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THE RELATION OF THE NATIONAL MENTAL HEALTH ACT TO STATE HEALTH AUTHORITIES [1]

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This is indeed a significant occasion. For the first time in the history of the United States Public Health Service, the State and Territorial health officers are meeting with the State mental health authorities to discuss ways and means of jointly working toward improving mental health. It means that the problem of mental illness is finally being attacked in a realistic manner commensurate with its seriousness and extent—in short, as a public health problem. When one considers the prevalence of mental illness and its cost to the community in terms of loss of productivity and the expense of care, let alone in terms of human suffering, the need is clear for a public health approach to the problem of mental illness.

It has been conservatively estimated that more than 8 million persons in this country are suffering from some form of mental illness. Some 600,000 are now in mental hospitals, occupying more than half the hospital beds in the United States; and every year a quarter of a million new patients are admitted. The figures on hospital population by no means represent the number in need of such care since in many States admissions are determined by the availability of beds rather than by the need.

Until now, a concerted public attack upon the problem of mental illness has been hindered by the same factors that held back an effective attack on syphilis—the stigma attached by society, with the consequent reluctance to admit its presence and to seek medical aid

[1] Presented before the meeting of the State and Territorial Health Officers at Washington, D. C. December 3, 1946.

early. There is considerable evidence, however, of an improved attitude on the part of the public toward mental illness, which will not only permit but demand an effective program. Perhaps the most significant evidence of the public's concern is the recent passage by Congress of the National Mental Health Act, thus giving open recognition to the seriousness of the problem and making possible, for the first time in our history, a comprehensive, long-range program for the improvement of the mental health of the nation.

The National Mental Health Act amends the Public Health Service Act (Public Law 410, 79th Cong.) and follows generally the same legislative pattern in the field of mental health as do the provisions in the Public Health Service Act regarding other public health problems.

The act is aimed at bringing about direct action in three interrelated fields: Increased research in nervous and mental disorders, the training of mental health personnel, and the improvement and expansion of community mental health services. No funds are available for the construction of mental hospitals or for financing the institutional care of the mentally ill.

Research.—Under the National Mental Health Act, the United States Public Health Service is authorized to make grants-in-aid for research directly to universities, hospitals, laboratories, and other public and private institutions, and to qualified individuals. Research projects must first be approved by the National Advisory Mental Health Council, which is composed of six persons selected without regard to civil-service laws from the leading authorities in the field of mental health. This authorization should do much to stimulate research which otherwise might remain in the idea stage.

The act also authorizes the establishment of a National Institute of Mental Health in the Washington area, where coordinated studies will be conducted in the many sciences bearing upon the problem of mental health. There will be a full-time staff plus advanced students representing all the disciplines which may reasonably be expected to help solve the enigmas of mental illness. For clinical observation, the institute will include a hospital unit, the patients to be selected on the basis of the studies being conducted.

The law further provides for the appointment of research fellows in the various sciences related to mental health. The fellowship program will make it financially possible for capable students to contribute to science while enhancing their own value as professional workers in the field of mental health.

Training.—The shortage of well-trained personnel in the mental health field is one of the most serious handicaps to the development of an adequate mental health program. To promote training in this

field, the act authorizes the Public Health Service to make grants to public and other nonprofit institutions for developing and improving their training facilities. In this way, institutions that already provide training in mental health fields can expand to accommodate more students, and potential training centers—in hospitals, medical and other schools—can be developed. Grants may not be used, however, for the construction of buildings.

Training stipends will also be available to selected students in psychiatry, psychology, psychiatric social work, and psychiatric nursing. The number of trainees who may receive stipends is to be determined by the National Advisory Mental Health Council.

Grants-in-aid to States.—The third category of mental health activity which the act seeks to promote is the improvement of mental health services in local communities through grants-in-aid to States. It is this aspect of the national program in particular which is to be discussed in detail here. Under this legislation, the amount authorized annually for general health purposes is increased by $10,000,000, this sum to be made available to States for the development and expansion of mental health programs at the State and community level.

Of the total sum appropriated for this purpose, allocations will be made to the States on the basis of population, the extent of the mental health problem, and the financial need of each State.

Responsibility for the development and execution of the State plans in the field of mental health is vested in the State mental health authority, which functions in the mental health program as does the State health authority in other health programs. In the act, the State mental health authority is defined as "the State health authority, except that, in the case of any State in which there is a single State agency other than the State health authority charged with responsibility for administering the mental health program of the State, it means such other State agency."

In order that there may be no confusion as to the intent of Congress when it defined the State mental health authority, it may be pertinent at this point to quote from the Senate and House committee reports: "* * * in some States there is a State agency, separate and apart from the State health authority, which has primary responsibility for the preventive mental hygiene activities and the other activities related to the State's mental health program. Your committee does not contemplate by the new definition to include those State agencies whose activities in the mental health field are restricted to jurisdiction over mental institutions and their patients. It does contemplate substitution of the other State agency for the State

health authority where the former is really the State health authority in the field of mental health."

As in obtaining grants for other public health programs, in order to secure a grant under the National Mental Health Act, the State mental health authority must submit a plan to the Surgeon General for the development of mental health services in his State, together with budget estimates. When the State health authority is the designated mental health authority, a section on the mental health program need merely be included in the over-all State health plans. When another agency is the designated mental health authority, the plan for the mental health program is submitted directly to the district office of the United States Public Health Service for review and comment. You realize how necessary it will be for the State mental health authority to cooperate with the State health authority and with other interested State and local agencies in the preparation of plans, in order that all existing and potential resources may be utilized. Funds allocated to States for mental health programs must be expended for that purpose.

Demonstrations.—In order to encourage the further development of mental health programs in the States, the act authorizes that not more than 1 million dollars of the 10-million-dollar increase in general health funds can be utilized to enable the Surgeon General to provide demonstrations and to train personnel for State and local health work and to meet the cost of pay, allowances, and traveling expenses of commissioned officers and other personnel of the Service detailed to assist States. Because of the shortage of personnel, it will be necessary to locate demonstrations in strategic areas only.

In addition to the demonstrations, the United States Public Health Service, through its consultants assigned to the district offices, will offer consultative services to the States in developing their mental health programs.

What types of activities should be included in the plans of the State mental health authority in order to develop an adequate program for each State, utilizing the Federal assistance now made available under the Mental Health Act?

Of course not all of the activities to be described here can become immediate realities in all States. Nor need they be adopted *in toto* by every State. Programs naturally will differ with the special needs of each State. A program which is best for one State may not prove useful to another. Plans should be based upon the particular needs in the State, and should be geared toward meeting those which are most pressing. They should be reasonably flexible, drawn with an eye toward future growth.

In general, there are four basic activities which State plans should include:

1. There should be an appraisal of the State's mental health needs and resources, on the basis of which immediate and long-range plans should be developed. Although the State should assume responsibility for initiating the appraisal, the United States Public Health Service stands ready to offer consultative service and assistance when desired.

2. Where needed, the staff in the central office should be enlarged to carry out the functions incumbent upon the State mental health authority. Most important of these functions are:

(a) The development, subsidy, or operation of psychiatric clinical services for adults and for children. (This will be discussed more fully later.)

(b) The licensure of mental hospitals.

(c) The development of State-wide records of the incidence of mental diseases and emotional disorders.

(d) The training of professional personnel—psychiatrists, psychologists, and psychiatric social workers—for staffing State and local mental health programs.

(e) The development of research in the field of mental diseases and emotional disorders.

(f) The education of other professional health workers, particularly public health nurses, in mental hygiene in order that they may contribute to mental health in the performance of their regular duties.

(g) The development of a well-rounded and practical program of mental health education of the public.

(h) Liaison or consultation with other agencies, such as education, welfare, penal, courts, civil service, etc.

3. As these operations are developed, new services in the central office can be established. For example, a section on training might be set up to stimulate and coordinate in-service and out-service training programs for nurses, attendants, staff physicians, and other mental health personnel.

In this connection, the importance of a program for the psychiatric education of general practitioners must be emphasized. In the past, too many physicians have felt that they knew little or nothing about mental diseases. This attitude, reflected in their practice, can be blamed to a great extent upon those responsible for the physicians' training. This situation has changed recently to some extent. The war has served to stimulate the interest of many physicians in the emotional aspects of illness. Many doctors who prior to the war were unacquainted with or resistant to psychiatric concepts were confronted in their combat experiences with undeniable evidence of the influence of emotional disturbance upon bodily function. As a result, many are now eager to learn more about psychosomatic medicine and methods of treatment which they as general practitioners might competently apply.

We must take advantage of this new and hopeful trend. Aside from the acute shortage of psychiatrists, the character and magnitude of the problem of mental illness makes it imperative that the general practitioner help meet it. In mental, as in other illnesses, he is the first line of defense. Properly trained and sensitized to the presence of psychiatric disturbances, he can deal effectively with the milder cases, thereby possibly staving off a disabling illness. Needless to say, he must also learn when *not* to treat a patient himself, and to refer to the specialist those patients suffering from severe emotional illnesses.

As part of your State plans, then, a program for the education of the general practitioner in mental health principles and practices should be seriously considered. Perhaps your State or county medical societies, your universities, medical schools, or hospitals could be stimulated to set up some type of educational program, such as institutes, seminars, conferences, or refresher courses for general practitioners, and preferably in their own communities when possible. This educational project could be accomplished either through the grant-in-aid funds allocated to the States from funds appropriated under the increased ceiling authorized for general health purposes, or under the provisions of the Mental Hygiene Division, which authorizes funds to be appropriated to promote training.

4. We turn now to what is perhaps the central core of the State's program—the establishment and expansion of community mental health clinics.

It has been estimated that in the entire country there are only about one-fifth the clinic services needed. Those which are available are for the most part concentrated in the larger population centers. Fifteen States are entirely without mental health clinics, and there are large areas in other States where no psychiatric facilities whatsoever are available.

The present goal of the Public Health Service in the grants-to-States program is the establishment by the States of at least one out-patient mental health clinic for each 100,000 of the population. Although this goal is not immediately attainable owing to the shortage of personnel, it may eventually prove to be quite conservative in terms of the need.

There is a time-proven formula for providing mental health services to the community. However, there is no reason why a State mental health authority need follow it; it may be that in a given State another approach would yield better results. Following is the standard pattern:

According to best present estimates, a full-time all-purpose mental health clinic should be provided for each 100,000 of the population.

