Undoubtedly the number will be affected by future military operations in the Pacific. The current malaria rate among overseas personnel is between 10 percent and 20 percent of that experienced in the early stages of the war. This is due, in part, to the location of the present battle fronts, but to a greater extent it is the result of the excellent front line anti-malarial techniques practiced by the Army and Navy.

3. The solution to the returning carrier problem often suggested is one of widespread vector control in malarious areas where the densities reach significant proportions. To advocates of this proposal, we would respectfully point out that the extra-military cantonment program, which, incidentally, operates on a highly selective basis, requires a total annual expenditure of about \$10,000,000 and covers less than 5 percent of the area south of Washington and St. Louis, and east of Austin, Texas. Widespread vector control of this entire area would require over \$200,000,000 per year. Such an expenditure, under present conditions, would be unwarranted. This is especially true since complete eradication of the indigenous anopheline vectors is unfeasible.

By way of summary, MCWA proposes three types of attack on malaria, each type suited to a particular zone of the continental United States, according to vector distribution and other ecological factors.

Zone 1. The endemic area, in which a concerted attack against the vector will be instigated in all remaining major foci of infection. In each State the control organization will be ready for use in other areas if necessary.

Zone 2. The marginal areas, where vector densities are significant, but ecological factors are balanced against transmission. In this zone epidemiological and entomological surveillance will be practiced, with mobile control units immediately available.

Zone 3. Other areas, where vector densities and ecological factors are such that transmission is highly improbable, and the returning carrier will present a clinical problem only.

The weaknesses in this machinery are inadequate laboratory diagnostic services, unavailability of trained epidemiologists, and a lack of proper awareness on the part of the practicing physicians of the necessity of prompt recognition and reporting. These same weaknesses apply also to the other less significant tropical and infectious diseases. The proposed tropical disease training program may afford a partial solution.

to take the training. On April 1, these two were enrolled in Johns Hopkins University for a special course dealing with tropical diseases. It appears that, for the present, it will not be possible to recruit sufficient veterans to carry on the program as originally planned. Recruiting efforts will continue, but there is no optimism over possible results.

Facilities in the Atlanta office are now being expanded so as to provide training for technicians now employed by or recruited by State and local health department laboratories. In Atlanta a laboratory is now being developed designed to serve three purposes: one, to offer intensive training in laboratory diagnosis of tropical diseases; two, to serve as a diagnostic laboratory for the examination of smears and specimens referred by State health department laboratories and for the examination of malaria smears and other diagnostic survey substances; three, to serve as a branch distribution center for diagnostic and reference materials which can be utilized by technicians in State and local health department laboratories. Also, the present training course in the Atlanta office is being expanded to include general medical entomology, parasitology, and sanitary practices used in the control of insect-borne and other infectious diseases.

The original plan for tropical disease education included provisions for a full-time itinerant lecturing team to visit State and county medical societies and discuss these problems. At present those who are qualified to participate in such a lecture program have more urgent duties, and it is considered inadvisable by the staff of the Atlanta office to sponsor lecturers who do not have wide experience and reputation in the field of tropical diseases. Instead, educational materials designed to assist locally sponsored tropical disease education programs for the medical and allied professions will be supplied. These materials will consist of lantern slides, film strips, motion pictures, bulletins, reference digests, and other source and reference materials. Such outstanding tropical disease experts as Dr. Henry Meleney and Dr. Carroll Faust have agreed to review and contribute to the content of these materials. I would like to point out that it takes much time and effort to develop these materials and that they cannot be made available immediately.

It would be of assistance, in order to carry the program to medical schools and medical societies, if the State health departments would provide a roster of men qualified and willing to participate in the locally sponsored programs.

CHAIRMAN WILLIAMS: Gentlemen, you have heard the presentation of the malaria program. Is there any discussion?

DR. GILBERT COTTAM (South Dakota): Mr. Chairman, I would like to ask if there is any information available as to the production of DDT, or as to when it will be available in the open market.

MR. HOLLIS: It is doubtful if any DDT will be available commercially through the calendar year '45, and as far as we now see in the calendar year '46.

CHAIRMAN WILLIAMS: I might add to that that one or two States have secured DDT for special health measures. Each request has been acted upon by the War Production Board on its merits.

DR. HENRY HANSON (Florida): We are using quite a bit of DDT in Florida, and so far it looks as though we are getting good results.

I want to compliment the three speakers on the manner in which they have presented this program.

CHAIRMAN WILLIAMS: For them, I thank you.

Is there any further discussion?

The next item on this afternoon's program is, "Health Education," by Dr. Mayhew Derryberry.

HEALTH EDUCATION

DR. MAYHEW DERRYBERRY:

Health education is universally accepted as an essential part of the public health program. Descriptions of the control activities for such various diseases as tuberculosis, venereal disease, malaria, the acute communicable diseases, cancer, and the degenerative diseases, always list health education as one of the important and necessary parts of the program. Even persons engaged in inspection and law enforcement have recently stated that health education is a necessary tool in assisting them to achieve their objectives.

Coupled with this universal agreement on the importance of health education, there is almost complete disagreement on what constitutes a good health education program. In one department, a series of news releases, radio broadcasts, and occasional talks to groups on invitation constitute the health education program. In another, health education activities are all centered around the school child, with syllabi, pamphlets, essay and poster contests, special campaigns, et cetera. In a third, the program consists of the production and distribution of films, pamphlets, posters, and radio transcriptions, and the use of special mobile visual units to take the message to the people. In a fourth, every member of the department staff carries on health education in his daily contacts, and no other planned educational program is undertaken. In still a fifth, emphasis is placed on the solving of health problems by the people of the community through their utilizing the technical guidance which the health department can provide.

This wide variation arises, in part, from difference in objectives. In the early days of public health, the provision of facilities for purification of the water supply, or the passage of legislation providing for the pasteurization of milk, prevented much illness, regardless of how little the people knew, or how they behaved. The only health education needed was that required to win the support of enough people in the community to assure the appropriation of the funds, or the passage of the legislation.

Today, however, public health has reached the point where it is apparent that many diseases cannot be controlled without full citizen understanding and participation. The provision of X-ray and diagnostic facilities, sanatoria, and rehabilitation services will not reduce tuberculosis unless people know the value of an X-ray of the chest, have one taken periodically, and take the necessary treatment if diagnosed as having the disease. The best tumor clinics in the world will not reduce the mortality from cancer unless citizens avail themselves of the diagnostic services they provide, and take treatment when necessary. The principal objective of health education today is the stimulation of public action and individual participation in preventive health activities.

This over-all objective of citizen participation is much more difficult of attainment than enlisting support for the program of the health department. It is difficult, first of all, because everyone, including the housewife, the laborer, the white-collar worker, the domestic, and the unemployed, must become informed about how to protect his health and must act on that knowledge. Secondly, it is difficult because few people are sufficiently interested in their own health to do anything about it--at least not until they get sick. Therefore, it requires an intensive educational program to achieve any degree of success.

Realizing some of the difficulties involved, the Public Health Service, in cooperation with several States, set out in 1941 to experiment in methods of stimulating individuals to participate in the solution of their individual and community problems. The Public Health Service began by assigning individuals trained in public health and education to work as regular members of local health departments. The tasks of these workers were those prescribed by the Committee on Professional Education of the APHA in its statement of the functions of health education. They were: To assist in planning and organizing a program of health education suitable to the area of assignment; to aid the community in organizing itself to find and solve its health problems; to assist in promoting, organizing, and guiding study programs in health for various groups in the community; to contribute to the improvement of the quality of health education of the school child through work with teachers, supervisors, and administrators; to conduct an information service to answer inquiries about health, to prepare, select, assemble, and distribute health education materials needed to meet community needs; to conduct a speaker's bureau, conferences, meetings, and radio programs; to assist with the in-service training of public health personnel; and to provide for a continuing appraisal of health education activities.

Some of you may say, "But these tasks are the functions of all members of the health department staff." It is true these broad educational functions are part of the responsibility of the entire staff, but what does adequate performance of these tasks require?

Let us look at the health educator as he or she undertakes only two of these functions: assisting the community in organizing itself to find and solve its health problems and promoting study programs among various groups. As a beginning, she must know what organizations already exist in the community, what they do, who directs them and what are their interests. One health educator in a community of 60,000 found over 200 agencies and organizations in the community. It was her first task to learn something about them, how many members each had, what they had already done in health education, and if they were willing to expand their program. It was particularly important to ascertain which parts of the population were members of the various organizations and which parts would be left out of any program that worked only through existing organizations. To gain this information, she interviewed more than 300 persons in about two and a half months' time. These people included representatives of the medical and dental societies, school authorities, welfare leaders, agricultural workers, voluntary agency executives, and a host of lay leaders in both the rural and urban parts of the community.

In addition to finding out what agencies there were, what were their interests and their activities, these preliminary interviews were held in order to discover both what information and what misinformation existed in the community. What do the people know about the health department and its program? Are they confused about its activities? Here are a few of the questions which citizens have asked the health educator:

"What does a health officer do except put up placards?"

"Why should I be interested in public health? It is only for the poor people. It is not important to me."

"Does a public health nurse have to be as well trained as our hospital nurses?"

Most of these interviews were conducted in areas served by above-average health departments.

These are attitudes the health educator must know before a program is begun. She must be prepared to interpret the work of the health department in a very elementary fashion in such situations.

Oftentimes the people in the community feel that there are no health problems. The president of the Parent-Teachers Association in one community of 60,000 stated that she had read about the great reduction in the tuberculosis death rate and was sure there was no need to do anything about tuberculosis in her community. Actually, there had been an average of 100 deaths per year during the past five years and 83 new cases had been discovered within the year.

A home demonstration agent in a county of 75,000 seriously reported when interviewed that there was no further need for venereal disease education in that community for it had been covered by a five-minute presentation to all of the 700 members of her clubs during the past year.

Certainly such misconceptions and lack of understanding must be removed before constructive health education can take place. Unless this is done, the health education lecture, film, news release, or pamphlet may miss the mark and accomplish no good whatsoever.

Interviewing to uncover the necessary information is time-consuming and demands skillful handling. It requires more intensive work than the health officers, nurses, or sanitarians can spare from their own professional tasks. Yet, this preliminary step has great potentialities for building and extending good public relations in all directions. It requires a real sense of timing, an ability to get along with all classes of people, and an awareness of the fact that, when properly approached, people can be stimulated and guided to take an active part in various public health programs. If, however, the interviews are not skillfully conducted, people will not be stimulated to work on the problems of the community. Instead, they may become antagonistic, and oppose any activity, particularly if they feel a set program is being forced upon them.

Out of these interviews grow actual planning at the level of development within the community. Study group meetings are held and people learn of problems on which they plan to do something. No more does the health officer receive such generalized invitations as, "Would you come out to the East Side Garden Club and speak on some health subject which you think would interest our members?" Instead, the invitation is specific. "Can you come out and discuss with us how we can get more well-baby clinics in the Eastern section of town?" or "What can be done about getting sanatorium care for the tuberculosis cases which have been found in this community?"

The preliminary interviews not only result in more meaningful invitations, but also they greatly increase the number of groups that ask for information. In one community, where only 32 meetings had been held during the three years prior to the arrival of a health educator, the number mounted to 400 during the first year and a half of her work in that area. In attendance at many of the meetings to provide the technical information the people wanted were the health officer, the nurse, or the sanitary engineer, depending on the problem under consideration. Thus, because of the preliminary arrangements and planning done by the health

educator, the educational work by the other members of the staff became more effective and reached a larger number of people.

In order to serve all those that want information from the health department, the staff must be willing to meet with groups at the time they want to meet. This will mean meetings at night as well as during the regular working day. In one or two health departments we have found health officers who felt that night work by the health educators was unnecessary. They objected to the irregular schedule of the health educators. Certainly the objection could have arisen only from a misunderstanding of health education.

As groups in the community become informed about the problems, they undertake to sponsor various health department activities such as: Well-child conferences, maternity classes, drives for early diagnosis of tuberculosis, rat campaigns, foodhandler classes, et cetera. Thus, the health department finds itself being asked to do the things it was set up to do and has been wanting to get under way. The people feel responsible for the success of the activity instead of blaming the health department for not being more efficient.

From the above discussion it should be fairly clear that health education should be a generalized continuing function. The effectiveness of the health educator is greatly restricted when his work is limited to one field, such as tuberculosis, venereal disease, cancer, or dentistry. Furthermore, if there is a special health educator for each specific public health activity, the several programs compete with one another for public attention to their mutual disadvantage.

Turning to another function, such as school health education, we find the health educator equally active in learning what the present program is. Do the teachers understand and maintain a healthful environment for the children? Are the window shades adjusted properly, is the heat kept regulated? Are the toilets kept clean and supplied with water, soap, and towels? (In one school a health educator found that the boys' toilet was locked, and had been for four months, because of a burst pipe.)

What is being done to find the children who need medical attention? Are the teachers sensitized to behavior symptoms which they should recognize and bring to the attention of a physician? Is anything done about children who are found needing attention? Is health instruction devoted to the study of health problems of the school and community, or are the health periods devoted entirely to physical education?

After learning the school program, the health educator works with the school staff. When the group becomes concerned about some problem, the health instruction period is no longer a period of entertainment where someone from the health department brings in and shows a film. Instead, the children seek answers to problems, and the movie showing becomes a method of learning.

Learning how to solve health problems is no different from learning arithmetic or geography. No educator would show a film on the process of addition, or put up a poster showing the boundaries of a State, and expect the students to learn addition or geography from such passive experiences. These techniques might be used to stimulate interest or provide information, but learning that will influence behavior requires more intensive participation on the part of the learner.

It is the health educator's task to be the resource person for the teachers, to assist them in setting up problem-solving situations for the children, to provide informational material in the form of references, pamphlets, visual aids, and technical personnel who can answer questions raised by children; to arrange observational tours and work experience in health agencies. She guides the teacher to sources of information and assists her in evaluating materials when the advice from various sources differs.

To go into similar detail regarding all the functions ascribed to health education earlier in this paper is impossible. It should be obvious, however, from the description of the activities of a health educator on only two of the functions mentioned that the amount of work requires full-time personnel in every health department of the size prescribed by the Committee on Local Health Units of the American Public Health Association. It should also be obvious that successful accomplishment of the many and varied tasks a health educator is asked to perform requires a well-trained individual. Certainly, interviewing community leaders and stimulating their interest in a public health program should not be entrusted to an individual who is not thoroughly grounded in the basic public health sciences and the techniques of interviewing as well. Likewise, work with the schools requires an intimate knowledge of education to assure success.

The number of individuals who are trained in public health and education is extremely small. Therefore, if effective programs are to be carried on, personnel must be trained.

As a beginning towards meeting this need, a grant of \$40,000 was received in January 1943, from the W. K. Kellogg Foundation. Twenty-four individuals (17 on fellowships from the W. K. Kellogg Foundation and the remainder on stipend from the States) began training in March. An additional grant of \$32,000 was received in June 1943, for the academic year 1943-1944. The National Foundation for Infantile Paralysis made available \$50,000 in 1944, and we have just been notified that \$60,000 will be available for the academic year 1945-1946. These grants provide fellowships to train a reservoir of personnel from which future employees of the Public Health Service and private agencies may be recruited. The money cannot be used to pay stipends for present employees of State and local health departments. Federal grant-in-aid funds may be used, at the discretion of the State health departments, to provide training for such individuals.

The type of training which health educators should receive has been defined by the Committee on Professional Education. It includes basic preparation in the health sciences, education, and the social sciences. It is our belief that educators should have such basic public health courses as epidemiology, vital statistics, bacteriology, public health administration, environmental sanitation, school and community health education, and, in addition, courses in adult education, public relations, and sociology. These courses of study are now offered by the Universities of Michigan and North Carolina and Yale University. It is anticipated that the University of Minnesota also will provide a satisfactory curriculum for such training during the coming academic year.

The functions of the health educator, working in the local health department, have been discussed in considerable detail. This emphasis on the local program is not intended to detract from the importance of having a strong Division of Health Education in the State health department. If, however, it is agreed that each local department shall have the services of a well-trained health

educator, then the functions of the Division in the State department become analogous to the functions of other Divisions at the State level. They are:

1. Planning and developing a State-wide program in public health education.
2. Encouraging and promoting the development of programs in local health departments, utilizing trained personnel who are capable of working in all phases of the public health program and are also sufficiently competent in education to work with the schools.
3. Recruiting personnel and arranging for their training and assignment.
4. Assisting the medical, nursing and sanitation personnel in their educational work by providing them with an educational mechanism and advice on effective techniques of education in various local situations.
5. Consulting with local health departments and local health educators on all matters pertaining to health education.
6. Maintaining relations with the press and the public, preparing articles, and approving special stories and speeches by department personnel.
7. Preparing or securing public health educational material, and distributing it through useful channels.
8. Correlating the educational endeavors of the other divisions or bureaus in the State health department.
9. Coordinating the activities of all agencies in the State interest in health education.
10. Developing and maintaining a continuing in-service program of training for public health personnel.

To carry out this variety of tasks in the State health department, personnel with specialized training will be required. The production of materials, news releases, exhibits, and other visual aids requires skills that are seldom found in an individual competent to direct the entire program. Larger departments can use more highly specialized personnel than can the smaller departments.

Since the Health Education Division and the local health educators will assist all special programs (such as venereal disease control, maternal and child health, tuberculosis control), the program should be financed by pooling grant-in-aid and State funds. If proper cooperative relationships can be established, voluntary agencies may also contribute to support of the program. In several States, tuberculosis associations, parent-teacher groups, junior leagues, crippled children's societies, et cetera, share in financial support.

Successful health education programs require close working together of departments of health and education. The need for such coordination has been recognized by the Federal health and education agencies and a very satisfactory arrangement has been developed for reciprocal consultant services. The Public

Health Service stands ready on request to assist States in appraising their health education needs and in the development of comprehensive State plans based on the problems and resources within the State. It is also willing to make available to States the benefit of its experience in the recruitment of personnel for training.

CHAIRMAN WILLIAMS: Gentlemen, you have just heard a complete, accurate, and lucid exposition of public health education. I hope there will be some discussion.

DR. CARL V. REYNOLDS (North Carolina): Mr. Chairman, I don't feel that I can keep my seat when this question is before the conference. I don't know of any new factor in public health activity that has been more fruitful than the introduction of the public health educator. And I mean that. In the last three or four years we have advanced in our section of the country very largely because of the public educators being among our active personnel.

The health educator should not work as an independent entity. She should always work under the direct jurisdiction of the State health officer, and in the departments in which she participates, under the director of that department. In the counties, she should work directly under the health officer, and if she comes into the nursing field, she should work with the nurses, or the sanitarians, or others.

As far as the press relations are concerned, I don't think the educator should be allowed to prepare and distribute articles unless each release is censored by the director of the division out of which it flows.

DR. P. E. BLACKERBY (Kentucky): I am particularly interested in learning whether any State has developed a planned program of health education wherein there is a good integration of methods and activities between the State health agency, the State department of education, and other agencies carrying on limited health education programs.

DR. DERRYBERRY: I think perhaps Dr. Underwood has done as good a job as any I know of.

DR. FELIX UNDERWOOD (Mississippi): We have a Division of Health Education jointly sponsored by the State Department of Health and the State Department of Education. Our Dr. Galloway is the Director of the Division and Dr. Patterson, of the Department of Education, is the Coordinator. We have nutritionists, physical education directors, and all the rest. We have a splendid working team, and the State Superintendent of Education, Mr. Vandiver, is just as much interested in our efforts as the State health officer. We go into it on a fifty-fifty basis financially, and it is working.

We have only about half a dozen health educators at the county and district level, and they are working just as Dr. Reynolds of North Carolina said they should work. They are under the local health officer, just like the nurse, and just like the sanitarian. It works.

