Conference of the U.S. Public Health Service with the State and Territorial Health Officers

PROCEEDINGS

FORTY-SEVENTH ANNUAL CONFERENCE

SURGEON GENERAL,
UNITED STATES PUBLIC HEALTH SERVICE
AND CHIEF, CHILDREN'S BUREAU
of the
FEDERAL SECURITY AGENCY

with

STATE AND TERRITORIAL HEALTH OFFICERS
STATE MENTAL HEALTH AUTHORITIES
STATE HOSPITAL SURVEY AND CONSTRUCTION
AUTHORITIES

NOVEMBER 15 *and* 17, 1948

FEDERAL SECURITY BUILDING
WASHINGTON, D. C.

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G E N E R A L S E S S I O N

November 15, 1948

The Forty-seventh Annual Conference of the Surgeon General of the United States Public Health Service and the Chief of the Children's Bureau with the State and Territorial Health Officers, the State Mental Health Authorities, and Representatives of State Hospital Survey and Construction Authorities convened at nine-fifty o'clock at the Federal Security Building, Washington, D. C., Dr. Leonard A. Scheele, Surgeon General, presiding.

ADDRESS OF WELCOME

Leonard A. Scheele, Surgeon General

The Forty-seventh Annual Conference of the Surgeon General of the Public Health Service and the Chief of the Children's Bureau with the State and Territorial Health Officers, the State Mental Health Authorities, and Representatives of State Hospital Survey and Construction Authorities will please come to order.

My task this morning has been made a lot easier by Miss Lenroot and Dr. Eliot yesterday. They said a lot of things which I will not have to say.

It gives me great pleasure to welcome you to Washington again. I am looking forward to hearing the results of your deliberations while you are here, and I offer you the full cooperation of our staff, as well as access to all the facilities we can place at your disposal which will assist you in making this meeting an overwhelming success.

Mr. Oscar Ewing, the Federal Security Administrator, has asked me to express his regrets to you that he is unable to attend this morning and to add his welcome to mine. He will return to town tomorrow, however, and will be with us on Wednesday morning, when he will address you at the general session at nine-thirty.

This morning I want to bring to your attention some of the current problems which the Public Health Service and the state and territorial health authorities face jointly. On Wednesday you will hear detailed reports on the new programs which were established in the Public Health Service since the last conference.

I will say very little this morning that is new, yet we have much progress still to make, and many things which we will discuss are, I believe, deserving of re-emphasis.

Public health has gone through an initial phase of progress in environmental sanitation, from which developed the science of public health engineering, with its modern methods of water and sewage treatment, milk pasteurization, and insect and rodent control. The turn of the twentieth century brought us positively into the control of communicable diseases.

Stimulated by the discovery of immunizing agents, this wonderful period in public health history was characterized by organized community efforts to control acute infectious diseases. It was an important era, especially because it introduced provision for personal services, especially those to children.

As an outgrowth of widespread environmental sanitation and communicable disease control, uncounted numbers of persons have been saved from premature death.

Chronic diseases now constitue one of our greatest public health problems. Their control must become a major

objective of the present public health era. We must all work hard with research scientists and clinicians to find new and effective measures to control the chronic degenerative diseases.

Control of mental diseases, cancer, cardiovascular diseases, diabetes, rheumatism, arthritis, multiple sclerosis, and other similar diseases must become the increasing concern of all of us responsible for public health programs.

This new emphasis in public health, together with the continuing need for even greater vigilance in sanitation and communicable disease control, points up the need for adequate coverage of our nation with local health units.

Local health units are organizations commonly known as city health departments and county health departments. Less than 5 per cent of the American people today have fully staffed, well-qualified, well-supported departments.

I hope you will pardon me for repeating some of my statements before the meeting of the Health Officers Section of the American Public Health Association in Boston last Tuesday. I believe they are important enough to bear repetition.

Within the next year an effective plan for insuring ultimate complete coverage of our country with local health units must be developed. I am convinced that unless definite action is taken by state and local governments to increase organized health services to the people, we shall not be able to advance adequately against the major causes of death and disability.

We already have evidence that the specialized programs themselves are still far from attaining their objectives, despite the money and effort devoted to them. The reason seems clear. In too many parts of the country there is no qualified organization to bring the new special services

continuously and effectively to the people.

Additional legislation will be required to insure adequate federal financial support for local health unit development. There is a legal ceiling on Public Health Service appropriations for general grants-in-aid to the states. There are no such ceilings on such specialized programs as tuberculosis, venereal disease, and cancer control.

The Congress and the federal agencies may well say to the states and communities, "It is your move". State aid to local jurisdiction falls far short of the needs. State aid to communities should supply high-quality consultative and technical assistance, liberal grants, and should require reasonable local financial participation.

The Public Health Service will continue to conduct demonstrations and be interested in the expansion of local health services. We will request that the ceiling on grants for general health programs be removed. We will support any legislation designed to bring more adequate public health services to every community. In this entire effort we have the full support of the Federal Security Administrator and our colleagues in the Agency.

Federal legislation, however, is not the only requirement for nation-wide extension of local health services. State and local governments must take more responsibility; they must support the recommendations of their central health agencies for well-planned, state-wide development of local units. State and local action, in fact, must be the spark plug for increased federal support.

All organizations must work with the public at state and local levels to get the comprehensive health services the people need. The Federal Government can only bear its share of the responsibility for leadership and help. The needs arise in the communities and the states; so must action arise in the communities and the states.

Our nation has never been richer; living standards have never been higher. Yet many of our problems can be attributed to the fact that states and their local jurisdictions still do not budget sufficient funds for health work. Allotted funds remain too meager to finance comprehensive health programs or provide for the adequate compensation of public health workers.

We must demonstrate to the people and to state legislatures that there is a tremendous need for larger health budgets. These budgets, in addition to extending the geographic area covered by health services, must pay health workers salaries commensurate with their responsibilities.

I ask each state health officer to talk with his governor and with other individuals and groups at home who will use their influence to intensify state and local action for full health-unit coverage and adequate pay.

One of my major concerns as Surgeon General is to improve the efficiency of the Public Health Service. The expanding magnitude of our responsibilities demands it.

Six months ago I appointed a Committee on Organization, composed of members of my staff, to make a comprehensive study of the organizational structure and working relationships of the Public Health Service at headquarters and in the field.

The Committee has worked throughout the summer, with the help of many other members of the Service in the various bureaus. They have come up with a series of initial reports which I regard as statesmanlike, reports dealing with general principles of organization and with the Committee's first area of inquiry, federal-state relationships.

It is too early to report here the outcome of the Committee's specific recommendations, but I can tell you that already the Public Health Service is moving away from a categorical disease approach in all of its activities and toward a more generalized and unified approach.

That trend will be accelerated in the immediate future, and its scope will be broadened. In research, clinical practice, and public health administration we cannot, and do not, deny the vital importance of specialization, but we do, and we must, abhor the isolation of special knowledge, skills, and services in watertight compartments.

The end result of isolation can only be stultifying, whether it occurs horizontally across the three major types of activity, or vertically through the scientific disciplines, the medical specialties, or the categorical health programs. The scope and depth of human knowledge, the infinite variety of special techniques are such that no one mind or group of minds can encompass them.

The Public Health Service, then, is putting its house in order so that we may use fully and more effectively the increased resources provided by Congress for the health of the people. Needless to say, we shall act within the framework defined by the Congress, but we shall seek legislation to authorize any basic changes which we believe to be necessary for efficient administration.

Simply, what we are aiming toward is to make of our large, sprawling organization a hard-driving, united team. The Public Health Service has grown; programs and separate units have multiplied so rapidly in the past ten years that there has not been time to prevent a somewhat unbalanced development.

We believe that the collaborating team is the best instrument for the pursuit of knowledge and the provision of health services. I hope that this will happen throughout the whole structure of research, clinical practice, and public health administration in the United States.

Our growing awareness of the need to focus attention on the total physical and mental health of man, rather than on piecemeal, specific aspects of his general health status, emphasizes the need for coordinating health services in each community.

Today we have several public health programs for which mass methods of determining disease prevalence in incipient stages are available. These techniques provide health departments with the weapons for multiphasic screening, a new concept of public health which is being applied at present in California.

However, these tools are of little value without a framework in which to operate, the local health departments.

The public health agencies and professions need to take a broader view of the services required in our communities. What would have been the outcome if, say, ten or twenty years ago, the official health agencies and professional societies had broadened their concept of a local health unit's functions?

That question, perhaps, can never be answered, but it may not be far from an accurate surmise that the current imbalance in many public health programs is a direct result of the minimum-service point of view.

The need for the so-called basic services cannot be denied, but they are not enough, and they have never been enough.

In this atomic age, full preservation of our manpower is vital to the very existence of democracy in the world. Neither state, local, or federal governments, nor voluntary agencies, nor professional organizations, nor the people themselves can afford to shirk their full responsibility to work together for higher levels of health.

I spoke earlier of the present interest of the Public Health Service in simplifying the administration of grants-in-aid to the states. It must be clearly understood that our ability to do so will depend on evidence in the state plans that the states accept their responsibility to carry forward the attack on inadequate health services of all types. We expect the special programs, stimulated by federal support, to be pressed with greater vigor.

Moreover, there are many fields, clearly within the province of public health work, in which the states should pioneer without the stimulus of categorical appropriations by Congress.

Housing, for example, holds first rank in social problems of today. Despite the distinguished studies made by the American Public Health Association under Dr. Winslow's direction, healthful housing has had almost no attention by official health agencies.

Safe and healthful housing involves far more than assurance of a safe community water supply and sewage-disposal system. Home accidents alone are taking an enormous toll of life and limb, which the forward-looking health department can no longer disregard.

If we expect to raise housing standards to modern levels; if we expect to clean up food-handling establishments; if we expect to eliminate insects and rodents from our communities, the health agencies must keep pace with modern developments in sanitary engineering. What engineering control has done for the work environment in ventilation, air sanitation, lighting, and accident prevention should be done in public places and private housing.

Moreover, the atomic age brings with it new health hazards which will yield only to well-planned, expertly administered engineering controls. In fact, peacetime uses of atomic energy require safe methods for handling radioactive wastes.

Engineers of the Public Health Service are working in close collaboration with the Atomic Energy Commission on this problem. We have units in training, and we shall expand our studies as rapidly as men can be trained in this field.

Local health units offer excellent opportunities for expansion of mental health services. The contacts of public health personnel, particularly of the nursing staff, with parents and children should be fully exploited.

The principles of mental health can be applied in prenatal and well-baby clinics, dental clinics, nutrition classes, and many other situations. Departments of education and health can accomplish much by cooperative programs for mental health of children, utilizing the experience of school-teachers in dealing with emotional problems of children.

We should examine critically the planning done to date under the Hospital Survey and Construction Act. We have been stressing the needs for rural hospitals, and this is proper. However, it is becoming clear that there are other areas of major importance for which provision has been inadequate, namely, improvement of the facilities of teaching hospitals, expansion of hospitals in some of our major cities, and construction of the costlier, but essential, central diagnostic and treatment centers. I would ask you to consider these shortcomings in this program.

I would ask you, also, to discuss the adequacy of federal financing of the total hospital construction program. I will appreciate your recommendations at the conclusion of this Conference.

I mentioned some factors in the personnel shortage; there are others. We must sell public health and recruit far down the line, in high schools and in undergraduate schools. Then we must teach better and more preventive medicine in medical schools and must interest more students in professional careers in public health. We must do the same in other professional schools.

These are examples of major problems which exist or may arise, and which should be given attention in current public health programs. There are, of course, many other important services partially developed or neglected.

My purpose is to stretch the minds of public health workers to a realization that theirs is a dynamic job, that they can never be satisfied with what has been done, or even with what is being done. Our satisfaction can be only in keeping a perpetual vigil over the needs of the people we serve, alert to new problems and new methods.

The local health unit is an ideal instrument only so long as it is flexible, ready to take the leadership in introducing new programs, ready to follow the lead of the community it serves, demonstrating the peculiar genius of the American people to accomplish their social aims by the cooperation of governmental and voluntary agencies.

I might say that the same applies to the state health agency as well.

Many of you have not fully adopted the grant-in-aid philosophy which the Federal Government has found so useful in assisting states with their health activities. It sounds slightly trite to say that as you receive, so also shall you give, but that is what I wish to say today.

Present interest of federal budget and appropriating bodies in local health units leads me to believe that in the not too distant future continued federal aid, and certainly expanded federal aid, to states for health work may well depend upon the extent to which reasonable proportions of such funds are channeled to communities and to service to individual groups of people. I believe that if you show a positive and increasing willingness to extend aid to local health units, it may be possible to increase appropriations to states, the additional funds being used largely for local health services.

The ideal local health unit will remain a dream so long as the men and women who serve in it lack the training they need. Estimates made by the National Health Assembly last May show that training is needed for at least 50,000 persons in order to provide minimum staffs for nation-wide health units.

The concept of formal training for public health work took shape only thirty years ago, when the first graduate school of public health was established in Johns Hopkins University. Others followed rapidly, but even today there are only eleven schools of public health in the United States and Canada. A new one, as most of you know, in the University of Pittsburgh is being developed by former Surgeon General Thomas Parran.

During the past three years the Public Health Service has developed a comprehensive program for in-service training of its own professional personnel in the research, clinical, and public health branches. Likewise, we have been able to help the professional schools to expand their research and training programs in the special fields of cancer and psychiatry. Under the new programs for dental research and heart disease we shall be able to give similar assistance in these special fields. As yet, however, we have been unable to give general assistance to the professional schools.

The Public Health Service proposes to expand its training program for its own employees to the limits of its legal authority. Our task would be made easier if the young doctors, dentists, and nurses who come to us from their basic training had been better indoctrinated in the principles and practice of preventive medicine during their undergraduate days.

As the field of public health widens, the variety of special knowledge and skills increases. On-the-job training and in-service training are needed in every area in order to keep staffs up to date. Few state health agencies have developed the type of training program which will improve their chances for recruiting competent workers and increase the efficiency of existent staffs. The state health departments which have developed comprehensive training programs are benefiting to an extent far in excess of the expense and effort involved.

The total problem of professional education and financing requires both study and action. A series of Acts of Congress, beginning in 1945, has given the Public Health Service an increasingly heavy responsibility and broad authority to augment medical research generally and training in special fields. Our advisory councils, who must study and recommend the approval of grants to outside institutions, have felt the need of objective data as a basis for their policies and actions in this field.

About two weeks ago the National Advisory Health Council recommended that the Public Health Service undertake a thorough study of its research and educational grants and fellowship programs, including the costs of medical education.

"One of the chief purposes of this study," the Council reported, "is to determine whether present Public Health Service programs or other methods may be recommended for the improvement and extension of medical education."

By assembling data on the costs of teaching facilities in relationship to the total costs of medical education, the Council hopes to be able to evaluate the effect of the grants programs on medical school finance and on medical education.

The Council further recommended that a special committee be appointed to develop the study. I expect to announce the committee within a few days. We are hopeful that the study will provide a basis for similar analysis of other branches of professional education in which the Public Health Service has a specific interest.

I am sure that all of you are concerned as to the impact upon your programs of the Selective Service Act of 1948. You are aware, too, of the extensive plans being made by the Department of National Defense and the National Security Resources Board for civilian defense.

The Public Health Service has been working closely with all these agencies, and we shall keep you informed as soon as plans which are taking shape can be made public. Organization of emergency medical services, provision of extra cantonment health and sanitation services, and maintenance of professional personnel for the civilian population are being given high priorities in planning.

On Wednesday morning Dr. Norvin Kiefer will discuss these problems in detail. I should like to stress the fact, however, that the state health authorities must take an active part in planning and organizing the needed services. If they do not, we may again experience the confusion and duplication resulting from the establishment of new agencies, which characterized many programs during World War II.

Here, too, the prompt expansion of local health services is of paramount importance. Through two world wars the lack of organized services in local communities has increased the cost of emergency health programs and handicapped efforts to provide adequate civilian services and facilities.

We cannot afford to let this happen again. The local health unit should be the strongest link in a coordinated national program for medical defense. Considering the inadequacy of local health services throughout the country, it would appear that this most important link is indeed a weak one.

In the light of modern knowledge and modern concepts, we are coming to see that public health is not and never has been a thing in itself, but a part of a larger whole, man's social effort for the conquest of disease and the attainment of health.

Such a concept includes the achievements of clinical medicine, the professional schools, the private hospitals, as well as the achievements of public agencies in the field of medical care. It includes the whole history of medical research in this country, a field in which state health agencies should be much more active. And, of course, the total concept of public health includes all those collective efforts by official and nonofficial agencies to apply preventive measures for the protection of all the people.

By some insight, conscious or dimly sensed, the people of the United States, through their Congresses, have maintained in the Public Health Service that unity of functions (research, clinical medicine, and public health administration) which constitutes the public health movement of today.

Since 1939 the Public Health Service has been a constituent unit of the Federal Security Agency. That shift placed the Service where it could best grow and develop to fulfill its destiny, that is, it placed the major health agency

in close administrative relation with the educational and public welfare programs of the Government. I hope that the importance of health in our land will soon be recognized by its inclusion in a department of our Government.

The health policy of the United States Government, as represented by congressional acts and the work of the Public Health Service, the Children's Bureau, and related programs, has never been partisan, or even bipartisan; it is nonpartisan. We of the Public Health Service and our federal colleagues are going to do all in our power to keep it that way.