It is preferable that this service be integrated with other health services in the community. The basic staff of the clinic should consist of one psychiatrist, one psychologist, two psychiatric social workers, and the necessary clerical assistance. One psychiatrically trained public health nurse may be substituted for one psychiatric social worker. The clinic should be available to all segments and all ages of the population.

The State mental health authority should take responsibility for furnishing sparsely settled and rural areas with centralized service in the form of traveling clinics, to provide mental health services otherwise not available to them. It is essential that there be a nucleus of local persons, perhaps in the school or health agency, which will carry out the recommendations made by the traveling team and establish some sense of continuity between visits. One member of the central clinic staff, perhaps the psychiatric social worker, should be permanently located in the branch office and the other members should come at regular and frequent intervals to provide a more complete service.

These clinics, whether mobile or stationary, should furnish three broad services: (1) A community clinic; (2) an auxiliary service to the mental hospital; and (3) an agency for community mental health education.

Such a clinic would serve the community by providing out-patient psychiatric treatment or psychological counselling for patients not in need of hospitalization and, most significant, for patients in the early stage of illness, when the prospect for cure is greatest. The accomplishment of this objective would require the active cooperation of other community agencies in carrying out, when indicated, plans for modification of the patient's environment.

It would serve the mental hospital by providing prehospitalization service and by referring those in need of institutional care to the hospital; by providing supervision and follow-up treatment of provisional-discharge or convalescent posthospitalization cases; and by supervising care-and-custody and boarded-out cases.

The mental health education function of the clinic would include dissemination of information about mental health principles and practices, active case-finding programs, and the study and control of mental disease from an epidemiological standpoint. The clinic cannot do the educational job alone. It needs to coordinate its educational activities with those of the school, the health department, and other community agencies.

The estimated cost of such a clinic would be approximately $40,000 to $45,000, depending upon whether it was stationary or mobile.

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Although the establishment of an all-purpose clinic for each community should be the goal, special problems frequently make themselves felt in a community before the need for an all-purpose clinic is appreciated. For example, there may be a pressing need for a child guidance clinic, for psychiatric services in the court, for an industrial psychiatric clinic. In such a case, it would be logical to initiate the mental health program by first establishing those services most urgently needed in the particular area. However, the program should not be allowed to stop there. It should be logically and progressively expanded to include the provision of mental health services for the whole community.

In developing your program, you should take advantage of whatever clinic facilities are available at present. These should be carefully scrutinized, expanded if feasible, and fully utilized. In some communities, a private nonprofit organization may furnish some degree of psychiatric service. If it were possible to give such an organization assistance through the State mental health authority, its facilities could perhaps be more widely utilized. It is important, therefore, that an appraisal of psychiatric resources be made at once in order to determine what facilities, either public or private, can be built upon and expanded.

After a clinic has established itself and demonstrated its worth through successful treatment of behavior problems in children, relieving psychoneurotic patients, and successfully supervising former hospital patients, it can expand into more truly preventive fields. These might include such programs as parent education, the promotion of special classes for exceptional children, marriage counselling, therapeutic recreational activities, and cooperative projects with courts and other agencies.

Such expansion, however, can succeed only if the clinic has full community support and approval. In this connection, close cooperation with other State and local lay and professional organizations in building up a good mental health program is so important that it cannot be too strongly emphasized. The State mental health authority will need the active cooperation of school administrators, welfare agencies, and professional and lay organizations, both in the preparation of plans and in carrying them out. It would be well, for example, for the State mental health authority to have an advisory board representing the various interested State agencies and organizations.

A State mental hygiene society can also be of great assistance in building up your program. Here is a grass-roots movement that can give much support. If such an organization already exists, the State mental health authority should call upon it to learn what the community attitudes are and what needs to be accomplished, and to

utilize its influence and efforts toward developing your program. If none exists, the State mental health authority should take an active part in establishing one. The National Committee for Mental Hygiene freely offers assistance in helping you organize a State mental hygiene society. It is hoped that chapters will eventually be set up in every State.

The establishment of a comprehensive mental health program need not wait until all or even most of the enigmas of nervous and mental disease are solved. Troubled people need help now, and we know enough to make our effort worth while. If community mental health services are set up, new techniques can be applied as they evolve. This has been the pattern in the development of programs for the prevention and control of venereal disease, tuberculosis, and other public health problems. The same principles can be applied successfully to mental disorders.

THE HOSPITAL SURVEY AND CONSTRUCTION ACT[1]

By V. M. Hoge, *Medical Director, Chief, Division of Hospital Facilities, United States Public Health Service*

The history of the Hospital Survey and Construction Act is of more than passing interest, since it illustrates the power of concerted action in a democratic nation. At the American Hospital Association conference in 1943, a resolution was passed in the house of delegates to the effect that the association should seek Federal aid in the construction of needed hospitals. One year and two months later, this resolution bore fruit with the introduction of Senate Bill 191 under the bipartisan sponsorship of Senator Lister Hill of Alabama and Senator (now Justice) Harold Burton of Ohio.

During the hearings, it soon became apparent that this was one bill the objectives of which everyone could agree upon. The bill had the immediate support of the American Hospital Association, the Catholic Hospital Association, and the Protestant Hospital Association. All major farm and labor organizations, organized medicine, dentistry and nursing, as well as numerous other groups and individuals of national importance, rallied to the support of this legislation.

The bill, as originally introduced, provided for a program of indefinite duration and, after the first year, set no ceiling on the funds that could be appropriated. It came out of the Senate committee with a limitation of 5 years on the duration and a limit of 75 million dollars per year on the funds that may be appropriated.

[1] Address before the Maryland-District of Columbia Hospital Association, Washington, November 25, 1946.

The Senate regarded the bill as one of great social significance and gave it profound study, passing it on December 11, 1945. It was then referred to the House of Representatives where further changes were made. The original bill called for a sliding scale of grants, in which the Federal contribution ranged from 33⅓ percent in the wealthiest State to 75 percent in the poorest State. As passed by the House, the Federal contribution was set at 33⅓ percent of the cost in all States. On August 13, 1946, the bill was signed by the President and became Public Law 725.

Let us now examine the contents of this act. It has four major parts, which broadly outline its purpose and objectives. Part A is a declaration of purpose; part B provides for the surveys and planning; part C provides for construction of hospitals; and part D sets forth the various administrative provisions. I should like to discuss briefly each of these parts.

Part A, or declaration of purpose.—This part states that it is the purpose of this act to assist the States to make an inventory of existing hospitals, survey the need for new hospitals, and develop a program for the construction of public and other nonprofit hospitals and health centers. The act makes it clear that hospitals to be built under this program are to augment existing hospitals and in no sense are to replace those now in satisfactory operation.

Part B, dealing with surveys and planning.—To assist the States in carrying out the surveys of need required by the act, 3 million dollars are authorized to be appropriated. One and one-half million dollars has been appropriated and is now available for allotment to the States. These allotments are made on a straight population basis, and no State is to be allotted less than $10,000. Funds from the Federal Government for this purpose must be met by non-Federal funds, at the rate of one-third Federal to two-thirds non-Federal funds. Application forms have been distributed and are now being received from the States requesting their allotments. These funds, unlike most Federal appropriations, do not revert to the Treasury if not used during the year, but remain available until expended.

In order to qualify for survey funds under this program, a State must do a number of things. First, it must designate a single State agency to carry out the survey. In a number of States this has already been done, either by action of the State legislature or by executive order of the Governor. Second, the State must appoint an advisory council to consult with the survey agency. This council is to be composed of widely representative individuals from nongovernmental organizations and State agencies concerned with the construction, operation, and use of hospitals. It must include persons not concerned with the operation of hospitals but who are familiar

with the need for hospitals in urban and rural areas. A third condition for the approval of a survey grant is that the State must agree to carry out a survey of all hospital and public health facilities in the State and prepare a program for the construction of needed facilities.

It may be pointed out here that the comprehensive survey required in this act is unique in Federal health legislation. Federal grants for non-Federal hospitals are not new. They have been made under a number of different programs in past years; notably under the wartime Lanham Act, which also provided aid to voluntary as well as public hospitals.

In all these programs, the negotiations have been on a direct Federal-local level with the Federal agency determining the need in each instance as best it could. The distribution of hospitals and health centers, however, will not make sense unless the needs of each community are viewed in relation to neighboring communities and to the State as a whole. When these community needs have been analyzed throughout the State, a long-range plan for both construction and service can then be developed. The act requires that this be done before funds can be allotted to any construction project.

Fortunately for the progress of the program, many of the States have started comprehensive surveys under the guidance of the Commission on Hospital Care.

Part C, providing for the construction of hospitals.—In order to "assist the States" to construct the facilities found to be needed, Public Law 725 authorizes the appropriation of 75 million dollars annually for 5 years beginning with the fiscal year ending June 30, 1947. It should be made clear that the expression "to assist the States" does not refer to State-owned facilities only, but to all facilities within the State authorized by the act.

Although the survey funds are allotted on a straight population basis, the formula for allotting the construction money takes into account the difference in wealth among the States, as well as the population. This results in a per capita allotment of Federal funds starting at 24 cents in the wealthiest State. The reasoning behind this formula is that the gross deficit in hospital facilities becomes progressively greater in the States with less financial resources. The allocation of funds, however, remains the same in all projects in all States, i. e., one-third Federal and two-thirds non-Federal.

Part D, setting forth the administrative procedures.—It should be emphasized that the Hospital Survey and Construction Act is not another public works program. It is solely a grant-in-aid program in the interest of the national health. It delegates the major share of individual responsibility to the individual State. In making these provisions, Congress was apparently mindful of the fact that the con-

struction and operation of hospitals are essentially community responsibilities. In line with this philosophy, the law sets up specific limits within which the Surgeon General may prescribe regulations affecting the distribution and construction of all facilities authorized under the act. These regulations in turn must be approved by the Federal Hospital Council and the Federal Security Administrator.

As I have mentioned before, the Hospital Survey and Construction Act places unusual responsibilities on both the State governments and the public in general. Advisory councils are required at the State levels. A Federal Hospital Council with both advisory and administrative duties is required at the Federal level. This council, as required by law, is composed of eight members, with the Surgeon General serving as chairman ex officio. To quote the language of the act, "four of eight appointed members shall be persons who are outstanding in fields pertaining to hospital and health activities, three of whom shall be authorities in matters relating to the operating of hospitals, and the other four members shall be appointed to represent the consumers of hospital services and shall be persons familiar with the need of hospital services in urban or rural areas."