I was a little apprehensive, to begin with, that the nurses might be jealous of these educators. I suppose we will have some trousers in the group when the war is over but they are all women so far. They went to the University of North Carolina for a year; then they went the rounds. They go to AMA

headquarters, to Bethesda here--all of it is in the course. The work has actually been going on in the field for about six or eight months. The health officers are pleased. The nurses not only are not jealous but they feel, now, in the counties where the health educators are at work, that they couldn't get along without them.

Educators start in my State at a little higher salary than nurses. These women are college graduates, and all but one has more than a bachelor's degree in education; they have taught school, and are otherwise well qualified. So we do start them at about \$15 a month above the starting point for nurses. I don't think we could get health educators of the type we have in Mississippi, and that I am sure other States have, for the beginning salary that we pay nurses, and we haven't got enough money to pay all the nurses what we pay the few health educators we have.

DR. BLACKERBY: How well did your teachers respond to your health educators' program?

DR. UNDERWOOD: Very well, indeed. We are having a series of workshops over the State, and the colleges and the University of Mississippi are teaching, and giving credits to these teachers who take courses in health education.

DR. BLACKERBY: Do you like your workshop programs?

DR. UNDERWOOD: Yes, sir.

DR. DERRYBERRY: I would like to mention Dr. Cross' program in Illinois.

DR. ROLAND R. CROSS (Illinois): We have six or eight public health educators now in Illinois. They are women who have college degrees, and have gone to North Carolina for their year's work there, then come back for their field training in Illinois.

We have also set up in Illinois a public health education program in our teacher training institutions. We propose to train our teachers in public health education, so that they may be able to work effectively with the public health educators. The curriculum has been accepted by the University of Illinois, and the normal schools are prepared to go ahead with it.

MR. FRANK STAFFORD (Office of Education): For the past nine years, Indiana has had a joint program of education and health. It was set up by written agreement between the State Board of Health and the Board of Education.

It has been very satisfactory. I served as director of that division for three years before coming here with the Office of Education, and I can agree with Dr. Underwood's comments about its effectiveness, both on the State and local level. We have public health people in education trained at North Carolina and Michigan; we have four more in training now, and plan for seven more in the coming year.

DR. DeKLEINE (Michigan): Are your health educators employed by the State?

DR. UNDERWOOD: Yes.

DR. DeKLEINE: They are not employed locally?

DR. UNDERWOOD: No, we employ them and send them out to the counties. We assign them. They are on the local budget.

DR. DEKLEINE: Do you shift them about from district to district so that for the time being the local people pay for them? How is that arranged?

DR. UNDERWOOD: We have selected our health educators at the State level, and gotten the scholarships for them. After they have finished their training the health officers interested in having such a service put in their bid. We assigned them to those health officers who were particularly interested.

The budget is divided four ways, and we get a good spread over the State so that it won't take much money from anyone. The division is this way: the county board of education, 25 percent; the city department of education (located in the county seats, the largest town in the county) 25 percent; the local department of health 25, and the State Department of Health 25. The State Department of Education doesn't have fluid funds they can put into it, so the education's funds are put in at the local level. Health puts it in at both levels, local and State.

Dr. DEKLEINE: What has been the beginning salary?

DR. UNDERWOOD: Eighteen hundred.

CHAIRMAN WILLIAMS: The next item on the program is, "Factors Influencing the Preparation of Public Health Nurses," by Nurse Officer Mary Dunn.

FACTORS INFLUENCING THE PREPARATION OF PUBLIC HEALTH NURSES

MISS MARY DUNN:

It is assumed, generally, that health programs will expand greatly when peace comes. This expansion will call for more trained personnel, including public health nurses.

If we are to prepare nurses to assume the many new and varied responsibilities that will be theirs, we should give thought: (1) to the most economical and effective type of preparation; (2) to the selection of promising recruits for public health nursing; and (3) to opportunities for financial assistance for essential training.

The largest number of nurses needed undoubtedly will be staff nurses or general public health nursing practitioners. The 1944 census of public health nurses revealed that only nine States had reached the minimum wartime ratio of one staff nurse to every 5,000 population. It has been estimated that if the goals of public health nursing are to be met, there should be at least three times as many public health nurses as are now available, or a total of 60,000 to 65,000.

How are these staff nurses to be prepared most effectively and most economically? Many through additional basic nursing education programs in our universities and colleges, programs which have as their objective the preparation of a community nurse well-prepared in the curative and health phases of nursing, who may take her place equally well as a hospital or public health staff nurse.

Schools of nursing should examine their resources and incorporate in the nursing care of patients in every department of the hospital, particularly the out-patient department, the factors in home and community which have to do with the prevention of illness and the maintenance of health. They should develop interlocking relationships with social and health agencies of the community such as would furnish a more satisfactory and continuous care of patients.

Assistance may be secured from public health agencies whereby the students may have opportunity to observe, assist, or give nursing care in homes and community. As a further means of developing the student's background, an affiliation of two, or preferably three months, may be arranged with a public health nursing agency. Such an affiliation is usually planned during the student's last year of training and is not to be confused with the supervised practice period of the Senior Cadet. It might be well to define what is meant by an affiliation, as contrasted with the Senior Cadet period.

An affiliation is an integral part of the required basic nursing curriculum of combined theory and practice. It precedes the Senior Cadet period, and emphasizes the educational opportunities the student is to derive.

The supervised practice period of the Senior Cadet Nurse is experience beyond the required program of combined theory and practice, varying from 24 to 30 months in length. It serves to satisfy certain existing requirements of most State Boards of Nurse Examiners for graduation and registration. The Senior Cadet period represents an additional six to twelve months' experience and emphasizes the service the Senior Cadet may render to the receiving institution or agency.

To return for a moment to the basic nursing curriculum which prepares the nurse for staff nursing in public health, the question might well be asked if any such programs are in existence at the present time. Yes, but to a very limited extent. Many schools of nursing are attempting to enrich their programs, but few have actually attained this broader goal. The final determination as to whether this goal has been met is made by joint evaluation and accreditation of such programs by the National League of Nursing Education, whose major responsibility is approval of the basic content, and by the National Organization for Public Health Nursing, whose function is to evaluate the public health nursing content of such a program. To date, only one such school of nursing, the Skidmore College Department of Nursing of New York, has been thus accredited. Two other schools seeking this type of accreditation are to be visited this spring, and it is anticipated that several others will apply within the next year or two.

For a long time to come increased emphasis will be placed upon the development of basic nursing preparation. The comprehensive programs will of necessity produce only a limited number of nurses, and accordingly the existing postgraduate programs should be improved and expanded. Those courses designed to prepare public health nursing supervisors and instructors, and clinical experts in such fields as psychiatry, orthopedics, pediatrics, obstetrics, and tuberculosis, should have special attention.

Let us next consider certain factors that are influencing the selection of recruits for public health nursing. The urgent immediate nursing needs of the armed forces and the pending Draft Bill for Nurses call for a most careful review and classification of available nurse power. Recent directives of Procurement and Assignment Service of the War Manpower Commission are concerned with the classification and reclassification of all nurses to determine those available for military service, those holding essential nursing positions, those holding essential positions but replaceable, and those who may be deemed essential for postgraduate study. Obviously, these decisions will have a marked effect upon the selection and equitable distribution of graduate nurses for essential public health nursing positions, including those who may be classified as essential for study.

A directive of February 8, 1945, from the Procurement and Assignment Service, stated that "A nurse may be classified as essential for postgraduate study, whether she is receiving Federal funds or paying her own expenses, under the following conditions:

1. The length of the course is not more than one year, and less if possible.
2. She graduated prior to January 1, 1944, and submits a statement to the Local Committee from her future employer that she has been accepted for a definite essential position for which she needs further preparation.
3. She has been graduated since January 1, 1944, and is not eligible for military service, and submits a statement from her future employer that she has been accepted for a definite essential position for which she needs further preparation. In some few cases, the Committee may feel that an essential classification should be given an eligible nurse graduated in 1944, because she is already enrolled in a postgraduate program and has accepted a definite essential position.

The nurse taking postgraduate work on a part-time basis while holding a position is to be classified as to her essentiality in her position.

In order to secure proper selection and equitable distribution of graduate nurses to fill essential positions, it is imperative to maintain a small but constant flow of graduate nurses to postgraduate programs and courses.

Senior Cadet experience in public health nursing should serve as a source for securing desirable candidates for public health nursing. From information recently received from schools of nursing, and from our Public Health Service District Offices, it is learned that between July 1, 1944 and April 1, 1945, 402 Senior Cadet Nurses have been assigned to public health agencies in 32 States. Of these 402 Senior Cadets, 176 have been assigned to official health agencies, and 240 to visiting nurse associations. The length of experience has ranged from three to six months.

It may be of interest also to know that a recent review of Trainee Application Forms indicated that \$22,793 of Title VI funds has been budgeted by eight States to pay the stipends and maintenance costs of 47 Senior Cadets.

A final factor, and a very important one, to be considered in its bearing on public health nursing preparation is that of financial aid for educational purposes.

Under Public Law 346, Servicemen's Readjustment Act of 1944 (commonly known as the "G. I. Bill of Rights"), Federal aid for further study will be available to nurses returning as veterans of World War II. Universities and colleges report that already nurses released from military service are availing themselves of this opportunity for further preparation.

Although there still remains nearly a full quarter before the end of the current fiscal year, there has been already allotted from Federal funds, administered by the Public Health Service, greater amounts for public health nurse training than for any previous year. An analysis shows the following (exclusive of that previously mentioned as allocated for Senior Cadet Nurses):

<u>Source and Amount of Funds</u>	<u>Number of Students</u>
Nurse Education (Bolton Act) \$809,695	2,459
Title VI 157,959	284
V. D. 10,069	21
Total \$977,723	2,764

Bolton Act funds include \$32,464 allotted to 4 schools of nurse midwifery providing training for 44 nurse midwives.

In addition to the foregoing 2,764 public health nurse trainees, many more have enrolled in the different "on-the-job courses" financed through Bolton Act funds. At least one million dollars has been made available for public health nursing preparation during the current fiscal year, through funds administered by the Public Health Service.

Public health nursing service is effective in relation to the number and quality of available nurses. As the war progresses, the major civilian health problems remain ahead of us. Dr. Parran has said, "The cumulative effects of fatigue, long hours of work, worry, anxiety, and grief are bound to result in a lower level of civilian health and greater susceptibility to disease." Increasingly, more home bedside nursing is being done by public health nurses. As group hospitalization increases, more patients are hospitalized, but with fewer days of hospitalization per patient. Patients are discharged from the hospital still requiring skilled nursing care.

Every effort should be directed to the most effective and economical preparation of nurses who will assume the many new responsibilities of public health nurses in the future. The quality of service to be rendered will depend, also, upon the type of young woman attracted to the profession. Interest in the profession will be measured in terms of the durable satisfactions to be experienced and the acceptable personnel policies. There should be a salary scale commensurate with the responsibilities and the professional preparation of the nurse, opportunities for further advancement, job security, and assurance of retirement pay.

CHAIRMAN WILLIAMS: You have heard Miss Dunn's exposition of the public health nurse situation. Is there any discussion?

DR. BLACKERBY: Were there any conditions imposed in the law for these cadet nurse trainees whereby they committed themselves to service in the armed forces?

MISS DUNN: She is to render essential nursing service where most needed, be that military or civilian.

DR. BLACKERBY: Down in my State not long ago I was told by a member of the State Nursing Board that, out of the cadets graduating, not more than 20 percent of them had applied for service in the Army.

MISS DUNN: Would you like to answer that, Miss Henderson?

MISS JEAN HENDERSON (Division of Nurse Education, USPHS): As of April 1st, 60 percent of the graduates of the Cadet Nurse Corps had chosen military service.

CHAIRMAN WILLIAMS: Are there any further questions? Thank you, Miss Dunn.

The next subject is, "Transition of Sanitary Engineering from War to Peace," by Mr. Abel Wolman.

TRANSITION OF SANITARY ENGINEERING FROM WAR TO PEACE

MR. ABEL WOLMAN:

Mr. Chairman, Ladies and Gentlemen:

I am appearing today largely at the request of the Committee on Sanitary Engineering, which is an agent, or a unit, of the National Research Council, functioning under the Division of Medical Sciences. It was created in the fall of 1941 at the request of the Surgeons General of the Army and the Navy and the Public Health Service to assist in the consideration and development of programs in this particular field.

This group was assigned a war task, and very early it was confronted with the dual problem of personnel selection and personnel guarding. The issue was, how to spread out, to the greatest advantage both for military and for civilian purposes, a limited supply of sanitary engineers in this country.

Early in its existence, therefore, the Committee requested of the Board of Procurement and Assignment of the War Manpower Commission that the group it represented be given privileges and status such as had already been provided for doctors, dentists, nurses, and veterinarians. The War Manpower Commission chose the Sanitary Engineers Committee as its advisory group, and its Chairman, your present speaker, as a member of the Board of Procurement and Assignment. We can't claim over-all success, but we have had a measure of agreement as to the release and assignment of sanitary engineers to foreign service or to military service in this country, and we have been able to restrain somewhat the drain on civilian sanitary engineer practitioners. Certainly, to this group I need hardly labor the point that you have operated with remarkable success despite limited sanitary engineering service. Many of us believe such service was too limited, but it was all that could be provided under the circumstances.

The stage has now been reached, however, when it appears probable that there will begin to be a return, either through compulsion, through choice, or through necessity, of some military assignees to civilian occupations. It is that particular transitional objective that I want to call to your attention, at the request of the Committee. The reason is this: Many of the individuals who hope to return to civilian occupations, particularly with State and local and Federal health departments, are already concerned about the apparent disappearance of their original jobs. Some are concerned about the fact that they may return to inadequate salaries. Some feel, that in the process of drawing in belts, there has been elimination of certain occupational opportunities. We have already had some instances where men who have served their country have been released, and find no place to go.

We have listed on the roster of sanitary engineers at the War Manpower Commission a total of about 6,500 individuals. Of these I would say that about 3,600 are performing a truly sanitary engineering function. Of that group, about 1,500 are commissioned officers in some branch of the Federal service. There are 960 in the Army, about 133 in the Navy, and about 411 in the Public Health Service. There are not quite 800 whom we have classified as essential sanitary engineers in civilian practice, and we have managed to preserve those individuals in their civilian operations.

With the approval of the Board of Procurement and Assignment of the War Manpower Commission, we have set in motion machinery for clearance of all of the sanitary engineers who may be released from military service during the next year. We already have had requests for release under an Army order of 1944, in accordance with which an officer has the privilege of requesting his release.

The machinery that we have established in the War Manpower Commission consists, we hope, of a simple technique: first, there must be a request from the employer of the engineer whose release is asked. Second, there must be approval by the State adviser whom we have appointed to represent the War Manpower Commission in the individual States. (In general, that State adviser is the State sanitary engineer of the individual State department of health.) Third, the War Manpower Commission Board of Procurement and Assignment must finally agree and so recommend to the War Department. We have had three requests, one in New Hampshire, one in Ohio, and one in California, for the release of returning officers in the sanitary engineering group. They are being processed. They are of uneven circumstances, of uneven weight, and what our success will be in returning them smoothly to civilian jobs, where they apparently are very badly needed, remains to be demonstrated.

In order to assist advisers and groups such as ours in the smooth transition of those people to civilian life, two documents ought to be called to your attention. One was prepared by the Public Health Service and the American Public Health Association on opportunities in the general field of public health. Already there have been distributed some 3,000 copies to Army separation centers. It is an excellent study, prepared in simple language, applying directly to the general counsellor program. We hope it will be universally used. It isn't intended as a textbook of public health opportunity, but is meant to guide the counsellor when a returning soldier reaches his office. We are supplying copies of this publication not only to these counsellor officers, but to the Veterans' Administration, War Manpower Commission offices, State representatives of the U. S. Office of Education, and to all of our State advisers.

In addition, there has been prepared by the subcommittees of the Committee on Sanitary Engineering a specialized study, dealing primarily with sanitary engineering functions. We expect to distribute about 10,000 copies, so that men who return will not flounder around getting back into civilian life.

Our purpose is to put this problem before you, not only because we owe it to these men to find placement for them in civilian occupations; but also because we owe it to the civilian population to utilize their sanitary engineering skills in providing services which have been lacking over too long a period. We are not over sanguine as to the speed with which this can be done. We do believe that this group in front of me, as well as our sanitary engineering subcommittees, should exert their utmost effort to develop for these people procedures for rapid transition to peacetime occupations.

CHAIRMAN WILLIAMS: Gentlemen, you have heard Mr. Wolman's presentation of the situation. Are there any questions?

DR. DeKLEINE: I would like to ask Mr. Wolman how we may learn of engineers who may be available to States.

MR. WOLMAN: The State advisers will be informed of all returning men. We have an agreement with the Army, and I believe we will have one with the Navy and with the Public Health Service, whereby we will be informed when individuals are likely to be released. We hope to circularize those lists to all State advisers.

If we miss someone, as we are likely to do, we hope that State counsellors, officers of the district offices of the U. S. Public Health Service, the State health officers, the Vocational Guidance people, the Veterans' Bureau, will advise us of any man they find who has any sanitary engineering training or past experience.

The Committee, and the Board of Procurement and Assignment, you will recall, is a war agency, and only a war agency. It is permitted to carry on this semi-war undertaking right now, but when it disappears as a war agency we may have to create, perhaps through the Public Health Service and its offices, a continuation of this process.

DR. DEKLEINE: Are you also in a position to provide some estimate of the fitness of these men for a given situation?

MR. WOLMAN: We can do that. As I pointed out, we have a large roster showing where these men were and what their prior training and experience was. That roster is available to any applicant or to any interested agency.

We have a great deal of information. We think that we ought to be able to tell anyone that Mr. A. or Mr. B. is qualified. We do not, of course, intend to set ourselves up as substitutes for civil service review.

DR. CARL N. NEUPERT (Wisconsin): May I ask a question about Procurement and Assignment in regard to engineers? Again we have an engineer about to leave us. We have lost one complete set of sanitary engineers. We have a man from the Public Health Service helping us out the beginning of this week. We are very grateful, but it would seem wiser at this stage if we could keep the man we have trained. How effective is Procurement and Assignment in engineering right now?

MR. WOLMAN: It was apparent as far back as 1942, that it was going to be exceedingly difficult to preserve civilian status even in the professional group, particularly for men under 33 years of age. Although we did preserve that status for a certain length of time, we finally found that we were doing it as a disservice to the individual. We ran into a very curious but perhaps to be expected psychological situation wherein a young man had been declared essential by us, and perhaps by his health officer, but found himself in the position where he felt that he ought to be permitted to enter military service, no matter what we said.

That drain on the younger group has gone on ever since 1942. We have interfered with it from time to time, but I think we have interfered sometimes with misgivings, because there were factors concerned other than the simple determination of essentiality to community work.

Mr. Tisdale, would you want to add to that?

MAKING PUBLIC HEALTH POSITIONS MORE ATTRACTIVE

DR. JOSEPH W. MOUNTIN:

Like housekeeping, personnel administration is a job that is never finished. Each day recurring tasks must be performed, and, periodically, major readjustments are superimposed on this routine. Today, the great problem of public health organizations is that of meeting difficulties resulting from a shortage of qualified workers, both professional and nonprofessional. In many communities this shortage is so great that not even the minimum basic public health activities are being maintained.

Unfortunately, it is commonly supposed among health administrators that the termination of current hostilities will automatically solve the problem; it is thought that former incumbents of public health positions will immediately return to their usual work, and that if more people are desired, they can be obtained with facility. "Qualified personnel are not now available," runs this argument, "therefore nothing can be done." "When the war is over, there will be a surplus of applicants, and the job will solve itself." Thus responsible individuals tend to rationalize their present position of "do nothing" and "wait and see."