The Public Health Service is a public servant. Each member of our team is proud to name our calling. We take this role to mean that we do the chores assigned to us by the people of the United States.

But it is no hired man's job. To us it is a task calling for creative thinking of a high order. It calls, also, for leadership. Unless we can bring these qualifications to the job of public servant, we cannot discharge its responsibility with the moral and intellectual integrity it demands.

The job also offers limitless possibilities for satisfying work with colleagues in scores of professions, hundreds of institutions and health agencies. Collaboration in man's great quest for health is, to our way of thinking, the highest human endeavor.

We expect to go on serving in that capacity with the same good, self-imposed discipline and integrity which our professions and our predecessors in the Service have taught us. The Public Health Service has one sole interest, to do and to be only what is best for the health of the people. As in the past, we await their orders, and we await yours, too.

(The Conference adjourned at ten-thirty o'clock)

GENERAL SESSION

PUBLIC HEALTH SERVICE

November 17, 1948

The Conference reconvened at nine-fifty o'clock, Dr. Scheele presiding.

CHAIRMAN SCHEELE: Ladies and gentlemen, it gives me great pleasure to introduce to you this morning, as our first speaker, Mr. Oscar Ewing, Federal Security Administrator. I do not believe we have to introduce him to you, since you met him last year and heard him speak here, and many of you have seen him out in the states and along the line since that time.

THE JOB AHEAD

Oscar R. Ewing
Federal Security Administrator

This is the second opportunity I have had to welcome the State and Territorial Health Officers in their annual conference. And, now that the American people have concluded the little argument they have recently been conducting among themselves, I hope to look forward to the same privilege for at least 4 years more.

Quite seriously, the election has, I think, made one thing crystal clear. The American people stand foursquare behind the great social and economic program which was initiated under the Roosevelt administration and has been carried on so vigorously and wholeheartedly by President Truman. With every year, it becomes more apparent that health is the keystone of this structure. And with all the interruptions of war and

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postwar adjustment behind us, we have a golden opportunity to complete the whole program -- to expand and develop it to the point where we can all say, "This, now, is pretty nearly it." And that's precisely what we propose to do.

I want particularly this morning to talk to you about the National Health Assembly which was convened in Washington last May. And, also, my recently published report to the President outlining a 10-year plan for developing the health resources of this Nation.

But first, I should like to pick up a few loose pieces concerning the reorganization within the Federal Security Agency which has taken place during the past few months. There have been a number of questions raised as to just how far your own relationships with the various operating programs will be affected by our new regional set-up.

As I see it, these relationships will have to work themselves out as we have experience with the new organization. Probably certain little adjustments will have to be made. This is particularly the case in respect to the State audits. But, broadly speaking, we anticipate the continuance of existing lines of cooperation between the operating agencies and the State personnel with which they deal. You will, I assure you, be able to continue to do business pretty much as you always have.

The chief objective we are shooting for, in this new regional set-up, is the coordination of all our programs -- whether they concern health or education or child welfare or social security and employment security. We expect our Regional Directors to develop a working knowledge of each one of these programs, so that they can discuss their inter-relationship with State officials in over-all terms.

Part of the reason for this shift is purely administrative. Formerly, as you know, the various units of the Agency had their own regional grouping, each with little or no geographical relation to the other groupings. Each unit,

for instance, had its own auditing service -- its own lines of contact with State officials. To a great extent, these activities duplicated each other. This was obviously a wasteful and inefficient administrative procedure, and we were determined to put an end to it.

But there was another even more vital reason for this coordination of administration. Over a period of some years, within the Agency, we have been acutely conscious how closely the problems of, say, education, health, child welfare, social and economic security are all inter-related. We have come increasingly to recognize that, in the final analysis, we are not dealing merely with a group of separate problems. We are dealing with one problem.

The problem of security in its broadest sense is, at base, single and indivisible. Each aspect is important to the extent that it serves to meet the needs of the "whole man".

What is important is that each program be administered with a full awareness of this inter-relationship. In other words, the more all the units of the Agency work together towards a common objective, the greater will be our accomplishment in all the various fields of our activities.

Then, too, just a word concerning the question of the possible Federal grants-in-aid, through the States, to support our local public health services. Dr. Scheele has already discussed this important subject, so there is no need for me to attempt to cover the same ground.

I'd simply like to say that, although the Bureau of the Budget has made no concrete promises, it has exhibited a definite interest in this proposal. It is my opinion that, if the States themselves exhibit a genuine effort to cooperate by extending grants-in-aid to communities, there is reasonable expectation that increased Federal funds for this purpose will be available.

Such funds, of course, would be directed to the State Health Departments and not administered directly to the local communities by the Government. But the main thing is, to make possible the expansion of our already established local public health services, and to provide these services for the greater areas of population which today they do not reach.

Now as to the Health Assembly and the report to the President.

Last January, as you all know, President Truman asked me to work out a 10-year plan to develop the health resources of the Nation and to raise the health standards of all the people. In attacking this problem, my first instinct was to secure the best help and advice that I could. That is why I invited some 800 representatives of all the professional organizations and public and private agencies, dealing with health matters in the United States, to convene in Washington as a National Health Assembly. Some of you attending this convention were part of that gathering.

What this Assembly accomplished exceeded my most optimistic hopes. In a 4-day session, it came through with a thorough-going analysis of our present national health resources, and a series of highly practical and concrete proposals of what could be done to achieve the purpose which the President had in mind. I have seldom seen a group of people who worked together so magnificently, or who developed such a high degree of unanimity in the face of so many difficult problems.

My report to the President is not the official report of the Assembly. That is being published separately. My report is an independent appraisal which, however, draws heavily on the findings of the Assembly and in every major respect except one, I think, follows its recommendations.

I am not going to take your time by attempting to recapitulate the health situation in the United States as it exists today.

You know the story of the serious shortages of doctors, dentists, nurses. You know how unevenly this medical personnel is distributed throughout the country, especially in relation to the rural districts. You know how badly we are in need of more hospitals, and how grave are the deficiencies of our public health services.

And you know also the mounting pressures of chronic diseases -- and the 25 million of chronic invalids we have in our midst. And the hundreds of thousands of crippled or handicapped children. And the great problem of vocation rehabilitation of our civilian disabled.

Underlying this whole problem is, of course, the cost of adequate medical care. Today, millions of families can usually afford to visit a doctor only on occasions of extreme urgency. Hospitalization, for even a brief period cannot be fitted into the average family budget. The luxury of periodic checkups, of preventive treatment -- the vitally important stitch-in-time -- can be obtained, for the most part, only by the comparatively well-to-do.

And of final "practical" importance is the grim fact that each year, through sickness and partial or total disability, the Nation loses some 4,300,000 man-years of labor -- an estimated annual loss in national wealth of 27 billion dollars.

The facts and figures, as brought out in the findings of the National Health Assembly, are worth the most careful study. What my report to the President does is to go right down the line, item by item, and set up a series of specific objectives towards which we can all work.

It proposes to institute an immediate Nation-wide plan to expand the numbers of doctors, dentists, nurses, sanitary engineers, and other medical personnel, so that by 1960 our medical manpower will be 40 to 50 percent above present figures. Much of this manpower, we hope, will inevitably be attracted to rural and small-town practice.

To do this it proposes to build new medical colleges, expand the facilities of the present ones, and also to establish scholarships which will enable qualified young men and women to undertake the long and expensive training which many of them otherwise could not afford.

It proposes, during the next 10 years, to increase the number of hospital beds by at least 65 percent -- the maximum goal we can hope to achieve -- with special emphasis on rural districts and the smaller communities.

It proposes to establish an integrated hospital system--a series of hospitals, one at least in every State, which will embrace every kind of hospital facility, from the local diagnostic clinic up to a modern fully equipped medical center, staffed by specialists in every field of medicine. Such a system will serve to make available complete diagnostic facilities to every doctor, no matter how small the community in which he lives. And it will establish a method of referral for patients which will give, let us say, a farmer living in an isolated rural district prompt access, in case of need, to the most highly specialized treatment.

The plan proposes to extend our public health services to the 25 percent of our population, chiefly in rural areas, which do not now have even a full-time health official; and to staff fully all public health departments and house them in modern public health centers. In the small town and rural districts especially, it proposes to equip these centers with X-rays and all the other modern diagnostic facilities which the average physician cannot himself afford to purchase.

It proposes to provide rehabilitation service for all the 250,000 men and women in civilian life who each year become disabled through illness or injury.

It proposes to extend as rapidly as possible our maternal and child health services, and various child welfare services, in order to reach the millions of mothers and children who are now cut off from these benefits.

It proposes to double or triple the amount of Federal aid for medical and related research as quickly as necessary scientists can be trained for this purpose.

It proposes to delve more deeply not only into such matters as cancer and diseases of the heart, but into the causes of chronic invalidism and the diseases of old age, and to make fuller provision for extending effective medical care to their victims.

It proposes to focus more and more attention on mental health, promote research in the field of psychiatry, and in the mental-emotional aspects of physical illness, and to expand manpower and facilities for both preventive and curative work in this field.

And it proposes to promote dental research and expand the facilities of the schools and public health services in caring for the teeth of our children.

Such a program, if it can be accomplished -- and I believe sincerely it can be accomplished -- would in truth constitute a modern miracle. With these facilities at our command we can make health bloom among large areas of our population where today there is still far to much unnecessary sickness and disease.

But there is one other consideration which, to my mind, is vital to this whole project. That is the problem of payment for medical care. Certainly, to try to make available all the facilities we propose without taking steps to bring them within the reach of the average pocketbook, is to beg the whole question.

Now at this point, I'd like to say a few words on the very controversial subject of health insurance.

I am not interested in national health insurance as a system in itself. I am interested only in the health of the Nation. If I have become a staunch advocate of this particular method, it is because I have examined carefully all the alternatives and have yet to find a system which will do the job more effectively.

Our basic problem is how to provide adequate medical care for the some 68 million people who live in families where the total income is less than $3,000. An average family of four persons or more trying to live on that level just cannot afford to pay for medical care on the present fee basis.

The National Health Assembly, in its medical care panel discussion, turned in a unanimous report in favor of some sort of insurance. The only difference of opinion lay in whether the purpose would be better served by voluntary or national health insurance.

To my mind, the chief drawback to voluntary health insurance is that the people who need it most can't afford it. The voluntary method would have to operate on a standard charge--the same for everybody. Most standard charges would inevitably be too heavy a burden on the lower-income groups. Under national health insurance the cost varies with the amount of the income of the beneficiary -- on a small percentage deduction from his weekly pay envelope.

Such a system, in conjunction with our 10-year plan, would enable every individual in the country and his family--regardless of race, creed, color, economic status, or place of residence -- to have the amount and quality of medical care now available only to the genuinely well-to-do in the larger centers of urban population, and at an annual cost of only a comparatively few dollars.

This method of approach to the problem is essentially the democratic method. It applies the same principle which underlies our old-age and survivors insurance program--that magnificent effort, on the part of the Roosevelt administration, to afford some means of security for our old people during their declining years.

National health insurance has been attacked as a socialist experiment--just as social security insurance was attacked--and in fact, as the idea of public education was attacked less than a century ago. In making these attacks its opponents have indulged in all manner of abuse and misrepresentation. They have pictured it as a system under which the entire medical profession will be regimented under government control.

The simplest way to meet such attacks is to explain how the system works.

Suppose national health insurance should go into operation tomorrow. In every community, each doctor would decide individually for himself whether or not he wanted to practice under the system. If he decided he did, he and the other like-minded doctors would get together with the local committee set up to administer the system.

This committee would operate on a strictly decentralized basis, much as our local drafts boards operated during the war. The doctors would sit down with the committee and work out a basic set of service fees--so much for an ordinary office visit, so much, let us say, for a tonsillectomy, so much for delivering a baby. These fees would be agreed to as a fair and reasonable scale for the community for which they were set.

Then, each person covered by the insurance would select his own physician. The physician would decide whether or not he wanted that particular patient. If, later, either wanted to renege on his choice, he would be free to make the change. The only difference between the insurance system and the present system is that the doctor would receive his fees out of the general insurance fund, rather than through the somewhat painful process of collecting it from his patient.

What could be simpler?

Attacks on national health insurance could be summarily dismissed as ridiculous if they were not backed by ruthless forces in the United States who close their eyes to the health needs of our people. Fortunately, there is an increasing number of younger, more socially minded physicians, as well as many older and more thoughtful doctors, who see the problem clearly in terms of national health.

But let us always remember there are literally 68 million people in this country for whom anything like adequate medical care is completely beyond their resources. Each year 325,000 persons die needlessly in this land of ours whose lives could have been saved if they had been given proper medical attention. Each year we see hundreds of thousands of our children, and literally millions of our adults, fall victims to sickness and crippling disease which proper medical attention could have averted. Each year we see millions of man-hours of productive labor lost because of this reason, as well as billions of dollars of national income. The waste in our human resources--our productive capacity--is incalculable. The pain and suffering involved is beyond measuring.

I am stressing the importance of national health insurance, because, as I have said, it is, in many respects, the keystone of this 10-year plan we are proposing. It is here, probably, that we shall meet the strongest opposition.

But this difficulty must not blind us to the amount of hard work which lies ahead, if we are to go forward with the remainder of the plan. This plan is in no sense a project of the Federal Government, as such, or something which can be tied up in a single package and enacted into legislation by the Congress. It is primarily a blue-print--a series of suggestions for coordinated action on all phases of the health problem which, broadly speaking, must be initiated at State and community level. In other words, its success depends upon what the people themselves are willing to do about it.

For that reason we must start laying the groundwork now. Every community must organize its own committees to

analyze the plan in relation to its own community resources and community needs. These committees must establish liaison with similarly organized State groups under your leaderships charged with coordinating these resources and meeting demonstrated needs in a State-wide program.

Equally important is the need to start, now, a State and local campaign of education to explain the scope and purpose of the plan and to demonstrate what it will mean to the health and well-being of every citizen of the community--to rally all business, professional, and civic organizations, together with the churches and the labor unions, for an all-out effort to start the ball rolling.

To set such a project in motion requires responsible State and local leadership. It requires the unstinted faith and determination of men and women who can spearhead such a campaign and carry it through to a successful conclusion.

I am putting this up to you, as an organization and as individuals, to undertake this responsible job. We are set to go on the most comprehensive program of health that has ever been offered to the people of the United States.

If we all put one shoulder to the wheel we can translate this program into a living reality. And with the facilities we shall be able to command, we shall create a standard of health and well-being for the entire country such as no nation has ever dreamed.

CHAIRMAN SCHEELE: I want to thank you, too, Mr. Ewing, for your excellent address.

Mr. Ewing has outlined the ten-year plan, and now before us lies the opportunity to execute as much of this plan as we can.

One of the duties, Mr. Ewing, of the relationship between the states and, through the states and communities and the various medical groups in the Government, the Children's Bureau and the Public Health Service in this present instance, is that we work very much as a team, and while there are imaginary lines as between communities and states and the Federal Government, there are no such lines between our thoughts and our actions in working together, so I am sure that all of us will be striving hard to bring into being a large part, if not all, of that ten-year plan, which I am sure you all agree with.

The next items on our agenda are discussions, by several of our staff, of new programs in the Public Health Service, which have come into being since the last meeting of the state and territorial health officers.

The next speaker will be Dr. C. J. Van Slyke, who is Director of the National Heart Institute, who will speak on the National Heart Act. Dr. Van Slyke!

THE NATIONAL HEART ACT

C. J. Van Slyke, Medical Director
Director, National Heart Institute
National Institutes of Health

Ladies and Gentlemen: I have the privilege to appear before you today to give you a rather factual presentation of the National Heart Act. I feel that I must ask you to focus your attention on one link of the big health chain which the Administrator has just spoken about.

I am going to try to keep this informal presentation brief, and I would invite your particular attention to the fact that I am only going to give a portion of the program which relates to diseases of the heart, since the grants-to-states part of the program will be discussed, immediately following my talk, by Dr. Estella Ford Warner.

As you know, the National Heart Act was proposed in the closing session of the last (Eightieth) Congress, that is, in June, and it provides that the purpose of the Act is to amend the Public Health Service Act to support research and training in diseases of the heart and circulation, and lead the states in the development of community programs for the control of these diseases, and for other purposes.

Subsequent to the passage of the National Heart Act, the Surgeon General established in the National Institute of Health the National Heart Institute. It is one of the National Institutes of Health.

The National Heart Act also provides for a National Advisory Heart Council. This Council is comprised of sixteen members, four of whom are ex officio members, as the Surgeon General of the Public Health Service, the representatives of the Army, of the Navy, of the Veterans Administration.

In addition to these four members, there are twelve appointive members. The law provides that not less than six of these appointed members shall be competent in the diagnosis, prevention, treatment, and research of heart diseases.

With this permission, and with the approval of the Administrator, the Surgeon General has appointed six so-called professional members and six lay or community-leader members.

The medical members include Dr. Paul Dudley White of Boston, who also serves as Executive Director of the Heart Council; Dr. Tinsley Harrison, the President of the American Heart Association, from Dallas; Dr. Irvine Page of the Cleveland Clinic; Dr. C. A. Elvehjem, Dean of the Graduate School at the University of Wisconsin, whose primary interest has been in biochemistry and in nutrition; Dr. B. O. Raulston, the Dean of the University of Southern California Medical School.