The Public Health Service has advisory councils to assist in all its major programs. The Federal Hospital Council, however, has more than advisory functions. It assists the Surgeon General in formulating the regulations for the administration of the act. Moreover, should a State plan be disapproved by the Surgeon General, the State may submit its plan to the council. If the council approves it, the Surgeon General must abide by this decision.

It will be recalled that there are two separate and distinct parts to this program. The first is the survey phase. This is under a State agency whose function is to conduct an inventory of existing facilities, to determine the need for new facilities, and to prepare an over-all program for the eventual meeting of these needs. This agency is, in a sense, a temporary agency whose function ends when the over-all program has been set up.

In the second or construction phase, a new agency comes into being. Although it is anticipated that in most instances this will be the same agency, this need not be the case. In any event, the new agency is permanent for the 5-year period specified in the act and has considerably heavier responsibilities than the agency set up for survey and planning. Whereas the law requires the first agency to prepare an over-all program, the second agency must prepare a State plan, of which construction is but a part. The State plan will include, among other things, the selection of projects in relative order of need.

After the State plan has been approved, an allotment may then be made to the State This will remain available for 2 years, during

which time approved projects may be charged against it. These funds are not turned over to the State agency at the time of allotment but are credited to the State and left in the Federal treasury. Payments on projects are made in installments as construction expense is incurred. These payments will be made to the State agency for transmission to the applicant or will be made directly to the applicant if for any reason the State is unable to handle the financial transaction.

In summary, the Hospital Survey and Construction Act makes the following provisions:

1. Authorizes 3 million dollars to pay one-third of the cost of State surveys and planning. One and one-half million dollars of this amount is now available.

2. Authorizes 75 million dollars per year for each of 5 years, beginning this year, to pay one-third of the cost of construction. Any portion of these funds not actually appropriated or used during any year may be added to the authorization of succeeding years. No construction funds have been appropriated as yet.

3. The States must designate a single State agency and advisory council for both the survey and planning phase and for the construction phase of the program.

4. After the State plan has been approved by the Surgeon General, allotments may be made to the State based on its authorized share of the funds.

5. After allotments have been made to a State, project applications may then be made to the State agency.

6. To be approved by the State agency, the project must have been included in the original over-all program. The State may, however, modify its original program from time to time.

7. To continue to receive allotments under this program after July 1, 1948, each State must have enacted what amounts to a hospital licensure statute.

In our enthusiasm over the enactment of the Hospital Survey and Construction Act, we should not overlook its limitations. Hospitals are expensive to build and require highly trained personnel for their operation. Consequently, it is in the wealthier States and metropolitan areas that our best facilities are concentrated. In the rural areas where the need is great, the mere provision of Federal funds to cover one-third of the construction cost will not solve the problem.

We must also face the fact that the funds authorized for 5 years cannot provide all the health facilities needed. Indeed, they will not meet all the urgent needs. Even if all the Federal funds are fully matched by non-Federal money, the total will take care of barely one-fourth the facilities required. How far rising costs will have

reduced this percentage, it is difficult to say, but we know it to be considerable.

Nevertheless, with this act hospitals have been brought into and made a part of the public health structure. The act reflects the current concept that public health includes responsibility for the treatment and care of the individual. It recognizes, also, that hospitals are an integral part of our social fabric, on a par in the community with the church and the school. This concept is not new, but its implications have seldom been fully realized in practice. Its application in the current program should have a profound influence on the future development of hospitals in this country.

LEGISLATION ON HOSPITAL SURVEYS, CONSTRUCTION, AND LICENSING ENACTED BY STATE LEGISLATURES IN 1945 AND 1946 (AS OF NOVEMBER 15, 1946)[1]

FOREWORD

The attached tables I, II, and III will bring up to date (as of November 15, 1946) the corresponding tables published as part of the paper on "Legislation on Hospital Surveys, Construction, and Licensing Considered by the State Legislatures in 1945" in the December 21, 1945, issue of PUBLIC HEALTH REPORTS (vol. 60, No. 51, pp. 1519–1539).

Since that paper was published, the Hill-Burton Bill, S. 191, which has had a strong influence on State hospital legislation, has become the Hospital Survey and Construction Act. This legislation, introduced in Congress on January 10, 1945, became law on August 13, 1946 (Public Law 725, 79th Cong.). This Federal enactment makes all the more important State legislation authorizing State-wide hospital survey and construction programs and hospital licensing, inasmuch as most States will need specific enabling legislation to participate in this new grant-in-aid program, and further because State legislation establishing minimum standards of maintenance and operation for the hospitals to be aided is a requirement of the Federal act.

Attention is called to the fact that table III is not intended to cover all hospital licensing laws, but only those enacted by the States in 1945 and 1946. Since hospital licensing is not in all States a new State function, 1945 and 1946 legislation does not include *all* hospital licensing laws. On the other hand, since State-wide hospital survey

[1] From the Division of Hospital Facilities, Bureau of State Services, U. S. Public Health Service.

and construction programs are new, tables I and II are intended to be exhaustive.

It has been found that from the beginning of the calendar year 1945 through November 15, 1946,

Thirteen States have enacted laws authorizing State-wide hospital surveys and planning:

Alaska	Indiana	South Carolina
Arizona	New Mexico	Vermont
California	Oklahoma	Virginia
Delaware	Rhode Island	Washington
Illinois		

Sixteen States have enacted laws authorizing State-wide hospital survey and/or construction programs:

Alabama	Missouri	Puerto Rico
Connecticut	New York	Texas
District of Columbia	North Carolina	Utah
Florida	Oklahoma	Virginia
Maine	Oregon	West Virginia
Mississippi		

These 16, however, include 2 States, Oklahoma and Virginia, which have separate hospital survey and planning laws; 1 State, Texas, whose law was ruled invalid by the State's Attorney General; and 1, Connecticut, whose law is limited to facilities for chronic disease patients.

With allowances made for these circumstances, it might be said that 25 States have enacted legislation still in effect which authorizes either State-wide hospital survey and planning programs or State-wide hospital construction programs of broad coverage, or both.

Fifteen States, during the above stated period, have enacted hospital licensing laws covering hospitals of one type or another:

Alabama	Indiana	Oklahoma
California	Maine	Pennsylvania
Delaware	Maryland	South Dakota
Georgia	Nebraska	Texas
Illinois	Nevada	Utah

Attention is called to the diversity among these State laws in the type of hospitals to be licensed thereunder.

The purpose of this study has been to bring together in summary form substantive legislation authorizing State-wide hospital survey and construction programs and hospital licensing. Appropriation acts, therefore, have not been included.

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TABLE I

Provisions of State legislation, enacted during 1945 and 1946, covering State-wide hospital surveys and planning (as of November 15, 1946)

Legislation	Agency administratively responsible for survey and planning	Advisory Council	Extent of administrative agency's authority	Remarks
Alaska ch. 11, Laws 1946 (S. 21).	Territorial Department of Health.	Council to be appointed by Governor, including representatives of the Alaska Development Board, Alaska Native Service, Veterans' Administration, Federal Works Agency, U. S. Public Health Service, Territorial Department of Health, "and an Alaskan resident from each Judicial Division, constituting the Board of Health."	Empowered to make a survey of all hospitals and health centers; compile conclusions as to additional hospital and health centers needed in conjunction with existing facilities, to serve adequately all the people of the Territory; to accept and expend Federal funds for survey and planning; and "acting on the advice of the Advisory Council," to approve the construction of hospital and health center facilities.	Similar to model hospital survey bill of Council of State Governments.
Arizona ch. 19, Laws 1945 (S. 2-X).	State Health Department	A committee of 6 members, to be appointed by the Governor—1 representative of each of the following: Hospitals, medicine, nursing, agriculture, labor, business.	Substantially same as under Delaware ch. 88, Laws 1945.	Somewhat similar to the model hospital survey bill of the Council of State Governments.
California ch. 56, Laws 1946 (A. 88-X).	State Department of Public Health.	15 members to be appointed by Governor, representing nongovernment organizations or groups, State and local agencies, concerned with operation, construction or utilization of hospitals, including consumer and medical representation.	Required to survey, evaluate the sufficiency of existing hospitals and health centers, and compile conclusions as to additional facilities necessary, together with existing facilities, to serve all the people of the State. Authorized to accept and expend Federal funds for purposes of this act.	Shows influence of both the Federal Hospital Survey and Construction Act (S. 191) and the model State hospital survey bill of the Council of State Governments.
Delaware ch. 88, Laws 1945 (S. 195).	State Board of Health	None	Required to survey all hospitals and health centers in State and to compile conclusions as to additional hospital and health center facilities needed, in conjunction with existing facilities, to serve all the people of the State. Authorized to apply for and receive Federal funds for survey and planning purposes.	Similar to model hospital survey bill of the Council of State Governments.
Illinois S. 336, Laws 1945.	A new commission of 9 members set up under this act: 3 Senate members, 3 House members, and 3 to be appointed by Governor.	None	Required to study hospitalization and medical-care needs of State and report to next Assembly.	State-wide hospital facility survey and planning program will probably be based, not on this law, but on an executive designation.