That there is insufficient analysis in these foregoing assumptions should be quite apparent to those familiar with public health administration. Of course, this drying up of the personnel reservoir may be attributed in large part to the war and its consequent demand for the services of the men and women of our country, but other controllable factors are involved that merit serious consideration. In the first place, qualified public health people were not available in sufficient numbers even before the declaration of war, and since then very few new ones have been developed. Again, those that have remained on the job are getting older, and many have already fallen out of the ranks further to deplete already inadequate numbers. As for public health people now in military service, it should not be assumed that all of them will return to their previous positions, or that many demobilized persons not formerly in public health work will choose that sphere. In this latter connection the report, "Postgraduate Wishes of Medical Officers,"¹ published recently in the *Journal of the American Medical Association*, is informative. In brief, an analysis of questionnaires returned by 21,029 medical officers revealed that only 110 desire postwar training in public health. Not all of these represent a postwar accession to this field; actually a high proportion are thus merely indicating additional training they desire before resuming their usual work. And there is no assurance even that all of these will re-enter such work.

For the present, our educational institutions cannot be of great help. Full-length professional education of engineers and scientists has all but come to a stop. Soon the same may be said of the training of physicians, since under war conditions relatively few candidates are available to enter premedical courses. True, a large amount of wartime educative training has been carried on at schools and colleges in conjunction with various branches of the armed forces, but it is training directed toward the end of enabling the individual to meet particular situations of limited scope that might be expected to arise in the conduct of military operations. There is one notable exception to this general rule, and that is the training of young women for nursing. The Cadet Nurse Training Program has been a success. Largely through its operation, the number of candidates entering upon initial training throughout the country has increased from the prewar level of about 35,000 annually to approximately 65,000. There is no question but that these

nurses constitute an important postwar public health potential, but it must be observed that they are being trained through an accelerated course, and that certain studies have been reduced or eliminated, studies that, in the past, have proved to be of great value in supplying a broader background for participation in the general public health program.

So much for training, and what may be expected in the way of new public health personnel in the near future. With the exception of nurses and possibly technicians, there just won't be any, for some time. Right now there is a world-wide shortage of physicians, and no one can tell when new ones will be turned out in sufficient numbers. The prospects for engineers may be somewhat better, but they are not too bright. Additional first-class research workers are not likely to become available for some time.

What will be the general personnel picture in the United States immediately after the war? A great demand from all sources for well-qualified people may be expected, at least in the early years of the peace to come. Ours is the only great nation whose capacity to produce has remained unimpaired, and the demand for our goods will probably be world-wide. In order to meet this demand, manufacturing industries, at least for a time, will have to work at top speed. And along with a high level of activity in the factories, there may be anticipated a heavy demand for transportation, communication, and various forms of personal service. In other words, public health will be looking for personnel in a highly competitive market.

To meet this competition, public health positions must be made more attractive than they have been. It is that point in particular I wish to emphasize. But how can these jobs be made more attractive? The principal factors that determine the attractiveness of any job are rather obvious, but may be taken as a point of departure. They are, first, financial remuneration; second, selection on merit; and third, opportunity for professional development. On these three scores, it cannot be said that public health positions have in the past invited favorable consideration, nor can it be maintained that responsible public health administrators have faced the situation frankly. Unfortunately, there has prevailed the tradition not only of housing public health staffs physically in the basements, but also of placing them at the bottom of the salary scales. Merit as a basis for employment and promotion frequently yields to preferential treatment of one type or another, and opportunity for professional development in public health often is limited indeed. There has been a feeling on the part of too many that public health positions are in the nature of a "Call" to the particular individual, and that no other consideration need be entertained. It seems likely that with the din of industry and the jingle of coin as distractions this "Call" will continue to go unheard by many desirable candidates.

A start on a well-planned program for making public health positions more attractive is long overdue. Such a program requires more than setting up qualifications for applicants--it also means getting down to what the job has to offer. A necessary and desirable step in bringing about optimum employment conditions in public health service is the institution and extension of an impartial method for the selection and advancement of personnel--a civil service or a merit system. Such a plan when instituted by statute may be referred to as "civil service"; when originated by administrative rule, it is often called a "merit system." This is a rather fine distinction between terms but, in either case, the objective is the same--to apply the best and most enlightened principles of personnel administration to public service.

State civil service systems and their counterpart, merit systems, have followed a long and arduous course since the first State civil service law was passed by New York in 1883. Massachusetts followed with such a law 2 years later, after which 20 years elapsed before the States of Illinois and Wisconsin, in 1905, adopted laws defining the conditions of public employment. To date, such laws establishing State-wide civil service have been enacted in 20 States; six of these have constitutional provisions on which the system rests in whole or in part.

State merit systems have originated under somewhat different circumstances than State civil service systems. With one or two exceptions, States where merit systems exist have been moved to their establishment by the requirements of Federal laws and regulations attached to financial allotments to the States for "grant-in-aid" programs under the Social Security Act. As a result of these provisions 31 States and Territories have established merit systems. The effect of Federal requirements may be deduced from the fact that in 1940 alone, the year immediately following their adoption, 12 States established merit systems affecting public health personnel.

In the interest of promoting and maintaining sound personnel policies, Federal administrative agencies are authorized to examine civil service or merit systems of States and Territories receiving "grant-in-aid" funds. Such systems when submitted by the States and Territories are considered under two headings, and approval or disapproval is given either or both of these parts. The two parts thus examined are: 1. The basic law or rule. 2. The classification and compensation plan. The score to date for 51 States and Territories with the U. S. Public Health Service is:

	<u>Reviewed</u>	<u>Approved</u>
Law or rule	50	45
Classification and compensation plans . .	46	20

It is obvious that the most marked failures to come up to par have appeared in classification and compensation plans. And this is precisely the vital point where work must be done if success is to be achieved in making public health positions more attractive. In addition, the civil service laws of four States were judged defective in one or more respects. Also, one State and one Territory operating a merit system have not had their implementing rules approved.

The Public Health Service does not attempt to tell States how much they shall pay their appointees, but the desirability of generous compensation as an aid in employing the more competent personnel is stressed. However, in determining the necessary qualifications of candidates for the basic public health positions of medical officer, nurse, and engineer, the Public Health Service does insist that the States require certain predetermined attainments as a condition of appointment. Beyond that, also in the matter of job specifications, is the stipulation that positions carrying titles such as biologist, chemist, zoologist, be filled only by people who have taken such degrees. The adoption of a retirement plan, while not obligatory, is strongly urged since it contributes effectively to the initial employment and the retention of desirable personnel. A source of great disappointment is the fact that less than half of the States have thus far devised such a plan.

It is in the holding of qualifying examinations that performance by the States and Territories has been least satisfactory. To date, with the exception of a small number having well-established civil service agencies, few have held examinations recently for professional personnel employed in public health positions. Examinations held usually have been designed for clerical, stenographic and fiscal employees. Following them, come the nurses. This sequence can be accounted for not only by the fact that nurses are most numerous among the other classified members of health department staffs, but also it is largely due to the cooperation and sympathy with the merit system plan shown both by individual nurses and the National Organization for Public Health Nursing. There is no apparent reason why persons of other professional categories have been examined so rarely. Certainly all should realize that the ultimate success of personnel administration on a merit basis for public health personnel will depend in great measure on the active support of those professional groups that are represented in the staffs of health departments. The current scarcity of suitable candidates for vacant positions need not act as a deterrent against examining and certifying acceptable present incumbents, whose employment predates the period of the war.

Shortly after the adoption of the Federal requirement that systems of personnel administration be set up on a merit basis, the need arose for suitable test items and up-to-date examination procedure which would aid in the selection of persons capable of performing the duties of the position. In order to avoid setting up special machinery at the Federal level for assisting the States in preparing this material, the help of the American Public Health Association was requested jointly by the U. S. Public Health Service and the Children's Bureau of the U. S. Department of Labor. That Association very graciously undertook this exceedingly difficult task. A small, highly competent staff has been employed for more exacting duties, but the greater part of the work is done voluntarily, by consulting health officers, nurses, engineers, and others representing the several specialties in public health. Up to the present, this unit has prepared 114 separate sets of examination material for positions in public health nursing, laboratories, sanitation, and health administration. Twenty States and two cities have made use of some or all of these examination items. Additional test items for still more extensive use are now available for all grades of foregoing fields of work.

Objections have been raised against the use of these test items on two counts: first, a fixed charge is made, and second, the items are not offered for outright sale. Anyone who takes the time to investigate can readily assure himself that the fees charged for this service compensate for only a very small fraction of the effort that is involved. The items cannot be sold, since sale precludes their use elsewhere and thus the cost of production is increased several fold. Comparability of examinations would be reduced accordingly by outright sale.

The best way to compare qualifications of applicants for positions is through the use of standard test items. There is little hope for reciprocity between States and communities in the acceptance of credentials presented by candidates for public health positions unless it be on the basis of certification for positions with similar job specifications and common examination techniques. Such reciprocity is necessary to that freedom of movement among health jurisdictions which professional public health workers desire above all else. At present, the worker, and particularly the health officer, usually is required to be a resident of the State, and not infrequently he must also be a resident of the local community, where he wishes to be employed. Actually, once employed, he is

practically frozen on the job, or at least fixed within the system of which the local position is a unit. Excessive mobility, of course, is not desirable, but at least the feeling that one might move to another position if he so desired is mighty comforting. This movement should be planned so as to broaden the horizon of the individual and enrich his experience, and not altogether to gain a larger salary. Mobility should be permitted both up and down within a State health structure, and laterally among States. The Federal agencies also could well be brought into the exchange so that Federal, State, and local employees might acquire familiarity with the requirements of related positions. In fact, upon such an exchange may hinge the final success of our present Federal-State-local partnership in public health.

In addition to stabilizing employment for public health workers and adjusting compensation, their jobs must be made otherwise rewarding. A person should feel that he is performing useful work and that he is utilizing to good advantage the knowledge and skills he possesses. The traditional routine of a small local health department is often quite stultifying, to say the least. A sense of frustration naturally follows upon the discovery that unsatisfactory conditions cannot be followed by the application of corrective measures. "Go and see your doctor," may be discreet advice to give parents on finding that their children need corrective work, but it does not impress the aggressive health officer or a discerning public as doing very much. Educational effort, such as this, has its place but it is not a satisfactory substitute for more tangible forms of remedial service. In many instances only by increasing the size of the health district and by encompassing within the public health program a wider range of activities will it be possible to provide necessary latitude for professional and technical development of the staff and permit placement of individuals according to their interests and capabilities.

Opportunities for employment should be extended to professional persons outside the traditional categories of physicians, nurses, and engineers. There is a broad group with good basic training in biology who have much to contribute, but are now largely ignored. Entomologists, in particular, can give fresh impetus to a flagging malaria control program. The newer insecticides and rodenticides open up still greater possibilities for control of disease-bearing vermin, and in this program chief reliance must be placed on entomologists. Unquestionably veterinarians have been snubbed by public health people. There are many diseases in animals transmissible to man which veterinarians are most competent to handle. They are especially familiar with animal food products, and should have many suggestions for improving food sanitation.

Another type of professional person whose activities are becoming of more and more importance to the public health program is the health educator. The health educator is the vanguard of the advancing public health program. He is both psychologist and salesman. He goes direct to the people and shows them how and why they need public health measures. It is amazing, the tremendous strides taken by some of these people toward awakening the latent demand for public health services. Recently a local health officer from North Carolina reported that he had put on first one, then two, and finally three health educators, and that all were doing well. When asked if he was going to employ any more, he replied, "No, not until I can increase my general staff; the health educators have stimulated folks to the point where they are running our legs off."

Up to the present time social workers have been used relatively little in the field of public health. The restricted scope of health programs may account for this. However, with the inclusion of more extensive medical care in public health service, social workers, and especially medical social workers, should be of increasing value; and, as mental hygiene expands, the psychiatric social worker will become indispensable.

A large part of the total public health job falls in the broad category of business administration: preparing estimates, hiring people, purchasing commodities, paying bills, keeping records, making reports, operating institutions, and the like. The general run of physicians and nurses, and to a lesser extent engineers, are not suited by interest or training for this field. Much of the inefficiency one encounters in public health can be attributed to the fact that good business methods have not been incorporated into administrative practice. Public health could well use competent business administrators.

Provisions should also be made for extensive employment of persons auxiliary to the more strictly professional groups. To do this, public health must be broken down into component parts. On analysis, one finds that seemingly complex operations contain many elements that can be segregated from the whole and set up as individual jobs to be performed by persons of less scientific training than formerly was thought necessary. By doing this, and using auxiliary workers, it will be possible, first of all, to effect economies, and second, to save the more highly trained people for their particular types of work. Moreover, this plan will afford employment to many persons who otherwise would be excluded from an important branch of public service.

There is, of course, the fear that auxiliary workers may not exhibit that fidelity to duty which is commonly associated with persons of professional outlook. Most health administrators have had painful experience with low-grade sanitary inspectors. The lay health visitor continues to be anathema to professional health workers in this country despite the fact that she has been the main reliance for home service abroad. Recent successful experience with lay venereal disease investigators indicates that our previous adamant position may not be altogether tenable. Now registered nurses have dread visions of aides just over the horizon whose only qualification is that they are motherly souls anxious to do good. Here again professional groups show an inveterate propensity to oppose developments which they believe contrary to their particular interest. When properly selected, trained, and supervised, people of limited technical background can do highly satisfactory work in certain fields of essential service. Also, experience has amply demonstrated that a guild spirit can be infused into those who follow the simpler crafts as well as those engaged on more intellectual pursuits.

Finally, all the jobs that are now available should be described and entered in suitable registers. The same should be done for the jobs that are likely to be established in the near future--that is, within perhaps the next few years. Shortly there will come back from the military services some well-qualified persons looking for employment in public health and many others who might be induced to follow public health work as a career. They will wish to know exactly where these jobs are, what qualifications are prescribed, and the salary each position carries. Anyone looking for employment or anyone who wishes to be trained for a job, then can plot his course accordingly. For example, if a candidate wants to be a health officer in Alabama, or California, or New Hampshire, there should be readily available the information that will answer the very points that have just been enumerated.

Public health is entitled to a place of importance and prestige among Federal, State, and local social services. To maintain a level of performance in keeping with this ideal, it has need of individuals possessing the inherent attributes that are required for success in any responsible position. Public health is looking for essentially the same kinds of persons to act as supervisors, clinicians, research workers, and general staff workers, as are employers generally. Administrators have no reason to expect that a fair proportionate share will enter the public health field unless there is a forthright examination and re-examination of the whole range of personnel policies and practices. Relying on the "Call for Service," and maintaining a lofty indifference to such mundane matters as compensation, promotion, professional advancement, security, and eventual retirement can only lead up a blind alley of narrowing usefulness.

CHAIRMAN WILLIAMS: You have heard Dr. Mountin's paper. Do I hear any discussion or questions? Dr. Atwater, do you wish to discuss Dr. Mountin's paper?

DR. ATWATER: It seems to me that Dr. Mountin has said very clearly the important things about the merit system as they concern the American Public Health Association. We are glad to have established working relationships with twenty of the States, as Dr. Mountin has reported, and 114 examinations have been prepared so far for these twenty States and two cities. We are ready to carry any of the rest of the load that may be given to us under circumstances best known to you in the individual States.

DR. NEUPERT: We are concerned with merit systems in the Personnel Committee, and we have not had an opportunity to go over the new material. I hope we can arrange for another meeting at four o'clock tomorrow in this room.

I have some material submitted by the Public Health Service dealing with the merit system and with the training program that needs digestion. It is in compliance with the new Public Health Law. I take this opportunity to call it to your attention. I hope each member of the Personnel Committee will stop and get it.

CHAIRMAN WILLIAMS: Any further discussion? The meeting is adjourned.

(The meeting adjourned at 4:40 o'clock.)

WEDNESDAY MORNING SESSION

April 11, 1945

The meeting convened at 9:15 o'clock, the Surgeon General, Dr. Parran, presiding.

CHAIRMAN PARRAN: The session will be in order. Shall we proceed to the report of the Committee on Venereal Disease, Dr. Austin, Chairman.

DR. BURTON F. AUSTIN (Alabama): Our Committee met yesterday with seven members in attendance and representatives of the Army, Navy, Public Health Service, Office of Education, and National Social Hygiene Association.

After considering the form used by the armed services for report of V. D. contact, it was recommended that reports be sent in duplicate to State health officers, unless the Service Commands and the State health officers otherwise agree in writing.

There were several members who felt that some of the county health officers were not using these contact reports to the best advantage, and that they should be routed through the State health departments. Others felt that in some counties, especially those with large cities, the contacts could be followed up at an earlier date if the report went direct to that county or city health officer. We recommend that exceptions be made in those cities after agreement by the Service Command and the State health officer.

Our next consideration was of methods for making greater use of and obtaining better cooperation from private practitioners. They should report contacts, and use the epidemiologic services provided by the health department.

We decided that we should intensify our effort to get better case and contact reporting by practitioners. It is recommended that physicians be paid for making diagnoses and referring venereal disease cases to the health department when suitable public health diagnostic facilities are not available. It is also recommended that educational programs, emphasizing personal interviews and correspondence with physicians, be intensified.

Next considered was the advisability of adding penicillin to the drug list available to private physicians and clinics. Should the distribution of penicillin be contingent upon physicians allowing their patients to be interviewed for contact information by a representative of the health department, when they do not wish to secure this information themselves? It is recommended that penicillin be provided physicians on the same basis as other drugs for treatment of gonorrhea. Many of the States now provide physicians with drugs without that contingency, although they do request them to make reports on the progress of treatment.

Methods for extending and improving training programs for case-finding and prevention purposes were next considered. Should the Public Health Service sponsor a three- to nine-month formal training course for V. D. investigators in one or more colleges? If such a course is desired, would the State and Territorial Health Officers subsequently employ on State pay rolls V. D. investigators thus trained, if they satisfied State Merit System requirements?

Some of the State health officers reported that these male investigators had done splendid work. A representative of the Navy explained that warrant officers and others are being taught to do these investigations. The Navy is contemplating a course comparable to a college course for these men, giving them perhaps nine months to a year of actual training and experience. They want to know if we could offer any inducement to these men after they get out of the service. The Navy representative was advised that neither as a Committee nor as a group could we assure employment for these individuals, but that we would certainly give due consideration to a person so trained. The Committee recommends approval of a training program for male venereal disease investigators.

The next question was: Should the Public Health Service make funds available for the rental of beds for treatment of venereal disease cases responsive to intensive therapy, when such in-patient care is more desirable to the health department than the establishment of a rapid treatment center? And should the Public Health Service provide funds for the continuance of the rapid treatment center program under a project-grant plan rather than under the formula used for the allocation of regular venereal disease control funds? Should the Public Health Service reconsider the stipulation regarding conformance to State Merit Systems for employees in the rapid treatment center program for the coming year?

The consensus was "yes" on each of those questions.

The next question was: Should clinics be largely converted from treatment facilities to centers for interviewing, case-finding, diagnosis and referral?

The answer to that was "yes."

The next question was: Should clinical treatment of asymptomatic syphilis be terminated when 30 arsenical and 40 bismuth injections have been administered? It was decided that the word "asymptomatic" would be struck out and "latent" inserted in its stead, and then the consensus was "yes."

The next question was: In order to adjust clinics to their new functions, it is necessary to obtain uniform analyses of present operation. Should approval be given to the Public Health Service plan to obtain these data through simplified cost analysis forms, instructions and forms to be supplied to the State health officer by a representative of the district office? After it was explained that personnel from the district office would come to each State, in order to secure such data on a uniform basis, and the proposed form to be filled out was presented, the Committee voted "yes."

The next question was: Should the monthly clinic report be amended to include data regarding diagnostic and referral activity? The answer is "yes."

Mr. Chairman, that is the recommendation of your Committee, and I move, sir, that it be approved as read.

CHAIRMAN PARRAN: Thank you, Dr. Austin. Is the motion supported?

(The motion was seconded.)

The report is open for discussion.