The six state or community members are: Mr. Albert J. Wolf of New Orleans--these people whom I speak about have business interests, and I will make that a standard consideration; I will refer to their medical interests. Mr. Wolf is also a trustee of the Turo Infirmary, New Orleans; Mr. E. B. MacNaughton of Portland, Oregon, who, in addition to his business interests, is Trustee of the Good Samaritan Hospital and President pro tem of Reed College in Portland; Mr. Maurice Goldblatt of Chicago, whom most of you know or know of, who has given a million or a million and a half dollars in support of cancer research and is tremendously interested in health research, having given very enthusiastic support to the heart program; Mr. James Adams, who has served on the National Advisory Cancer Council; Mrs. Albert D. Lasker who, together with her husband, has set up the Albert and Mary Lasker Foundation; and Mr. Ernst Mahler of Wisconsin, an Austrian-born chemist, who gave us Kleenex as one of his chemical products, and who is very much interested in heart disease; as a matter of fact, he has recently made a substantial gift to the Hypertension Foundation.

I think I might turn now to the functions of the National Health Institute. We have a function to carry on research, and I would put that within the pocket of intramural research.

Quite obviously we do not have the space we need to expand this program broadly, but we hope, when the new clinic facilities are ready in 2½ to 4 years, to expand our facilities locally at that time.

In the meantime, they are setting up cooperative research arrangements with certain of the leading medical institutions in this country and, through that, we hope not only to promote more and better research in the cardiovascular field but, also, to provide a staff for the new institution when and at the time it is opened.

Through the National Heart Act it is possible, if appropriations are made, to put funds out in five different ways. Three of these ways by which funds go out will be to institutions, and two of the ways will be to persons.

The first way is through grants for the construction of research facilities, and I would read that part of the law to you to indicate how very broadly Congress has gone in setting up the authority (not the funds, but the authority), because not only do they provide for construction of facilities, but they do provide for the maintenance, acquisition of ground, the leasing, equipment, and maintenance of such hospital, clinic, laboratory, and related facilities, and for the care of the research patients therein.

A second way we are authorized to give funds in support of the cardiovascular program is the old research grants program, which you are very well acquainted with, research grants for specific research projects.

A third way--and those grants, of course, like all grants, must be approved by the National Advisory Heart Council--to give funds is through teaching grants to medical schools to improve the cardiovascular teaching which they do, to correlate it better, to coordinate it.

The remaining two ways that funds are given to the outside are in the nature of awards. The first of these is the heart training award. That provides for support of training of essentially a young physician, an M. D. man or woman, in order that his or her competence in the prevention, diagnosis, and treatment of heart disease may be promoted.

The aim of this part of the program, of course, is to provide more people competent to handle heart disease, take care of the patient load.

The final way that funds are awarded is through research fellowship awards, and they are aimed at the support of the individual, intended to promote the competence of the worker in doing independent research, particularly in the cardiovascular field.

The National Heart Institute, under the National Heart Act, has a couple of other functions.

No. 1, they are required to maintain an office of heart information and to provide such information not only to lay groups, but to professional groups.

Knowing the antipathy which Congress has evinced toward information specialists in the past, a perusal of the law in this regard indicates that they have gone approximately 180 degrees out of phase in setting up, really, a command that heart information be given out.

We also shall set up an office of statistical research, and we shall try, within the limits of practicality, to maintain intelligence on all the heart research which is being carried out in this country. It is a difficult problem, and correlation in this regard will be difficult.

I am leaning to one side, as I said initially, on a discussion of the control-grants side of the heart disease program, since Dr. Warner will discuss that and will also give you a bird's-eye picture of the administrative setup through which this operates.

There are just a few odds and ends I would mention, though. If, in just walking into the hall this morning, these things come up, if you have a need for a research grant or construction, or your college has come to you and asked about it, all applications for these grants are to be addressed to the Surgeon General, from whence they will be sent to the Division of Research Grants and Fellowships for processing. The applications will then be funneled to the appropriate institute and, thence, to the appropriate study section and appropriate advisory council.

The reason for this, of course, is that you are not then required to make a determination as to just where the applications should be sent, and we in the Public Health Service can provide you with a commonplace, an undifferentiated receptacle for receiving these things and let the administrative detail fall to us.

Next, I should like to mention that we recognize, in much of this grant support of research projects, that there has been in the past a lack of stability. They are one-year grants, and that is a pretty difficult way to run a research program, not knowing more than two or three months in advance whether you are to have funds for the next year.

Fortunately, the Bureau of the Budget has accepted, and in the mental health appropriation last year the Congress accepted, the principle of making contract authorizations so that you can give cash for one year and give contract authorizations to cover two or three or four additional years, so they have assurance of stability.

When the time for renewal comes up, they convert the year of contract authorization into cash; then they add to that another year of contract authorization, so they have continuously some stability.

Quite obviously they are not going to do that indefinitely, because there must come a time when a project shall be re-evaluated in its entirety.

Penultimately, I should like to mention briefly the fact that we are doing our very best to cooperate not only with our parent agencies in the Federal Government, but with all voluntary agencies. We have had conversations with the American Heart Association, and it is well agreed that if there is ever any conflict in the field of activities which every one of us has, there is a waste of funds; therefore, we hope that all of our effort jointly will be supplemental and complementary in knowing the conflicting activities.

If and when the National Institute of Health has their new clinical facilities, we shall have added to our facilities out there about one square foot of bed space and two additional square feet of laboratory space in ratio. It will be a 500-bed hospital, but that does not indicate the magnitude of the plant or the ability to provide research facilities under the provisions of the National Heart Act.

Frankly, under the old Public Health Service Act the Surgeon General has authority to make laboratory facilities available to outside, nongovernmental agencies. It is our hope that through the special research fellowship award, by compensation to a person, we can get professors from universities here and abroad, research workers, to come to Bethesda and spend time with us, taking care of the compensation through special research fellowships providing laboratory space, supplies, attendants, equipment, and this device will not only be productive of a great amount of good research work but, because the scientist from the University of Chicago

will be alongside the scientist from Tulane, from the University of Paris, probably from Australia, the catalysis which will result from the intermingling of scientists will go far to promote the research program in which we are so interested.

I have, as I said, specifically stayed away from the control program, which is probably closest to the immediate interests of the state and territorial health officers, and Dr. Warner will cover that point.

I would therefore, in closing, say that the National Heart Institute is not failing to take cognizance of that important facet, but they are reserving that for the subsequent presentation.

(Dr. W. Palmer Dearing, Chief, Division of Commissioned Officers, assumed the chair.)

CHAIRMAN DEARING: Thank you, Dr. Van Slyke.

I do want you to realize, as these two parts of the heart program are discussed, first by the Director and secondly by the Chief of the Division which administers control grants, how much as a unit we see this program in the Public Health Service.

As in all the special disease programs, we are most desirous and strive constantly to see that they keep in proper balance with the total program and that the various parts of the activity on heart disease, the research and education and the control activities, are all balanced and all unified, and to present a concerted attack on this greatest of our health problems.

Dr. Warner, then, Chief of the States Relations Division, will discuss the control aspects of the heart disease work in the Public Health Service.

DR. ESTELLA FORD WARNER (Chief, States Relations Division): Thank you, Dr. Dearing.

HEART DISEASE CONTROL PROGRAM

Estella Ford Warner, Medical Director
Chief, States Relations Division

Members of the Conference: I think there need be not too much explanation as to the administrative setup. Dr. Van Slyke has mentioned it; Dr. Dearing has mentioned it. I think it should be of interest to you, as health officers and people working in the field of public health, to find that within the Public Health Service itself we are attempting to make the effort to break down some of the categorical approaches in grant-in-aid programs.

The funds appropriated for heart control grants will go to the National Heart Institute but, jointly, the National Heart Institute and the Bureau of States Services, the Division of States Relations, will work out the plan or the needs for their control phase as covered in the law, as envisioned in the total program, and submit such budgets to the Budget Bureau and the Congress.

Having received those budgets, or whatever sums are appropriated, the portions are allotted to control grants for the Bureau of States Services and the Division of States Relations. The Division of States Relations already carries the general grants-in-aid allocations, so we then have one step in the direction of trying to tie together various programs and various activities and various budgets and allocations of money for public health as it goes to the states.

It implies, of course, and there is actually and will continue to be actually and more actively, as we get more sums of money from the Congress to operate upon, that there is actively a two-way flow between the National Heart Institute and the Bureau of States Services and the Division of States Relations.

Dr. Van Slyke's office and our office keep very close touch with each other. We know where we stand and where we are going, and I think it points a way to a new administrative method of trying to pull together some of our various interests in public health which are growing and expanding.

Now just a word about our program of this year; then we shall dismiss that and go into our regular control program as envisioned for next year.

Congress in its last moments this year passed the National Heart Act and appropriated the small sum of money, amounting to only about $500,000, with which to get the National Heart Institute into operation.

The administrative decision was made that half of that sum of money should go into grant activities. The law specifically states that control grants shall be allocated on a regular formula basis, and spells out the formula, which includes population and per capita income, with $250,000 spelled out on a formula basis to forty-eight states and two territories, which would mean very little money for anybody. The legal decision was that under our laws that sum of money could be used on a project basis at the discretion of the Surgeon General.

So for the remaining portion of this year the sum of money which we allocated for grants, $250,000, is being considered on a project basis and not as a grant-control program, a grant-in-aid program for control.

The several state and territorial health departments have been advised of this plan and have been invited to submit projects in heart control or in a heart program for consideration.

It was our hope and our intent that such projects might reflect one phase of what might ultimately, as years go by, be a part of the total heart program within the state.

The projects submitted could be definitely as a result of the decision and desire of the health officer. His desire

and his decision, of course, would be definitely based upon the facilities available, the amount of money that might be available, and the opportunity of carrying forward such plan as might be initiated for the last six months of this year.

We have currently received about twelve or fourteen plans spelled out, and we know of another four or six that are on the way but have not yet been received in the mails.

Those projects, presented under the control appropriation for this year, are being handled as projects. Those plans are submitted to the National Heart Institute and the National Advisory Council, and the decision is made there as to which of those projects, out of the sums of money available to us, can be accepted, approved, and returned to the states with the money to go ahead for the rest of this year.

That is out of line and a complete departure from our regular control program and the regular operation of the grants-in-aid, and the only reason we could consider it at all this year was because the sum allocated was so small that it would be of no purpose to anybody in attempting to do any portion of the heart program.

So now let's dismiss our 1949 budget of $250,000 and let's dismiss the projects which you have submitted. Some of them will be returned, not all fourteen, but maybe all fourteen; it depends upon what they are and the amount of money requested.

Let's go on to next year, when, we hope, we will be operating under the regular grant-in-aid program for heart control.

What is our objective? Our objective on such a program, of course, is obvious, to apply the best of our knowledge and medical services and community services, the best of our techniques, to minimize disease and disability and prevent death.

We are all perfectly aware that we do not know too much about controlling heart disease; we are all perfectly aware that we have no quick and easy method of determining heart disease, particularly in its very earliest stages.

So we are having to take, in all our activities, what is known and try to apply the best of that knowledge, in the best method we know about, to a program for the purpose of expanding the time between the discovery, as early as possible, of heart disease and the time of disability and death.

We cannot immunize against it; we cannot do some of the other things we do in our control of the public health program, but we do have a problem, and we do know we will do anything we can.

The other thing which is perfectly apparent is that we are embarking upon a program in another disease category. It is the hope that in embarking upon this problem we will bear in mind very definitely what has transpired and what is going on in cancer, which is called also a chronic disease, and patterns for such a program have been very well set up in many states. Bear that in mind.

Bear in mind that there are other disabilities which affect persons of middle age and old age (not exclusively limited to those age groups, but more commonly), such as diabetes--we have mentioned cancer--cardiovascular disease, probably arthritis coming up some day for further consideration, probably other things.

The point is that embarking upon a new program related to heart disease, it should be reviewed and planned in connection with other chronic diseases and it should be reviewed and planned in cooperation and in coordination with other activities within the community, other agencies, professional groups, hospitals, other programs currently operated.

That points to a new technique which we have been hearing about considerably during this Conference, and that is the possibility of developing something which goes under different names, but Dr. Halverson's pet term for it is "the multiphasic clinic," where the various tests or examinations are applied at one time rather than in a series of individual plans.

The other thing I think is interesting in that approach is that we are getting back to the point--we have not completely lost it; in fact, I think we have not lost it at all, though it becomes very befogged at moments--where we are thinking of the individual as a whole rather than of the individual who may have a heart or who may have heart disease or cancer or may be emotionally disturbed or may have tuberculosis or something else. We are thinking of looking at the whole person and planning our public health program on that basis.

As to the program itself, I have not too much to say as to the content at this moment, but will give you some information as to what is planned on that.

The program is your own determination, the determination of the states. The plan of operation in the control grant follows exactly the plan of any other control grant. The state submits its plan for its program; it is supported by a budget; it is reviewed very carefully and approved or disapproved, or there are more conversations on it, and it is sent back to the health department with whatever the recommendation may be.

It is followed through with the usual routines which you follow with any other control grant, the audit of the accounts, program review, and such assistance in consultation as we can offer you from the district or the central offices.

There are severalthings within your current operations which could be very well developed and could be very well

focused upon your heart-disease program. It is our intent in the Division and is already under preparation--we have had some hints in this direction--to submit to you, as suggestions merely, some of the things which seem to be feasible content of a heart-control program, and to support those suggestions with such information of active programs, of going programs, as to how those programs were conceived, what they are doing, and some of the basic principles which have been adopted by persons in the active field; to submit those to you as material to suggest or to hope that they will receive your consideration, and probably give you suggestions as to something you might also apply.

Another point Dr. Van Slyke mentioned is the Heart Advisory Committee. Dr. Duckett Jones was named by the Chairman to serve as the chairman of a committee to consider control grants and the broad policies and principles under which control grants would operate.

Dr. Duckett Jones was to name his own committee and call them together. We met last Friday, a committee quite representative of all the interests in not only the health but the welfare field and voluntary agencies which might be interested in this total picture of heart disease, but I will strengthen it further and say of chronic disease.

We met all day; we came out with some decisions, agreements as to over-all policies, over-all principles of the program. They are exceedingly broad.

Those are to be submitted by Dr. Jones to the National Advisory Council for their approval or disapproval, as they see fit, but we hope approval, and those ultimately, after action of the Advisory Council, will be submitted to you as the broad principles or the broad policies of the control program.

I think the principles and policies, as we determine them here today, are sufficiently broad that they give you great leeway in the development of your own program, and are not in the least confining as to type or possible inclusion in such a program.

There will come along, too, as I indicated, materials which will be evolved out of a small group of us, a small group assigned by Dr. Jones and the Advisory Council to work out some of these suggested areas of interest in the total program. It is a new program as to categorical approach; it is not a new program as to the usual methodology. It does require a new consideration as to disease and treatment, but we are hoping that you will remember that heart disease embraces a great deal more in the community than just the health department, and that you will plan your activities with that well in mind.

(Dr. Scheele assumed the chair.)

CHAIRMAN SCHEELE: Would you like to ask any questions on the heart program before we move on to the next item on the agenda? Apparently not.

Next we will hear a paper on stream pollution. This field is interesting in that it reminds us of a recent action which at least eight of the state health officers are fully aware of, and I hope that, actually, all are fully aware of the program.

In the recent Ohio River Valley Compact we have set a new pattern of state cooperation, by which seven states (and we hope soon Tennessee as an eighth state, after its legislature meets) will be working as a unified whole on a problem of mutual interest to those eight states.

Several of you are currently in river basin areas where we hope time extensions of similar multistate cooperation can go forward.

Mr. Mark D. Hollis, who is Chief of our Sanitary Engineering Division and who is well known to all of you, will discuss stream pollution. Mr. Hollis!

MR. MARK D. HOLLIS (Chief, Sanitary Engineering Division): Thank you.

STREAM POLLUTION

Mark D. Hollis
Assistant Surgeon General
Chief, Engineering Activities

Members of the Conference: This morning I am going to limit my comments to a very brief analysis of the recently enacted legislation, and not go into a dissertation on stream pollution.

Over the past five years, appropriations to the Public Health Service stream pollution control have been about $50,000 per year. These moneys have been used to support obviously very limited technical investigations at the Cincinnati Station and to meet, as far as we could, the more urgent requests for consultation services by the states.

I preface my comments with that to point out that we are going into this new stream pollution program without a very well established machine, certainly with a shortage of personnel, and it is going to tax all of us to get such a machine built to meet the first appropriations which will be met, we hope, to carry out the provisions in the Act.

As for the Act itself, Public Law 845, referred to as the Water Pollution Control Act, passed in the closing hours of the last session of Congress, it is enabling legislation only, and carries with it no appropriation, only authority for appropriation.

At best, the first money which would be available to put into effect the provisions of the Act would be under the first deficiency bill, which would be available perhaps in March. I repeat, that is the earliest time. I would not forecast that Congress will make such an appropriation.

In summary, the Act itself might be summarized under four headings. These four headings set forth the declared policy of Congress, and they are:

1. To recognize, preserve, and protect the primary rights and responsibilities of the states in controlling stream pollution. That, I think, is very important.

2. To support and aid technical research, with emphasis on devising methods of treatment for the more difficult industrial by-product wastes.

3. To provide federal technical services to the state and interstate agencies and to industries.

4. Finally, to provide financial aid to state and interstate agencies and to municipalities in the formulation and execution of stream pollution abatement programs.

More specifically, pertinent sections of the Act provide that the Surgeon General shall prepare and adopt comprehensive programs for eliminating or reducing pollution of interstate waters and tributaries, in which programs the plan is to be devised in close collaboration with allied interests and shall give due regard, under the Act, to the conservation and propagation of fish and aquatic life, recreational uses, and agricultural, industrial, and other legitimate water needs.