Illinois S. 436, Laws 1945.	A new Commission on the Care of Chronically Ill Persons—9 members: 3 Senate members, 3 House members, Director of Public Welfare, Director of Public Health, and Director of Illinois Public Aid Commission.	None	Required to study adequacy of hospitalization and other treatment facilities for chronically ill and to report to next Assembly.	
Indiana ch. 101, Laws 1945 (S. 51).	State Board of Health	None	Same as under Delaware ch. 88, Laws 1945	Similar to model hospital survey bill of the Council of State Governments.
New Mexico ch. 136, Laws 1945 (S. 263).	State Public Health Department	12 members to be appointed by Governor and to include representatives of nongovernment groups, and of State agencies, concerned with the operation, construction, or utilization of hospitals.	Required to carry on all hospital surveys and planning programs and to report on same to Surgeon General, U. S. Public Health Service.	Similar to survey segment of Federal bill, S. 191.
Oklahoma ch. 1 c, Title 63, Session Laws 1945 (H. 476).	State Commissioner of Health	6 members: Chairman, State Board of Public Affairs; Dean, Oklahoma School of Medicine, University of Oklahoma; and 1 named by each of the following 4 organizations: State Medical Association, State Osteopathic Association, State Hospital Association, State Nurses' Association.	Directed to survey need for hospital and health center facilities, develop programs for their construction; to carry out standards of the Surgeon General, U. S. Public Health Service, for developing such programs; and to make reports required by Surgeon General. Authorized to apply for and accept Federal funds for survey and program planning.	Similar in some respects to Federal bill, S. 191. Note that after a survey of all existing hospitals and health centers in State, their sufficiency to serve "all the *indigent* people of the State" is to be evaluated and additional facilities planned accordingly. Note, however, that Oklahoma ch. 1 e, Title 63, Session Laws 1945, the 1945 hospital construction bill (See Table II) provides for a State-wide hospital construction program to serve "all the people of the State".
Rhode Island ch. 1597, Laws 1945 (H. 713).	State Department of Health	None	Same as under Delaware ch. 88, Laws 1945	Similar to model hospital survey bill of the Council of State Governments.
South Carolina Act 561, Acts 1946 (S. 124).	Research, Planning and Development Board.	11 members consisting of 3 from State Hospital Association, 3 from State Medical Association, 1 from State Dental Association, 1 from State Nurses' Association, the State Health Officer, and 2 citizens.	Required to survey all hospitals and health centers in State, compile conclusions as to additional hospital and health center facilities needed, in conjunction with existing facilities, to serve all the people of the State; to determine State aid necessary to supplement local funds to construct needed hospitals and health centers; to study all plans in State for hospital care of indigent; to establish minimum operating standards for hospitals receiving Federal aid under this act; to recommend to next Assembly, through Governor, on legislative action needed to effectuate an adequate State-wide hospital program; and to receive Federal funds. Authorized to accept services from State Board of Health, U. S. Public Health Service, other Federal agencies, and American Hospital Association and its affiliates.	Similar to, but goes further than, model hospital survey bill of Council of State Governments. Requires that general program covering standards of survey, evaluation of need, and statistics, to be gathered by Research, Planning and Development Board, first be approved by State Advisory Council. Also requires all applications for Federal aid to be first approved by Budget Commission.

Provisions of State legislation, enacted during 1945 and 1946, covering State-wide hospital surveys and planning (as of November 15, 1946)—Continued

Legislation	Agency administratively responsible for survey and planning	Advisory Council	Extent of administrative agency's authority	Remarks
Vermont ch. 5, Laws 1945 (H. 238).	A new commission of 5 members to be appointed by Governor under this act.	None	Substantially same as under Delaware ch. 88, Laws 1945.	Similar in some respects to model hospital survey bill of Council of State Governments.
Virginia ch. 5, Laws 1945 (S. 27).	State Department of Health	None	Same as under Delaware ch. 88, Laws 1945.	Similar to model hospital survey bill of Council of State Governments.
Washington ch. 212, Laws 1945 (S. 233).	State Department of Health	A council of representatives of nongovernment groups, and of State agencies, concerned with the operation, construction, and use of hospitals—to be appointed by State Director of Health.	Substantially same as under Delaware ch. 88, Laws 1945.	Shows influence of both the model hospital survey bill of Council of State Governments and of the Federal bill, S. 191.

TABLE II

Provisions of State legislation, enacted during 1945 and 1946, covering State-wide hospital survey and/or construction programs (as of November 15, 1946)

Legislation	Agency administratively responsible for State program	Advisory Council	Extent of administrative agency's authority	Remarks
Alabama Act 211, Acts Regular Session 1945 (S. 107).	State Board of Health	Council of 13 members: 3 hospital administrators to be appointed by State Hospital Association, or by Governor, if the association fails to appoint; 1 member of State Board of Censors, to be appointed by that board; 4 members of the lay public, to be appointed by the Governor; State Health Officer; State Director of Public Welfare; Director of State Planning Board; Director of Finance; and Attorney General. State Health Officer to be chairman. (Note that the master hospital plan to be determined by the State Board of Health must be approved by the Advisory Council and that the latter is also required to "Approve the policies and regulations necessary for carrying out the purposes of this Act.")	Authorized to acquire, construct, maintain, and operate public hospitals, health centers, and related facilities; to administer Federal, State, and other funds for this purpose; to contract with any political subdivision or nonprofit association, for same purpose. Required to set up a master hospital plan, dividing State into regions, districts, and zones. Authorized to establish regulations providing standards for construction and operation of hospitals established under this act and providing for their annual licensing.	No specific provision is made for nonprofit voluntary hospitals to benefit from construction funds, either State or Federal. Although establishment of a master hospital plan for the State is required of the State agency, this act does not mention a survey of existing facilities; it does, on the other hand, provide for purely local determination of hospital needs (which seems to be contrary to a State-established master plan). Act 211 was dependent on the constitutional amendment proposed in Act 210, Acts of Regular Session 1945. This constitutional amendment, passed at the general election of November 5, 1946, empowers the State to acquire, own, and operate hospitals, health centers, and other health facilities, appropriate funds therefor, and to authorize political subdivisions to appropriate funds for such purposes.
Connecticut Public Act 437, Acts 1945 (Substitute for H. 144.)	A new Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm, consisting of 5 electors appointed by Governor and, ex officio, the Commissioner of Health and Commissioner of Welfare.	None	Required to study problems of care and treatment of the chronically ill, aged, and infirm; to initiate a program, with the cooperation of State agencies concerned, to coordinate and develop existing resources for such care and treatment; to plan and, subject to approval of the General Assembly, construct or otherwise acquire, staff, and operate such buildings as necessary for care of such persons; to fix rates for care at such institutions and adopt regulations to carry out this act; to report and recommend biennially to Governor and General Assembly and draft legislation necessary to carry its recommendations into effect.	

Provisions of State legislation, enacted during 1945 and 1946, covering State-wide hospital survey and/or construction programs (as of November 15, 1946)—Continued

Legislation	Agency administratively responsible for State program	Advisory Council	Extent of administrative agency's authority	Remarks
District of Columbia Act 648, 79th Congress (S. 223).	Federal Works Administrator	None	Empowered to "make surveys and investigations, to plan, design, and construct hospital facilities in the District of Columbia"; to enter into leases with private agencies for operation and maintenance of such hospital facilities or usable separable portions thereof; to sell or convey in exchange for other properties any such hospital facilities or usable separable portion thereof to private agencies. In carrying out purposes of this act, required to provide a hospital center. (Hospitals participating in such center required to convey to the Government, clear of encumbrance, land and buildings now held by them or to sell same at prices approved by Federal Works Administrator and pay proceeds to the Government, at option of Federal Works Agency.)	
Florida ch. 22851, Acts 1945 (H. 724).	Authorizes the Governor to designate the agency. (See column 5.)	Authorizes the Governor to appoint a council "to conform with the terms of Federal legislation."	With specific reference to Federal legislation designed to assist States to survey the need for hospital facilities, which in conjunction with existing facilities, will be sufficient to serve all the people of the State, to develop construction programs, and to construct public and other nonprofit hospitals in accord with such programs, ch. 22851 authorizes the Governor to provide for carrying out such purposes in accordance with standards of the Surgeon General.	Shows influence of Federal bill, S. 191.—On Aug. 28, 1946, the Governor, acting under this law, designated the Florida Improvement Commission as the State agency administratively responsible for the program.
Maine Public Act 223, Laws 1945 (H. 844).	State Department of Health and Welfare.	None	Required to survey the need for additional hospital and health center facilities, which, together with existing facilities, will be sufficient to serve all the people of the State. Authorized to accept the provisions of any present or future Federal law making funds available for public health services of all kinds, including hospital and health center construction, and to meet requirements in connection with such funds.	Similar to, but goes further than, the model hospital survey bill of the Council of State Governments.

Mississippi ch. 363. Laws 1946 (H. 430),	The newly created Mississippi Commission on Hospital Care.	Council to be designated by the Commission on Hospital Care and to include representatives of nongovernment groups, State agencies, consumer interests concerned with operation, construction or utilization of hospitals.	Required to prepare and administer any State-wide plan for the construction, equipping and maintenance of hospitals and related facilities and to accept and administer Federal and other funds. Required to administer State grants-in-aid to public hospitals for construction and to contract with local hospitals so as to ensure that such hospitals will be constructed and operated in such manner that hospital services will be available to the people of the State at lowest possible cost. Authorized to inspect books of and to counsel with State-aided local hospitals to ensure sound accounting principles and efficient service. Authorized to establish an integrated State-wide nurse education program in connection with the State hospital system, to assist in promoting a voluntary prepayment plan of hospitalization insurance, and to receive and disburse funds from any source for promotion of a prepayment hospitalization plan.	While this law does reflect the influence of Federal bill, S. 191, it possesses an individual character and reflects an analysis of Mississippi's particular needs.
Missouri H. 459, Laws 1945	Division of Health of State Department of Public Health and Welfare.	7 members—to be appointed by Governor with advice and consent of Senate: 2 representatives of consumers of hospital service, 5 representatives of State and nongovernment organizations. Each of the 7 members must have at least 5 years of Missouri residence.	Authorized to survey all hospitals and health centers; to formulate a State plan for construction of additional facilities; to receive Federal and other grants for survey and construction and to pay them out under such provisions as attached to such grants; to render reports required under such grants; to provide and require compliance with such minimum standards of hospital maintenance and operation as necessitated by such grants.	Shows influence of Federal bill, S. 191.
New York ch. 666, Laws 1946 (A. 2739).	State Temporary Commission for Postwar Public Works Planning "or such other State agency as may be designated by the Governor." (See column 5.)	None	Required to carry out inventory and survey the need for construction of hospitals and health centers; to develop a program for construction of public and nonprofit hospitals and public health centers; and to construct such facilities. (Department of Taxation and Finance authorized to accept, as custodian, Federal funds for survey and planning and for making payments for construction of hospitals, public health centers, and related facilities.)	Shows influence of Federal bill, S. 191. — On August 2, 1946, the Governor designated the Temporary Commission for Postwar Public Works Planning as the agency to administer the hospital survey and planning program.