DR. GILBERT COTTAM (South Dakota): Mr. Chairman, as a member of this Committee, I would like to amplify one section to bring out the point that in our State we have had very excellent success with the employment of women of mature age. The only trouble has been that we have been unable to get training for them. They have been thorough in their work. I personally like the idea, and I didn't want this report to go through without that modification. That is all right with you, isn't it?

DR. AUSTIN: Yes, quite all right.

CHAIRMAN PARRAN: The amendment to the report is accepted. Is there further discussion?

(It was put to a vote, and carried.)

The report of the Committee on Business Management, Dr. Beelman, of Kansas, Chairman.

REPORT OF THE COMMITTEE ON BUSINESS MANAGEMENT

DR. FLOYD C. BEELMAN:

The Committee on Business Management during the past year has again directed its efforts towards the further reduction and simplification of procedures governing business transactions between the States and Federal agencies.

Early in the fiscal year, an advisory subcommittee composed of eight State fiscal agents was appointed. This subcommittee met with consultants of the U. S. Public Health Service and the Children's Bureau during the week ending December 9, 1944. The report of the subcommittee is as follows:

"The Committee first reviewed last year's report in order to check the recommended changes that had been effected by the Public Health Service. Nearly all of the suggestions made in reference to Title VI and Federal Venereal Disease Control Funds were accepted. Of course, that is very gratifying to the Committee, and gives us encouragement to continue our work.

Before proceeding with that part of our report dealing with recommendations, we find it necessary to remind the States that they have a responsibility to file reports on time. By conscientious cooperation in this matter the States can greatly assist the Public Health Service.

We submit the following suggestions for consideration for inclusion in the 1946 regulations:

- (1) A partial lump-sum budget of Personal Service items. Explanation: We suggest that within each project the Personal Service items be grouped as to titles of positions without separating these positions in accordance with annual salary rates.
- (2) Annual report of expenditures of salaries in summary by project instead of in detail by items.
- (3) Discontinue quarterly 'Report of positions abolished and established.'
- (4) Eliminate quarterly report of 'Budgets in force.'
- (5) Prepare and distribute a Manual of Instructions with subject index. Explanation: We find that it is most difficult to operate under the present manual with the many amendments that have been promulgated.

The Annual Combined Report and Plan, used this year for the first time in some States, was presented and explained. We feel that it has considerable value for the preparation of the annual budget, and other fiscal procedures.

It has been suggested that the present procedure for computing quarterly payments to States be changed. We are strongly against any change, and recommend that the present method be continued.

The first draft of regulations to be promulgated in accordance with the new Public Health Service Act was presented to the Committee for review and comment. Some discussion with members of the staff of the Public Health Service.

brought out the need for certain suggested requirements to which the Committee voiced objections. We hope that we will have an opportunity to review the final draft of the regulations before they are presented to the State and Territorial Health Officers for adoption. These tentative regulations indicate a reduction or contraction in the administrative latitude now enjoyed by the State Health Officers in the administration and expenditure of funds. We hope this is not the intent of the U. S. Public Health Service. Further, we feel there should be no rigid regulations governing expenditures of State and local funds over and above those expended for matching, so long as Federal funds are not used to effect replacement or reduction in expenditures of State and local funds.

We recommend that the joint Public Health Service--Children's Bureau budget now in use by approximately twelve States be offered to all the States. A complete set of all combined forms, together with regulations and instructions for their use, should be sent to all States in order that each State might have the opportunity to decide whether or not it chooses to use the combined forms rather than the individual forms of each agency. In examining the combined forms, we find that some of the recommendations for changes in the present Children's Bureau forms which were not accepted are reflected in the combined budgets.

In connection with the joint forms we make the following recommendation: Show in Columns 14 and 15 amounts of State and local funds to be used as matching, also interline other amounts of State and local funds available, which are not needed for matching. Allow reporting expenditures from these additional or interlined items, if the expenditures made from items listed for matching are not sufficient to meet the matching requirements without the necessity of submitting revision budgets to bring within the plan these additional funds necessary for matching.

Comments

We recognize that both the Public Health Service and the Children's Bureau must review the budgets of all the States in a comparatively short period, immediately preceding the beginning of the fiscal year. When there is a delay in approving State budgets and plans, the States are put to great inconvenience by the necessity for delaying the preparation of pay rolls, the setting up of account forms, etc. The greatest embarrassment is, of course, the delay in paying salaries. Employees are entitled to their salaries when they are due, as well as to the payment of traveling and other expenses which they incur. We believe that the following procedure, if allowed at the Federal level and put into operation by the States, will relieve the agencies of much of their work load during the short period in which they review all budgets and plans, and would also make it possible for the States to continue without interruption projects already in force and pay salaries without delay. It is recommended that a basic plan and budget be submitted prior to the beginning of a new fiscal year in accordance with present regulations or amended regulations, which may be promulgated, which plan and budget shall be substantially identical with the plan and budget in operation during the fourth quarter of the fiscal year immediately preceding the new fiscal year covered by the new plan and budget. The only changes that would be made in the new budget would be the reflection of statutory or other planned salary increases. New projects and changes in projects already in operation would be covered in supplemental or revision budgets, which might accompany the original plan and budget to be considered separately, or might follow at any time preceding the beginning of the quarter in which it is intended that revisions or amendments shall be put into operation."

A progress report on the use of the Annual Combined Report and Plan Form, and the Form for Report of Public Health Personnel, Facilities, and Services, was given by Dr. Dean of the U. S. Public Health Service, as follows:

"With the recommendation of this Committee and the approval of the 1944 Conference of State and Territorial Health Officers, the Annual Combined Report and Plan was tried out in 13 States of Districts 1 and 2 last year. This series of schedules, as most of you know, was developed by the Service as a replacement for two separate documents that were formerly required: the Annual Narrative Plan and the Annual Narrative Report. The Annual Combined Report and Plan, involving the use of designated symbols, combines the characteristics of a report on activities in operation with proposals for extending, improving, or modifying particular services in the future.

Results were encouraging so far as they could be appraised on the basis of a single year's use. Certain revisions in both the form and instructions appeared desirable and have been incorporated in the draft now in press for use this year. The general method employed appeared to both the State and Federal health agencies to be an improvement over that previously used. Experience with the Report of Public Health Personnel, Facilities, and Services has been the same.

This year, use of the new reporting system is being extended to Districts 3, 4 and 7. Although we have not yet had final replies from all States in these Districts, some 30 States will probably participate.

Operations of the Public Health Service, and, we believe, those of the State, will be facilitated in several ways when these forms--or some revision of them--are used throughout all States. Summarization of particular items of information for Nation-wide coverage is one of our recurring needs. Of course, this summarization is difficult when different forms are used in different parts of the country. Also, a single set of instructions can be issued and preparation and review of the report can be expedited.

A few problems remain before we can extend the use of the new system to all areas. First, the Bureau of the Budget, which must approve all forms used by Federal Agencies for collecting information, has said that the form should afford more quantitative data. Certain types of such data are in keeping with the purpose of a Combined Report and Plan, but the character of quantitative data formerly collected has not proved satisfactory. This fact was one of the reasons for developing the present type of report, which we regard as a substantial improvement. Explorations are being made of various possibilities for meeting the Budget Bureau's demand, without changing the general structure and sense of the form.

Next, during the drafting of the proposed new regulations (which you have all had the opportunity to review), there developed a sentiment for requiring State plans one year in advance of the fiscal year for which they would be effective. The financial statement (Form DF-537) is being revised with the hope that this interest in long-range forecasting may be met by submission of plans 90 days prior to the beginning of the fiscal year. Argument for the one-year-in-advance schedule still persists, however. This development is so recent that there has been no time to orient the Annual Combined Report and Plan.

As long as State plans are required currently, as at present, we hope that this Committee will recommend adoption of the new reporting system as an official requirement in all States. Otherwise, we should like to continue a study of means to meet the changed requirements of the regulations."

DR. BEELMAN: The Annual Combined Report and Plan is recommended by the Committee to all the States for adoption.

A progress report on the use of the Joint Budget Form and Comments on Audit Findings was given by Mr. James D. Hall, of the U. S. Public Health Service, as follows:

Joint Budget Form

"The use of the Public Health Service and Children's Bureau Joint Budget Form is still in the experimental stage, though fairly well advanced. Most of the States using it prefer it to the single form.

You will recall that the joint form was instituted as an experiment, in 1943. In that year five States used it: Maryland, Indiana, Florida, Tennessee, and Utah. In 1944, three additional States used it: California, Kansas, and New Hampshire. In the present year, four additional States are using it: Oregon, South Dakota, Montana, and Wyoming. For the coming fiscal year, six additional States have requested its use: Ohio, Massachusetts, Michigan, Washington, Mississippi, and Maine.

As with many new forms, some 'bugs' have been found and eliminated. Undoubtedly it can be further improved. (Your Sub-Committee of fiscal agents gave us valuable assistance in suggesting a number of improvements, and we wish to thank them for their helpfulness.) As each Federal agency is given new-activity appropriations, difficulties will arise, because of the required additional and unwieldy width of the sheet. However, an effort is being made to overcome this difficulty by combining certain funds in a single column, when such may be done with clarity and ease.

Comments on Audit Findings

We have never been able to secure sufficient well-trained auditors to catch up with the backlog of work accumulated. We have a smaller staff of field analysts this year than last, and it begins to appear that we may lose instead of gain ground in the auditing program.

Since July 1, 1944, audits have been completed, or shortly will be, in twenty States, covering 32 audit years. About one-half of these reports have been completed and received in the Central Office. Of those received, about one-half have been reviewed and letters written. Compared with the total exceptions taken, a relatively small amount of penalties were invoked, since many exceptions were taken to technical violations rather than to irregularities."

DR. BEELMAN: Following discussion of this last report, Dr. Frechette recommended that audit reports be made in two parts: one containing, as nearly as possible, all recommendations of the auditor regarding changes, corrections, or proposed improvements in State fiscal procedures; the other, financial data.

The use of the Joint Budget Form was approved and its use by all States was recommended.

This report would not be complete without some report of discussion of the proposed new rules and regulations of the U. S. Public Health Service governing grants to States under Section 314 of Public Law 410 which consumed much time of Committee members in the combined Committee meetings. The Committee on Business Management is in full accord with the objectives of the U. S. Public Health Service in the proposed rules and regulations.

These objectives apparently are:

1. To have available reasonably accurate information as to State health
2. To insure utilization to the fullest extent of funds deposited in the Federal treasury marked for allotments to States.
3. To increase efficiency and to simplify insofar as possible the procedures, reports, and budgets which are necessary in accordance with the new Law 410 governing grants to States.

The decided departure from well-understood and tried principles governing grants to States to others not readily understood, and possibly not as workable, leaves the Committee with some slight apprehension. We feel, however, that with the increased flexibility which these new rules and regulations allow the U. S. Public Health Service, no State health program need be jeopardized by lack of funds during the coming period of adjustment.

The Committee on Business Management recommends that the services of the subcommittee composed of State fiscal agents be made available as expert consultants who may be of assistance and guidance at any time during the coming fiscal year, to the end that complete harmony, understanding, and cooperation between the States and the U. S. Public Health Service may be continued.

Mr. Chairman, I recommend adoption of the Committee's report

CHAIRMAN PARRAN: You have heard the motion.

(It was seconded, put to a vote and carried.)

Thank you very much, Doctor.

The report of the Committee on Interstate and Foreign Quarantine, Dr. Hanson of Florida.

REPORT OF THE COMMITTEE ON INTERSTATE AND FOREIGN QUARANTINE

DR. HENRY HANSON:

Disposal of Waste Matter From Railroad Coaches and Pullman Cars

The existing practice of disposing of toilet hopper and wash water wastes from railroad coaches and Pullman cars direct to the right-of-way during periods when such equipment is in service has caused considerable discussion through the past several years. The committee believes that steps should be taken to abate this insanitary practice and that in the designing of new equipment and in the reconstruction and rehabilitation of existing equipment, consideration should be given by the railroads to the installation of some type of holding system in which waste matter could be retained and properly disposed of at yards or terminals equipped for the purpose. Since a considerable building and rehabilitation program will be carried on by the railroads as soon as material and manpower are available, the time seems opportune to initiate a program governing the control over discharge of fecal and other waste material from railroad cars in service. In support of this, the following resolution is presented with recommendation that it be adopted by the Conference:

(The Resolution expressed the intention of the State and Territorial Health Officers to seek State and local regulatory legislation.)

River Basin Authorities

There was referred to the committee a resolution adopted by the health commissioners of the States signatory to the Upper Mississippi Agreement, reading as follows:

(The Resolution expressed the intention of the Board of Health Commissioners of Minnesota, Iowa, Missouri, Illinois, Indiana, and Wisconsin to discuss the establishment of River Basin Agencies with the State and Territorial Health Officers and with the Surgeon General, to assure proper consideration of public health.)

There are now bills before the Congress to establish a Columbia Valley authority, a Missouri Valley authority, and a Savannah Valley authority, and there has been some discussion as to the possible introduction of legislation establishing similar authorities in other rivers. It thus seemed advisable to the committee that the Conference of State and Territorial Health Officers should recommend to the Congress that, in the preparation of any legislation for the establishment of river valley authorities, consideration be given to the inclusion of measures designed to protect and promote the public health in the areas involved, as well as provisions authorizing the river valley authorities to cooperate with the appropriate health and stream sanitation authorities in the planning and development of the projects. The committee further recommends that the Executive Secretary confer with the Surgeon General regarding these matters.

Legislation Now Before the Congress on Water Pollution Control

The committee gave some consideration to the legislation relating to water pollution control now before the Congress, since this legislation was referred to by both Dr. Parran and Dr. Williams in the opening session of the Conference. The bills before Congress are H.R. 519, H.R. 587, H.R. 592, S. 330, and S. 535. The

committee recommends to the members of the Conference that they individually study the pending legislation and make their recommendations and desires known to their respective senators and representatives. This recommendation seems particularly desirable since it is expected that hearings on the bills now before the House of Representatives will be held in the near future.

The committee considered the resolution presented by the Upper Mississippi River Board of Health Commissioners endorsing, in principle, the Federal-State cooperative type of water pollution control as exemplified in the Spence Bill, H.R. 592. The committee recommends that a similar resolution be adopted by the Conference.

Certification of Interstate Milk Shippers

At its 1944 meeting, the Conference approved the committee's recommendation that the Public Health Service prepare a plan for the certification of interstate milk shippers by a procedure similar to that for the certification of shellfish shippers, and report back to the committee. Accordingly, such a plan was prepared and submitted to all State Health Officers for their comment in the Surgeon General's letter of Nov. 24, 1944. Because of the lack of a universally accepted standard, the plan proposed the publication of three separate lists of milk shippers, certified in accordance with their compliance with three different standards. Only 24 of the 53 States and Territories responded to the Surgeon General's letter. The committee recommends that States which have not already replied to the letter submit their comments as soon as possible.

Certification of Restaurant Equipment Needs by Local Health Officers

Disease outbreaks resulting from contaminated foods have increased steadily since the start of the war. In 1940, 218 outbreaks were reported with 5,588 cases; in 1943, there were 285 outbreaks with 13,938 cases. A similar increase is reported in all forms of dysentery: for the first 12 weeks of 1945 there were 7,794 cases, and only 3,414 for the corresponding period of 1944.

Sanitation in food establishments has suffered as a result of wartime restrictions making difficult the procurement of essential equipment and utensils.

In cooperation with the Public Health Service, the Office of Civilian Requirements of the War Production Board has prepared a plan to enlist the aid of the State and local health authorities in certifying the need for specific equipment items essential to the maintenance of minimum sanitary standards. This plan is explained in detail in the letter of March 31, 1945, from the War Production Board. (Copies of the letter were presented to the Conference on Monday.) Additional copies will be sent to all State and Territorial Health Officers, with the request that they in turn transmit the information to the local health departments in their respective States. The committee recommends that all State health authorities cooperate fully in promoting the success of this plan.

Importation of Farm Labor

Since, under international agreements, the War Food Administration must assume responsibility for the health and medical services of imported farm workers, as well as for the proper housing and sanitation of such workers, the Medical Division of the War Food Administration has requested that the Conference give consideration to the following resolution:

(The Resolution would enlist the cooperation of the State Department of Health in carrying out health and sanitation work under the Federal Farm Labor Supply Program.)

The committee recommends adoption of the Resolution.

Quarantine Regulations

Under Public Law 410 it has become necessary for the Public Health Service to revise all existing regulations pertaining to the Service. This step will require revision of both foreign and interstate quarantine regulations. The proposed foreign quarantine regulations are now being drafted.

A suggested draft of the interstate quarantine regulations, with which this Conference is particularly concerned, has been prepared and copies are being made available to the members of this conference. The committee recommends that the members review these regulations and supply the Surgeon General, at an early date, with any comments and criticisms that they wish considered in preparing the final draft.

These proposed regulations do not modify the present policies and procedures of cooperation with State health agencies, but, with the new authority provided for in Public Law 410, it is believed that the cooperative effort can be greatly strengthened and more effective results obtained.

Suggested Modification in Manual of Recommended Practice for Sanitary Control of the Shellfish Industry

The committee gave consideration to the memorandum dated March 19, 1945, submitted by Dr. Getting, setting forth the difficulties that the northeastern State authorities were having in applying the sections in the Manual of Recommended Practice for the Sanitary Control of the Shellfish Industry, issued by the Public Health Service September 1, 1944, covering the bacteriological methods for examination of shellfish meats and the coliform organism limits for such meats, with particular reference to soft-shell clams.

The specific recommendations made in the memorandum are as follows:

1. That a committee of investigators from State and city public health and conservation laboratories, representing the soft-shell clam producing States and Territories, be appointed by the State and Territorial Health Officers Association.
2. That this committee examine the present and recommended bacterial methods and standards for soft-shell clams.
3. That this committee plan and carry out the necessary investigations and make recommendations for workable bacterial methods and standards and their interpretation.
4. That the findings of the committee be presented to the U. S. Public Health Service for consideration in the establishment of final standards relating to shellfish.

5. That the present standards and methods be regarded as accessory to and interpreted in terms of the findings of careful and repeated sanitary surveys of growing waters and conditions surrounding production.

6. That the U. S. Public Health Service issue a letter of interpretation of Section 3.3, p. 15 of the Manual--that part dealing with bacterial standards for soft-shell clams.

Since the soft-shell clam industry is largely confined to the northeastern coastal States from Maine to New Jersey, the committee recommends that the health officers of these States make such arrangements as they see fit in carrying out paragraphs 1 to 4 of the above recommendations.

The committee was informed that, in applying the requirements set forth in the Manual, it was the expectation of the Public Health Service that the bacteriological results obtained in the examination of shellfish meats would be considered in connection with proper sanitary surveys of growing waters in determining the probable safety of the product. If this is not clear in the present Manual, it will be included in the letter of interpretation of that section of the Manual dealing with the bacteriological examination of shellfish meats which is now being prepared by the Public Health Service.

CHAIRMAN PARRAN: Do you move approval of the report?

DR. HANSON: I do.

(The motion was seconded, put to a vote, and carried.)

CHAIRMAN PARRAN: The Committee on Hospitals and Construction, Dr. Edward McLaughlin, of Rhode Island, Chairman.

REPORT OF COMMITTEE ON HOSPITALS AND CONSTRUCTION

DR. EDWARD A. McLAUGHLIN:

The task of this committee was the review and consideration of Senate Bill 191.

The committee believes this to be a very important and necessary legislative measure for the promotion and protection of the health of our people. It strongly endorses the purposes and substance of S. 191. However, the committee recommends that the same be amended as follows:

1. The State Department of Health should be designated as the sole agency for carrying out the purposes of the act.
2. The \$5,000,000 specified in Part B, Sec. 611, be authorized as an outright grant to the States with no provisions for State matching.