In other words, it is a plan of broad water use, considering all allied interests, and not a narrow public health measure.

I think that would bear emphasis because, in general, the health authorities in the country have been prone to look on stream pollution as it affects public and municipal water supplies and other more direct health problems, and not in terms of its total broad use.

Further, the Act encourages interstate compacts, uniform state laws, and declares pollution of interstate waters to be a public nuisance and subject to abatement as provided under the Act.

A brief comment on uniform state laws. Certainly it was not the intent of Congress, as one derives from reading the committee reports on hearings, that there should be one law which would be adopted in all states. Rather, it was the intent of Congress that the fundamental principles, which certainly are common to all the states, would be embodied in whatever legislation we would have in the states.

Section 2(d) of the Act sets forth a regulatory provision. This is, again, very important. In general, the regulatory provision requires that formal notification by the Surgeon General be given to those who are causing excessive pollution and, under certain conditions, formal hearings are to be instigated by the Federal Security Administrator, after which federal court action may be instigated.

However, under the Act, no federal action can be taken without the consent of the state in which the pollution originates.

The Act establishes a Water Pollution Control Advisory Board, composed of five federal representatives, including the Public Health Service, the Departments of Army, Interior, Agriculture, and the Federal Works Agency, and six nonfederal representatives, to be appointed annually by the President.

I might digress a moment to say that the five federal representatives have been duly named under the Act, and we understand, as of thirty minutes ago, that the six nonfederal representatives will be named in the next two or three days.

There are six financial provisions under the Act, and these financial provisions have a five-year limitation, beginning with the current fiscal year.

First, there is the loan for the construction of remedial measures. That is 22 million 500 thousand dollars per year.

Second, the grants to states and interstate agencies of 1 million dollars per year. This money is to be granted for that formula equitably between the states, and I might interrupt to say that the definition of "states," of course, includes territories and the District of Columbia. It is to be granted to the states for expenditure by the state water pollution control agency.

That does not necessarily mean the state health department in all cases. The exact wording of the law is to the effect that unless otherwise specified, it will be to the state health department.

However, thus far, we find that there are about twenty states where, very definitely, there is no question but what the state health department is the authorized water pollution control agency. There are New England states in which it is not, and the remainder of the states are as yet not determined, principally not determined because of a lack of a clear-cut law setting forth the agency of state government which has the authority.

The other financial provision of importance to the Public Health Service is $800,000 per year for five years, or a total of 4 million dollars, for the construction of our Cincinnati laboratory.

For administration to the Public Health Service a sum each year not to exceed 2 million dollars. As you know, the Bill is a joint measure; certain elements can be administered by the Federal Works Agency, and to that agency there is an authorized appropriation of 1 million dollars per year for grants to states, municipalities, and interstate agencies for advanced planning of remedial works. That is for advanced detailed plans for sewage and industrial waste treatment plants.

Also, to the Federal Works Agency for administration a sum not to exceed $500,000 per year.

Under the loan provisions, the 22-1/2 million dollars for the construction of treatment works, there is a limitation on the federal loan of one-third of the total cost or $250,000, whichever is the smaller. That means that the loan is in there for the benefit of the smaller municipalities.

The loans are to be administered by the Federal Works Agency on application of the municipalities, but are acted on only after approval by the state water pollution authorities and by the Surgeon General.

These loans are 2 per cent and are second trust.

That is a general summary of the Bill itself.

On administration, we feel rather strongly that it must be approved on a basis of watersheds and the operating entity, rather than state boundaries.

Water, as you know, does not respect state boundaries, and it seems rather difficult, and would be rather difficult, to set up a national stream pollution program and carry out the provisions which are required of the Surgeon General unless the problem were approved on a watershed basis.

I might say, as a matter of interest, that the Army Engineers have set up their control programs, interest in navigation, flood control, and so forth, on a watershed basis; so has the Geological Survey, the Fish and Wildlife Service, and so forth.

We feel that in the development of a comprehensive program we must consider all water uses; we must catalog water uses by the total stream; and we must establish stream standards by streams. That would certainly not be uniform throughout all streams.

Accordingly, we are proposing to set up fourteen watershed offices. The fourteen is based largely on a careful analysis of the Army Engineers structure, the Geological Survey structure, and so forth, and that more nearly is coterminous to the other federal agencies with which we will be working closely.

It will be the function, we hope, of these river basin offices to operate with considerable autonomy and be the group which will work directly with the states, with a close tie-in, of course, to the regional offices of the Public Health Service.

In an effort to make a start at some establishment of where the federal responsibility and action starts, we are thinking at the moment that the Public Health Service will work toward the development of the comprehensive program, the establishment of legitimate water uses and stream standards, in close collaboration with the states, and leave to the state agency itself the job of approaching cities and industries to get the necessary remedial actions.

Obviously, in many instances there will be very highly technical work required, some elaborate investigations and stream surveys, in which case we are developing in our Cincinnati Station the technical arm of the program which will be drawn in to serve country-wide on the more highly technical aspects.

I think that gives us a general summary of the bill. I have left out details purposely because, as most of you know, there has been planned for December a series of regional meetings with the state authorities, meetings which we are extremely hopeful that the state health officers will be able to attend. If their time does not permit, at least they will have their proper representatives present.

At these meetings we are going to put before the states the regulations which have now been drafted, which will provide the guide lines under which the program will be administered.

The regulations have not been adopted; we did not wish them to be adopted until the states had reviewed them with us, almost line by line, and had given their counsel and judgment before we put them into effect.

Those meetings, as I say, have been announced some time back, and I am sure you are familiar with them.

In closing, I would like to refer a moment to the opening remarks of the extremely highly trained men who launched this program, and it was to that end that the Surgeon General addressed himself by correspondence to the state health officers a short time ago, outlining that difficulty, and asked if there were in the states trained men, first, who had an interest in this program and, second, who perhaps could be spared by the states to submit an application for entrance in the Public Health Service.

We wish to say that we are most appreciative of the very splendid reactions we have had to that letter, and we thank you very much for it.

CHAIRMAN SCHEELE: Are there any questions on Mr. Hollis' presentation?

I assure you that we do not ordinarily try to proselyte people, but in this particular instance we are proselyting to your best interests.

The next item is one which is very timely, in view of the world situation as it continues to stand today, and also in view of the fact that just Monday, since you have arrived here for this Conference, the report to Secretary Forrestal has been published.

The next item is public health planning for national defense, by Dr. Norvin C. Kiefer, who is in charge of the Health Emergency Planning Unit of the Public Health Service. Dr. Kiefer!

PUBLIC HEALTH PLANNING FOR NATIONAL DEFENSE

Norvin C. Kiefer, Senior Surgeon
In charge, Health Emergency Planning
Office of the Surgeon General

I greatly appreciate this opportunity to speak to the State and Territorial Health Officers on public health problems related to national defense. In order to keep within my time limit, I will confine my remarks to three general categories of medical and health problems: those arising in extra-cantonment areas, those related to civil defense plans and those which pertain to the security of our national resources.

The most immediate problem is the provision of public health services in extra-cantonment areas. The total increase in the armed forces which has been authorized is small by comparison with the huge number of men in military service at the end of World War II. There are, nevertheless, some special problems which make the current situation more critical than the mere numbers of men would indicate.

For example, during weekend leaves, which will be granted freely, civilian clothing usually will be allowed, and obvious identity with the armed forces thus will be temporarily lost. Furthermore, the weekend leave makes possible a wide range of travel from the camp. These liberties may produce serious problems, not only for military police and civilian authorities and organizations, but for civilian health officers.

In peace-time, there is likely to be more public interest in civilian pursuits than in military problems. As health officers, however, we are directly concerned because it is our responsibility to protect the soldier from civilian health hazards and, also, to meet any public health demands imposed by the special problems of civilians in extra-cantonment areas. The Selective Service Act of 1948 stipulates

that no persons shall be inducted until adequate provision has been made for various services including such shelter, sanitary facilities, water supplies "as may be determined by the Secretary of Defense to be essential to public and personal health"(1).

Recently, extensive appraisals of current personnel shortages in health departments near military installations have been conducted. Initially, it appears that expansion of these departments is not necessary because they have maintained the increased staffs which were necessitated by the war. Existing services could, however, rapidly become inadequate if a substantial number of public health personnel were offered higher salaries elsewhere and lured away. The expansion of the military forces might in itself create just such a situation.

In August of this year, the Secretary of Defense addressed to the Federal Security Administrator a request that the Public Health Service resume extra-cantonment public health activities similar to those in which we engaged during the war. A team composed of Army-Public Health Service personnel made several reconnaiscance surveys in the Second Army Area. As a result of these pilot studies, it was concluded that the chief problems in areas about camps to which selectees were to be sent were, in order of importance: (1) housing, (2 or 3) recreation, (3 or 2) education and (4) public health.

In order that the needs in these fields may be met on a decentralized basis, the Army, Navy and Air Force have been encouraged to discuss their problems with officials of the regional offices of the Federal Security Agency.

It is hoped that these efforts will serve to integrate all extra-cantonment public health activities of the military forces, the Public Health Service, and State and local health officers. The Public Health Service is ready to help you to develop and maintain these services.

Now I wish to turn to the medical and public health aspects of civil defense. Before presenting a few of the details

of civil defense plans to you, I would like to have you contemplate their importance.

Until the twentieth century, war was largely an affair between opposing military forces; that is, the civilian was involved only indirectly or not at all unless, of course, his army was defeated and his homeland was invaded by the enemy. In the first World War, civilians in uninvaded areas were killed in moderate numbers, chiefly by a new instrument of warfare - the air-borne missile. By the time of the second World War, great improvements - I suppose we have to call them improvements - occurred both in missiles projected from the ground and in air-borne agents of destruction. The saturation raids on Hamburg are said to have resulted in 60,000 deaths;(2) the fire raids on Tokyo cost the lives of over 80,000 Japanese.(3) Still we Americans could find comfort in the knowledge that our distance from the theaters of war assured us that at the worst we probably would experience no more than abortive attempts at invasion or sporadic token air raids.

Then, on August 6, 1945, one single plane destroyed a large part of a city of one-third of a million persons, killed or fatally injured about 80,000 of its inhabitants and injured over 80,000 more.(4) The atomic age had arrived - and our security born of distance had vanished forever.

Some of you come from cities which have populations similar in number to that of Hiroshima. Any of you can easily develop an arithmetical factor to adjust these casualty figures to apply to your own city. Using a city of one-third of a million people as a basis, please try to imagine yourselves and your medical colleagues suddenly faced with the necessity of caring for 800 injured persons, most of whom are badly hurt. Now multiply that number by 10 and think in terms of 8,000 injured persons. And finally, 10 times more-80,000 persons! Eighty thousand, many of whom have to be sorted from an equal number of dead bodies - sorted amidst a rubble of leveled buildings with a multitude of fires rapidly growing into a holocaust. It defies my imagination.

Furthermore, in a very short time you would be faced with the problem of restoring and maintaining your public health system to protect the lives of the surviving injured and the 180,000 who had not been injured but who might die, unnecessarily, because their food and water supply no longer was protected against contamination, and because they were massed together or evacuated under conditions which would be ideal for the spread of contagious diseases. There would be babies to be fed, women to be delivered. If you fared no better than Hiroshima, ninety per cent of your physicians either would be dead or incapacitated.(4)

These things can't happen in the United States? Why not?

I have reviewed this terrifying picture for only one reason - to serve as a grim reminder of what could happen in the future if we do not begin immediately to plan for adequate civil defense measures. Let us examine more closely the events following the atomic bomb disaster in Hiroshima.

We are told(4) that the entire population was thrown into a hopeless panic. Hysterical, aimless activity or wild flight were the most common individual reactions. First aid teams did not function. There was no attempt at rescue work except that by close friends or relatives of trapped victims. For three days no organized medical care was provided to the injured. When medical teams finally did arrive from other Japanese cities they were not numerically sufficient to cope with such huge numbers of casualties, nor did they have adequate supplies. No one will ever know how many persons died needlessly, died because of lack of rescue services and medical care.

We cannot ridicule the Japanese for their lack of preparedness because the people of Hiroshima had not even dreamed of a disaster of this type and magnitude. But now that we know the potential destructiveness of the atomic bomb, we certainly are fully warned of the dire consequences of lack of adequate preparation.

We dare not forget that the medical and public health personnel, equipment and facilities, including hospitals, would likely be subjected to extremely high rates of destruction. This means that most of these services would have to come from outside the damaged area, from the nearby small towns and the more distant cities. In the light of these possibilities, plans for mutual assistance between municipalities therefore become indispensable. This requires that we solve huge transportation and communications problems, to meet dire contingencies, and provide for adequate assistance to stricken areas.

War of the future will truly be "total war" and there will be no areas beyond the potential range of enemy attack. It is quite possible that at the outset of another war the civilian would be subjected to heavier attack than the soldier - and he might remain in this unenviable status throughout the war.

Are you by any chance thinking that effective organization of all of these services is too complex and enormous a burden for civilians, that the task should be turned over to our military forces? When an army is compelled to divert its efforts to civilian problems, its effectiveness as a fighting force is diminished. The function of the military man is to protect, not to care for his civilian brother; his task is to fight the enemy, to carry the battle to enemy territory and thus keep it from his native land.

It is the duty of the civilian population to plan, organize, train and provide for its civil defense. The prevention of enemy air attack on this country is a task for the armed forces. But when, as must happen at least occasionally, enemy planes break through and drop their lethal cargoes, it is the responsibility of the civilian to care for himself and to repair his damage. The civilian population and the military forces will become mutually dependent: each has its own task; if either is defeated, the other cannot survive.

Following an extensive study of the civil phases of national defense, Secretary Forrestal established, in March 1948,

an Office of Civil Defense Planning within the National Military Establishment. He appointed Mr. Russell J. Hopley, President of the Northwestern Bell Telephone Company, to be the Director. Approximately thirty persons were selected to develop the initial broad plans for the various special fields of civil defense.

You will note the substitution of "civil defense" for the term "civilian defense" which was employed in the second World War. This change has great significance for you, as State civil authorities, because of the intended implication that, in the event of another war, this phase of national defense is a responsibility of civil government.

The first basic plan for civil defense, entitled "Civil Defense for National Security",(5) was released to the public three days ago. Fifty copies of this 300-page document were sent to the Governor of each State. I urge that you immediately obtain one from your Governor's office. I shall discuss only a few salient points:

1. It is recommended in the report that a permanent Office of Civil Defense be created and placed directly under the Secretary of Defense.

2. Under the Director of this office would serve four Deputy Directors. One of these deputies, who would be a physician, would head a group consisting of the Medical and Health Services Division, the Radiological Defense Division, the Chemical Defense Division, and the Special Weapons Defense Division. The Public Health Service has had an active role in the formation of the plans of the Medical and Health Services Division. I have worked on these plans for several months - first as Associate Medical Advisor and currently as Medical Advisor.

3. Proposed functions, organization, training and war-time operations of the Medical and Health Services Division of the Federal, Regional, State and Municipal Offices of Civil Defense are discussed.

4. The Medical and Health Services Division of the National office is divided into three main branches: Medical Services, Public Health Services and Administrative. The Public Health Branch consists of ten sections: Communicable Disease Control, General Sanitation, Industrial Medicine and Hygiene, Veterinary Medicine, Maternal and Child Health, Laboratory, Nutrition, Vital Statistics and Mortuary Services, Public Health Nursing and Mental Hygiene. Eight of these sections will be headed by Public Health Service officers assigned as consultants to the Office of Civil Defense Planning.

5. The publication includes a description of each field of civil defense activities. All of these fields - of which medical and health services comprise only one - are inter-related and it therefore should prove advantageous for you to read the entire plan. In order to avoid production of a huge volume, the discussion was, in each instance, limited to general policies and broad principles. Considerable elaboration of these plans is necessary. For this reason, detailed technical manuals will soon be prepared. The Public Health Service will assist in their preparation.

6. Sanitary Engineering is not included in the Medical and Health Services Division. It is a Branch of the Engineering Division which is under the Deputy Director for Technical Services. Senior Sanitary Engineer Gordon E. McCallum of the Public Health Service is Advisor for Sanitary Engineering. In my opinion, if sanitary engineering is separated from other public health services in State Offices of Civil Defense, administrative difficulties and confusion may arise because in most States these are functions of a single agency - the State Health Department.

7. This point perhaps has the greatest significance for you: "...it is suggested that each Governor may

wish to appoint his State Health Commissioner, or equivalent, to the position of Chief Officer of the Medical and Health Services Division of the State Civil Defense organization".

In some States this recommendation may not be accepted. An Office of Civil Defense, complete with personnel, may already have been formed without placing the State Health Officer in the key medical position. I can only hope that each of you has already acted on my recommendation, made in Chicago last June, that you immediately begin active participation in your State civil defense planning.

It is a policy of the Office of Civil Defense Planning(5) the existing governmental agencies be asked to assume those civil defense functions which are closely related to their usual activities. We have advocated that the State Health Department should assume these civil defense responsibilities. We believe it is well-suited because it consists mainly or wholly of full-time employees who have had considerable administrative and organizing experience. In addition, it is accustomed to broad programs involving the general public; and it derives from State laws its civil authority which in many cases is, during emergencies, far-reaching and extremely powerful.