Provisions of State legislation, enacted during 1945 and 1946, covering State-wide hospital survey and/or construction programs (as of November 15, 1946)—Continued

Legislation	Agency administratively responsible for State program	Advisory Council	Extent of administrative agency's authority	Remarks
North Carolina ch. 1096, Laws 1945 (H. 594).	The newly created N. C. Medical Care Commission of 20 members, of whom 18 appointed by Governor and 2 ex officio. Last 2 without vote. Of the 20, 3 representatives of the State Medical Society, 1 of the State Hospital Association, 1 of the State Dental Association, 1 of the State Nurses' Association, 1 of the State Pharmaceutical Association, 1 of Duke Foundation; 10 of agriculture, labor, industry, and other interests, and, ex officio, Commissioner of Public Welfare and Secretary, State Board of Health.	Five-member council, to be appointed by Governor and to include representatives of nongovernment groups, and of State agencies, concerned with the operation, construction, or utilization of hospitals and allied facilities.	Authorized to administer State fund aid for hospitalization of indigent; to survey needs for hospital and health center facilities and the need for State aid to furnish them, and to make recommendations and report on these needs to the next Assembly; to set up and administer any Statewide plan for construction and maintenance of hospitals and health centers; to administer loans to medical students; and to expand the Medical School of the University of North Carolina.	While this law shows the influence of Federal bill S. 191, it goes beyond it and provides for programs which supplement a hospital survey and construction program.
Oklahoma ch. 1e, title 63, Session Laws 1945 (H. 478).	State Commissioner of Health.....	Ch. 1e provides for no council, but refers to the State Advisory Council, presumably the one set up in Oklahoma ch. 1 c, title 63, Session Laws 1945. (See Table I.)	Directed to formulate and submit to the Surgeon General of the U. S. Public Health Service for approval, a State plan setting forth a hospital and health center construction program sufficient, in conjunction with existing facilities, to serve all the people of the State. Authorized to carry out approved State plan; to make reports required by the Surgeon General. Required to review the State plan from time to time and submit necessary modifications to Surgeon General and Federal Advisory Council. Authorized to accept Federal funds for construction and for administrative expenses and to comply with regulations relating to their expenditure.	Shows influence of Federal bill, S. 191.
Oregon ch. 285, Laws 1945 (H. 395).	State Board of Health.....	Council of 8 members, to be appointed by Governor and to represent nongovernmental groups and State agencies concerned with the operation, construction, or utilization of hospitals. Chairman of council: Secretary of State Board of Health.	Required to survey existing hospital and health center facilities in State and those necessary to serve all the people of the State; to formulate a State program providing for construction and maintenance and operation in order of relative need and when funds are available for such purposes; and to provide such methods of	Shows influence of Federal bill, S. 191.

			administering the State program as required by the Surgeon General. Authorized to process construction applications; to apply for and receive Federal funds for carrying out purposes of this act. With respect to any application for construction, authority of State Board of Health shall cease on completion of that construction.	
Puerto Rico Act 38, Acts 1946.	Insular Commissioner of Health...	None	Authorized to expend $2,100,000 appropriation for preparation of plans and specifications, survey and acquisition of lands, construction and equipment of general district and municipal hospitals, tuberculosis, mental disease, chronic disease, and cancer treatment hospitals and medical centers; to accept Federal aid and fulfill requirements therefor. In the event Federal aid does not materialize within a reasonable time, Commissioner of Health required, with Governor's approval, to use the $2,100,000 appropriation for the construction of district hospital at Ponce.	A confused law. The administrative agency's authority as sole insular agency to develop a hospital construction program appears limited by the reference to the master plan for district hospitals adopted by the Planning Board and by the requirement that the Health Commissioner's priorities system for construction be approved by the Planning Board.
Texas H. C. R. 34, Laws 1945.	A new Hospital Survey Commission of 15 members, to be appointed by the Governor: 2 members from each of the 4 sections of the State, east, west, north, and south, with the remaining 7 from the State at large. Further, 6 members to be actively engaged in hospital work, 2 to be representatives of the press, 2 to be Senate members, 2 to be House members, 1 an architect, 1 an attorney, and 1 the President of the Texas County Judges Association. (See column 5.)	None	Authorized to survey existing hospitals and the need for additional hospitals and health centers, to recommend improvement of inadequate conditions, to execute the hospital program in conjunction with any and all Federal agencies, and to distribute Federal grants-in-aid in accordance with survey data and regulations.	A very confused bill. Although "said commission is hereby authorized and requested to make a comprehensive survey," it is also resolved in this measure "that the State Department of Public Health of Texas be designated as the agency to make necessary surveys." H. C. R. 34 was ruled invalid by the State's Attorney General within a month after its approval on June 6, 1945. On Sept. 18, 1945, the Governor designated the State Board of Health "to carry out the purposes" of Federal bill S. 191, with the aid of an advisory council named by the Governor at the same time.
Utah Public Act 58, Laws 1945 (S. 234).	State Department of Health.....	None	Authorized to receive Federal funds which may be made available for surveying, planning, constructing, and operating hospitals, public health centers, and related facilities, and for other health purposes.	This law is very brief, providing little other than what is given in the foregoing column.

Provisions of State legislation, enacted during 1945 and 1946, covering State-wide hospital survey and/or construction programs (as of November 15, 1946—Continued

Legislation	Agency administratively responsible for State program	Advisory Council	Extent of administrative agency's authority	Remarks
Virginia ch. 208, Laws 1946 (S. 253).	State Department of Health	None	Authorized to receive Federal funds for construction of public and other nonprofit hospitals and related facilities, such funds to be expended under regulations adopted by the State Department of Health.	Shows influence of Federal bill S. 191.
West Virginia ch. 100, Laws 1945 (H. 321).	State Department of Health	Authority conferred by this act on State Department of Health may be exercised only with joint approval of Commissioner of Health and the existing Public Health Council. (Also authorizes the Governor to appoint such advisory council as may be necessary under Federal law.)	Authorized to cooperate with the Federal Government in a hospital construction program; to inventory existing hospitals and public health centers, to adopt and supervise the administration of such a State-wide plan for the construction of additional hospitals and public health centers as may be necessary under Federal law making Federal aid available for such purposes.	Shows influence of Federal bill S. 191.

TABLE III

State legislation enacted in 1945 and 1946 providing for hospital licensing (as of November 15, 1946)

Alabama Act 211, Regular Session 1945 (S. 107).—Section 6 of this act authorizes the State Board of Health to license annually all hospitals "established under this act." (The act provides for the administration of Federal and other aid for public health centers and public and nonprofit general, tuberculosis, mental, chronic disease, and other types of hospitals.) The title of the act, however, authorizes the State Board of Health to license "all the hospitals in Alabama (except the Alabama State Hospitals, Partlow State School for Mental Deficients, tuberculosis hospitals, and hospitals operated by the Federal Government), whether private, nonprofit, or public."

California Ch. 1418, Laws 1945 (A. 601).—Requires licensing, by the State Department of Public Health, of all types of hospitals except Federal, State, county, and city hospitals; any hospital conducted by the regents of the University of California; hospitals conducted by or for religious groups depending on spiritual means for healing; and mental institutions under the jurisdiction of the State Department of Institutions.

Delaware Ch. 87, Laws 1945 (S. 94).—Requires a license from the State Board of Health of any sanatorium, rest home, nursing home, boarding home, and related institution for care of the "aged, infirm, chronically ill, or convalescent persons," operated by any person, partnership, association, or corporation.

Georgia Governor's Act 623, Laws 1945 (H. 732).—Authorizes the State Board of Health to license all hospitals, sanatoria, infirmaries, maternity homes, nursing homes, and other institutions for hospital or nursing care, except those operated by the Federal Government. Also authorizes the State Board of Health to deliver to any public hospital authority any funds made available by the Federal Government or by any other source, provided the State Board of Health expends all funds in accordance with any direction from the State or Federal Governments or the donor of the funds. Empowers the State Board of Health to prescribe the purposes for which any such funds may be used by any such hospital authority. This act is not to become effective until funds are made available to the State Board of Health for the purposes of this act by the Federal Government, State, any of the State's political subdivisions, or from any other source.

Illinois H. 252, Laws 1945.—Gives to the State Department of Public Health the function of licensing private nursing homes for physical illnesses. It specifically excludes institutions for mental illness and all hospitals.

Illinois H. 397, Laws 1945.—Requires a license from the State Department of Public Welfare for any private mental institution and any mental unit of a private general hospital.

Illinois S. 141, Laws 1945.—Requires a license from the State Department of Public Welfare for all private mental institutions and special mental departments in private general hospitals.

Indiana Ch. 346, Laws 1945 (H. 390).—The State Board of Health will license all hospitals, excluding mental institutions, through a newly created council, which will have important policy and administrative functions.

Indiana Ch. 335, Laws 1945 (S. 206).—Creates a new Indiana Council for Mental Health with various powers, including general supervision of public psychiatric institutions and the power to license private psychiatric institutions.

Maine Public Act 355, Laws 1945 (S. 405).—Requires a license by the State health agency for all public and private hospitals in the State, excluding State and Federal hospitals.

Maryland Ch. 210, Laws 1945 (S. 66).—The licensing powers given to the State Board of Health by this law apply to all hospitals in the State, except Federal hospitals.

Nebraska Public Act 169, Laws 1945 (H. 284).—Requires a license from the State health agency for any maternity hospital.

Nevada Public Act 73, Laws 1945 (A. 62).—Requires a license from the State health agency for any maternity hospital. This licensing requirement is apparently restricted to private hospitals.

Oklahoma Ch. 1b, Title 63, Sessions Laws 1945 (H. 468).—Gives to the State health agency the power to license all non-Federal hospitals in the State, except State mental hospitals.

Pennsylvania Act 68, Acts 1945 (S. 243).—Provides for licensing, by the State Department of Welfare, of mental hospitals operated by any person, copartnership, association, or corporation other than State hospitals.

South Dakota Public Act 108, Laws 1945 (S. 62).—Requires a license from the State Board of Health for every hospital and nursing home, except duly incorporated children's institutions. This measure was referred to the general electorate and adopted at the general election of November 5, 1946.

Texas Ch. 342, Laws 1945 (H. 127).—Requires a license from the State Department of Public Health for all private convalescent homes. This law defines a convalescent home as "any place or establishment where three or more pension or old age assistance recipients are housed for hire or profit," and specifically excludes hospitals.

Utah Public Act 54, Laws 1945 (S. 26).—Requires a license from the State health agency for any maternity hospital.

INCIDENCE OF DISEASE

No health department, State or local, can effectively prevent or control disease without knowledge of when, where, and under what conditions cases are occurring

UNITED STATES

REPORTS FROM STATES FOR WEEK ENDED DECEMBER 21, 1946

Summary

A total of 137 cases of poliomyelitis was reported for the current week, as compared with 197 last week, 90 for the corresponding week last year, and a 5-year (1941–45) median of 55. Last year's figure is the largest previously reported for a corresponding week since 1930. Only 9 States reported currently more than 4 cases, as follows (last week's figures in parentheses): *Increases*—Michigan 11 (6), Missouri 13 (4), North Carolina 6 (1), Oklahoma 9 (2); *decreases*—New York 11 (14), Ohio 5 (10), Illinois 7 (18), Texas 5 (14), California 19 (21). Since March 16, the approximate average date of lowest seasonal incidence, 24,626 cases have been reported, as compared with 13,251 and 18,933 for the corresponding periods, respectively, of 1945 and 1944, and a 5-year median for the period of 12,056. Of the current year's total for this period, 13,222 cases, or 54 percent, were reported in the North Central areas.