The committee is strongly in accord with that portion of the act providing for a Federal Advisory Council to act only in an advisory manner to the Surgeon General.

The committee recommends to all State health officials for the purpose of uniformity that "Hospital Schedules of Information" and "Public Health Center Schedules of Information" as prepared by Commission on Hospital Care be used in making surveys.

It further recommends that State health authorities familiarize themselves with S. 191, seek the cooperation of all groups in their respective States who are interested in Public Health, Hospital Construction, and Hospital Services.

The committee recommends that in the formation of the State Advisory Council provision be made for a hospital architect and the State sanitary engineer to serve on the council in addition to other interested groups.

In conclusion we recommend that a copy of this report, when adopted by the Conference of State Health Authorities, be forwarded to the Senate Committee on Education and Labor and to the House Committee on Inter-State and Foreign Commerce.

Mr. Chairman, I move the adoption of the report.

(The motion was seconded.)

CHAIRMAN PARRAN: It is moved and seconded that the report be adopted. Is there discussion or are there questions?

DR. BIERRING: Could we have some remarks from the Chairman on this matter?

CHAIRMAN PARRAN: I feel that the State Health Officers should have entire freedom in making any recommendations concerning this measure which they desire. S. 191 is not an Administration measure. It is true that we were consulted in connection with its general terms, but the American Hospital Association--in fact the three hospital associations of the country--are sponsors of this bill.

There was a great deal of discussion concerning the amount of authority to be given to the Federal Advisory Council. The Public Health Service has not been averse to sharing administrative responsibility with such councils. However, some criticism has been voiced by the American Public Health Association, and other groups, to vesting in an Advisory Council whose membership is preponderantly representative of hospital administration, as much authority as the bill now gives to it. On the other hand, in the course of the hearings, Senator Taft of Ohio, among others, took the position that any Federal advisory committee became a rubber stamp of the Administration, and therefore did not exercise any real control. The State Health Officers can choose between those two points of view. In my testimony I did not take a strong position either way, since the points of view differed so widely.

I think a valid point has been made concerning the desirability of eliminating the requirement of matching the first 5 million dollars, particularly from the point of view of the time necessary to secure State funds for this particular purpose.

The first, and perhaps the most important recommendation of your committee is that the State Department of Health should be designated the sole agency for carrying out the purposes of the Act. On that point I should like to have discussion from the State Health Officers themselves. I think that the attitude of the Public Health Service is shown by the fact that we are not only willing, but anxious, to be the Federal agency administering the Act. We believe that the hospitals of the future will be much more an integral part of the total public health system than they have been in the past. That statement is obvious, I am sure, to all of you.

The major question, perhaps, revolves around imposing this requirement upon the States, when perhaps in some the State health agency would not be willing to take the responsibility, or would not be interested in it. In other instances, there may already be in existence a State hospital authority administering State mental hospitals or other institutions. Some States give aid to voluntary and other hospitals--Pennsylvania is one example. Dr. Campbell, in Pennsylvania that work is administered under the State Department of Health?

DR. J. MOORE CAMPBELL: The State Department of Welfare, although I might say there is a bill in the Legislature at the present time transferring the administration of the mental disease hospitals to the State Health Department.

CHAIRMAN PARRAN: But the grants-in-aid of State funds to hospitals that give care to indigents is under the State Welfare Department. In the State of New York, the State Welfare Department has the responsibility for licensing all hospitals, of whatever type, if they receive any public funds whatever for the care of indigent patients.

Perhaps this would be a good time to ask the State Health Officers here assembled if any such officer would be unwilling to accept responsibility for administering this Act and would prefer to see it lodged in some other department. May I ask that question?

DR. BIERRING: Mr. Chairman, we all recognize the sponsorship of the American Hospital Association and the rather strong endorsement of the American Medical Association in the first hearing. It appears that both Associations

are generally in favor of designating the State Department of Health as the administrative agency for carrying out this program. Of course there are exceptions in the States that you have mentioned. But I think the general feeling over the country is that the State Health Department is the logical body to carry out the purposes of this Act.

CHAIRMAN PARRAN: Thank you, Dr. Bierring. I think I am right in my impression that several States have passed laws recently designating the State Health Department as the agency which would carry out the purposes of S. 191. The State of Georgia is one that comes to mind.

DR. BIERRING: The State of Washington also, I think.

CHAIRMAN PARRAN: Have other States represented here taken that action?

DR. SHARP: The State of West Virginia.

DR. UNDERWOOD: I think Tennessee has.

DR. MITCHELL: Maine has.

DR. COTTAM: South Dakota, without knowledge of this Act at the time, passed a bill authorizing the State Board of Health to administer hospitals.

DR. RICE: Indiana.

DR. MOUNTIN: Didn't Maryland, also?

DR. OSBORNE: Connecticut hopes to.

CHAIRMAN PARRAN: Such a measure is pending in California.

DR. MATHEWS: It is pending in Oklahoma, too.

DR. McLAUGHLIN: In Rhode Island, too.

DR. CROSS: And in Illinois.

DR. McKAY: In Utah we were successful in securing passage of such a bill. It was introduced by the State Medical Association.

CHAIRMAN PARRAN: Is there further comment?

(It was put to a vote, and carried.)

Dr. Rice, of Indiana, Chairman of the Committee on Health Programs, has a report to make.

REPORT OF THE COMMITTEE ON HEALTH PROGRAMS

DR. THURMAN B. RICE: This Committee met with the Tuberculosis Committee and the Hospital Committee, so that the opinions here expressed are opinions representative of all three groups.

The Committee begs to submit its recommendations on the following six subjects:

1. Physical Fitness Program. There has been much criticism of health and medical agencies since it has been found that so many of our young men are unfit for military service. We propose the following statement of principle:
 - a. The basis of real physical fitness is general health. This responsibility for the health of the people has been and properly remains the responsibility of the health department.
 - b. We would encourage physical fitness programs in schools, clubs, and other suitable organizations when they are, in our opinion, properly conducted.
 - c. We would encourage such training, games, and activities as will reasonably be expected to improve health and physical fitness and can be continued without being constantly whipped up by artificial means.
 - d. We should cooperate with all sane and reasonable efforts toward physical fitness made by medical, health and educational groups under responsible leadership.
 - e. We recommend that members of this group use their legitimate influence to prevent the passage of H.R. 2044, which bill seems to be a means of continuing a program not under adequate professional management.
 - f. We recommend the principle of Federal grants-in-aid for the improvement of physical fitness programs, provided the funds are channeled through official State health and educational departments.
 - g. We believe that an efficient, effective health program for all children will result only when the following five points are effectuated:
 1. The public departments of health and of education, as well as specialized personnel within each department, agree to the principle of integration of school health programs with the health program of the community and with the educational program of the schools.
 2. Each agency and profession respects the contribution of the others.

3. The agencies agree to an administrative plan which will promote the most efficient and cooperative direction of the several phases of the program and the supervision of the several types of professional workers.
4. The professional workers of each agency are permitted to perform services in their professional fields for the best interest of all children.
5. Sufficient funds become available to carry out the program.

These five points have been used elsewhere.

We believe that the U. S. Office of Education, U. S. Public Health Service, and the U. S. Children's Bureau should form a coordinating committee to plan jointly the activities of the Federal Government in school health, including the integration of the existing programs, the planning of any extension of these programs, the formulation of over-all policies and the establishment of regulations governing the administration of any funds that may be made available, to plan with State departments of education and health for a program of health and physical education in the schools, including training of personnel and the development of teaching materials and conservation of the health of all children of school age.

2. Dental Health Program. Dental caries is by far the commonest lesion to which the American citizen is liable. Great progress has been made in the understanding of the causes underlying this condition and it seems as if we may soon be in a position to utilize this information in a practical program of prevention.

It is recommended that:

- a. S. 190, a bill to provide for, foster and aid in coordinating research relating to dental diseases and conditions, be supported by the members.
- b. The principle of Federal grants-in-aid be extended to the use of dental funds, provided the moneys are channeled through official State health authorities in the manner found useful in connection with venereal disease and similar problems.
- c. The establishment of dental divisions in State departments of health be encouraged.
- d. Demonstration programs to test preventive methods and to develop administrative procedures designed to reduce the cost and increase the utilization of dental care be conducted and supported. Such programs are to be conducted in harmony with the policies of the local, State and National dental associations.

- e. Surveys covering the fluorine content of water supplies be made to the end that advantage may be taken of the possibility that dental health may in the future be improved by the addition of fluorine salts to the water supplies.
3. Mental Hygiene. We have recently been much concerned by the evidence that the mental health of our people is far from satisfactory and that the ravages of war may easily augment the seriousness of the situation. We believe that the same broad principles of public health apply to the problems of mental illness as to the problems of tuberculosis, venereal disease, malaria, and other preventable diseases. We must find the cause, develop better methods of treatment, train competent personnel to work in the field, care for the ill, and educate the public. Since the problem does fall into the public health field, it is important that a well-integrated program be developed so as most effectively to bring it under control insofar as possible.

In connection with this need, a bill, H.R. 2550, has been introduced into Congress. This bill would provide for grants-in-aid to the States, to be administered by the State Health Departments to develop such diagnostic clinics and treatment centers as may be needed, in addition to the facilities for psychiatric care already available. The bill also provides for funds to be used for the training of personnel in the mental health field, and for demonstrations and education of the public in mental health. It further provides for the erection of a research institute for the study of nervous and mental diseases and for funds to conduct research, both at the institute and elsewhere, by making fellowship grants.

This bill seems to meet the basic needs in the field of mental public health and is, in the opinion of the Committee, a desirable piece of legislation. We recommend that the Health Officers' Conference endorse for passage this bill, H.R. 2550.

4. Industrial Hygiene. Inasmuch as the problems of industrial hygiene are coming to be of the greatest consequence, and also inasmuch as the funds for the prosecution of such work have been inadequate, a resolution is proposed for the consideration of the Resolutions Committee.

I think it is not necessary to read the resolution in detail. It has been handed to the Resolutions Committee, which would arrange for funds for this work.

Another resolution has been given to the Resolutions Committee. It has to do with the recommendation that we do whatever we can to prevent the passage of H.R. 525. That bill has for its purpose the setting up in the Labor Department here, and also later in the labor departments of the various States, of a fund for creating Commissions of Industrial Hygiene in the various State departments. We think that it would be duplication and that it belongs with health and should stay there.

5. Red Cross Blood Donor Campaign for Civilian Use. The Health Officers' Conference understands the need for the closest cooperation between the State Health Departments of the several States and the American Red Cross to the end that the interests of the health departments, the prestige of the American Red Cross, the welfare of the public, and the safety of blood donors may be protected. To this end, we recommend that the regulations drawn up for the control of this program should be worked out jointly by the Executive Committee of the State and Territorial Health Officers' Association and the American Red Cross.

With this provision observed, we recommend the fullest cooperation of the several health departments with the American Red Cross in collecting and processing of human blood for civilian use.

6. The next division of this report has to do with four things that are simply recommended for attention; they are not recommended for passage or anything of that sort, but only that they receive your thought.

We strongly recommend increased attention to the whole matter of the diagnosis and treatment of tropical diseases which may be introduced into this country when our military personnel return. Surveys should be made to determine whether or not insects or other vectors responsible for the spread of these diseases exist in the various communities, to the end that adequate precautions for prevention may be taken.

The next point we call attention to is something that Dr. Hanson has already had in his report. We are merely calling attention to it. The attention of the health officers is called to the report which has been distributed to the members, entitled, "Manual of Recommended Practice for the Sanitary Control of the Shellfish Industry." This is an extremely important report which has been worked out by the U. S. Public Health Service since our last meeting. It will be of particular interest in those States which produce shellfish for the market but is also of great interest to the remaining States which consume these products. In view of the fact that meat shortages are causing a marked increase in the consumption of nonrationed shellfish, we believe that this report is of far greater interest and importance than it would be in more normal times. It seems likely that the increased consumption of these products will continue, and that increased effort must be made to insure their safety.

Complaint is made by health officers of the States producing such products that the rules are impractical in certain respects. On the second page of the mimeographed memorandum which has been handed out to the members will be found certain recommendations which are worthy of attention. This report is intended neither to recommend nor condemn the Manual but to call attention to it, and to recommend that it be further considered and tried out before it is set up as a manual of official standards.

Attention is called to the great increase in the number of frozen food lockers throughout the United States. Many of these plants are being set up without proper provision being made for reserve compressor strength. Many are being inadequately insulated; many plants are being

overloaded; and many of the older plants are coming to be in need of repair. In case of a breakdown, the health hazard in some instances is very great inasmuch as the patrons may be unaware that the food has been allowed to become warm, or inasmuch as they may be unwilling to discard food which has been improperly refrigerated.

Attention is called to the increasing prevalence of swine-borne brucellosis. It is believed that about 70 percent of this disease is in agricultural districts and that, definitely, the more severe cases are contracted by farmers, slaughterhouse employees, and veterinarians, while handling diseased hogs or freshly slaughtered animals. The disease is quite common in both acute and chronic form and is responsible for much disability and suffering.

Respectfully submitted. I move its adoption.

CHAIRMAN PARRAN: Is the motion supported?

(The motion was seconded.)

CHAIRMAN PARRAN: Is there discussion?

DR. OSBORNE: I think that the Committee's report might have an amendment to it, so that instead of stating that industrial health is coming to be of great importance, we can say industrial health problems have been of greatest importance to industrial workers, and will be, during the post-war years, of more importance than ever.

CHAIRMAN PARRAN: Does the Chairman, on behalf of the Committee, accept the amendment?

DR. RICE: Yes. I will be glad to.

DR. R. L. CLEERE (Colorado): Mr. Chairman, I would like to recommend that the word "swine-borne" be deleted from the section pertaining to brucellosis, because, certainly in some sections of the United States, there is an increase of caprine and bovine brucellosis as well as the other strain.

DR. RICE: I believe it would be well to say "swine in addition to bovine."

CHAIRMAN PARRAN: Is that agreeable, Dr. Cleere?

DR. CLEERE: It is.

DR. DeKLEINE: In the report the program of physical fitness is said to be largely the responsibility of the public health official. I think we should say that it is also the responsibility of the medical and dental profession. The resolution may be a little stronger if that wording is included.

CHAIRMAN PARRAN: Dr. DeKleine's amendment is accepted by the Chairman, without objection.

Further discussion?

(It was put to a vote, and carried.)

We will hear a discussion of surplus property, in accordance with the action taken by the Association of State and Territorial Health Officers last evening. We are very fortunate in having here today Mr. Harry Rosenfield, who is on the Administrator's staff, and has been concerned with this problem. Mr. Rosenfield, will you come forward and give us a discussion of the problem.

DISCUSSION OF SURPLUS PROPERTY

MR. HARRY N. ROSENFELD (Assistant to the Administrator, FSA):

Because of legislation affecting surplus property and negotiations that have been going on for more than a year, the Federal Security Agency and its various units, particularly the Public Health Service and the Office of Education, have become deeply involved in the problem of surplus property and its disposition. We frankly need the advice and guidance of your experience.

We conceive of the function of the Federal Security Agency and of its units in this way: To assist the Surplus Property Board and the various disposal agencies, as well as the medical, health, and other related institutions and agencies, to the end that all derive the maximum benefit under the Act.

Whenever one talks of surplus property, it seems to me to be a fair question to start with a rather prosaic question: What is in it for us? Honestly, I can't say that I can give you any figures. We don't know what is in surplus. If any of you can tell how much we are going to have left of the medical supplies on Iwo, maybe we will know what will be surplus. In other words, what is surplus depends upon what is left after the war use is over.

We do know, though, that there are between 60 and 100 billion dollars' worth of materials in general which may be surplus. We do know that approximately 225 million dollars of surplus medical materials is likely to be available. By that I mean clinical thermometers and hospital beds and surgical instruments and the like. We do know that there will be just too many millions to count of bulldozers and typewriters and desks, and the things without which you can't operate hospitals and medical institutions, but which are not "medical" or "health" supplies.

What is in it for us, then? I should like to put it in this way. There is an enormous opportunity for health and educational interests. (You will permit me to leave the word "educational" out for the moment.) It seems to me there are three or four things we ought to bear in mind, so that we can understand what the problem is, and it is then for you to decide what you would like to do about it.

There is opportunity for the replacement of equipment and materials of a sort which one hasn't been able to buy. There is opportunity for the extension of existing programs and for the expansion into new programs, in areas, in institutions, and in agencies which could not otherwise expect to have the means to afford this type of equipment. I should say, then, that the effective distribution of surpluses--and I am not talking for the moment of how it is to be done--can give a favorite climate to public health services for the next generation. I would like to answer the question, "What is in it for us?" with that general comment.

The effective distribution of surpluses depends in great measure, of course, upon the Surplus Property Act. With your permission, I should like to make a very cursory review of its pertinent provisions. The Surplus Property Act, passed last year after considerable discussion, set up a Board of three members, appointed by the President subject to confirmation by the Senate. Those three

members right now are former Senator Gillette, former Governor Hurley, and former Lieutenant Colonel Heller. That Board, under the legislation, is given general direction and supervision over the disposal of surplus property.

The Act sets up a series of priorities--a familiar word. It says that first chance at available surpluses shall be given to Federal agencies. Let's put it in these terms: The Public Health Service, as a Federal agency, would have an opportunity to get medical supplies for its directly operated health institutions before anybody else would get a chance at them. Veterans Administration presumably would be in the same position, and so forth. The first priority, then, is for the Federal agencies.

The second priority--by "priority" I mean opportunity to get surpluses--is for State, local, and nonprofit health and medical institutions and agencies; and the third, after you get through the first and second (Federal, State, local and nonprofit), is general commercial distribution. There are certain other special considerations which the Act spells out, such as veterans, small business, farmers, which aren't directly involved here.

Let's come back to the second priority. You are going to be hearing a lot about Section 13 of the Act, because it provides for disposal on a priority basis to States, their political subdivisions and instrumentalities, and to tax-supported and nonprofit institutions.

There are three things I would like to call to your attention concerning that provision. One, the Surplus Property Board is required to prescribe regulations for disposal to States and their instrumentalities, to tax-supported and nonprofit institutions, and the Act says that "the Board shall determine on the basis of need what transfer shall be made"--"on the basis of need what transfer shall be made." The first problem, then, for the Board to decide is, Who gets what, and why? to put it bluntly, on the basis of need.

The second problem I would like to call to your attention is this, and perhaps I can do it best by reading a very short paragraph:

(a) "In formulating such regulations, the Board shall be guided by the objectives of this Act and shall give effect to the following policies, to the extent feasible and in the public interest.

(b) Surplus medical supplies, equipment, and property suitable for use in the protection of public health, including research, may be sold or leased to the States and their political subdivisions and instrumentalities, and to tax-supported medical institutions, and to hospitals or other similar institutions not operated for profit which have been held exempt from taxation."

I would like to call your attention to the fact that the language there is, "surplus medical supplies, equipment, and property suitable for use." That would mean, and the Surgeon General has interpreted it to mean, more than the 250 million dollars' worth of specifically medical supplies. That is, in a medical school this blackboard is suitable for medical use and research, and certainly a rostrum such as this is "suitable for use." In other words, anything that would be needed for effective and efficient operation of a medical and health service is encompassed within this provision.

The third thing I would like to point out to you is that the Board is enjoined by Congress, when fixing either the sale or lease price, to take into consideration any benefit which has accrued or may accrue to the United States from the use of such property in the particular fashion in which it is distributed.

Specifically, then, there are three problems that the Board has before it, and which ultimately we have before us: the determination of need; the determination of what equipment is suitable for use, such as we are interested in; and the determination of the benefits which come from either previous or subsequent use. What does it all mean? Let's see if we can put it this way: The first means that health agencies and institutions--I am talking on the State level after we have passed the Federal level--that State, local, and nonprofit private institutions in the medical and health and related fields will be given a time preference, a time priority, before the material is put out for commercial sale.