This is a heavy responsibility. If you accept it you and your top staff members undoubtedly will have to assume heavier work burdens, time expenditures and personal sacrifices. In the event of war it will become the most important single function which your department has; in the event of enemy attack on any part of your State, it will temporarily become the only job to which you and your staff can devote attention.

It will require the utmost cooperation between your department and the State Medical, Dental, Nurses', Veterinary and similar professional organizations. Without their help, your program is destined to fail. In return for their assistance, you can provide leadership, full-time capable administration and legally constituted authority.

Are you prepared to furnish them? If not, can you make adjustments and improvements so that you can promise to deliver in the near future? Effective leadership, adequate plans, good organization and sufficient personnel are necessary if we are to be prepared to prevent the needless loss of tens of thousands of lives.

Apprehension over the possibility of not having adequate personnel and essential equipment leads us to the third phase of our subject - the discriminate use of resources which are vital to our national security.

The federal agency which is charged by law with the responsibility for evaluating these resources and making recommendations to the President is the National Security Resources Board. The members of this Board are of Cabinet rank; the chairman is a civilian, Mr. Arthur Hill. He has a full-time staff representing the various special fields. Dr. James Crabtree is Chief of the Medical Services Division. Under him are five full-time experts in medical and related personnel, nursing, environmental sanitation, medical supplies and hospital facilities. In addition, he is advised by a group of civilian and government consultants.

Although the duties of his organization are extremely numerous, the main objectives may be summarized in three categories:

1. To determine the total present and potential resources in manpower, materiel, and facilities. It is the policy of the National Security Resources Board to request civilian organizations to prepare inventories of such resources. The American Medical Association, for example, has been asked to furnish rosters of physicians, and the American Dental Association for similar lists of dentists; the national hospital organizations are preparing analyses of hospital and related facilities which are or can be made available.

2. To estimate the total minimum war-time need for these resources. In conformity with the general policy of the Board, official federal agencies have been asked to undertake these studies. The National Military Establishment will contribute estimates of military needs. Civilian needs for medical and related personnel, equipment, hospitals, laboratories and clinics will be computed by the Public Health Service. The Department of Commerce will estimate civilian needs for medical supplies.

3. To weigh estimates of needs against data on national resources and then to recommend appropriate measures to correct actual or potential deficiencies so as to protect national security. This is the difficult task and huge responsibility of the National Security Resources Board.

The national deficit of general hospital beds totals substantially over 100,000. The Hospital Survey and Construction Act is aimed at reduction of this shortage; but this is a long-range plan and, even when completed, will not entirely relieve the shortage.

It seems certain that extraordinary war-time demands for medical and related services will result in shortages of physicians, dentists and nurses and, to a lesser extent, all other categories of medical and public health personnel. Because the supply cannot be increased rapidly, the medical component of the National Security Resources Board must develop policies and plans for effective utilization and distribution of professional persons and, wherever possible, employment of auxiliary workers.

The total of military and civilian demands will almost undoubtedly exceed the potential supply. The National Security Resources Board will have to make vitally important decisions which cannot be any more valid or reliable than the data and the estimates on which they are based. The Board cannot rely on an estimate based only on a simple ratio of doctors to civilians. Detailed substantiation will be required. Full

consideration must be given to all possible variations in the problems of individual communities or geographic areas, such as, to list a few, population densities, availability of hospital facilities, strategic war-time industrial importance, and vulnerability of municipalities to enemy attack.

The Public Health Service has asked the Council on Medical Service of the American Medical Association for its assistance in this difficult assignment and has been assured of cooperation. In the matter of estimation of basic requirements for public health personnel and facilities we solicit your help.

I have presented to you some of the medical and public health precautions which must be taken against a war which we hope never will occur. It is quite possible that for many years we may not be completely assured of lasting peace and that our plans will therefore have to be projected into a far distant future.

Those of us who provide medical and public health services are exceptionally fortunate in one respect: our time and efforts will have been profitably spent whether we are to have war or peace. The need for preparations to assume the responsibilities which we have discussed should provide another stimulus to the strengthening of health departments. The wide range of activities which will be required, together with the necessity for utmost understanding and cooperation between official agencies, voluntary organizations and professional associations, should contribute to the extension of the horizon of future public health work. And, finally, all of these plans are applicable to peace-time disasters - floods, tornadoes, explosions, fires and others. Man may eventually be able to live in peace with his neighbor. But there is little prospect that he will be able to control all of the unpleasant surprises which nature can inflict on him.

REFERENCES

(1) Public Law 759, 80th Congress, Chapter 625, 2nd Session, S. 2655 (The Selective Service Act of 1948).

(2) The Effect of Bombing on Health and Medical Care in Germany. Morale Division, United States Strategic Bombing Survey. Medical Branch Report. War Department, Washington, D. C., October 30, 1945.

(3) The Effects of Bombing on Health and Medical Services in Japan. United States Strategic Bombing Survey, Medical Division, June 1947.

(4) The Effects of Atomic Bombs on Health and Medical Services in Heroshima and Nagasaki. United States Strategic Bombing Survey, Medical Division, March 1947.

(5) Civil Defense for National Security. Report to the Secretary of Defense by the Office of Civil Defense Planning. November 1948.

(Dr. R. C. Williams, Chief, Bureau of Medical Services, assumed the chair.)

CHAIRMAN WILLIAMS: Would you care to discuss Dr. Kiefer's paper?

I want you all to notice how neatly we have gotten everybody on the platform into the program. My part is to tell you that there is a recess until two o'clock.

(The Conference adjourned at eleven twenty-five o'clock.)

G E N E R A L S E S S I O N

Consideration of Committee Reports

November 17, 1948

The Conference reconvened at two-fifty o'clock, Dr. Dearing presiding.

CHAIRMAN DEARING: Will the meeting please come to order.

The next item is the presentation of committee reports to the session. The first report to be heard is from the Environmental Sanitation Committee, to be presented by Dr. Kilbourne.

Editor's Note: The material which follows represents that part of the Report officially approved by the State and Territorial Health Officers Association at their Official Annual Meeting, November 15 - 17, 1948.

COMMITTEE
on
ENVIRONMENTAL SANITATION

B. K. Kilbourne, M. D., Montana - Chairman

M E M B E R S

L. J. Roper, M. D.	Virginia
Madelene Donnelly, M. D.	Idaho
John S. Wheeler, M. D.	New Hampshire
Russell O. Saxvik, M. D.	North Dakota
Bruce Underwood, M. D.	Kentucky

C O N S U L T A N T S

Public Health Service

James G. Townsend, M. D.
Mark Hollis
C. H. Atkins

Children's Bureau

Marian M. Crane, M. D.

R E P O R T

The Committee on Environmental Sanitation of the State and Territorial Health Officers' Association begs to submit the following report:

The Committee feels the importance of environmental sanitation in the total public health movement warrants greater emphasis than it now receives, especially in certain basic categories. In general, health agencies have allowed the sanitation program to drift into routine performance. While we have been attacking the traditional sanitary hazards, new problems have risen and grown to a size more conspicuous than our success in combatting them

In the larger cities progress in basic sanitation has kept pace reasonably well with national growth. The quality of public water supplies, extent of sewerage services and suppression of disease-carrying insects generally are satisfactory; at least the gross health implications of these environmental factors have been brought under control. To a much lesser extent has been met the national need in milk and food sanitation, control of excessive stream pollution, rodent control and sanitation of metropolitan fringe areas. Similarly in need of improvement are the sanitation services for schools, smaller communities and rural areas.

As yet undiagnosed is the full health significance of sub-standard housing, excessive noise, refuse disposal problems, inadequate recreational facilities, and air pollution, especially in congested areas (smoke, fumes, poor ventilation, irritating pollens and the like). Health officials have yet to develop their potential role in reducing appalling home accident fatality rates.

In view of the emphasis on local health services, it is felt urgent that the Public Health Service address itself more vigorously to the problems of developing workable techniques and operating patterns of general sanitation for application at the Federal, State and local levels. Specifically,

there is need for a broader approach to fundamental and applied research in the sanitation field, establishment of uniform standards, program demonstrations, training of personnel and provisions for more specialized advisory services to States.

The complexities and difficulties involved in securing adequate environmental health provisions in the populous environs of incorporated cities is well known to state health departments. Information was presented to your Committee indicating the probability of more rapid expansion of such areas, with a resultant heavy impact on many areas already faced with acute conditions. The recommendation, as amended and approved by the Committee on Environmental Sanitation, follows:

Recommendation 1 - Study of Environmental Health Problems

That the United States Public Health Service undertake, on request from the State Health Officer, at the earliest possible date a comprehensive study of the environmental health problems of urban fringe areas, for the purpose of assisting state health departments in developing adequate measures for the correction and prevention of undesirable sanitation conditions.

Following the recommendation of the 1947 Conference, plans have been prepared by the National Office of Vital Statistics for the collection and analyses of supplemental data on accidental deaths. All state offices of vital statistics have been advised of the suggested activity, which it is planned to undertake in cooperation with a few states for an experimental period. Such a trial period would provide an opportunity to develop satisfactory procedures before attempting to secure nation-wide collaboration and reporting. The Kansas State Board of Health, Nassau County (N. Y.) Health Department and National Safety Council have assisted in planning this activity.

Following is a statement of the training programs of the U. S. Public Health Service Training Division at Atlanta, Georgia:

"Experience in operating the regional field training stations in Georgia, New York State, Kansas, and Ohio, during the past year or two has been helpful in establishing the patterns of field training by which the States can be aided best. We are now proceeding along the following five avenues which are considered the most productive methods of operation.

(a) Expanding training activities in cooperation with universities and schools of public health.

(b) Lending assistance to state-operated field training centers for public health personnel by loan of personnel and equipment.

(c) Enlarging facilities at Cincinnati and Columbus for field training for Regular Corps Officers, U. S. Public Health Service, and State Sanitary Engineer personnel.

(d) Developing the Denver regional sanitation field training center to serve the Rocky Mountain States.

(e) Establishing a "Special Services" branch at headquarters Training Division to serve foreign visitors and also to help cities and states with housing training activities."

Your Committee desires to commend the Public Health Service for the establishment of the training centers and urges the several states to utilize more extensively the advantages for training offered at this center.

The Committee requested the Public Health Service to advise it regarding:

(a) The present status of publication of ratings of interstate milk shippers.

(b) Revision of recommended milk ordinance.

(c) Disease outbreaks in water, milk and food for 1946.

The following report from the Public Health Service personnel was submitted:

"Publication of ratings of interstate milk shippers. As the milk shipping States have thus far failed to submit ratings of their milk shippers, it has been impossible for the USPHS to publish periodically a list of the names and ratings of interstate milk shippers for the information of milk shortage areas, as requested by the 1946 Conference. The publication of such a list has been postponed until such time as the larger shipping States are in position to undertake the necessary rating work either through their own staffs or by the assignment of milk consultants from the Public Health Service when and if such assignment should become possible. It is suggested that the Committee invite the attention of the Conference to the urgent need of providing at least one qualified milk sanitarian in each of the larger shipping States for the rating of interstate milk shippers.

Revision of recommended milk ordinance. A new edition of the Milk Ordinance and Code will be printed next year. A revised ordinance without the code will be mimeographed within the next few months. It is believed that the revised ordinance can be adopted by non-Standard Milk Ordinance areas without creating undue enforcement difficulties, and by Standard Ordinance areas without any material change in procedure or disruption of existing programs. It is suggested that the Committee call attention to the desirability of country-wide uniformity in milk sanitation standards, to the benefit of both the public health and the industry.

Disease outbreaks from water, milk and food for 1946. The number of outbreaks traced to milk reached a new low in 1946, while those traced to food reached a new high. Nearly

six times as many outbreaks were traced to food (299) as to water (32) and milk (19) combined. While outbreaks attributed to water and to milk declined during recent years, a steady increase in food-borne outbreaks has occurred. These figures offer an obvious challenge to health officers to control the cause of food-borne disease. It is suggested that the Committee call attention to the fact that protection of water and milk supplies deserves continued effort to maintain past gains, but control of food sanitation obviously demands increased emphasis."

At the Forty-sixth Annual Conference, it was agreed that the Interstate Quarantine Regulations that were effective in 1947 could be relaxed insofar as they apply to the manufacture of lather brushes. Accordingly, Section 72.21 of the Regulations is now being revised to include the following provisions:

(a) The acceptance of methods of destroying anthrax spores other than exposure to steam under pressure. This will permit the use of flowing steam which has been demonstrated to be effective and desirable.

(b) The exemption of badger hair from sterilization except in those cases where the Surgeon General finds that it is needed.

(c) Plant inspections and collection of samples at the discretion of the Surgeon General.

(d) Registration of identifying mark with the Surgeon General.

Under this revision, it will not be necessary to make inspections at any specified interval, and the annual renewal of certificates will not be required. The provision of registering an identifying mark will be retained and kept available for tracing the source of shipments of brushes. It is believed these new regulations will provide adequate control and at the same time minimize the efforts devoted to the control of anthrax spread through the shipment of lather brushes.

The success of the shellfish control program of the Public Health Service depends largely on the degree of co-operation and interest shown in it by the States. In keeping with the original arrangements made between the States and the Public Health Service many years ago the program has been a voluntary one with little or no federal regulatory action on the part of the Service. So long as consuming States demand shellfish which are produced and handled in accordance with generally recognized recommended practices, the Public Health Service and the producing States will have little trouble maintaining reasonable compliance. However, when consumer interest in safe shellfish falls off, non-certified dealers are able to ship their products to consumer areas with few barriers. For continued protection consuming States should require that all shellfish originate from dealers whose names and certification numbers appear on the semi-monthly lists issued by the Public Health Service.

The following resolution is proposed for the consideration of the Association:

WHEREAS, the success of the shellfish control program of the Public Health Service depends largely on the degree of cooperation and interest shown in it by the States; and

WHEREAS, the shellfish producing States and the Public Health Service will have little trouble maintaining reasonable compliance so long as consuming States demand shellfish which are produced and handled in accordance with the generally recognized recommended practices of the Public Health Service; and

WHEREAS, when consumer interest in safe shellfish falls off, non-certified dealers are able to ship their products to consumer areas without sufficient protection to the consuming public; therefore be it,

RESOLVED, by the Association of State and Territorial Health Officers that each State Health Officer be asked to inform the Public Health Service of present regulations or policies in his State with respect to the acceptability of non-certified shellfish for sale within that State, and further, that steps be taken to see that these regulations or policies be strengthened, where necessary, so that interstate shipment of shellfish will be rendered less attractive to those of the industry who may not meet generally accepted standards of production and handling.

It has come to the attention of the Committee that the U. S. Department of Agriculture has been asked to consider a proposal to federally grade uninspected drawn poultry. After due consideration the Committee recommends disapproval of this action and in consequence has submitted to the Resolution Committee a resolution substantiating this action.

Respectfully submitted,

ENVIRONMENTAL SANITATION COMMITTEE
B. K. Kilbourne, M. D. - Chairman

CHAIRMAN DEARING: Thank you, Dr. Kilbourne.

Is there any discussion or comment on this report?

(Upon motion regularly made and seconded, it was voted unanimously to adopt the report.)

CHAIRMAN DEARING: I can say for the Public Health Service that we indeed welcome the report which this Committee has given us, feeling that the broader approach to the problem of sanitation is necessary to keep up with this changing world and the development of new techniques. Your support and your cooperation and your leadership in carrying on and developing this field is what is necessary to make it go.

The next committee report is from the Federal Relations Committee, Dr. Hutcheson, Chairman.

COMMITTEE
on
FEDERAL RELATIONS

R. H. Hutcheson, M. D., Tennessee - Chairman

M E M B E R S

H. E. Hilleboe, M. D.	New York
C. Earl Albrecht, M. D.	Alaska
A. J. Chesley, M. D.	Minnesota
Frederick MacCurdy, M. D.	New York
Roy Norton, M. D.	North Carolina
Grady F. Mathews, M. D.	Oklahoma
George W. Cox, M. D.	Texas
Charles Capron	Vermont

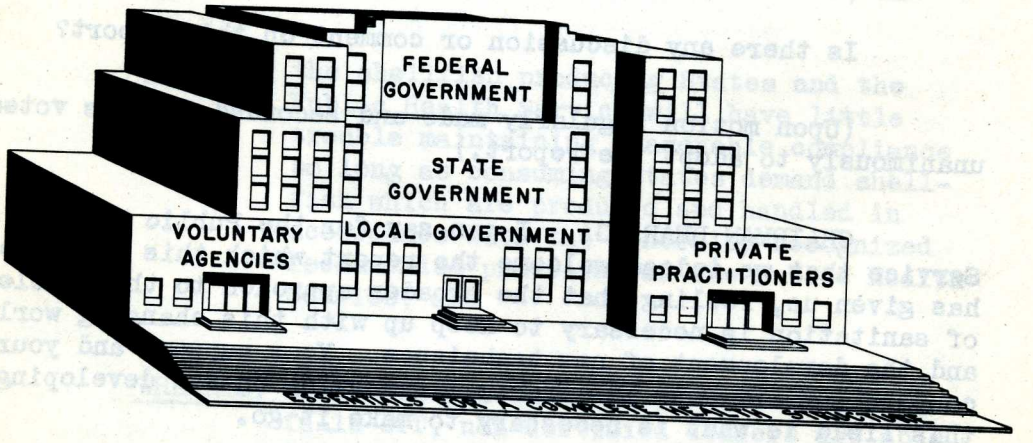
C O N S U L T A N T S

Public Health Service

Estella Ford Warner, M. D.
Joseph W. Mountin, M. D.
Robert H. Felix, M. D.