For the current week, a total of 3,338 cases of influenza was reported, as compared with 2,875 last week, 68,551 for the corresponding week last year, and a 5-year median of 2,717. States reporting currently more than 200 cases are as follows (last week's figures in parentheses): Texas 1,726 (1,365), Virginia 525 (255), South Carolina 500 (498). During the 21 weeks since the approximate average date of lowest seasonal incidence (July 28), a total of 30,315 cases has been reported, as compared with 309,301 for the same period last year and a 5-year median of 30,177.

Of 62 cases of tularemia reported for the week, 12 occurred in Illinois, 9 in Kansas, and 6 each in Virginia and Tennessee. To date a total of 1,114 cases has been reported, as compared with 789 for the corresponding period last year. The incidence this year has been above that for any prior year since 1941.

Deaths recorded during the week in 93 large cities of the United States totaled 9,378, as compared with 9,612 last week, 10,458 and 9,305, respectively, for the corresponding weeks of 1945 and 1944, and a 3-year (1943–45) average of 10,821. For the year to date, 460,804 deaths have been recorded for the same cities, as compared with 460,330 for the corresponding period last year.

Telegraphic morbidity reports from State health officers for the week ended Dec. 21, 1946, and comparison with corresponding week of 1945 and 5-year median

In these tables a zero indicates a definite report, while leaders imply that, although none was reported, cases may have occurred.

Division and State	Diphtheria			Influenza			Measles			Meningitis, meningococcus		
	Week ended—		Median 1941–45	Week ended—		Median 1941–45	Week ended—		Median 1941–45	Week ended—		Median 1941–45
	Dec. 21, 1946	Dec. 22, 1945		Dec. 21, 1946	Dec. 22, 1945		Dec. 21, 1946	Dec. 22, 1945		Dec. 21, 1946	Dec. 22, 1945	
NEW ENGLAND												
Maine	8	1	1				217		13	1	0	1
New Hampshire	0	1	0				1	2	2	1	0	0
Vermont	0	0	0		65		207		3	0	0	0
Massachusetts	25	5	5				125	124	167	0	2	4
Rhode Island	1	0	0	1	7	7	16	1	10	0	0	0
Connecticut	0	2	1	5	17	2	141	5	13	0	1	2
MIDDLE ATLANTIC												
New York	24	8	14	[1] 6	[1] 95	[1] 10	175	317	294	4	12	12
New Jersey	9	4	6	3	103	13	80	14	38	1	6	4
Pennsylvania	26	10	9	5	66	3	644	297	455	4	11	6
EAST NORTH CENTRAL												
Ohio	4	38	13	4	191	17	138	8	46	2	3	3
Indiana	7	11	7	5	717	20	5	16	16	1	4	4
Illinois	1	4	4	5	585	11	17	184	64	2	10	9
Michigan [2]	2	16	11	2	6	4	8	219	59	2	5	5
Wisconsin	0	4	3	31	1,293	31	58	31	142	3	3	3
WEST NORTH CENTRAL												
Minnesota	8	7	7			1	3	4	4	0	2	2
Iowa	3	9	2		270	1	7	3	33	0	8	0
Missouri	6	6	5	3	46	3	5	53	13	0	1	1
North Dakota	0	1	2		1,134	24	1	1	3	0	0	0
South Dakota	1	3	3		1		1	4	7	0	0	0
Nebraska	0	0	1		514	11	1	4	4	0	0	0
Kansas	14	5	8	1	7,715	15	3	56	25	0	0	1
SOUTH ATLANTIC												
Delaware	2	0	0					6	1	0	0	0
Maryland [2]	14	16	10	2	115	11	24	12	12	0	0	8
District of Columbia	1	1	0	1	6	3	17	2	2	0	0	1
Virginia	13	15	12	525	4,796	383	92	40	40	3	2	6
West Virginia	2	7	4	89	7,219	18	160	2	14	3	3	1
North Carolina	4	37	9			7	87	31	31	0	0	1
South Carolina	6	7	7	510	2,696	421	24	56	24	3	0	0
Georgia	14	8	8	15	298	71	14	3	13	0	0	2
Florida	1	6	7		12	9	34	6	6	1	0	1
EAST SOUTH CENTRAL												
Kentucky	12	4	3	4	6,816	18	52	120	12	5	2	2
Tennessee	10	20	11	25	394	56	4	3	13	2	7	4
Alabama	8	7	9	51	1,205	143	14		3	2	4	2
Mississippi [2]	12	14	8							1	1	1
WEST SOUTH CENTRAL												
Arkansas	4	18	11	58	2,021	97	10	10	35	0	2	0
Louisiana	2	9	10	4	44	11	6	3	5	1	1	1
Oklahoma	2	6	6	23	1,170	97		17	11	0	2	2
Texas	29	88	53	1,726	14,496	1,509	21	49	49	2	7	4
MOUNTAIN												
Montana	0	1	1	19	943	15	48	8	26	1	1	1
Idaho	1	1	1	19	1,144	2	4	30	4	0	1	0
Wyoming	3	0	0			15		15	12	0	1	0
Colorado	13	6	8	18	539	36	10	8	27	0	2	2
New Mexico	2	3	0	2	24	3	28	3	3	0	0	0
Arizona	1	9	0	163	1,608	154	77	9	8	0	0	0
Utah [2]	0	0	0	1	9,434	43	2	32	19	0	0	1
Nevada	0	0	0					31		0	0	0
PACIFIC												
Washington	1	3	3		54	4	25	148	40	1	3	3
Oregon	5	2	2	4	426	18	31	16	45	0	0	1
California	18	31	20	8	266	102	59	287	202	3	20	11
Total	319	454	361	3,338	68,551	2717	2,696	2,290	4.018	49	127	127
51 weeks	15,893	18,200	15,236	220,512	378,199	364,402	660,721	125,960	594,435	5,584	7,837	7,837
Seasonal low week [3]	(27th) July 5–11			(30th) Jul. 26–Aug. 1			(35th) Aug. 30–Sept. 5			(37th) Sept. 13–19		
Total since low	7,265	11,303	8,749	30,315	309,301	30,177	20,636	23,401	32,227	918	1,342	1,342

[1] New York City only.
[2] Period ended earlier than Saturday.
[3] Dates between which the approximate low week ends. The specific date will vary from year to year.

Telegraphic morbidity reports from State health officers for the week ended Dec. 21, 1946, and comparison with corresponding week of 1945 and 5-year median—Con.

Division and State	Poliomyelitis			Scarlet fever			Smallpox			Typhoid and paratyphoid fever [4]		
	Week ended—		Median 1941–45	Week ended—		Median 1941–45	Week ended—		Median 1941–45	Week ended—		Median 1941–45
	Dec. 21, 1946	Dec. 22, 1945		Dec. 21, 1946	Dec. 22, 1945		Dec. 21, 1946	Dec. 22, 1945		Dec. 21, 1946	Dec. 22, 1945	
NEW ENGLAND												
Maine	1	1	0	34	30	30	0	0	0	0	0	0
New Hampshire	1	0	0	4	0	8	0	0	0	0	0	0
Vermont	0	1	0	11	4	4	0	0	0	0	0	0
Massachusetts	1	3	3	124	111	238	0	0	0	2	2	1
Rhode Island	1	0	0	20	10	9	0	0	0	0	2	0
Connecticut	2	0	0	18	22	28	0	0	0	0	0	0
MIDDLE ATLANTIC												
New York	11	11	7	249	233	279	0	0	0	3	3	3
New Jersey	0	0	0	79	31	79	0	0	0	2	1	0
Pennsylvania	2	0	1	101	137	163	0	0	0	3	2	2
EAST NORTH CENTRAL												
Ohio	5	0	1	232	205	243	0	1	1	1	0	1
Indiana	1	1	0	37	55	60	0	0	0	0	0	1
Illinois	7	3	2	121	110	136	0	1	1	1	2	2
Michigan [3]	11	2	0	137	185	155	0	0	0	2	1	1
Wisconsin	3	4	1	54	106	141	0	0	0	0	0	0
WEST NORTH CENTRAL												
Minnesota	2	2	1	27	32	69	0	0	0	0	0	0
Iowa	4	5	0	33	42	46	1	1	0	0	0	0
Missouri	13	1	0	28	40	46	1	0	0	1	0	1
North Dakota	2	0	0	2	12	12	0	0	0	0	0	0
South Dakota	1	0	0	3	7	19	0	0	0	0	0	0
Nebraska	0	0	0	15	27	25	0	0	0	0	0	0
Kansas	4	2	0	25	56	60	0	0	0	0	0	0
SOUTH ATLANTIC												
Delaware	0	0	0	6	6	4	0	0	0	0	0	0
Maryland [3]	0	0	1	15	28	43	0	0	0	1	0	1
District of Columbia	1	1	0	4	12	16	0	0	0	2	0	0
Virginia	2	0	1	60	75	45	0	0	0	3	1	3
West Virginia	0	0	0	56	38	38	0	0	0	0	0	0
North Carolina	6	0	0	24	48	48	0	0	0	0	0	0
South Carolina	0	0	0	3	7	7	0	0	0	0	1	2
Georgia	1	4	0	17	15	23	0	0	0	0	2	1
Florida	0	3	0	1	5	6	0	0	0	0	5	3
EAST SOUTH CENTRAL												
Kentucky	1	0	0	50	30	32	0	0	0	1	0	2
Tennessee	0	0	0	27	29	49	0	0	0	2	2	1
Alabama	0	1	0	25	10	21	0	0	0	2	0	1
Mississippi [3]	4	4	0	5	30	22	0	0	0	0	0	1
WEST SOUTH CENTRAL												
Arkansas	3	0	1	5	17	8	0	0	0	1	1	1
Louisiana	3	0	1	9	12	8	0	0	0	0	0	1
Oklahoma	9	0	0	1	63	30	0	0	0	0	1	1
Texas	5	7	3	41	131	48	0	0	0	6	5	5
MOUNTAIN												
Montana	0	1	1	6	14	14	0	0	0	0	2	0
Idaho	1	0	0	6	6	7	0	0	0	4	0	0
Wyoming	0	0	0	6	1	4	0	0	0	0	0	0
Colorado	0	0	0	35	36	36	0	0	0	0	2	1
New Mexico	2	1	0	16	22	6	0	0	0	0	1	1
Arizona	0	1	1	8	16	5	0	0	0	4	0	0
Utah [3]	2	1	1	27	22	54	0	0	0	0	0	0
Nevada	1	0	0	1	0	1	0	0	0	0	0	0
PACIFIC												
Washington	3	4	1	27	12	44	0	0	0	0	0	1
Oregon	2	0	2	26	44	37	0	1	0	0	2	2
California	19	26	10	95	213	196	0	0	0	0	3	3
Total	137	90	55	1,956	2,397	2,712	2	4	8	41	41	47
51 weeks	25,092	13,648	12,358	111,108	170,178	137,454	332	343	730	3,966	4,814	5,418
Seasonal low week [2]	(11th) Mar. 15–21			(32nd) Aug. 9–15			(35th) Aug. 30–Sep. 5			(11th) Mar. 15–21		
Total since low	24,626	13,251	12,056	24,813	36,360	36,360	53	70	114	3,491	4,190	4,833

[2] Period ended earlier than Saturday.
[3] Dates between which the approximate low week ends. The specific date will vary from year to year.
[4] Including paratyphoid fever reported separately, as follows: Massachusetts 1 (salmonella infection); New York2; Illinois 1; Michigan 1.