The next thing that is important is the price problem. What we need is going to depend in great measure on what we will have to pay for it. There are three things we ought to notice in that. The Act specifically bans donations, except in the very limited field where the property has no commercial value or where it would be cheaper to dispose of it by donation than to sell it. But that is not quite as bad as it sounds. We have mentioned that there are price preferences; that is, that in setting the price, the Board may consider past or future benefits from the use of this equipment. We may suppose that, at least when there is adequate surplus available to meet demands, the sales price on most specifically medical surpluses will be the cost of packing and transporting--"Come and get it," is what it will be. That is no firm commitment, but we have every reason to suppose that to be so.

A third item is very important. The Act contains the language, "sale or lease." Conceivably, if a small hospital in a rural area couldn't afford a very expensive X-ray machine and the Surplus Property Board were willing to make it available, it could lease the machine for a dollar a year for three or four years and then write it off at that basis.

So much for the Act. How does it work? There are three parties to the operation. There is the Surplus Property Board, which has the ultimate authority. There is the buyer, you folks or the people you represent, the hospitals and the medical clinics and so forth. Between them, there are the disposal agencies. Perhaps I can put it this way: Suppose we think of Sears Roebuck with its home office in Chicago. If you go into the Sears Roebuck home office you can't get a clinical thermometer, but the home office in Chicago determines policies of sale, policies of distribution, etc. That is the role of the Surplus Property Board at the present moment. It is a policy-making agency; everything else stems from it, but you can't buy things from it. You have to go to the retail outlets, and these retail outlets are known in the gobbledygook of Washington as disposal agencies.

The other day the Surplus Property Board issued an order designating about eight disposal agencies, each with a specific field. By and large, I should think that you would be interested in two of them: Treasury Procurement, which handles consumer goods--the things that we would ordinarily be interested in--clocks, surgical equipment, desks, typewriters, pads, and all other such things; and Reconstruction Finance Corporation which, in addition to handling capital and producer's goods, handles contract termination inventories. As to RFC, let me point out this: Suppose some firm were manufacturing hospital beds; come VE-Day and

contract termination and they have 3,000 beds on hand; they would go to RFC, so that we would be interested in RFC as well as Treasury Procurement.

How it works raises all sorts of problems, and I am getting into questions on which we are anxious for your advice and guidance. There are these three groups. The Surplus Property Board is one. Now let's take the claimants, the people who want the stuff, the buyers. Just as there is a provision for materials suitable for use in public health, so there is an almost identical provision for education. Education and health are treated similarly in the Act, and have the only specific preferences of that kind.

I am told that there are some 6,000 different possible claimants in the medical field. There are some 120,000 claimants in the educational field. That is the one side, the buyers. On the seller's side, there are eleven regional offices in Treasury Procurement and some thirty-four regional and suboffices in RFC, so that the problem isn't quite as simple as just going somewhere and finding out what they have. Consequently, the Surplus Property Board, with whom the Surgeon General and the Commissioner of Education and the Administrator have been in very close consultation, has seen two basic problems confronting it in the effective distribution of medical surpluses.

The first of these problems of distribution is to devise some way of making known to the Board and the disposal agencies what the needs are for surplus property. This has to be done in an administratively feasible manner. It obviously wouldn't make sense for each hospital, or each health clinic, to be traipsing around with different types of lists. There has to be some orderly process. But that is one of their enormous problems: How are we to make known what our needs are?

Conversely, the next problem is: How can we arrange for an orderly manner of dealing with the disposal agencies? The two problems, then, are needs--how are we going to get them calculated, first, and how are we going to make them known? and secondly, how are we going to deal in an orderly fashion with the disposal agencies?

That leads me to the developments that have taken place, and they are very considerable. The Federal Security Agency, the Public Health Service, and the Office of Education have been asked for their advice by the Surplus Property Board and the disposal agencies. I think you will be interested in what has happened with the Office of Education. About a year ago, the Surplus War Property Administrator, the predecessor of the present Board, requested the Commissioner of Education to establish a representative committee in Washington to represent all of the elements and aspects of education: public, private, college, elementary, secondary, vocational, parochial, and so on. They were all represented in one committee advisory to the Commissioner of Education, at the request of the surplus property authorities. Apparently it has been working quite well. They have served as a conduit both ways. The surplus property people can get easily to a representative group, and the profession can in a representative fashion get to the surplus property people.

Within the last month or so, one of the members of the Surplus Property Board wrote to the Commissioner asking him to transmit to the education people in the States the conviction of the Surplus Property Board that a similar type of representative State-wide cooperative mechanism ought to be established in each

State. That has not as yet been done, but it is apparently the Board's conviction that it should be.

Another development of considerable interest is a pending request by the Surplus Property Board to the Federal Security Agency requesting that the Public Health Service and the Office of Education act as liaison between the Board on the one hand and the claimants and the disposal agencies on the other. This plan would involve, if accepted, obligations: (1) a two-way conduit, from the disposal agencies to the claimants as to what is available, and from the claimants to the disposal agencies as to their needs; and (2) a certification function in certifying estimates of need. The Board has been trying to solve its two problems in this way. We mentioned earlier that there are two problems; how to get an estimate of consumer needs, and how to get an orderly process of dealing with the disposal agencies: apparently the Board thinks that its purposes would be served best through utilizing our services.

Someone is going to do this job. I don't know who it is going to be, but someone is going to do it. The Board has offered an opportunity for it to be done on a professional basis. If it isn't done in that way, some other than a professional basis will have to be chosen. It might be done by the War Production Board. Conceivably, it might be done by Treasury Procurement alone. But we are particularly anxious for your advice and guidance; how you think the job ought to be handled in line with these two problems: how to get the needs determined and how to develop a reasonably effective and orderly manner of dealing with the agencies.

CHAIRMAN PARRAN: Thank you very much.

I wonder if Mr. Bugbee would care to discuss this matter. I know the American Hospital Association has been concerned about it.

MR. GEORGE P. BUGBEE: Our Association has a committee that has been wrestling with this question, but we have been somewhat discouraged in trying to set up a practical working program.

The first problem results from the provision for dispensing surpluses to nonprofit organizations. The American Hospital Association has many public hospital members, and I think the distinction is unfortunate if carried too far. Also, the inclusion of nonprofit organizations as beneficiaries under this Act causes difficulty in establishing the proper means to channel information from the individual consuming units to the disposal agencies. We must be sure that in such an arrangement there is equal consideration for both the government and the nonprofit group.

I do not imply that nonprofit groups should share more than the government groups, but the public agency, having dealt primarily with other public agencies, can evaluate a difficult thing such as need, while the nonprofit group is not too accustomed to dealing with that type of problem. It is to be hoped that a program can be worked out without irritation on either side.

One of the complications we have met and have no answer to is, that if there is a limited supply of a given surplus and a large requirement, the controversial question of determining priority of need arises. That is a real difficulty, whether you do it "first come, first served," or how you do it. It seems

to us that the United States Public Health Service is a very logical agency on the Federal level to consider these medical surpluses. I think it will be more difficult to be sure what should be the agency on the local level. The suggestion of local committees is of interest, and I suspect this group are wondering what should be their responsibility in the States as this program develops.

DR. BIERRING: This Conference has an interest in the proposal to establish the United States Public Health Service as a central liaison agency, and through them, effect cooperation with similar agencies, or boards, or committees, in the individual States. I am hoping, of course, that the American Hospital Association and other organizations will be represented on these State agencies.

In the State of Iowa the matter has been assigned to the Board to which I have already referred. It seems that some similar body in each State might act very effectively with the United States Public Health Service in carrying out the provisions of this Act.

CHAIRMAN PARRAN: Dr. Riggin, would you care to enter the discussion at this point?

DR. RIGGIN: Dr. Parran, the Health Officers' Association considered this question last night from various angles. They doubted very definitely the wisdom of the United States Public Health Service setting up a big division which might involve the sending of officers or establishing of offices in the various States to handle this particular problem of surplus medical and hospital supplies.

CHAIRMAN PARRAN: Mr. Rosenfield has given a very clear presentation of what the broad problem is. We know the provisions of the law. The Surplus Property Board will comply with those provisions and give preferential treatment to health and educational institutions. Then the question is, How is that going to be done? It seems to me there are two alternatives: one, that there should be set up in the two disposal agencies, namely, the RFC and Treasury Procurement, a professional group familiar with medical and hospital and other health supplies. The Public Health Service alleges no special competence in this field. I know that the Army, the Navy--certainly the Army--have had a very large organization dealing with the purchase of these very same supplies. If such personnel were available from the Army, one would think the same brains which bought the supplies would be most familiar with where they were and what they were like and how best to dispose of them. So I would raise the question as to whether or not the Treasury Procurement and RFC might be able to secure such talent now, so that when surpluses become available, the procurement job will have been done.

The Public Health Service in the beginning would be willing, even anxious, to respond to requests from the Board for the assignment of an adviser, or a liaison officer to work with this problem, as well as to assign one or more such officers to Treasury Procurement and RFC. That would be one pattern.

The other pattern conforms with what the Board has asked the Administrator if he is willing to accept as a larger responsibility. That is setting up an organization throughout the country requiring offices in every State and perhaps suboffices, in the larger communities which would have full responsibility for determining the total need for all of the many thousands of items which go into this broad term, "health and medical supplies"; would then make that total need known to the Board and certify relative needs.

I frankly was disappointed in the first regulations which the Surplus Property Board issued. Those regulations mean, in effect, that until some item is a glut on the market there is to be no price concession to States or hospitals or other institutions. From the standpoint of the Board, that probably is good business. I am not complaining that that decision was made, but, certainly if the price of a microscope is the full going rate, I think the need would be much smaller than if the microscopes were sold at ten cents on the dollar, or for the packing and crating cost. And so this question of determining need is a very elusive thing. Do we mean need? Or do we mean effective demand from the consumers, the hospitals and the health departments of the country? If we mean effective demand, then that demand is going to vary greatly, depending upon the price at which the articles are made available.

DR. RINGLE: We have a set-up in the State of Washington, recently authorized by the State Legislature, in which there is an organization to purchase for the different departments in the State, for counties and municipalities and so forth, surplus goods offered for sale by the Government. The State can buy any amount and then resell it to whatever organizations care to buy it within the State. It is, I think, a plan similar to that Dr. Bierring, of Iowa, described. I think it will probably work, but of course the State will have to have the information available as to what material is available.

CHAIRMAN PARRAN: I see Captain Watson Miller, who has been very close to this problem. I wonder if he would give us his views.

CAPTAIN MILLER: It seems to me that there is a great deal of exploratory work to be done before you can determine the best means for relating the three elements involved here. I am wondering whether there should be assigned, maybe under Federal aegis and supposedly under the Public Health Service, some individuals in the State and community that you might call moderators, beneficial moderators, who will understandingly inspect and audit the various interests and the estimation of need.

It seems to me if commissions or bodies are set up in each one of the States, in, let's say, the educational field and the health field, that there will be a good deal of confusion. So I have been thinking of some such institution as the Chairman has here suggested. There are bound to be differences of opinion; there is bound to be vociferous claiming, at least as to the articles in short supply, and I think somebody has to advise the Government as to what the relative needs may be.

CHAIRMAN PARRAN: Miss Switzer, would you care to comment on this subject?

MISS MARY SWITZER (Assistant to the Administrator, FSA): I would like to ask Dr. Bierring and the representative from Washington whether their State-wide committees, or boards, are going to decide the need and enter into negotiations for the procurement of supplies without cost, or for a certain price differential, or are they just going into the purchasing business?

DR. BIERRING: The thought of this Board in Iowa really originated with the Governor, and he early this winter designated some of us to investigate this matter.

MISS SWITZER: Then your Board really could do anything the Governor gave it to do; it is a Governor's appointed Board, not a legislative Board. The Board

in Washington is really a central purchasing department, isn't it?

DR. RINGLE: I think that is right. I think it will be a purchasing agent, trying to fulfill the requests made by the different departments in the State and other individuals.

MISS SWITZER: Would it deal with anything except governmental groups? Would it deal, for instance, with the voluntary hospital group or other health groups that might want to come in under the Act?

DR. RINGLE: I doubt that, unless they could some way purchase through the State Health Department, for example.

MISS SWITZER: It is a question of how our agency and its parts can be helpful, and keep controversy from arising, and assist in the early stages so as to develop a smooth-running machinery. We are anxious for help and suggestions.

CHAIRMAN PARRAN: Several alternatives have come to mind. One is along the line indicated by Dr. Riggin; another would be something which would parallel what was done by the educational people last year. There might be a meeting here in Washington of the committee of the State Health Officers, a committee of the American Hospital Association, your joint committee representing the Catholic and Protestant Hospital Associations, the American Public Health Association, the American Dental Association, the AMA, and perhaps the Association of Medical Schools. Perhaps there might be still other groups which ought to send representatives to such a conference.

Mr. Rosenfield, would you care to close the discussion?

MR. ROSENFELD: Mr. Bugbee succinctly indicated the problems that go into the determination of need, which is one of the basic problems. I would like to point to one issue which is very important in determining among yourselves which of the various ways that Dr. Parran has indicated might be the best. There will be two allocations on the basis of need: one on the Federal level, and one on the State level. Take microscopes. Microscopes are medical supplies, clearly; educational supplies, clearly; but the food and drug people use microscopes, and all sorts of private laboratories use microscopes. So that somewhere in Washington someone is going to have to determine which groups get 4,000 microscopes suddenly declared surplus in Tampa, Florida, or Philadelphia. How many go to commercial use? how many go to health? how many go to education? Someone here in Washington must make that decision, and someone must tell the person who makes the decision what the facts are from the point of view of the medical and the health issues.

There are many things you want on which that kind of determination is going to be made. Let's take sheets. I don't suppose the hospitals can operate without sheets; you certainly can't run boarding schools without sheets; and clearly sheets are an item of extensive commercial sale. So you have that type of problem. The question of need is going to have to be settled on the Federal level.

Secondly, you are going to have to settle it on the State level. What are the relative needs of the various agencies? Some States, of course, have centralized purchasing, and some States have an over-all Board. Someone is going to be in

there pitching for health on both the Federal and the State levels of determination.

I don't know that I have anything more to say except that we are extremely grateful for what advice we can get.

(The meeting adjourned at twelve o'clock.)

WEDNESDAY AFTERNOON SESSION

April 11, 1945

The meeting convened at two o'clock, Dr. L. R. Thompson presiding.

CHAIRMAN THOMPSON: Dr. Reed, will you go ahead with your discussion?

THE ROLE OF SCHOOLS OF PUBLIC HEALTH

DR. LOWELL REED:

Reviewing the role of the schools of public health in the training program, there are several things to be kept in mind. The first is that the schools themselves are in a constant state of evolution, and have been ever since they started. The first school, at the Massachusetts Institute of Technology, began with an integration of biology and sanitation. It was followed by the schools that first aimed at training medical administrative health officers, and that have since broadened to include a number of different concepts. So we should keep it in mind that schools are not static. They are constantly shifting and changing, hoping that they are improving.

The second thing to bear in mind is that schools of public health are graduate schools associated with universities. Most of our students have, when they come to us, a medical degree, an internship, a graduate degree in some science related to public health, or at least they have a collegiate degree with, usually, considerable experience in the field of health.

Then, also, as we look at public health training we will have to remember that it has at least three main phases. There is the problem of procurement and orientation, that is, getting the people that are to be trained and orienting them to the field of public health. Then there is the question of academic training. Thirdly, is the question of what we call experience training or in-service training. We should understand the difference between those three fields if we are to understand the position of the schools.

In the early days, when the schools were being founded, it was thought by many people that they would be automatic instruments for procurement. I think our experience contradicts that. We have learned since that time that the schools are not going to attract their quota of students. We have found out that it resolves itself into the opportunity existing in the field of public health, and that, in a very fundamental way, procurement rests with the health officers. As positions for people in public health are created, we find it easier to procure the people that we need and to train them. So, although schools of public health have been and will be active in attracting people to the field, we shall have to look to the opportunities in public health itself to do the real job of procurement. We see that illustrated in the schools themselves. The best students that we get come from the areas where there are the best opportunities.

The second thing that I would like to discuss is the question of in-service, or experience, training. In the early days, it was considered a responsibility of the school to provide what was called field experience. It was planned that the schools would set up field areas, and put their people out in these field areas. From that they were supposed to be trained, in the sense of having practical experience.

We have found that this does not work, because real field experience, real in-service training, is dependent upon the student's having some responsibility assigned to him. He gets his in-service training only if he has a job in public health that he is responsible for. The schools do not have responsibility in any sense for administering public health. They cannot delegate responsibility to their students, and so they cannot give the kind of in-service training that we feel our students need.

We need in-service experience as a part of our training in administrative public health. It should be developed under control of the health officers, with cooperation from the school. We might develop programs in public health comparable to internships in medicine, with positions available to students in the early days of their development, positions permitting them to spend a limited time in health offices, with assigned responsibilities of a defined character. Thus they could get the practical experience that they need.

If we are to have any programs of in-service training such as that, cooperation by the public health officers and the schools is necessary. We should have to have some approved mechanism, since good student training implies that the head of the area is interested in developing young persons around him. And so I would like to see, at some time in the immediate future, consideration of the development of a broad in-service training program for people entering the field of public health, a program that is cooperative between the health officers and the schools, but one that would mainly be dependent upon the health officers, since they are the ones who would have to provide the places for these people to get their training. The approval of such areas might well be in the hands of the American Public Health Association. I am quite certain that, like internships, they would have to be approved. They could not be just picked up hit-or-miss.

When I make these remarks, I am sure it raises a question about the training areas around the schools themselves. From the very start, schools have had field training areas that they have used. Initially we thought those training areas would be those in which we would give our students experience, but as the schools have gone on we have realized that isn't possible, since there would be too many students in a given area to use it for in-service training. These areas, however, constitute extremely valuable laboratories for public health departments. There students can carry out studies of various administrative problems, but he is not likely to get all the experience of administration that we think he should have. Do not confuse the areas for in-service training with the specific areas around the school, such as, for example, the Eastern Health District in the vicinity of our own school.

Academic education in the schools of public health is a rather complex question to review. The educational program is wide, and it covers a good many fields. Since the last war, practically all schools started with the concept that they would train administrative health officers. They aimed at producing medical men who would become health officers in counties, districts, and States, and administrative officers in the Federal Government. Time, however, has extended that training very much. We have found that our administrative course has been sought out by a variety of people who were going to administer in other fields.

This shows up in several ways--in the desire of people who are to administer nursing programs, sanitary programs, dental programs, to be admitted to such courses. It shows up in the extension of these administrative courses to people who are going to administer specialized programs in such fields as tuberculosis and venereal disease control.

Experience with graduates of these schools brings out an interesting point. Recently I surveyed the records of all graduates of our school who had taken public health degrees, either the Master of Public Health or the Doctor of Public Health, and who were in service in this country. I found that all but two of them were in the field of public health at the present time. That rather surprised me,

because I thought we had more that had been dropped by the wayside. Equally interesting, 30 percent of these graduates were not in organized, tax-supported health departments; they were not in State, county, or city health departments. They were in the foundations, administrators of medical care programs, administrators of hospitals, administrators of special health private agencies of one kind or another, or they were in the universities teaching public health. And so I think you should remember that there are 30 percent of the graduates who have left organized public health, in the sense in which we started our training, but have gone into activities that are equally valuable. I think we may expect that in the future schools that train administrators of this sort will find that their graduates will continue to be drawn off into these other fields.

Most of the schools have been extending the concept of their basic course directed toward health administration, and, instead of confining it, as it was in the initial days, to a course designed to train health officers to administer areas of certain types, it is now thought of as training for broad health administration. The schools are planning to extend that course to people who will administer medical care programs, or be hospital administrators. Several of the schools already are engaged in setting up a course for hospital administrators, looking forward to the hospital programs that are being discussed.