Children's Bureau

Edwin F. Daily, M. D.
Sarah S. Deitrick, M. D.
John C. McDougall



R E P O R T

Mr. Chairman, members of the Association, ladies and gentlemen:

As the meeting date of the Conference of the State and Territorial Health Officers with the Surgeon General of the Public Health Service and the Children's Bureau approached, it became evident that the Committee on Federal Relations could not possibly clear in the Committee meeting all of the questions assigned to the Committee for discussion; therefore, the Chairman, with the approval of the officers of the Association, appointed a Subcommittee on Fiscal Affairs. This Committee, composed of: -

Robert G. Webster, Chairman - California
S. C. Newitt, Secretary - Louisiana
Albert L. Albright - Kansas
H. B. Halliburton - Tennessee
Floyd Harrington - Oklahoma
Robert T. Malone - Illinois
Fred B. Ragland - Florida
C. C. Shoro - New York

was requested to meet in Boston and consider those questions referred by the Chairman of the Committee on Federal Relations. The Subcommittee's report and recommendations, as amended and approved by the Committee on Federal Relations, follows:

Recommendation 1 - Budgetary Procedure

That proposed changes and simplifications in the budgetary procedure, as prepared by the Public Health Service and the Children's Bureau, be endorsed.

Comment: The proposed changes, and the use of the new form "Schedule of Estimated Expenditures for Health Services", further simplifies the data required to be submitted in the initial budget, and will represent a desirable step for the States.

Recommendation 2 - Identifiable Expenditures

(a) That column 10 on the proposed form "Schedule of Estimated Expenditures for Health Services" be eliminated.

(b) That Column 11 be renumbered 10, and that it be used for both Public Health Service and Children's Bureau figures.

(c) That no tabulation be made of "identifiable expenditures" as proposed.

(d) That the instructions be changed accordingly.

Comment: The proposal of the Children's Bureau for the tabulation of "identifiable expenditures" appears to disregard the fact that in a great many situations the public health functions are conducted by generalized services. The tabulation as proposed would include only the personnel engaged exclusively in MCH-CC activities, which figure would appear to be of little significance since generalized services are operated in a large number of the states. This separate column is also in conflict with the recommendations of many years for uniform handling and reporting of all Federal funds.

Recommendation 3 - Report of Expenditures

That report of expenditures be in the same form and in no greater detail than the "Schedule of Estimated Expenditures for Health Services".

Comment: The advantages of a simplified budgetary procedure are lost if expenditures must be reported in greater detail than the original budget.

Recommendation 4 - Clarification of Regulations

That in proposed regulation 51.1 (b) following the words "Cooperating Agency", the following words be inserted: "which term is used only in relation to the heart disease control program".

Comment: Such an insert will provide clarity in the definition of "Cooperating Agency", which has application only to the heart program.

Recommendation 5 - Annual Report

That section 51.14 (a) (4) of the proposed new regulations be changed to read that the annual report be due 90 days (instead of 45 days) after the end of the fourth quarter.

Comment: It is impossible for most States to prepare the annual report before that time, because of necessary delays in making disbursements and other factors.

Recommendation 6 - Re-Allocation of Funds

That Children's Bureau allocation of reserve funds and reallocation of non-reserve B funds be made as early as possible in the fiscal year, and preferably not later than January first. In order that States may plan the orderly, useful and economical use of funds, it is also recommended that State health departments be urged to send in necessary reports and release unused funds necessary to expedite this action.

Comment: The most beneficial use of supplementary allocations cannot be made when funds become available late in the fiscal period. Late allocations often lead to hurried "year end" spending.

Recommendation 7 - Statement of Encumbered Funds

That the requirement for the listing of the name of vendor and description of commodity purchased be eliminated from the form on which statement of unliquidated encumbrances is presented at end of fiscal year. (Joint Financial Report Form 11.5 - Grants-in-Aid Manual 17.1, Exhibit 1.9 and Exhibit 6)

Comment: Identification of purchases by document should be adequate for review and auditing purposes. (This recommendation was made in 1947 and is repeated this year.)

Recommendation 8 - Mental Hygiene Matching Funds

That the provision in the mental hygiene program, which enables the use of one percent of the costs of institutional care for matching purposes, be continued.

Comment: The proposed deletion of this provision in the future might serve to eliminate the possibilities of a mental hygiene program in some States. (See Grant-in-Aid Manual 13-3-4B)

Recommendation 9 - State Financial Participation

That Section 3 of the proposed regulations for MCH and CC programs, as distributed by the Children's Bureau on May 13, 1948, be revised to read essentially as follows:

"State plans shall provide that a portion of the cost of carrying out such plans will be met by State and/or local funds".

Comment: The proposal in the regulations would appear to permit the Children's Bureau to designate proportions of matching funds as between State and local sources, which might embarrass the States in their fiscal programs;

the specific source of matching funds seems to be of no importance in the total matter of requirements for matching money.

Recommendation 10 - New Reports

That no new reports or forms be initiated during a fiscal year, but that all changes in reports and forms be announced prior to, and be made effective only at, the start of a fiscal year. (See Section 17, Proposed Regulations for MCH and CC Programs, May 13, 1948)

Comment: Fiscal and accounting procedures must be set up at the beginning of a fiscal year, and be geared to providing all required information. Changes made in the middle of a fiscal year lead to confusion and difficulty.

Recommendation 11 - Limitations on Expenditures

That States be permitted to include a portion of the costs of State level local public health administrative functions, epidemiology, purchase and/or manufacture of biologics, and certain laboratory procedures, as a part of the MCH program. (See MCH Informational circular No. 20, Item A, page 3)

Comment: It appears reasonable that MCH funds should participate in the support of these functions, which contribute substantially to the MCH program. (Previously recommended in 1947)

Recommendation 12 - Development of Local Health Unit Services

That the Committee approve in principle a resolution urging the strongest possible support by this Association, by State and local health departments and by civic organizations, of legislation at State and Federal levels designed to promote full-time local health services covering the entire Nation, and, that this question be referred to the Committee on Resolutions to draft an appropriate resolution.

Recommendation 13 - A. P. H. A. Merit System Service

That the Committee approve in principle a resolution endorsing the examination program of the merit system service of the American Public Health Association and that this question be referred to the Committee on Resolutions for appropriate action.

Recommendation 14 - Central Clearing House for Visiting Trainees to the U. S.

That the U. S. Public Health Service take steps necessary to act for the several States in setting up a central clearing house through which all assignments of personnel for training by national and international official and voluntary organizations shall be made.

Recommendation 15 - Annual Official Conference and Meetings

(a) That the Public Health Service and Children's Bureau notify the State and Territorial Health Officers Association, previous to the beginning of each fiscal year, of the national and regional meetings to be called by these agencies during the following 12-month period, to which State health department personnel will be invited. The Association will evaluate the present schedule of meetings now being held annually and make recommendations as to which should be continued. Hereafter, it will evaluate the relative importance of requests made by organizations or groups to the Public Health Service or Children's Bureau for future meetings.

(b) It is further recommended that plans for a special or emergency meeting be submitted to the Executive Committee of the Association of State and Territorial Health Officers for consideration. This is not intended to interfere with regional meetings called by mutual consent of State health officers.

Recommendation 16 - Pre-marital Blood Test Legislation

That the U. S. Public Health Service make a study of the pre-marital blood test laws which have been passed in

approximately 38 States and Territories, with the view of formulating a uniform bill applicable to all States.

Recommendation 17 - Recruitment and Training of Public Health Personnel

That the U. S. Public Health Service develop an effective plan on a long-range basis toward increasing the number of personnel entering the public health field, including all of its specialties. This is a matter of prime importance in meeting the critical public health problems now confronting the Nation, and is vitally related to the problem of national security.

Recommendation 18 - Public Health Planning and National Defense

The Committee received reports from various officers of the service on the general problems of national security. The Committee recognizes that, in the event of war, health will occupy a far more important role in the Nation's security than ever before.

The Committee is also aware of many deficiencies in our national health structure that would, in the event of war, seriously weaken or threaten the security and morale of the people. Outstanding among these deficiencies are:

(a) Shortages of personnel and facilities.

(b) Maldistribution of health resources, and

(c) Weaknesses and lack of geographic coverage in local public health organization.

The Committee therefore recommends:

(a) That the Public Health Service keep the State and Territorial Health Officers currently informed on developments and plans in the field of national security, looking to means of jointly strengthening the total public health resources of the country to meet the extraordinary demands of war.

(b) It is obvious that health services, whether peace-time or war-time, require organization; it is equally clear that if the people are to be assisted in bearing the physical and mental strain of a war emergency, this organization must be local. It is recommended, therefore, that each State health officer, in cooperation with other State agencies and the Public Health Service, proceed as promptly as possible to the development of a form of war-time organization that, in event of war, could be activated and utilized to meet the extraordinary demands of war.

(c) Because civil defense is the responsibility of civil government and, in accordance with a general policy of utilizing, wherever possible, existing governmental agencies to conduct civil defense activities, it is recommended that, in each State, the State health officer or his representative be appointed Chief Officer of the Medical and Health Services Division of the State organization for civil defense.

Recommendation 19 - Federal Grants-in-Aid

A Subcommittee on Federal grants-in-aid was appointed by the President in Chicago in June 1948 and presented its report before the Annual Meeting. Membership on the Subcommittee included:

F. C. Beelman, M. D.	Kansas
Wilton Halverson, M. D.	California
L. E. Burney, M. D.	Indiana
Carl Neupert, M. D.	Wisconsin
R. L. Cleere, M. D.	Colorado
R. H. Hutcheson, M. D.	Tennessee
H. E. Hilleboe, M. D.	New York

It was recognized by the Subcommittee that certain problems in regard to Federal grants-in-aid can be solved only by legislative action; others can be met by policy and procedural changes within the Federal Security Agency.

This Subcommittee recommended:

(a) That the two health programs under the Children's Bureau and the several health programs under the Public Health Service be brought under one medical administrative authority within the Federal Security Agency, or in any new department that might be established to include national health functions. It was also recommended that the President and Secretary of the Association meet with the Federal Security Agency and the Hoover Commission on Governmental Reorganization to determine what can be done to accomplish this objective. The Association will then proceed to take whatever further steps are necessary to get action on this recommendation which has been pending for several years.

(b) That the various grant-in-aid formulas in the Public Health Service and Children's Bureau be simplified and made more uniform and equitable in operation; that acceptance and support of health programs by the States, as well as the States' needs and resources, be considered; and that further efforts be made by the Children's Bureau to simplify their regulations and the use of funds administered by this Agency, particularly in regard to approval of minor details of program operation.

(c) That financial ceiling be removed on grants-in-aid funds for general health under section 314-c, Public Law 410, and that grants-in-aid ceilings for existing types of activities in maternal and child health and crippled children's service be removed under sections 501 and 511, parts 1 and 2, Title V, of the Social Security Act of 1935, as amended.

Recommendation 20 - Conference Reports and Recommendations

It is recommended by the entire Committee:

(a) That the United States Public Health Service classify, analyze, and publish with proper indexing the recommendations of the Conference for the past 10 years.

(b) That this publication be brought up to date annually.

(c) That it be made available to each member of the Conference prior to the next annual meeting and each annual meeting thereafter.

(d) That the United States Public Health Service and the Children's Bureau report annually to the Conference as to action which has been taken regarding the recommendation of the previous session.

The Committee is indebted to the U. S. Public Health Service and the U. S. Children's Bureau for making available the consultants in the various fields, and wishes to express the Association's thanks to the Surgeon General, Dr. Leonard A. Scheele, and to Miss Katherine Lenroot, and their associates.

Respectfully submitted,

FEDERAL RELATIONS COMMITTEE
R. H. Hutcheson, M. D. - Chairman

(Upon motion regularly made and seconded, it was voted unanimously to adopt the report.)

DR. WILLIAMS: I just want to point up one of the remarks which Dr. Hutcheson made about the necessity of the State health officers sending in their data if they wish the allocations to be made on time. We are now holding up the allocations for the last half of the fiscal year because three States have not sent in their fourth-quarter reports. Those States are Rhode Island, North Dakota, and Missouri.

If any of you have any influence with the State health departments of those three States, I would suggest you use it, because we cannot get out these allocations for the last half of the year until we get the reports.

CHAIRMAN DEARING: The next report to be heard is from the Hospital Survey and Construction Authorities Committee, Dr. Beelman reporting.

COMMITTEE
on
HOSPITAL SURVEY AND CONSTRUCTION AUTHORITIES

John A. Ferrell, M. D., North Carolina - Chairman

M E M B E R S

E. A. McLaughlin, M. D.	Rhode Island
George C. Ruhland, M. D.	District of Columbia
C. H. Overman	Florida
J. H. Bankston	Louisiana
James Dack	Michigan
D. V. Galloway, M. D.	Mississippi
D. J. Hurley, M. D.	Nevada
Sanford Bates	New Jersey
Robert T. Lansdale	New York

C O N S U L T A N T S

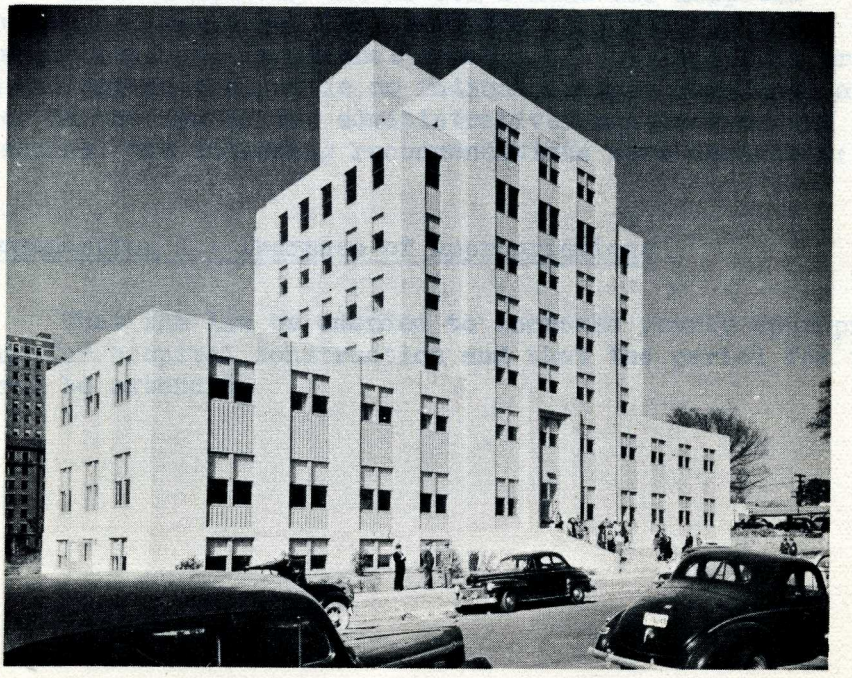
Public Health Service

Vane M. Hoge, M. D.
Douglas N. West
Allen M. Pond
Riley H. Guthrie, M. D. (Alternate)

Children's Bureau

Miss Ruth Taylor
Miss Mildred F. Walker
Miss Edith M. Baker

Jefferson County Health Center - Birmingham, Alabama



R E P O R T

PREAMBLE

It was agreed that the States in general were proceeding with their programs satisfactorily but that they reported certain situations which presented problems. A major problem confronted by State Program Directors appears to be the steadily increasing cost of hospital construction. Reference was made to the need for programs of recruitment and training of medical, nursing, and auxiliary personnel. Importance was attached to the development of proper diagnostic and follow-up services, which might lessen the demand for general hospital beds. Concern was shown relative to problems relating to maintenance and operation of hospitals, particularly in rural areas and in areas of low economic level.

Committee members pointed out the excellent assistance and helpful cooperation provided by the United States Public Health Service, and it was agreed that the program exemplified a very desirable Federal and State working relationship.

In anticipating the nation's need for hospital resources and services, the committee explored the long range economic and functional aspects of this hospital program and agreed that, while no radical changes were indicated either in the law or the administrative organization and procedures, the following recommendations were desirable:

Recommendation 1 - Increase of Appropriations

That the law be amended to increase yearly appropriations for hospital construction and that the period for the program be extended.

Recommendation 2 - Administrative Funds

That funds be provided for administrative purposes:

That the Act be amended to provide for Federal funds to States to assist them in administering the construction program under Public Law 725 to the end that within the limitation set by the Surgeon General the States be aided in expenses in this connection.

Recommendation 3 - Administration of the Law

That Federal Authority for the administration of the law remain with the Hospital Facilities Division of the Public Health Service, and that adequate funds for personnel be provided.

Recommendation 4 - Recruitment and Education

That there be developed a sound program for the recruitment and education of physicians, nurses, and hospital personnel needed to staff the contemplated coordinated system of hospital facilities.

In view of the above recommendations, the following four resolutions A, B, C, and D are respectfully submitted and their adoption recommended.