Telegraphic morbidity reports from State health officers for the week ended Dec. 21, 1946, and comparison with corresponding week of 1945 and 5-year median—Con.

Division and State	Whooping cough			Week ended Dec. 21, 1946							
	Week ended—		Median 1941–45	Dysentery			Encephalitis, infectious	Rocky Mt. spotted fever	Tularemia	Typhus fever, endemic	Undulant fever
	Dec. 21, 1946	Dec. 22, 1945		Amebic	Bacillary	Unspecified					
NEW ENGLAND											
Maine	18	44	39								
New Hampshire			2								
Vermont	25	19	19								1
Massachusetts	166	124	126		1						
Rhode Island	28	24	24								
Connecticut	36	41	39	1	1						2
MIDDLE ATLANTIC											
New York	226	169	202	13	9		2				1
New Jersey	144	106	106								1
Pennsylvania	177	90	93						1		3
EAST NORTH CENTRAL											
Ohio	83	52	92						4		4
Indiana	26	13	13						5		2
Illinois	105	38	54	8			2		12		10
Michigan [2]	201	119	119	1					2		1
Wisconsin	143	70	94	1					1		17
WEST NORTH CENTRAL											
Minnesota	9	23	23	1							1
Iowa	14	3	9								6
Missouri	13	9	9				1		4		3
North Dakota	1		7								
South Dakota		5	2								3
Nebraska	5	5	3								
Kansas	24	17	32				1		9		1
SOUTH ATLANTIC											
Delaware	4	1	1								
Maryland [2]	54	24	28					2	4		1
District of Columbia	4	6	7						1		
Virginia	84	46	46			10			6		4
West Virginia	10	8	13								
North Carolina	50	31	48								
South Carolina	27	86	41		2						
Georgia	10	6	6		1				1	8	4
Florida	2	3	5							2	1
EAST SOUTH CENTRAL											
Kentucky	52	6	19						1		
Tennessee	6	8	16			1	1		6		
Alabama	5	14	12							6	4
Mississippi [2]									2	4	5
WEST SOUTH CENTRAL											
Arkansas	15	1	12		2				1		
Louisiana	7		1	6						2	1
Oklahoma	17	1	3				1				1
Texas	170	147	128	5	390	32			1	11	7
MOUNTAIN											
Montana	5		9								
Idaho	1	17	12								
Wyoming	8		3								
Colorado	10	16	17	1							
New Mexico	10		8	3	1						
Arizona	55	9	9			11					
Utah [2]	1		8						1		1
Nevada	1	4									
PACIFIC											
Washington	23	27	23								3
Oregon	6	8	9								
California	65	90	90	4	9		1				5
Total	2,146	1,530	1,541	44	416	54	9	2	62	33	93
Same week, 1945	1,530			32	365	80	3	1	24	77	37
Average, 1943–45	1,464			39	397	92	6	[1] 1	27	[1] 77	
51 weeks: 1946	98,565			2,394	16,423	6,351	609	571	1,114	3,327	5,254
1945	122,344			1,917	24,434	10,421	615	467	789	5,123	4,770
Average, 1943–45	130,504		[1]175,128	1,959	22,232	8,951	640	[1] 454	750	[1] 4,475	

[2] Period ended earlier than Saturday.
[1] 5-year median, 1941–45.
Leprosy: Michigan 2 cases; Louisiana 1 case; Colorado 1 case.

WEEKLY REPORTS FROM CITIES[1]

City reports for week ended Dec. 14, 1946

This table lists the reports from 86 cities of more than 10,000 population distributed throughout the United States, and represents a cross section of the current urban incidence of the diseases included in the table.

Division, State, and City	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
NEW ENGLAND												
Maine:												
Portland	0	0	1	0	19	0	1	0	8	0	0	------
New Hampshire:												
Concord	0	0	------	0	------	0	0	0	0	0	0	------
Vermont:												
Barre	0	0	------	0	------	0	0	0	0	0	0	------
Massachusetts:												
Boston	15	0	------	0	12	1	13	1	19	0	0	30
Fall River	0	0	------	0	------	1	2	0	2	0	0	6
Springfield	0	0	------	0	5	0	0	0	0	0	0	14
Worcester	1	0	------	0	------	0	7	0	2	0	0	28
Rhode Island:												
Providence	0	0	------	0	11	0	3	0	8	0	0	15
Connecticut:												
Bridgeport	0	0	------	0	1	0	1	0	1	0	0	1
Hartford	0	0	------	0	------	0	1	0	3	0	0	2
New Haven	0	0	------	0	13	0	0	0	3	0	0	7
MIDDLE ATLANTIC												
New York:												
Buffalo	3	0	------	0	------	0	5	0	11	0	0	8
New York	18	0	4	1	18	4	55	8	76	0	2	62
Rochester	0	0	------	0	8	0	3	0	10	0	0	3
Syracuse	1	0	------	0	------	0	2	0	7	0	0	31
New Jersey:												
Camden	1	0	------	0	------	0	1	0	1	0	0	2
Newark	0	0	4	0	8	0	1	0	14	0	0	19
Trenton	0	0	1	1	23	0	0	0	3	0	0	------
Pennsylvania:												
Philadelphia	6	0	7	1	18	0	23	0	30	0	0	52
Pittsburgh	2	0	------	0	316	0	9	0	15	0	0	16
Reading	0	0	------	0	2	0	2	0	4	0	0	13
EAST NORTH CENTRAL												
Ohio:												
Cleveland	1	0	8	0	87	0	6	3	26	0	0	22
Columbus	1	0	------	0	------	0	2	0	4	0	0	------
Indiana:												
Fort Wayne	1	0	------	0	3	0	3	0	3	0	0	1
Indianapolis	4	0	------	3	2	0	6	0	16	0	1	10
South Bend	0	0	------	0	------	0	0	0	3	0	0	------
Terre Haute	0	0	------	0	------	0	2	0	1	0	0	------
Illinois:												
Chicago	0	0	1	1	4	1	27	4	43	0	0	73
Springfield	0	0	------	0	------	0	2	0	2	0	0	4
Michigan:												
Detroit	4	0	------	0	3	1	2	1	35	0	0	75
Flint	0	0	------	0	------	0	3	1	5	0	0	3
Grand Rapids	0	0	------	0	------	0	1	0	7	0	0	9
Wisconsin:												
Kenosha	0	0	------	0	------	0	0	0	1	0	0	3
Milwaukee	0	0	------	0	7	0	3	1	13	0	0	112
Racine	0	0	------	0	------	0	0	0	5	0	0	5
Superior	0	0	------	0	------	0	0	0	0	0	0	------
WEST NORTH CENTRAL												
Minnesota:												
Duluth	1	0	------	0	------	0	0	0	0	0	0	3
Minneapolis	3	0	------	0	2	3	0	0	13	0	0	13
St. Paul	0	0	------	0	------	1	7	0	5	0	0	------
Missouri:												
Kansas City	0	0	------	1	------	0	4	1	3	0	0	1
St. Joseph	0	0	------	0	------	0	0	0	0	0	0	1
St. Louis	7	0	------	0	------	0	8	4	14	0	0	6

[1] In some instances the figures include nonresident cases.

City reports for week ended Dec. 14, 1946—Continued

Division, State, and City	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
WEST NORTH CENTRAL—continued												
Nebraska:												
Omaha	0	0	------	0	-------	0	5	1	3	0	0	2
Kansas:												
Topeka	1	0	------	0	-------	0	0	0	1	0	0	1
Wichita	0	0	------	0	2	0	2	0	2	0	0	3
SOUTH ATLANTIC												
Delaware:												
Wilmington	1	0	------	0	1	0	0	0	1	0	0	1
Maryland:												
Baltimore	4	0	------	0	7	0	6	1	11	0	1	57
Cumberland	0	0	------	0	2	0	0	0	0	0	0	------
Frederick	0	0	------	0	-------	0	0	0	0	0	0	------
District of Columbia:												
Washington	0	0	------	0	14	0	8	0	10	0	0	12
Virginia:												
Lynchburg	0	0	------	0	1	0	0	0	1	0	0	2
Richmond	0	0	------	2	3	1	1	0	7	0	0	3
Roanoke	1	0	------	0	2	0	0	0	2	0	0	------
West Virginia:												
Wheeling	0	0	------	0	1	0	2	0	2	0	0	5
North Carolina:												
Raleigh	0	0	------	0	-------	0	0	0	0	0	0	1
Wilmington	0	0	------	0	1	0	0	0	1	0	0	------
Winston-Salem	0	0	------	0	41	0	1	0	1	0	0	2
South Carolina:												
Charleston	0	0	11	1	3	0	1	0	1	0	0	------
Georgia:												
Atlanta	0	0	2	1	3	0	0	0	2	0	0	4
Brunswick	0	0	------	0	-------	0	1	0	0	0	0	1
Savannah	0	0	1	0	4	0	0	0	0	0	0	------
Florida:												
Tampa	3	0	------	0	-------	0	5	0	1	0	0	1
EAST SOUTH CENTRAL												
Tennessee:												
Memphis	1	0	------	1	-------	0	12	0	8	0	0	9
Nashville	0	0	------	1	-------	0	3	0	2	0	0	3
Alabama:												
Birmingham	0	0	------	0	1	0	3	0	2	0	0	------
Mobile	2	0	3	2	-------	0	0	0	0	0	0	3
WEST SOUTH CENTRAL												
Arkansas:												
Little Rock	0	0	------	0	1	0	0	2	0	0	0	------
Louisiana:												
New Orleans	0	0	------	0	-------	1	8	0	2	0	0	1
Shreveport	0	0	------	0	-------	0	3	0	0	0	0	------
Texas:												
Dallas	1	0	------	0	4	0	3	0	2	0	0	1
Galveston	0	0	------	0	-------	0	1	0	0	0	0	------
Houston	0	0	------	0	-------	0	5	2	1	0	0	1
San Antonio	2	0	1	1	-------	0	4	0	1	0	0	------
MOUNTAIN												
Montana:												
Great Falls	0	0	------	0	5	0	0	0	1	0	1	------
Helena	0	0	------	0	1	0	0	0	0	0	0	------
Missoula	0	0	------	0	-------	0	0	0	0	0	0	------
Idaho:												
Boise	0	0	------	0	-------	0	0	0	0	0	0	------
Colorado:												
Denver	4	0	6	0	1	1	0	0	18	0	0	15
Pueblo	4	0	------	0	-------	0	0	0	3	0	0	------
Utah:												
Salt Lake City	1	0	------	0	3	0	0	0	6	0	0	------