Increased opportunities for administrators of specialized programs, such as venereal disease and tuberculosis control, has resulted in the schools extending their opportunity for clinical training. That development started with communicable diseases, with the schools opening up opportunities for students to do postgraduate clinical work in that field. That program has now been extended to include pediatrics, tuberculosis, and syphilis. In some of the medical schools, the best postgraduate clinical work is being done in the schools of public health. It is rather surprising to see the number of men doing postgraduate clinical work in these schools.

Aside from the basic administrative course that has these elective variations, all of the schools offer training in basic sciences: they offer to train certain people as biochemists, bacteriologists, statisticians, protozoologists, entomologists, and so on. Most of these students are graduate students taking a science degree, usually Master of Science or Doctor of Science, or Ph.D., through this training.

The pattern of courses of study varies, of course, according to the school, but there are one or two observable trends. The schools are tying more public health courses to this type of training. That is, students that initially were allowed to come into the schools and concentrate completely upon their science, their bacteriology, or biochemistry, with very little in the way of public health training, are now being required to take certain basic courses in public health. We will, I think, turn out better students, since they will be trained as scientists but will also know something of the field of public health.

There is one other question that I would like to speak of, and that is the question of approval of schools. It has been a troublesome problem. The schools themselves have discussed it in their Association of Schools of Public Health. At the present time we have a questionnaire that is being filed with the Association by all the schools. It will provide much information needed to determine approval.

The suggestion has been made that the Association of Schools of Public Health itself act as an approving body. I, myself, think that is unwise. I think the proper approving body for the schools of public health is probably the American Public Health Association. The schools are having a meeting shortly and the matter will come up for discussion. The necessity for approval is, I think, apparent to all of you. We have seen schools of public health spring up in considerable number over the country, schools which under no circumstances could provide the necessary training.

I would like to close by emphasizing that the schools of public health have been constantly in a state of change. There never has been a feeling of satisfaction with the training offered. We have always been struggling to do more. All of the schools would welcome criticism and suggestions from the health officers. If you have ideas about school development, I know that every school would like to know about them. If you wish, you might send those ideas to me, as President of the Association of Schools of Public Health, and I will see that they get the attention of all of the schools.

CHAIRMAN THOMPSON: Thank you very much, Dr. Reed. Since all these papers on training deal with different phases of the same subject, possibly we had better leave the discussion until all of them have been presented.

Dr. Parran has asked me to ask you, Dr. Godfrey, if you will make your report of the Committee on Federal-State Relations at this time.

REPORT OF THE COMMITTEE ON FEDERAL-STATE RELATIONS

DR. GODFREY:

I will first go over a few items that the committee considered about which there was little or no difference of opinion.

We were pleased to note that there would be regulations forthcoming which would clarify the procedure for approval of laboratories producing smallpox vaccine. At present, those regulations require considerable research before you can find out just what they mean.

The proposal that regular formulas for allotment of State funds to the local communities within the State be drawn up was disapproved. It was also felt that such a formula should not be made a requirement of Federal regulations. It was believed, however, that we should study the experience of States that have adopted such a plan.

There has been a complaint by a number of large cities that the amount of funds which they have received has been small in comparison with the tax funds which they have contributed. Especially complained of was money for basic purposes, formerly under Title VI. It was explained that this money is primarily used to give a widespread coverage of full-time personnel to places that formerly had no such services; that it was not to improve the quality of care and the amount of care that might be given in the larger places but merely to supply the obvious deficiencies that might be there; that due to different State laws and policies, no fixed formula should be required.

Consideration of the proposed new regulations regulating the submission of reports and plans was referred to a subcommittee of the committee. Two State fiscal officers, Mr. Shoro of New York, and Mr. Kirkman of Maryland, met with Dr. Bierring and Dr. Riley of the Committee. This subcommittee reported substantial agreement with the representatives of the Public Health Service during an all-afternoon meeting. Discussion was in so much detail that I do not think it should be presented at this time.

With reference to the disposal of surplus property, the committee voted the following: "Our understanding of the Surplus Property Act leads us to believe that the preference provisions relating to health and medical supplies cannot be administered effectively outside of the Surplus Property Board and its disposal agencies, the RFC and Treasury Procurement, among others. Accordingly, it is recommended that the Public Health Service should not set up a division involving the regional and sectional offices for the disposal of surplus health and medical supplies in connection with Section 13 of the Surplus Property Act. To do so would drain off personnel needed for more essential public health service.

"It is further recommended that the Public Health Service, within the limits of its available personnel, should furnish technical advice when and if requested by the Surplus Property Board. The Association recognizes the great contribution which can be made by the wise disposal of surplus medical and health supplies, and believes that the Surplus Property Board and its disposal agents should agree to establish a strong staff of professional personnel, experienced in the business of health and medical supplies.

"It is further urged that the Surplus Property Board seek the advice of the many professional societies concerned with health and medical services."

I move the adoption, Mr. Chairman, of the report.

(The motion was seconded, put to a vote, and carried.)

DR. GODFREY: I would like to enter for the record, Mr. Chairman, that this report was adopted by the Association at its meeting last night.

CAPTAIN WATSON MILLER: Mr. Chairman, may I say just a word? What Dr. Godfrey says about the undesirability of draining off technical personnel that is needed in what his committee regards as more vital fields may be true, but there is no way in which the Federal Security Agency may, so far as we see it, remain in a neutral position in this matter. As I interpret the Administrator's viewpoint, there just isn't any way that we can avoid the responsibility that is sought to be placed upon us by the other branches of the Federal Government.

DR. GETTING: Mr. Chairman, I think it would be rather unfortunate to request the health departments on the State level to enter into this matter of surplus property, for the simple reason that most of the health departments are already so overloaded with work and so short-handed that they could not adequately handle the problem. Moreover, the procurement of personnel for health departments is contingent upon the releasing of certain individuals on a lend-lease basis from the Public Health Service and additional releases from the military service. Speaking for Massachusetts, and perhaps for some of my colleagues, I would hate to see any program which would interfere with the availability of public health personnel.

CAPTAIN MILLER: I think that viewpoint should be recognized, of course.

CHAIRMAN THOMPSON: Is there anybody else who has any comment?

DR. EIERRING: Would you ask Miss Switzer if she would say something?

MISS MARY SWITZER: I think there should be a united front on the part of professional organizations in their negotiations with the Surplus Property Board. I hope that some way can be found to bring together, under the auspices of the Public Health Service or the Federal Security Agency, or both, a representative group of this present organization, of the AMA and the Postwar Planning Committee of that group, and any other professional organization that has an interest in this field. If there isn't some considered group thinking on the problem, I am sure that there is much to be lost in the future.

CHAIRMAN THOMPSON: Mr. Rosenfield, do you want to make any further comment?

MR. ROSENFELD: With reference to the comment made by the gentleman from Massachusetts, I should have made it clear that in the request of the Surplus Property Board to the Agency there was, both implicit and explicit, an understanding that there would be a transfer of Federal funds to the States, whatever basis was worked out. The Federal agencies, that is, the disposal agencies, are fully aware that this activity would require an organizational expenditure which was not now and couldn't reasonably be expected immediately of the States.

The only other comment I have is that someone is going to do this job, you can rest assured of that. It is either done the way you want it, or it is done without asking you. I have the feeling that if the Public Health Service and those with whom it deals, such as your good selves, don't take the job in hand, it is going to be done by people who are not sympathetic to the purposes which you might have. In other words, it is going to be done by a group of people who are going to be selling it to get every last cent out of it, and since, as I gather, everyone feels that surplus property is going to be useful to you and to the interests that you represent only to the extent that you get it for very little, you should get in there and pitch. Otherwise, I suspect, you are not going to get very much of it for very little. What is going to happen is, that it will end up in the hands of speculators and you will pay pretty near normal prices.

CHAIRMAN THOMPSON: We have one more report, the Committee on Tuberculosis.

REPORT OF THE COMMITTEE ON TUBERCULOSIS

DR. BLACKERBY:

Careful consideration was given to the plans of the Public Health Service as outlined in the statement presented by Dr. Hilleboe at the first meeting of the Conference. It was unanimously agreed that the Conference approve the objectives of the Public Health Service in the following categories: Case-finding; training of personnel; and treatment and isolation.

On training of personnel, it is recommended that the Service stimulate the development of additional facilities for the training of public health nurses for supervisory services, as apparently there are only limited opportunities for such training at this time.

It is also recommended that encouragement be given to laboratory technicians better to qualify themselves in techniques of tuberculosis findings and interpretation.

It is also recommended that more physicians be trained for tuberculosis field programs and hospital administration.

In carrying out mass radiography, the Committee recommends that preference be given to the following groups in this order: (a) all hospital admissions, both in-patient and out-patient, including general hospitals, special hospitals, and custodial institutions; (b) all workers in industry; (c) school teachers and students of higher grades in secondary school and students in college; (d) special groups of the population, where morbidity and mortality rates are high.

It is recommended that more intensive epidemiological studies and investigations in the field of tuberculosis be made, and that case follow-up work be considered just as essential as case-finding.

It is recommended that attention be given to the need for social investigations into family economic circumstances and facilities for isolation better to safeguard those who are well, and promote resistance to the disease.

The United States Public Health Service is hereby requested to contact the Veterans' Bureau with a view toward having that agency provide for compulsory notification to State and local health authorities of cases of tuberculous veterans within the health officer's jurisdiction, and also to inform such health officers whenever a veteran with tuberculosis leaves a hospital where he has been under treatment.

Medical care and isolation: It is recommended that for the present, the Conference approve the plans of the United States Public Health Service in the use of grants-in-aid to apply only for developing more adequate facilities for case-finding and follow-up, together with the training of personnel.

It is recommended that the Public Health Service undertake at an early date to secure appropriations from Congress for tuberculosis hospital construction and maintenance in both general and tuberculosis hospitals, as is authorized in Public Law 410.

The Committee was instructed by the Association to refer to tuberculosis tests (Mantoux) in closing the report, and to suggest that the tests may be useful in surveys among school children.

I move the adoption of the report.

(The motion was seconded, put to a vote and carried.)

CHAIRMAN THOMPSON: We will now hear from Mr. Perrott.

A COMPREHENSIVE TRAINING PROGRAM FOR PUBLIC HEALTH PERSONNEL

MR. G. ST. J. PERROTT:

From the immediate prewar years to the present, the State and Territorial Health Officers have made an important contribution to the expanding training program for public health personnel. The major development of the prewar period was the provision of training opportunities under the terms of the Social Security Act, which anticipated the shortage of trained personnel that would confront health departments seeking to organize or expand. The onset of war created new shortages of public health personnel, leading to the development of emergency training for replacements, and for the new personnel required in war emergency areas. War is providing an additional stimulus to the training program, as demobilization creates the need for the education and training of veterans entering employment in public health, or returning to prewar jobs in this field. In recognition of the importance of this program, your Committee on Personnel at the 1944 Conference pointed out the desirability of the appointment in the State Health Departments of a personnel officer "to follow through on this new re-training and re-employment program now while it is in a developmental stage."

The next step is to prepare for the postwar period by the formulation and implementation of a comprehensive training program for the varied personnel required in an integrated national system of health and medical services. Some of you may recall the name of Lewis Meriam as an expert in the field of personnel training for the public service. Meriam's advice was: "Do not train for a specific class of positions without getting statistics, keeping statistics, watching statistics." As a basis for the postwar training program, we must heed this advice, get statistics on the number and types of public health personnel to be trained, and watch the statistics on the capacity of our schools of public health and other educational institutions to train them. The content of the training program must be appraised and adapted to present and postwar needs. Is it providing sufficient training in administrative methods for the health officer of the future who may be called upon to direct a rural health center which includes a small hospital, and provides not only preventive services, but a complete program of home, office and hospital care of the sick? Is it providing sufficient training for the average health officer of the present, who requires formal training in public administration as well as public health, and field experience prior to the assumption of his full duties? Another major responsibility of a comprehensive training program is the coordination of the Federal, State and local official health agencies, the national professional health associations and other national nonofficial agencies in a plan of technical cooperation. Finally, a broad training program must be implemented by adequate financial aid.

At the suggestion of the Surgeon General, the Public Health Service, in June 1944, took the first step toward the development of such a comprehensive program by the organization of a Committee on the Postwar Training of Public Health Personnel. I have had the privilege of serving this Committee as Chairman. It is on the Committee's recommendation that this session of the present Conference has been arranged, for the purpose of describing the nature of the comprehensive training program we envisage, and the more urgent problems requiring attention.

Scope of a Comprehensive Training Program

With respect to scope, a comprehensive personnel training program resembles the program of a local agency in three of the elements with which it is concerned, i.e.,

Recruitment of personnel

Induction training

In-service training

However, the scope of the comprehensive national training program widens to embrace a fourth major field, which may be described as pre-entry, or pre-employment, or pre-service training. We may review the relation of these four aspects of the over-all personnel training program, noting briefly the contribution to each of the institutions providing academic training.

I. Pre-employment Training

Under pre-employment training is included the basic professional or technical training required to prepare prospective entrants to employment in the public health field. Such training may be limited to academic study or to field practice, or may include a combined period of academic and field training. The administrators of a comprehensive personnel training program would have a triple responsibility here to insure, first, training adequate in scope and content, second, educational institutions and field centers adequate in capacity to meet the National need, and third, to recruit trainees whose personal and educational qualifications adapt them to successful practice in the field in which they specialize.

The schools of public health occupy the central position among the educational institutions in this field, being concerned with pre-entry training as well as with training following induction. Since Dr. Reed has defined the broad role of the schools of public health in a comprehensive training program, I shall omit discussion of this important subject.

While the schools of public health represent the major educational institutions in this field, it should be noted that a large number of colleges and universities, both in their undergraduate and graduate departments, contribute to pre-employment training, providing basic and advanced curricula for public health nurses, sanitary engineers, laboratory workers and other professional and technical public health personnel. Under a coordinated, national training program, the central administrative agency would develop criteria for the approval of all training institutions participating, cooperating with professional groups such as the National Organizations for Public Health Nursing and the Committee on Engineering Schools of the Engineers' Council for Professional Development which have developed criteria in their respective fields. The formulation of such criteria would involve an evaluation of the curricula offered to various types of public health trainees, to determine the adequacy of their content as formal preparation for specific employment.

An intelligent evaluation of academic curricula presupposes the existence of complete statements of the training requirements of the varied positions in

the public health field. We owe to the American Public Health Association, in particular, to its Committee on Professional Education under the able leadership of Dr. Shepard, the development of a series of statements on the educational qualifications of public health personnel which meets this need; and in his address before the Conference this afternoon Dr. Shepard will describe the basis for the training requirements which have been formulated.

A comprehensive training program would include funds to support grants-in-aid of personnel research to extend job analyses as a basis for the construction of new or modified curricula. It is notable, for example, that the necessity for requiring the completion of an approved program of study in public health nursing by every nurse participating in the public health program is being questioned by leaders in the field of public health nursing, who, furthermore, contemplate the extensive utilization of practical nurses as assistants to fully trained public health nurses. It seems possible that sub-professional personnel could be employed in additional public health activities. However, the adaptation of pre-employment training to meet such new personnel needs will require a well-planned program of personnel research.

At present trainees are selected without very good criteria of their probable success after training. Several methods of recruitment are possible:

1. A short orientation period before admission to formal training. This procedure has been used with considerable success by the New York State Department of Health, and will be described later by Dr. Godfrey.
2. National recruitment by the Public Health Service. Such a method of recruitment is being practiced now for the training of health educators. In general, the trainees have been superior individuals. Some States that are anxious to recruit qualified health education trainees have asked the Public Health Service to send them the application blanks of individuals living in their State who might accept training stipends from the State.
3. Development of aptitude tests as a basis for recruitment.

In many fields it is possible to test the aptitude of an individual and measure objectively his chances of success in a given profession. No research to determine what can be done along this same approach in the public health profession has been attempted, but it is a problem worthy of consideration.

II. Recruitment of Personnel

Improvement of the terms of employment in public health through promotion of the merit system represents one of the essential steps to be taken in a long-term program to attract an adequate number of personnel to this field. The importance of this measure is fully recognized by the members of this Conference. An important approach to recruitment can be made through the medical schools and schools of nursing by appropriate emphasis of the opportunities for specialization in public health administration or service in a special field of disease control. One of the newer possibilities is recruitment among veterans. As a contribution to this aspect of recruitment, the Committee on Professional Education of the American Public Health Association has compiled a summary of the training requirements for

professional and technical public health personnel for the use of employment counsellors. The second step in the veterans' program, a survey of present and postwar openings in State and local health departments, will be undertaken soon by the Public Health Service. Financial assistance in the form of scholarships and fellowships to selected students who could not personally finance basic public health training should be provided as an aid to recruitment.

III. Induction Training

I use the designation "induction training" to include the training financed under Titles V and VI of the Social Security Act and the Venereal Disease Control Act, as well as the short courses devised to provide emergency training during the war. This training, provided to meet requirements which should have been satisfied before induction, should be distinguished from the in-service training of new employees which is an important element in every well-planned personnel training program.

The pattern of this aspect of the training program is generally familiar to the members of this Conference, and the proceedings of your previous meetings indicate your awareness of its defects. The preparation of personnel for the expansion of health departments promoted with Social Security Funds justified the prewar emphasis on induction training and its continued emphasis under the modified terms enforced by the war itself. However, it should be an aim of the postwar period to restore to the broad training program the balance which has been lost during the continuing shortage of trained personnel, placing major emphasis on in-service rather than induction training. Such a realignment of the training program, particularly as it affects health officers and other medical personnel of health departments, may be necessary as a result of the marked decline in physician trainees under Title VI and the Venereal Disease Control Act since the war. Physician trainees, which numbered 332 in 1941, fell to 205 in 1942, to 88 in 1943, and to 51 in 1944 (fiscal years).

IV. In-service Training

The purposes served by the in-service training program have been aptly summarized as follows:

1. To make up for deficiencies in technical and scientific information required for the job generally;
2. To enlarge the outlook and understanding on the specific job;
3. To acquaint the staff with the fundamentals of personal and public relationships in order to encourage smoother functioning of the day-to-day job;
4. To keep the staff abreast of newer, technical, procedural and administrative developments as derived from experiences in other jurisdictions.

A variety of methods has been used to promote these objectives, including the following:

1. Orientation course
2. Field orientation in a well-organized health department or demonstration center
3. Conferences
4. Institutes
5. Staff meetings
6. Refresher courses
7. The more intensive type of practical experience comparable to the internship which industry has developed for the training of executives.

Field experience, provided either as a device for selection of trainees or a method of training, forms the subject of an address to this Conference by Dr. Godfrey, and I shall therefore omit any detailed consideration of the problems involved in this area of the training program.

The content of in-service training necessarily varies according to the needs of the employee group, which may be newly inducted or composed of old employees, of administrative or service personnel, professional, technical or sub-professional workers. The field of instruction may be the general public health activities of the agency, those of a single class of personnel, such as public health nurses, or the activities in a specialized field such as the control of venereal disease, tuberculosis, or malaria and other tropical diseases. The responsibility for arranging for the approval of field training centers, the provision of necessary supervisory and educational staff, and the general planning of in-service training for State and local units would be assumed by the central administrative agency in a national, coordinated program.

The Nature of the Training Program

In January 1942, Federal, State and local official health agencies employed approximately 12,500 professional and technical workers, including sanitation personnel, but excluding public health nurses. It is estimated that immediate postwar expansion of the public health program even to the level defined as adequate ten years ago would require personnel numbering upwards of 29,000, again excluding public health nurses. The nature of the increase in specific types of personnel is shown in the following table:

Type of health department personnel	Number of personnel in Federal, State and local official health agencies	
	Prewar (January, 1942) ^{1/}	First postwar year, level of adequacy as defined by Hiscock ^{2/}
Total	12,560	29,090
Physicians (health officers and administrators of special activities)	3,100	5,500
Dentists	360	4,280
Engineers	1,140	2,770
Sanitation personnel (except engineers)	3,650	8,500
Laboratory personnel (professional and technical)	2,670	4,880
Health educators	400	1,660
Other technical personnel	1,240	1,500

^{1/}With the exception of health educators, all State and local figures projected on the basis of the survey by Perrott, G. St. J. and Dorn, Harold F.: Current Needs for Health Personnel, Pub. Health Reports, 57: pt. 2, pp. 997-1000, (July 3, 1942). Federal figures are unpublished estimates by Mountin, Joseph W. and Flook, Evelyn (U. S. Public Health Service).