Resolution A - Extension of Program

WHEREAS, the hospital and health facility surveys of the respective States have shown that there is a great unmet need for hospital, health centers, and related health facilities, and

WHEREAS, it is not anticipated, in view of the high construction costs, the limitations of present Federal appropriations, and other factors, that these unmet needs will be satisfied within the five year program covered by Public Law 725, and

WHEREAS, the completion of the hospital surveys throughout the States have shown that if the Federal program under Public Law 725 is continued for only the five year period specified, only about 15-20% of the hospital needs, according to the criteria set up by said law will have been met, and

WHEREAS, under the limited program provided by the Public Law 725 communities in other than the high priorities are uncertain as to their participation in the present Federal program, which uncertainty is seriously interfering with the orderly completion of the plans and meeting of the public needs, and

WHEREAS, the program now being carried forward under Public Law 725 has been universally well received and supported by all national organizations concerned as a method of providing needed hospital and health center facilities; and the development of co-ordinated State hospital plans is believed to be a method of providing the needed facilities in a proper and economic manner, and it appears that the excellent Federal and State relationships developed in administering this law be continued beyond its five year limitation;

NOW, THEREFORE, BE IT RESOLVED, and it is hereby resolved by this Conference of State and Territorial Health Officers, that Congress be and is hereby petitioned to extend the program and provide for the continued extension of the same until the public needs are met under the provisions of Public Law 725.

Resolution B - Annual Appropriation

WHEREAS, the fiscal provisions of Public Law 725 will enable relatively few sponsors of needed hospital projects to be aided in meeting their responsibilities to their local communities, and

WHEREAS, there has been a steadily increasing cost for the construction and equipment of hospitals and related facilities, and

WHEREAS, the several States report applicants for Federal grant-in-aid toward the construction of needed hospital facilities far in excess of the funds now made available;

THEREFORE, BE IT RESOLVED, that the Association of State and Territorial Health Officers petition Congress to increase the annual appropriation materially, thus enabling the States more adequately to meet the demands being made by the various communities for increased hospital and public health center facilities.

Resolution C - Administrative Expenses

WHEREAS, Public Law 725 provides Federal funds to match 1/3 of the expenses of the States in conducting a hospital survey and developing hospital plans, but did not provide for paying any portion of the expense of the States in administering the law during the construction period, and

WHEREAS, no State plans are fixed but are subject to constant revision to meet the changing conditions in the States, and

WHEREAS, very often the same persons are engaged in the planning and also in the supervision of the construction under the law making it very difficult to prorate the expenses incurred in actual planning and in supervision of construction, and

WHEREAS, the States are in need of financial assistance in administering the construction program so that they will have sufficient personnel to administer the law adequately in accordance with the intent of Congress and in the interest of the best service to the people;

NOW, THEREFORE, BE IT RESOLVED, that the Association of State and Territorial Health Officers petition Congress to make available to the Public Health Service sufficient funds to continue to pay 1/3 of the planning expenses and also to provide 1/3 of the administrative expenses during the construction period under the provisions of Public Law 725.

Resolution D - Administration

WHEREAS, the administration of Public Law 725, the Federal Hospital Survey and Construction Act, requires training and experience in the broad fields of public health and hospital care as well as in the construction of hospitals, and

WHEREAS, the Division of Hospital Facilities of the United States Public Health Service has demonstrated its ability to carry out the details of the broad phases of the above program;

NOW, THEREFORE, BE IT RESOLVED, that the administration of the Hospital Survey and Construction Law, 725, be continued and retained as a responsibility of the Hospital Facilities Division in the U. S. Public Health Service, and further, be it recommended that sufficient funds and personnel be allocated to that Division to enable it to properly meet its responsibilities to the Congress and to the individual States in the expanding program.

Respectfully submitted,

HOSPITAL SURVEY AND CONSTRUCTION
AUTHORITIES COMMITTEE
John A. Ferrell, M. D. - Chairman

(Upon motion regularly made and seconded, it was voted unanimously to adopt the report.)

CHAIRMAN DEARING: The next report to be heard is that of the Infectious Diseases Committee, by Dr. Ringle of Washington.

COMMITTEE
on
INFECTIOUS DISEASES

Arthur L. Ringle, M. D., Washington - Chairman

M E M B E R S

Wilson T. Sowder, M. D.	Florida
Wilton L. Halverson, M. D.	California
James R. Scott, M. D.	New Mexico
Juan A. Pons, M. D.	Puerto Rico
G. J. Van Heuvelen, M. D.	South Dakota
James S. Moorehead, M. D.	Virgin Islands

C O N S U L T A N T S

Public Health Service

Raymond A. Vonderlehr, M. D.
Theodore J. Bauer, M. D.
Robert J. Anderson, M. D.

Children's Bureau

Katherine Bain, M. D.
Miss Ruth Doran

R E P O R T

The Committee recommends:

Recommendation 1 - Formulation of Uniform Reporting System

That the U. S. Public Health Service give consideration to the formulation of a more uniform system for the reporting of amoebiasis and that the various State and Territorial Health Departments cooperate with the U. S. Public Health Service and with other interested agencies in the development of such a system of reporting.

Recommendation 2 - Epidemic and Disaster Aid

That the Congress of the United States be requested to establish an epidemic aid fund of one million dollars to be made available to the U. S. Public Health Service.

The Committee reaffirms its previous recommendation of 1947.

"Epidemic and Disaster Aid: The great possibility of epidemics associated with or following major disasters is recognized. Such catastrophes are usually beyond the resources of local health departments and sometimes of State Health departments. In the past, the U. S. Public Health Service, through makeshift arrangements, has upon request provided assistance in meeting such problems. In order to insure adequacy of future arrangements to meet such problems, provision of more adequate financial assistance is advisable."

Recommendation 3 - Industrial Anthrax Problem

That the Public Health Service undertake a program to investigate the extent and severity of the industrial anthrax problem.

Recommendation 4 - Influenza Study Program

That the Association of State and Territorial Health Officers endorse the Influenza Study program of the World Health Organization in which the U. S. Public Health Service is collaborating and recommend a continuance of this program since the danger of the occurrence of another pandemic of influenza is recognized.

Recommendation 5 - Infant Diarrhea

The problem of diarrheal diseases in newborn infants in hospital nurseries stress the following features:

(1) Knowledge on etiology is inadequate.

(2) Preventive measures have more long-term effect than mere control of outbreaks.

(3) State Health Departments are accepting increasing responsibility in maintenance of standards and licensing of hospitals including the newborn service.

(4) The American Academy of Pediatrics has established both National and State Committees on the Fetus and Newborn.

Considering these problems and to make provision for aiding their solution, the Committee recommends:

(a) That State health departments take an active role in all phases of the problem and cooperate with the State Committees on Fetus and Newborn of the American Academy of Pediatrics.

(b) That various units of all State health departments give continuing consultation to hospital maternity and nursery services in relation to hospital planning and practices, and that cooperative activities be developed with hospital administrators and their associations.

(c) That the Children's Bureau and the Public Health Service collaborate in supporting expansion of programs for training of professional personnel.

(d) That the Public Health Service expand its research activities in this field.

(e) That on request, aid to State health department staffs be made available from the training and research centers.

Recommendation 6 - Fly Control Research

The Committee received a report from the U. S. Public Health Service, indicating that fly control measures in a study area have resulted in a marked reduction in infection disease, and death produced by Shigella infection. Following are the Committee recommendations:

(a) That research activities of the U. S. Public Health Service, the States and other agencies in this field be expanded.

(b) That particular emphasis be given to practical problems in etiology and epidemiology.

(c) That the U. S. Public Health Service and the various States make the maximum use of our present knowledge on the benefits of fly control in its relation to Shigella infection.

Recommendation 7 - Transportation of Hansen's Disease

Since further evidence indicates the futility of the present restrictive regulations regarding the transportation of cases of Hansen's disease, the Infectious Disease Committee strongly reaffirms its previous recommendation:

(a) That these regulations be re-examined and modified.

The Committee wishes to express its appreciation for the assistance of its consultants.

Respectfully submitted,

INFECTIOUS DISEASES COMMITTEE
Arthur L. Ringle, M. D. - Chairman

(Upon motion regularly made and seconded, it was voted unanimously to adopt the report.)

CHAIRMAN DEARING: The next report to be heard is from the Maternal and Child Health Committee, by Dr. Wilbar as Chairman.

COMMITTEE
on
MATERNAL AND CHILD HEALTH

C. L. Wilbar, M. D., Hawaii - Chairman

M E M B E R S

Edwin Cameron, M. D.	Delaware
T. F. Sellers, M. D.	Georgia
Walter Bierring, M. D.	Iowa
Dean Fisher, M. D.	Maine
Norris W. Vaux, M. D.	Pennsylvania
Ben F. Wyman, M. D.	South Carolina
Franklin Yoder, M. D.	Wyoming
W. V. Garnier, M. D.	Louisiana

C O N S U L T A N T S

Public Health Service

Mayhew Derryberry, M. D.
Harold R. Sandstead, M. D.
Charles L. Williams, M. D.

Children's Bureau

Samuel M. Wishik, M. D.
Miss Alice F. Brackett
Miss Marjorie M. Heseltine
John M. Saunders, M.D.(Alternate)
John T. Fulton, M.D.(Alternate)
Miss Clara Arrington(Alternate)

R E P O R T

In preparation of this report the Committee desires to express its appreciation to the consultants from the Children's Bureau and the representatives of the Association of the Maternal and Child Health and Crippled Children directors who attended the committee meetings and rendered valuable advice and counsel to the Committee.

The Committee recommends:

Recommendation 1 - Regulation for MCH and CC Programs

That the Association of State and Territorial Health Officers approve the proposed regulations for MCH and CC Programs as submitted by the Children's Bureau with the deletion of those items which are simply repetition of the Social Security Act with the changes recommended by the Committee on Federal Relations and the substitution, for Items 5, 9 and 16 thereof, of the following:

Item #5 State Health Department plans shall provide that the Maternal and Child Health and Crippled Children's Program Unit or Units, established pursuant to Section 201.4 hereof, shall be under the direction of a Doctor of Medicine who is a full time employee, during the hours of his employment by the State Agency. Crippled Children's agency plans shall provide that the Program Unit will, after June 30, 1950, employ a Doctor of Medicine either a full time employee of the agency or shared in full time employment with the Maternal and Child Health Unit of the Health Department.

Item #9 State Plans for Maternal and Child Health and Crippled Children's Services shall

provide that hospital, convalescent or foster home care, or appliances provided to individuals under the plans will be made available only to individuals who are receiving medical services provided or arranged for by the State agency in accordance with the standards and policies of the State plan.

Item #16 State plans shall provide after July 1, 1949 that professional personnel, hospitals, and other individuals or groups providing a service authorized by the State agency under the State plan shall agree not to make any charge to the patient or his family which is not specifically negotiated by the agency and the vendor.

Recommendation 2 - School Health Activities

That the Committee reiterates the principle that school health activities are the joint responsibility of school agencies and health agencies, with the school agencies responsible for the actual classroom teaching and the health agencies responsible for the health program and health service content.

Recommendation 3 - Cooperation of Activities in Health Programs

That the Association of State and Territorial Health Officers approve the resolution proposed by the House of Delegates of the American Medical Association at its annual session from June 21 to 25, 1948, concerning cooperation among the State Medical Association, State Health Departments, and State Congresses of Parents and Teachers in the area of public health, school health services and health education.

Recommendation 4 - Problem of Prematurity

That efforts to explore the problem of prematurity be continued with the idea of defining program content in this field, and with the goal of preventing prematurity from the maternal and pediatric standpoint.

Recommendation 5 - Public Health Dental Program

That a public health dental program for the prevention of tooth decay in children is important and desirable and that any Federal money appropriated for such a program should be in the form of grants-in-aid to the state and territories.

Recommendation 6 - Employment of Consultants

That the Children's Bureau employ part-time and full-time consultants in specialized fields related to the Maternal and Child Health and Crippled Children's programs which are not now covered or adequately met by the present staff of the Children's Bureau.

Recommendation 7 - Distribution of Special Program Reports

That wherever a state has a special program in the field of Maternal and Child Health which may be of value to other states, a report of this program be distributed to each of the states and territories, either directly from the state conducting the program or through the Children's Bureau and that the Children's Bureau attempt to critically analyze these programs and make available to the states the results of their analyses.

Recommendation 8 - Poliomyelitis Outbreaks

That the various state health departments, that have not done so already, draw up plans for organizing health facilities in anticipation of outbreaks of poliomyelitis.

Recommendation 9 - White House Conference

That the Association of State and Territorial Health Officers in preparation for the mid-century White House Conference of 1950, request the Children's Bureau to prepare information concerning the progress which has been made in child health since the previous White House Conferences and what the present Maternal and Child Health Programs might bring about in the way of accomplishment during the next decade and what additional programs are needed in the opinion of the Children's Bureau to make advances in this area.

Recommendation 10 - Planning Maternal and Child Health Programs

That the findings of the study on child health of the American Academy of Pediatrics be widely used as reference material in planning Maternal and Child Health Programs and be used as a vehicle for close relationship between practicing physicians and health departments in their joint endeavors to improve child health.

Recommendation 11 - School Lunches

That there be a continuation of federal assistance toward payment for school lunches with appropriations continuing at least at the present level.

Respectfully submitted,

MATERNAL AND CHILD HEALTH COMMITTEE
C. L. Wilbar, M. D. - Chairman

(Upon motion regularly made and seconded, it was voted unanimously to adopt the report.)

CHAIRMAN DEARING: The next report to be heard is from the Mental Health Committee, Dr. Perkins of Massachusetts, Chairman. Is Dr. Perkins in the audience?

DR. L. E. BURNEY (State Health Commissioner, Indiana): I believe Dr. Perkins did say that he would not be here today, so maybe I had better give it.

COMMITTEE
on
MENTAL HEALTH

C. T. Perkins, M. D., Massachusetts - Chairman

M E M B E R S

H. H. Erickson, M. D.	Oregon
Stanley H. Osborn, M. D.	Connecticut
M. A. Tarumianz, M. D.	Delaware
Charles A. Zeller, M. D.	Indiana
J. H. Bankston	Louisiana
R. L. Dixon, M. D.	Michigan
Felix J. Underwood, M. D.	Mississippi
George Freeman, M. D.	Montana
Anna Philbrook, M. D.	New Hampshire
David Young, M. D.	North Carolina
Edward J. Humphreys, M. D.	Ohio
Charlie R. Barber	Pennsylvania
Edward P. Reidy	Rhode Island
Coyt Ham, M. D.	South Carolina
T. C. Dale	Vermont
Joseph E. Barrett, M. D.	Virginia
Allen W. Bayley	Wisconsin

C O N S U L T A N T S

Public Health Service

James V. Lowry, M. D.
Miss Pearl Shalit
William Jenkins, M. D.

Children's Bureau

Henry H. Work, M. D.
Betty Huse, M. D.
Miss Doris Siegel

R E P O R T

The Committee on Mental Health conducted its meetings on November 14 and 15, 1948. Eleven members of the committee were in attendance and, during the informal sessions, an additional large number of invited guests representing mental health authorities of other states were in attendance.

Fourteen different items were considered on the agenda. Many of these were for discussion purposes and for the information of the assembled mental health authorities. Several of those items do not require consideration or action by the Association.

Of inestimable help to the Committee was a very fine 85-page document prepared by Dr. James V. Lowry and his associates in the Community Services Section of the Mental Hygiene Division of the Public Health Service. Among other things, this document provided a brief survey of the activities of every State participating in the National Mental Health Act Program during the past fiscal year. It was very informative, saved considerable time on the part of the Committee members, and the Committee was unanimous in desiring to express its deep gratitude to Dr. Lowry and his associates for their preparation of this brochure.

The items considered by the Committee, and which we believed to be of sufficient importance to be called to the attention of the Association in the form of recommendations or resolutions are as follows:

Recommendation 1 - Mental Hygiene Program Personnel

That in developing mental hygiene programs, State Mental Health Authorities utilize personnel that as nearly as possible meet the professional standards of the Committee on Professional Education of the American Public Health Association. It is further recommended that, as a step toward this desirable goal, the standards submitted to the Committee by the National

Advisory Mental Health Council be considered as a guide for the Surgeon General of the U. S. Public Health Service to use in taking up the matter with the proper committee of the American Public Health Association.

Resolution A - Grant-in-Aid Funds

WHEREAS, the problem of providing adequate public health services is a continuing operation, it is desirable that activities established by the States with the aid of federal funds be assured of the continuance of Federal grant-in-aid funds, and therefore be it

RESOLVED, that the Surgeon General of the U. S. Public Health Service request the Congress of the United States to establish contract authorization for the forward financing of grants-in-aid to the States.

Resolution B - Personnel

WHEREAS, an immediate, urgent and unmet need for well-trained personnel in psychiatry, psychiatric social work, clinical psychology and related disciplines has been expressed by the representatives of State mental health agencies attending this 47th conference of State and Territorial Health Officers, and

WHEREAS, it is the impression of this group that the requirements and policies of certifying and accrediting agencies have become increasingly rigid and restrictive, especially in the undue emphasis upon long formal and academic training beyond the doctorate degree, and in the lessened recognition of demonstrated competence over several years of service in the various professional fields, community hospitals and other health facilities,

THEREFORE, BE IT RESOLVED, that such certifying and accrediting bodies be requested to review their present practices and policies to the end that the following factors be considered and reconciled:

(a) reasonable competence in the field of the specialty so as to protect service to the public,

(b) the urgent and unmet needs of the State mental Health programs,

(c) more widespread and effective use of public mental hospitals as training facilities, and

BE IT FURTHER RESOLVED, that copies of this resolution be transmitted to the American Board of Psychiatry and Neurology, Inc., the American Board of Examiners in Professional Psychology, the American Association of Psychiatric Social Workers and other interested bodies.