City reports for week ended Dec. 14, 1946—Continued

Division, State, and City	Diphtheria cases	Encephalitis, infectious, cases	Influenza		Measles cases	Meningitis, meningococcus, cases	Pneumonia deaths	Poliomyelitis cases	Scarlet fever cases	Smallpox cases	Typhoid and paratyphoid fever cases	Whooping cough cases
			Cases	Deaths								
PACIFIC												
Washington:												
Seattle	0	0	------	0	-------	0	2	3	2	0	0	8
Spokane	0	0	------	0	5	0	0	0	4	0	0	------
Tacoma	0	0	------	0	2	0	0	1	1	0	0	1
California:												
Los Angeles	1	0	3	3	8	3	3	3	15	0	1	7
Sacramento	0	0	------	0	-------	0	0	0	1	0	0	------
San Francisco	1	0	4	0	3	2	2	3	11	0	1	3
Total	96	0	57	20	681	20	286	40	542	0	7	797
Corresponding week, 1945	89	------	1,442	64	786	------	432	------	706	0	3	543
Average, 1941–45	81	------	1,208	[2] 107	[3] 831	------	[2] 596	------	851	0	12	690

[2] 3-year average, 1943–45.
[3] 5-year median, 1941–45.

Dysentery, amebic.—Cases: Chicago 1; Detroit 1; Los Angeles 2.
Dysentery, bacillary.—Cases: New York 2; Philadelphia 1; Los Angeles 2.
Dysentery, unspecified.—Cases: San Antonio 6.
Rocky Mountain spotted fever.—Case: St. Louis 1.
Tularemia.—Cases: Boston 1; Indianapolis 2; St. Louis 3; Memphis 1.
Typhus fever, endemic.—Cases: Tampa 1; Birmingham 1; Mobile 2.

Rates (annual basis) per 100,000 population, by geographic groups, for the 86 cities in the preceding table (estimated population, 1943, 33,799,900)

	Diphtheria case rates	Encephalitis, infectious, case rates	Influenza		Measles case rates	Meningitis, meningococcus, case rates	Pneumonia death rates	Poliomyelitis case rates	Scarlet fever case rates	Smallpox case rates	Typhoid and paratyphoid fever case rates	Whooping cough case rates
			Case rates	Death rates								
New England	41.8	0.0	2.6	0.0	159	5.2	73.2	2.6	120	0.0	0.0	269
Middle Atlantic	14.3	0.0	7.4	1.4	182	1.9	46.7	3.7	79	0.0	0.9	95
East North Central	7.1	0.0	5.8	2.6	68	1.3	36.7	6.4	105	0.0	0.6	204
West North Central	24.1	0.0	0.0	2.0	8	8.0	52.3	12.1	82	0.0	0.0	60
South Atlantic	15.1	0.0	23.4	6.7	139	1.7	41.9	1.7	67	0.0	1.7	149
East South Central	17.7	0.0	17.7	23.6	6	0.0	106.2	0.0	71	0.0	0.0	89
West South Central	8.6	0.0	2.9	2.9	14	2.9	68.9	11.5	17	0.0	0.0	9
Mountain	73.9	0.0	49.2	0.0	82	8.2	0.0	0.0	230	0.0	8.2	123
Pacific	3.2	0.0	11.1	4.7	28	7.9	11.1	15.8	54	0.0	3.2	30
Total	14.9	0.0	8.8	3.1	105	3.1	44.2	6.2	84	0.0	1.1	123

FOREIGN REPORTS

CANADA

Provinces—Communicable diseases—Week ended November 30, 1946.—During the week ended November 30, 1946, cases of certain communicable diseases were reported by the Dominion Bureau of Statistics of Canada as follows:

Disease	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Chickenpox		40	2	168	355	61	19	97	202	944
Diphtheria		5	2	55	28	4	1	1	3	99
Dysentery:										
Amebic					5					5
Bacillary				1						1
German measles				6	14			8	5	33
Influenza		11			1	3			15	30
Measles		173	1	66	130	31	549	159	178	1,287
Meningitis, meningococcus			1	1	1		1		1	5
Mumps		3		100	375	44	112	34	123	791
Poliomyelitis	3	2		4	1		1			11
Scarlet fever		9	8	81	113	10		3	9	233
Tuberculosis (all forms)		7	6	126	53	36	7		49	284
Typhoid and paratyphoid fever				5					11	16
Undulant fever				2		1		5	1	9
Venereal diseases:										
Gonorrhea		23	9	206	112	44	34	54	74	556
Syphilis		8	2	89	106	14	5	12	52	288
Other forms									2	2
Whooping cough		13	1	35	147	36	15	1	10	258

CUBA

Habana—Communicable diseases—4 weeks ended December 7, 1946.—During the 4 weeks ended December 7, 1946, certain communicable diseases were reported in Habana, Cuba, as follows:

Disease	Cases	Deaths	Disease	Cases	Deaths
Chickenpox	2		Poliomyelitis	2	
Diphtheria	19		Tuberculosis	9	1
Malaria	10		Typhoid fever	23	
Measles	13				

Provinces—Notifiable diseases—4 weeks ended November 30, 1946.—During the 4 weeks ended November 30, 1946, cases of certain notifiable diseases were reported in the Provinces of Cuba as follows:

Disease	Pinar del Rio	Habana[1]	Matanzas	Santa Clara	Camaguey	Oriente	Total
Cancer	4	10	8	21	1	16	60
Chickenpox		4		1			5
Diphtheria	1	20	1		2	1	25
Dysentery, amebic		1					1
Hookworm disease		23					23
Leprosy		3					3
Malaria	17	8		5	2	53	85
Measles		14					14
Poliomyelitis	3	3	1		2	1	10
Scarlet fever	1						1
Tuberculosis	5	21	11	46	19	68	170
Typhoid fever	18	44	3	19	7	42	133
Whooping cough						2	2

[1] Includes the city of Habana.

ICELAND

Poliomyelitis.—Information dated December 3, 1946, stated that an outbreak of poliomyelitis had occurred in Rejkjavik, Iceland, and other parts of the country.

NORWAY

Notifiable diseases—September 1946.—During the month of September 1946, cases of certain notifiable diseases were reported in Norway as follows:

Disease	Cases	Disease	Cases
Cerebrospinal meningitis	15	Mumps	161
Diphtheria	305	Paratyphoid fever	16
Dysentery	5	Pneumonia (all forms)	949
Encephalitis, epidemic	5	Poliomyelitis	221
Erysipelas	555	Rheumatic fever	138
Gastroenteritis	4,218	Scabies	5,111
Gonorrhea	1,068	Scarlet fever	521
Hepatitis, epidemic	492	Syphilis	143
Impetigo contagiosa	5,038	Tuberculosis (all forms)	339
Influenza	1,564	Typhoid fever	4
Lymphogranuloma inguinale	3	Weil's disease	1
Malaria	2	Whooping cough	3,591
Measles	162		

REPORTS OF CHOLERA, PLAGUE, SMALLPOX, TYPHUS FEVER, AND YELLOW FEVER RECEIVED DURING THE CURRENT WEEK

NOTE.—Except in cases of unusual incidence, only those places are included which had not previously reported any of the above-mentioned diseases, except yellow fever, during recent months. All reports of yellow fever are published currently.

A table showing the accumulated figures for these diseases for the year to date is published in the PUBLIC HEALTH REPORTS for the last Friday in each month.

Plague

Portugal—Azores—Matriz.—For the period November 24 to December 7, 1946, 4 cases of bubonic plague with 3 deaths were reported in Matriz, Azores, Portugal.

Smallpox

China—Hong Kong.—For the week ended December 7, 1946, 188 cases of smallpox were reported in Hong Kong, China.

Liberia—Monrovia.—For the period September 24 to November 8, 1946, 150 cases of smallpox with 8 deaths were reported in Monrovia, Liberia.

Libya.—From the beginning of the outbreak in September 1946, up to November 22, 1946, 556 cases of smallpox with 86 deaths have been reported in Libya. For the week ended November 29, 1946, 50 cases of smallpox were reported.

Malay States (Federated)—Trengganu.—Smallpox has been reported in Trengganu, Federated Malay States as follows: Weeks ended—December 7, 1946, 232 cases, 29 deaths; December 14, 1946, 129 cases, 39 deaths.

Typhus Fever

Guatemala.—For the month of October 1946, 78 cases of typhus fever with 6 deaths were reported in Guatemala. Departments reporting the highest incidence are: Quezaltenango, 59 cases, 2 deaths; Sacatepequez, 8 cases, 1 death.

* * *

DEATHS DURING WEEK ENDED DEC. 14, 1946

[From the Weekly Mortality Index, issued by the National Office of Vital Statistics]

	Week ended Dec. 14, 1946	Corresponding week, 1945
Data for 92 large cities of the United States:		
Total deaths	9,590	10,201
Average for 3 prior years	10,370	
Total deaths, first 50 weeks of year	450,254	448,693
Deaths under 1 year of age	803	639
Average for 3 prior years	640	
Deaths under 1 year of age, first 50 weeks of year	33,369	30,306
Data from industrial insurance companies:		
Policies in force	67,314,498	67,250,961
Number of death claims	12,089	12,389
Death claims per 1,000 policies in force, annual rate	9.4	9.6
Death claims per 1,000 policies, first 50 weeks of year, annual rate	9.4	10.0

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