Figures on health educators from Shepard, W.P., Chairman, Committee on Professional Education, American Public Health Association, Proposed Report on the Educational Qualifications of Health Educators, Am. J. Pub. Health, 33: 998-1002 (August 1943).

^{2/}Unpublished estimates by Mountin, Joseph W. and Flook, Evelyn (U. S. Public Health Service), based in part on Hiscock: "Community Health Organization," except health educators, estimated by C. M. Derryberry.

These figures indicate the personnel to be reached in an expanding in-service training program. Over-all planning requires additional estimates of the number of students who may pursue public health training prior to employment in the field, as well as the number who may be admitted to training after induction. Estimates of the probable training load for each of the major types of personnel will be essential as a basis for planning the necessary extension of the facilities of existing educational institutions, the possible need for new academic facilities, as well as the field and demonstration centers essential in an integrated system of formal study and field training.

Both the pre-employment and in-service phases of the training program should be planned with reference to the immediate and long-term prospects for employment of special categories of personnel. The war has intensified the demand for physicians, nurses, engineers and chemists trained in public health work, for service in the field of industrial hygiene. The acute shortage of industrial hygiene personnel may be expected to continue in the immediate postwar period. Health educators represent another type of personnel for which the war emergency has increased the demand. The personnel inducted into such rapidly growing fields are relatively young compared with employees in the established field of general public health administration, for example. In the latter field, in which the retirement rate is relatively high, the training of replacements will form a higher proportion of the training load than in the newly developed areas of public health. It should be noted, however, that present trends in medical care point to an increasing need for physicians with training in public health, including administration, to serve as directors of medical prepayment plans, hospitals, nonofficial health organizations and welfare agencies concerned with public medical care. Thus, aside from the health officers and other medical personnel who will be required in the continued expansion of our local health departments, the movement toward increased organization of medical services is increasing the demand for physicians with basic training in public health.

Finally, appraisal of the training requirements of public health personnel should be made to determine an economical allocation of the training load between the schools of public health and related departments of graduate schools, as well as the undergraduate departments of colleges, and the technical and vocational schools.

Federal--State Relations, and Official Versus Nonofficial Responsibilities

What role should be assumed by the Public Health Service in a comprehensive personnel training program? How should the State Health Departments be integrated in the training activities? What criteria shall determine an appropriate division of responsibility between the Service, for example, and the American Public Health Association? What are the areas in which the foundations and other nonofficial agencies can contribute most significantly? Such questions as these can be considered only briefly and tentatively here, but they suggest the nature of the numerous preliminary problems to be solved.

It may be assumed that the Public Health Service would provide technical and financial aid to the States in support of State and local training activities according to the general pattern developed under Title VI. However, the objectives of Federal aid would not, as at present, be limited largely to the promotion of induction training, but would extend back to pre-employment training, and forward, to in-service training. A central office in the Service under the administration of an Educational Director would have as one of its functions the provision of a consultant service to the States in matters relating to the training program of small jurisdictions. As a second function, the central office would cooperate with the District offices of the Service in planning in-service training activities for State Health Department personnel. In addition to these cooperative services, the central office might serve as a screening center for the selection of trainees, and the direct recruitment of certain types of personnel, by conducting orientation courses and operating field orientation centers. Personnel research, the development of criteria for the approval of curricula and field training centers, and the coordination of statistics on personnel and training needs would be included among the general activities of the central office.

Aside from the conduct of their own personnel training programs, the State Health Departments would assume responsibility for personnel training in the small local health agencies. Selected State Health Departments might be called upon to maintain field training centers to be utilized on a regional basis. With respect to organization, the large State Health Departments would require a personnel unit headed by an Educational Director. As has been noted previously, your Conference has already recommended that the States appoint a personnel director to coordinate veteran training and employment.

The long experience of the American Public Health Association in the field of professional education, combined with its position as the professional organization of workers in public health, suggests it as the appropriate agency to appraise the schools of public health and the curricula of other educational institutions training public health personnel. Such an appraisal would be followed by its recommendation of the various educational units for approval. The evaluation and approval of field training centers would represent another activity appropriate to this association.

An example of a proposed project supported by voluntary funds, which will make a valuable contribution to education and personnel training, is the educational program for hospital administrators developed by the W. K. Kellogg Foundation. This project is of special interest in connection with the recent endorsement by the American Public Health Association of a national health program.

In conclusion, I should like to quote from the Association's official statement on this program, Recommendation VII b, as follows:

"State health departments should utilize those funds that may be available to train personnel in such technics as administration of health and medical services, and hospitals. Such a training program may contribute more than any other single activity to the future role of the official public health agency."

CHAIRMAN THOMPSON: Thank you very much, Mr. Perrott. Dr. Godfrey, will you continue the discussion?

ORIENTATION AND COMPLEMENTARY FIELD TRAINING

DR. E. S. GODFREY, JR.:

I want to confine myself to the training of physicians for work in public health.

We speak of orientation and complementary training. Orientation, I think, really means the selection of personnel and their introduction into public health as a career. It is a mutual determination. Many physicians are not acquainted with the background, the future, or the everyday work of public health departments, and it is just as important that they ascertain that it is a career upon which they desire to enter as it is for the administrative officer to know that he is a person suited to that kind of work.

There have been suggested some three different types of courses. One is an internship in a going concern, which is not particularly complete, and is certainly not a demonstration. That is the type of organization which we have in New York State generally.

Then, for the schools which recruit their own students and desire field training, there may be subsidized health departments which provide some sort of internship or observational experience supposed to give them an insight into what public health is and to show them something of the way in which things are done.

There is another type which is very little different from that: observational training in highly developed departments of health. This is primarily intended as a demonstration of what public health can do if supported by adequate funds and personnel.

I think that placing trainees under a so-called Educational Director and having their work done under the supervision of somebody besides the administrator of that health department, and not having them take a part, actually, in the performance of the duties of that department, is going to be a serious handicap to any training. In fact, I can't quite see how they would get training under that system. The training load will have to be accommodated to what the existing facilities of the health department are.

We know today that in our own health departments a considerable amount of time is required of the district health officer during the period of selection and so-called orientation or introduction, and it is not until they have been with the office for approximately three months that any work of value is returned which is commensurate with the amount of time that is spent by the administrator in guiding them.

I have had no experience with the subsidized type of health department. In reading over the report of the Kellogg Foundation, which I think has developed this system of field training more than any other, I was struck with the inadequacy of the observational course, which does not exceed a month. Then they have a higher step which lasts about three months, and then another higher one which goes on for nine months. I can see some virtue in a three-months field training if it is purely for the purpose of selection, and nine months if it is for the purpose of actual training.

There is one thing that I think needs to be thought about in connection with recruitment, and that is, that there are a number of good examination passers who do not possess the personalities that are necessary to individuals who are to administer public health work, or any of the related fields of work which have been mentioned by Mr. Perrott and Dr. Reed.

This period of selection should, I believe, continue throughout a year. It should not be less than three months. Our own experience has demonstrated that we cannot determine within three months accurately the whole possibilities of the individuals who apply for such training. We have had some individuals, of course, where we could tell within a week that they were of exceptional ability; with others, it has taken as long as a year to determine suitability.

There is a strong tendency, as you may know, when an individual is set in a civil service job to think that his work is done, he is finished and he is in. And it is a very hard thing to get him out. After the probationary period, the quality and the quantity of his work may drop quite severely.

Just a note about the selection of schools for individuals. I think that any health department which concentrates on one school is making a mistake. As I have been privileged to hear the deans of several schools of public health during this past winter, I have been struck with the variety of concentrations, as you might call it, in the different schools throughout the country. One is better in this field and another is better in that. I think it is important, too, from the standpoint of morale that you not have a Hopkins group and a Harvard group and a Columbia group, and so on, so that you have cliques formed within the organization. They are not conducive to an over-all appreciation of duties and obligations to the health department.

Our whole system of education and training of physicians was published in the Journal of the American Public Health Association some five years ago. We have modified it very slightly. I have in mind the idea of having a personnel board rather than an individual to make the selection, because I think there are different aspects to the qualities that are needed, and that sometimes one man with an obsession in one line and another in another line may have different ideas, not only in the way he presents the future to the individual but in his judgment of the individual's characteristics. Our system of selection, however, is not based on any one individual's estimate; it is based upon the estimate of a number of the district health officers under whom these men work, as well as that of the several division directors, especially the director of the local health administration. He is most closely in touch with the situation, and knows the qualities and the adaptability and aptitudes of the physician in training.

In the complementary training, the one feature that I think we have found quite important is the training in business management. We had a course which was conducted by the Maxwell Graduate School of Citizenship and Public Affairs of Syracuse University. It was attended by all of our district health officers and assistant district health officers, many of them older men who had never had any formal postgraduate training in public health.

This course in business training was a two-days-a-week course, given over a period of about three months. I feel it is one of the most important things that we did in getting business methods into the public health work. It is a deficiency which I have spoken about quite frequently during the past winter when we have had conversations with the deans of the schools of public health.

The situation in New York State when I took over the job of local health administration under Dr. Parran was that we had fifteen districts, and fifteen different filing systems, and we had fifteen different ways of doing everything that was done, with the exception of the techniques of investigations and things of that

sort. Those are things that lend themselves well to regimentation, if you want to call it that. A district health officer going from one district to another should know where to find things as well as in his own district.

I also want to say of the physician in training, that if when he enters the school he doesn't know how to write English and how to set up a letter, he ought to be taught that, too; and above all things, I think he ought to be taught how to think and to use the English language correctly. It seems to me quite remarkable that we should have so many who are graduates of colleges, medical schools and schools of public health who seem incapable of expressing themselves tersely and logically.

CHAIRMAN THOMPSON: Thank you, Dr. Godfrey. Dr. Shepard:

JOB ANALYSES AS GUIDES TO TRAINING REQUIREMENTS

DR. WILLIAM SHEPARD:

Public health is coming into its own. It receives much more of the public support which it deserves. Official health departments are becoming, in fact as well as in mind, a major function of government. None of us wastes time longing for a return of the old days. Public health is on the march and we are fully occupied with a rapid and fruitful advance. One of the problems we discuss most often these days is personnel, their selection and management.

Surgeon General Parran in his dedicatory address at the University of Michigan School of Public Health said, "The tripod upon which the public health structure of any country rests is:

1. A force of well-trained personnel.
2. The appointment, promotion and retention of personnel on a merit basis.
3. Adequate financial support, evidencing public understanding of the problems involved."

It is my contention that the third, adequate financial support, depends largely on the other two, well-qualified and properly handled personnel. That is what I wish to discuss with you today.

Great advances are being made in personnel selection and management. These new techniques are as important to the public health administrator as new methods for the control of communicable diseases. We can no more run a modern health department with rule-of-thumb personnel policies than we can depend on the olfactory sense to diagnose diphtheria.

Few here would deny that public health is a specialty in which both post-graduate training and practical experience is highly desirable. While an M.D. or R.N. without special training has often done very well in public health in the past, nevertheless, speaking generally, the individual with special training will do better and go farther than one similarly equipped but without special training. Certainly a young person seeking a professional career in public health today should be advised to obtain postgraduate education. That being the case, what kind of education is most desirable? It has been our custom to recommend one of the well-established schools of public health. Are they doing the job we need done?

In discussing these questions with health officers, there is pretty general agreement that their personnel do benefit from courses taken at schools of public health and that they bring back much of value to the community, and to the rest of the staff. They do, however, voice two main criticisms.

The first objection expressed by health officers to the results produced by schools of public health merely reflects the age-old difference in viewpoint between "those who do and those who teach." It is that the student gets too much theory and not enough practical instruction. Specifically, there is too much bacteriology and laboratory exercise, too much detail in statistical methods, too much philosophy and historical background.

The second objection expressed is that there is too little teaching of the things the health officer must do or know personally, such as: business administration (including correspondence, office management, personnel management, delegation of authority), political science and theory of government (including government and public health law), public speaking, health education, school health and community organization. In addition, there is sometimes expressed a desire for more knowledge of the background and potential values of public health nursing, medical social work and teaching.

These criticisms are supported by the fact that few health officers fail because they lack public health knowledge. There have been many examples of successful health officers whose public health knowledge was sketchy at best, but who were past masters at statesmanship. Failure, or at least lack of conspicuous success, is more often attributable to such things as lack of administrative knowledge, inability to understand people, failure to exert community leadership, lack of knowledge of community organization. Perhaps these are qualities that cannot be taught, but I doubt it.

In defense of the schools it must be pointed out that they are primarily institutions of higher learning. They are not vocational or trade schools. There are so many good ways of accomplishing the same results in public health administration that the last thing the schools wish to do is freeze the student's thinking. Their purpose is to encourage original thinking, based on sound knowledge of underlying philosophies. Only by such original thought can progress be made. The last thing the health officer would want is a recent graduate who is indoctrinated with the "one and only way" of doing things as taught at a given institution. He is likely to have his own pet "one and only" way, and will often expect the new appointee to accept it without question. The purpose of the schools, then, is to try to strike a happy medium between theory and application.

It is a fact, however, that teaching public health as a specialty is relatively new when compared with medicine, law, or engineering. It is quite different from teaching medicine, in which many indisputable facts must be taught; then the application of these facts demonstrated in the clinic.

It is also a fact that some schools of public health have, perhaps necessarily; had to build their curricula by means of the professor's introspection; that is, how he did things and why. This method may suffice for a time, but it is likely to lead to incompleteness, antiquation, and sometimes even distortion.

One method of keeping the teacher currently abreast of the changing demands upon his students is through occasional job analyses. In vocational schools the job analysis is the guide to the curriculum. This is because there is but one, or at most a few, best ways to lay brick, cut stone, operate a turret lathe. Not so with public health, where there is an infinite number of good ways to preserve and improve community health. Furthermore, we are seldom assured that any of our present methods are the last word. Public health work is a profession, not a vocation. Its advance, therefore, depends upon minds with a rich cultural and scientific background and practical ability.

Nevertheless, job analysis may offer a useful adjunct and guide to curriculum construction in schools of public health. There is a well-recognized technique for job analysis, which it might be interesting and helpful to apply to the work of the health officer. Briefly, it consists of listing all the different

things that the health officer actually does. When the list is complete, it is broken down into related and similar functions, then the educator and the health officer try to agree on what types of training are needed to best carry out these functions. Does anyone know exactly what the health officer does, and what proportion of his time is spent on each duty? From my observation, they spend a great deal of time on activities never learned at school. Perhaps they are functions that cannot, or should not, be taught for fear of indoctrination. But it would be interesting to find out. Possibly the Public Health Service could spare personnel to make a few analyses to see what they are worth.

One thing is certain, and it concerns all who are interested in the training of our future health officers and other public health people. There is a great danger of numerous and inferior schools of public health, attracted by Federal stipends springing up in this country. This possibility is increased by the attitude of some State fiscal agents who dislike to spend money outside their own State, even what was federal money to start with. State health officers must do all in their power to break down this prejudice by pointing out that:

First. It is far better to have a few good schools than to have inferior ones in every State.

Second. The volume of public health personnel applying for training in normal times will probably never justify as many schools of public health as there are medical schools; probably ten or twelve good ones would suffice.

Third. The best of training is none too good for those who will be entrusted with preserving the health of the citizens of the State.

Fourth. Such training is a complicated and expensive process requiring teaching personnel and facilities far beyond the resources of most States.

If this is not done, we are threatened with the diploma mills of two generations ago. This is a serious menace, and it merits the most careful consideration of this body. It is already being studied by the Association of Schools of Public Health and by the Committee on Professional Education of the American Public Health Association.

So much for the training of public health personnel to which this session is devoted, and for an important part of the first leg of Doctor Parran's tripod. When time permits, this group might profitably spend some time considering the best and most modern methods of selecting qualified personnel. The Committee on Professional Education feels that it has in its Merit System Unit a modern and helpful device for this purpose. Examinations of the most modern kind have been given in more than 100 localities, and demands for our services are increasing daily. These examinations are furnished States and cities at cost. They are proving far more trustworthy than anything we have had heretofore, since they test judgment as well as knowledge, and place less reliance on the glibness of the good talker and good writer. The method is described in some detail by Atwater and Long in the January 1945 issue of the Canadian Journal of Public Health. Its importance to the Health Officer is pointed out by Burney and Hemphill in the November 1944 issue of the American Journal of Public Health.

Once well-trained personnel have been selected, they are entitled to fair and modern treatment by their employer. Newer methods of personnel management may not be fully understood by those of us who were accustomed to hire and fire at will. They are important, however, as the second leg of the tripod.

With your help, the postwar period can bring into public health careers the ablest and most promising recruits we have ever seen. Facilities for their training will be developed as needed. Such training will be along the lines that you suggest, so long as your suggestions remain within the bounds of good science and good education. As more able young people are attracted to our field, better results will be obtained and greater support will be forthcoming, and thus a benign cycle is completed by attracting still more able people to the field. Much depends on the way they are trained, selected and supervised by their present employers.

CHAIRMAN THOMPSON: I imagine some of the State Health Officers will want to discuss these papers.

DR. GETTING: Mr. Chairman, I would like to discuss this problem of training from the point of view of a rather recent graduate of one of these schools of public health, from the point of view of one who is now engaged in training some of these men in the school, and then finally from the point of view of an administrator who is charged with the responsibility of selecting adequately trained men.

A short time ago I was requested by a school of public health to put in a paper what I thought were the ways in which a school of public health could better train men for the practice of public health, as we see it in the health departments. I attempted to do this, and reprints of this were sent to the various State health officers and various schools, and I was frankly surprised at the amount of comment and interest that was engendered by that particular article.

On the whole, I think our schools of public health have done an excellent job, but we have failed in one respect. Most of the teachers in the schools of public health have been confined to their intramural activity for a long period of years. Some of them have never had a great deal of experience in the field or practice of public health. Consequently, the teaching in certain fields, be it epidemiology or public health administration or any of the other specialties, has often been rather theoretical and dogmatic, and as has been indicated by some of the speakers, did not contain the type of material that the student needs when he becomes a practitioner of public health.

I, for one, urge that the schools of public health make greater use of the men who practice public health in their actual teaching, and that, in turn, the teachers of public health in schools be offered an opportunity to reactivate or to stimulate their knowledge of the practice by actual participation in the field of public health.

The student who has worked in the field of public health gets much greater benefit from attending a formal course in the school than the one who enters the school without such experience. The time is coming when the student should have actual field training, in addition to classroom and laboratory instruction, as an integral part of the course in public health, and when he should receive his advanced degree in public health only after such combined training.

DR. PARRAN: Is the Association of State Health Officers having a session later?

DR. BIERRING: At twelve o'clock tomorrow.

DR. PARRAN: That concludes the business for the afternoon. I want to express my appreciation to you for the valuable contribution and advice which you have given to us at our sessions this year. We are grateful to you for your presence.

DR. RIGGIN: Dr. Parran, the Health Officers wish me to express to you and the staff of the Public Health Service their appreciation of your calling this Conference this year. They know the difficulty that you had arranging it. They felt that it was extremely important that the meeting be held, and they are very grateful to you for the trouble that was taken.

DR. PARRAN: Thank you very much, Dr. Riggin. The Forty-third Annual Conference of State and Territorial Health Officers is adjourned.

(The meeting adjourned at four-fifty o'clock.)

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