Resolution C - Financial Support of Mental Health Programs

WHEREAS, the State Mental Health Authorities have requests from diverse agencies for financial support of their mental health programs, and

WHEREAS, the support of selected agencies can advance the general educational program and progress of the Mental Health Authority programs within the State,

THEREFORE BE IT RESOLVED, that certain basic information be considered by the State Mental Health Authority before financial support is extended. The following criteria are offered:

(a) the project to be supported is needed in the locality proposed,

(b) it is not a duplication, or otherwise superfluous to, existing services,

(c) as proposed it is an efficient, humane, and economical measure,

(d) there is reasonable expectance that the sponsoring agency will be able to fulfill the obligations implied if the support is granted, and

BE IT FURTHER RESOLVED, that in addition to the above basic requirements, the following detailed information about the agency should be submitted in writing before the application is approved:

(a) name, location, purpose, goal and administrative structure of the agency;

(b) personnel structure of the agency or the division of the agency concerned with the project;

(c) financial structure of the same;

(d) outline of the need, purpose, goal, and probably duration of the project, citing figures as far as reasonable;

(e) resume of any project of a similar nature carried out by the same agency or division within the previous calendar year;

(f) statement as to the need of the work.

The Committee was unanimous in expressing its deep gratitude to the Surgeon General of the U. S. Public Health Service for the leadership, the cooperation, and the backing given to the states during this past year in carrying out their mental health programs.

We are also deeply grateful to the consulting services which those connected with the U. S. Public Health Service have rendered during the past year and, particularly, to Dr. Carlyle Jacobsen of Iowa who sat with us throughout the Committee meetings and our executive session deliberations and offered considerable valuable advice and represented the National Advisory Mental Health Council.

Respectfully submitted,

MENTAL HEALTH COMMITTEE
C. T. Perkins, M. D. - Chairman

(Upon motion regularly made and seconded, it was voted unanimously to adopt the report.)

CHAIRMAN DEARING: It is particularly gratifying in this new and very important and very difficult field to have the strong support of this organization and the hard work of the great numbers who are willing to give their time and energy to help get it organized and to help this Committee and help the Public Health Service move ahead.

The last standing committee report is from the Special Health and Medical Services Committee, Dr. Gill of Alabama, Chairman.

COMMITTEE
on
SPECIAL HEALTH AND MEDICAL SERVICES

D. G. Gill, M. D., Alabama - Chairman

M E M B E R S

R. B. Aiken, M. D.	Vermont
W. S. Petty, M. D.	Nebraska
J. P. Ward, M. D.	Arizona
T. T. Ross, M. D.	Arkansas
(Dr. Easley substituting)	
A. E. Heustis, M. D.	Michigan
Daniel Bergsma, M. D.	New Jersey
John Porterfield, M. D.	Ohio
Welby W. Bigelow, M. D.	Utah
Carl N. Neupert, M. D.	Wisconsin
N. H. Dyer, M. D.	West Virginia

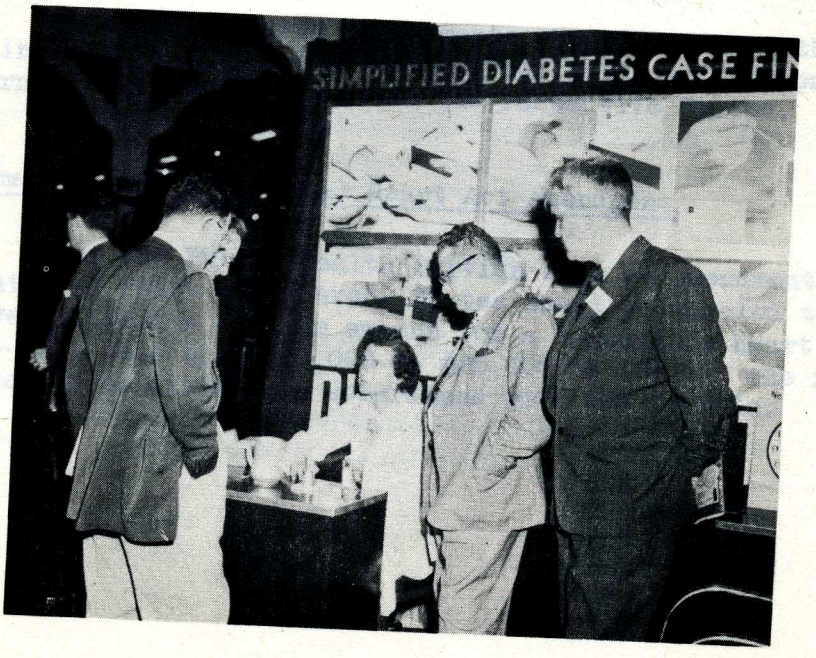
C O N S U L T A N T S

Public Health Service

Cassius J. Van Slyke, M. D.
John R. Heller, M. D.
Dale Cameron, M. D.

Children's Bureau

Arthur J. Lesser, M. D.
Miss Helen R. Stacey
Miss Florence L. Phenix



R E P O R T

CHRONIC DISEASES

Heart Disease

The Committee recommended:

Recommendation 1 - Cooperative Heart Activities

That State health departments should establish cooperative relations with the American Heart Association, its State and local affiliates and with State and local medical societies.

Recommendation 2 - Education in Diagnosis and Treatment

That State health departments should promote education of the general practitioner in the diagnosis and treatment of heart disease.

Recommendation 3 - Evaluating Facilities and Personnel

That State health departments should evaluate the teaching, diagnosis, and treatment facilities and personnel concerned with heart disease in the respective States.

Recommendation 4 - National Heart Act Amendment

That the Public Health Service seek an amendment to the National Heart Act whereby States would be enabled to receive at least a minimum amount for a reasonable heart program -- not less than $10,000 to $25,000 per State, the rest of money to be divided in accordance with the formula.

Diabetes

The Committee recommended:

Recommendation 5 - Cooperative Diabetes Activities

That State health departments should establish cooperative relations with the American Diabetes Association, its State and local affiliates and with State and local medical societies.

Recommendation 6 - Study of Diabetes Problems

Since the results of activities in diabetic control programs conducted by the Public Health Service with local health agencies indicate the diabetes control activities would be a practical and useful addition to the activities of a well-rounded local health department, it is recommended:

That where funds are available, consideration be given by the State and Territorial Health Officers' Association to plans to initiate studies of the diabetes problem within each of the States.

Recommendation 7 - National Diabetes Week

That State and local health departments endorse and support National Diabetes Week, December 6 - 12.

Cancer

In view of the increased recognition of cancer as a disease and the increased action by State health agencies in their relation to cancer as a public health problem, it is recommended:

Recommendation 8 - Determination of Cancer Hazards

That the State health officers should initiate and support the conduction of surveys for the determination of environmental cancer hazards, especially those of industrial nature, in order that corrective measures may be applied.

Recommendation 9 - Effective Control Methods

That the State health officers develop cooperative and integrated interests of their cancer control and industrial hygiene departments in order that effective control measures be determined as to industrial cancer hazards.

PUBLIC HEALTH DENTISTRY

With respect to the use of topical fluorides in public dental programs, the State and Territorial Health Officers' Association recommends the following:

Recommendation 10 - Inclusion in Health Programs

That all public health dental programs should include the topical application of sodium fluorides as a prophylactic measure.

Recommendation 11 - Sodium Fluoride A Preventive Measure

That topical use of sodium fluorides is a preventive health measure. It should be available to all children of specified age groups in any area where a program is developed.

Recommendation 12 - Training Personnel

That auxiliary personnel be trained to assist in this program.

Recommendation 13 - Rigid Adherence To Technic

That a technic which has been adequately tested should be rigidly followed.

Recommendation 14 - Continuation of Water Supply Studies

That it is recommended that studies be actively continued in the use of sodium fluoride in public water supplies or other vehicles.

HEALTH EDUCATION

Whereas, it is generally agreed that health education is one of the principal functions of a Health Department, and whereas, the Surgeon General has emphasized the contribution to health that can be made by educational and voluntary agencies, the Committee therefore recommends:

Recommendation 15 - Funds for Training

That the Public Health Service seek additional funds from whatever sources possible and continue to augment the number of health educators trained through administration of a fellowship program.

Recommendation 16 - Cooperation in Regional Conferences

That the Public Health Service join with the Office of Education in arranging regional conferences of State Directors of Health Education from Departments of Education and of Health with representatives of voluntary agencies.

PUBLIC HEALTH NURSING

Recommendation 17 - Nursing Education

It is recommended that the State and Territorial Health Officers' Association go on record as supporting and promoting the type of basic nursing education that is designed to prepare nurses who will be competent to function on the staff level in public health, as well as in institutional nursing.

Such programs of nursing education would permit recruitment of public health personnel from high schools.

The Association urges its members to give leadership in securing financial support of this type of nursing education from local, State and Federal sources.

PUBLIC HEALTH STATISTICS

The Association recommends:

Recommendation 18 - Public Health Conference

That the Association approves the establishment of the proposed Public Health Conference on Records and Statistics. In giving approval, it is specifically understood that the motions and actions of the Conference shall be subject to review by the Association prior to adoption. The approval further indicates the endorsement by the Association of the principle that integration of vital statistics and morbidity reporting is essential for better solution of both State and Federal problems.

Recommendation 19 - Statistical Coordination

The endorsement of statistical coordination in the planning, implementation and evaluation of the various special programs, both Federal and State, from the point of view of the measurement of results.

Recommendation 20 - Birth Registration

That it approves the adoption of the uniform birth registration number as adopted by the American Association of Registration Executives and the Council on Vital Records and Vital Statistics and that the Association further requests that the Council's plan for a Birth Register to be located in the State of birth, which will be a cross index to the location of an individual's vital records, be referred back to its Special Health and Medical Services Committee for further study and approval before it is put into effect.

SPECIAL SERVICES

The State and Territorial Health Officers recommends:

Recommendation 21 - Multiphasic Screening Demonstrations

That the Public Health Service establish on an investigative basis in cooperation with State and Territorial Health departments multiphasic screening demonstrations in several communities, and that the State and local health departments take the initiative in developing multiphasic screening programs which would tend to eliminate the duplication of screening efforts by various specialized public health programs.

HEARING AND SIGHT CONSERVATION

The Association recommends:

Recommendation 22 - Demonstration Programs

That the Public Health Service, with the cooperation of the State and Territorial health departments, establish demonstrations designed to determine and to demonstrate the most effective methods of conducting sight conservation and hearing conservation programs in local communities of varying sizes.

REPORT
of
SUBCOMMITTEE ON INDIAN AFFAIRS

A. J. Chesley, M. D., Minnesota - Chairman

M E M B E R S

E. Earl Albrecht, M. D.	Alaska
J. P. Ward, M. D.	Arizona
R. O. Saxvik, M. D.	North Dakota
G. J. Van Heuvelen, M. D.	South Dakota

The Association of State and Territorial Health Officers, at the request of the Director of Health of the Office of Indian Affairs, U. S. Department of Interior and of several members of the Association appointed a Committee on Indian Affairs. It is a sub-committee of the Special Health and Medical Services Committee.

The Director of Health stated that he needed the advice and assistance of the Association in a concerted effort to improve the field health services for Indians. He stated that the public health problems among the Indians as indicated by specific death rates are far greater than among the white population of the same States. He therefore suggested that the Committee members be selected from States with large Indian populations. The Health Officers of Alaska, Arizona, Minnesota, North Dakota and South Dakota were appointed as members of the Committee on Indian Affairs and the health officers of all States with Indian population and the Director of Health were invited to the Committee hearings.

After general discussion of the Indian health and medical care, the special problems in certain States and Alaska were considered. It is evident that inadequate

appropriations by the Congress and many difficulties peculiar to the Indian situation justify strong recommendations toward possible action by Congress in order to bring about greatly needed improvement in public health and medical care of the Indian population.

After thorough discussion of different measures the Committee recommends:

Recommendation 23 - Indian Health Program Transfer

That the entire health program of the Bureau of Indian Affairs be transferred to the U. S. Public Health Service.

Recommendation 24 - Indian Hospitals

That the Indian hospitals be operated similar to the present Marine Hospital program.

Recommendation 25 - Administration of Health Programs

That the preventive disease and environmental sanitation work be administered through the Public Health Service by the States as a special grant-in-aid for Indian health services.

These recommendations are based on the recognized need of local public health services for the Indian as well as the white population of the States and the known fact that the Indian service has not provided such services except for the provision of field (public health) nursing services.

This organization further reiterates that minimum Public Health Services at the community level include the provision of services of qualified medical health officers,

public health engineers, sanitarians, health educators, etc., as well as public health nurses; and are minimum basic essentials in improving the health of any people.

The Secretary of Interior also has shown his desire to improve the public health and medical care program for Indians in his request that the American Medical Association make field surveys of the facilities of the governmental agencies through special consultants.

The Special Health and Medical Services Committee wishes to express its appreciation to the consultants made available by the U. S. Public Health Service and Children's Bureau.

Respectfully submitted,

SPECIAL HEALTH AND MEDICAL
SERVICES COMMITTEE
D. G. Gill, M. D. - Chairman

(Upon motion regularly made and seconded, it was voted unanimously to adopt the report.)

CHAIRMAN DEARING: I believe now there is the special Committee on Resolutions, of which Dr. Bierring is Chairman.

RESOLUTION NO. 1

WHEREAS, human resources are the Nation's greatest assets; and

WHEREAS, the security and well-being of our country cannot be achieved unless basic public health services are available in every locality through adequately staffed and properly equipped local public health units; and

WHEREAS, at present more than 40 million persons in the United States live in areas not served by local public health units and less than 10 million persons live in areas served by units which meet basic minimum public health standards; and

WHEREAS, it is well known that annually, thousands of persons die unnecessarily from causes that could have been prevented; and

WHEREAS, many areas cannot with their own resources support local public health units staffed and equipped to the extent necessary for the provision of the basic public health services essential to the well-being of the community; and

THEREFORE, BE IT RESOLVED that the provision of adequate local health services is of paramount importance and that it be given highest priority in improving the health of the people; and further

BE IT RESOLVED that the Association of State and Territorial Health Officers urge the States to:

1. Enact legislation enabling the establishment of county and multi-county units where such authority does not now exist;

2. Develop statewide plans for local health unit coverage;

3. Develop state financial assistance plans for equitable allocation of funds to local health units;

4. Extend every possible assistance to medical and nursing schools in the teaching of preventive medicine and public health to under-graduate students in order to encourage their interest in public health as a career;

5. Assist in the development of local health councils;

6. Develop competent field training centers; and

BE IT FURTHER RESOLVED that the Association of State and Territorial Health Officers urge the support of Federal legislation for the provision of

1. Financial assistance to State Health Departments for developing and maintaining local public health units organized to provide basic full-time public health services in all areas of the Nation, and in the training of all types of personnel for local public health unit work; and

BE IT FURTHER RESOLVED that the Public Health Service, the Children's Bureau, all State Health Departments, voluntary organizations, and the general public be urged to support such legislation.

RESOLUTION NO. 2

WHEREAS, it has come to the attention of the State and Territorial Health Officers Association that the Hoover Commission for Governmental Reorganization is preparing its final report for submission to the President, and;

WHEREAS, the Association is naturally concerned with those phases of reorganization that affect the public health, therefore, be it

RESOLVED, that the President of the Association transmit to Mr. Hoover and the Chairman of the Committee, Mr. Voorhees, Assistant Secretary of the Army, the following recommendations for consideration of the Committee for inclusion in their recommendations:

1. The Association recommends that there be established a Department of Health, Education and Welfare in the United States Government in which all of the health activities may be brought together and that the person in charge of all health activities in this department be a career medical officer with broad experience and training in Public Health, responsible directly to the head of the department.

2. The two health programs under the Children's Bureau and the several health programs under the Public Health Service be brought under one medical administrative authority within the Federal Security Agency, or in any new department that might be established to include national

health functions. The Subcommittee recommends that the President and Secretary of the Association meet with the Federal Security Agency and the Hoover Commission on Governmental Reorganization to determine what can be done to accomplish this objective. The Association will then proceed to take whatever further steps that are necessary to get action on this recommendation which has been pending for several years.

3. In order to apply the scientific knowledge available for protection of the Public Health as an essential part of national security, it is necessary to establish full-time county health departments and to recruit and train throughout the nation, health department personnel, within a definite period of time. The State and local governments will need Federal financial assistance in the form of grants-in-aid to realize this attainable goal.

RESOLUTION NO. 3

WHEREAS, the American Public Health Association has assumed proper leadership, through its Merit System Service, in developing examination services for the selection of professional public health personnel and has, in this process, made use of the skills and experience of public health workers throughout the country; and

WHEREAS, the selection of the most highly qualified of the candidates for service in public health is basic to the effective functioning of public health programs; and

WHEREAS, the effectiveness of this program is evidenced by the fact that 75 percent of the States have made successful use of these examinations; and

WHEREAS, there is no other source for such services available to health authorities; and

WHEREAS, the Annual Service Plan has been developed by the Merit System Service to permit the wider use of examinations and has been endorsed by the Public Health Service, the Children's Bureau and the Executive Board of the American Public Health Association; therefore be it

RESOLVED:

1. That the Association of State and Territorial Health Officers record their endorsement of the examination program of the Merit System Service of the American Public Health Association; and

2. That they affirm their belief in the effectiveness of these examinations as one important tool in the selection of qualified public health workers; and

3. That they urge participation by State health departments in the Annual Service Plan - not only so that individual states may benefit from the use of these examinations, but also so that the program itself may have the support which is necessary to insure its continued development and extension.