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OPPORTUNITIES FOR PUBLIC HEALTH IN DISABILITY INSURANCE PROGRAMS [1]

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In most nations governmental programs of disability insurance have developed simultaneously with programs of health insurance. The provision of cash benefits to workers in partial compensation for wage loss due to sickness has been complemented historically by programs to assure the provision of needed medical care. Governmental programs along these lines have been typically preceded by voluntary programs.

In the United States, disability insurance complemented by medical care insurance has been promoted on a private basis for some years, mainly through voluntary group insurance policies carried by commercial companies (*1*). The first governmental social insurance program along these lines, however, with compulsory protection of all eligible workers, has been confined to disability insurance. Such a program was first inaugurated in Rhode Island in April 1943. In December 1946, California undertook a similar program. During 1947, the legislatures of a half dozen other States have considered such disability insurance legislation. All the State programs are being conceived and planned as an adjunct of the compulsory State programs of unemployment insurance. In addition, the Railroad Retirement Act was amended in 1946 to provide a relatively liberal program of compulsory disability insurance for the nation's railroad workers (*2*). Since these programs spread the risks of wage loss due to sickness or nonoccupational injury causing disability for less than about 6 months, they should be termed "temporary disability insurance" in contrast to "permanent disability insurance."

A central administrative requirement of any program of this type is to determine when a worker is disabled. This necessitates some system of medical certification of disability in order that the insurance fund will be used only for justified claims. To those concerned with public health and medical administration, the development of such a system of medical certification raises two questions:

1. What type of administrative framework should be used in a State to assure the most effective handling of claims, with respect to their medical aspects?

2. How can the disability insurance program be utilized as an instrument for improving the health of the people?

At present, in the two States in which disability insurance programs are operating, the medical certification procedure is administered entirely by the State agency responsible for the general program. Since disability insurance is developing in this country as an extension of unemployment insurance, the agencies

[1] From the Medical Care Administration Division of States Relations.

responsible for the latter are in charge. In neither State is the agency of public health significantly involved in the medical administrative process. It is the purpose of this paper to explore the best possible answers to the two general questions raised above since many advantages might accrue, both in terms of administrative efficiency and in terms of promotion of the general health, from assigning medical certification responsibilities to departments of public health.

Before exploring these general questions, brief descriptions may be given of the current manner of operation of these programs in Rhode Island and California.

CURRENT STATE PROGRAMS

Rhode Island program.—Rhode Island was one of the first States that established an employee, as well as an employer, contribution in its State unemployment insurance system, set up under the Social Security Act of 1935. During the high level of employment in the early war years, tremendous reserves were built up in this program and the Rhode Island legislature took action to utilize that segment of the fund which had been contributed by employees to build a disability insurance fund (*3*). This amounted to the proceeds of 1 percent of wages paid up to $3,000 per worker per year. Out of this fund, cash benefits would be paid to all workers covered by unemployment insurance when they are unable to carry on their normal occupation because of sickness of at least 1 week's duration. The benefits paid are modest, coming to a maximum of $18 per week for 20 weeks in a benefit year. The weekly benefit amount and the duration of weeks for which it is paid depend on the "wage credits" earned during the previous year. Because of the high level of employment and relatively high wages, most persons acquiring cash benefits are, at present, entitled to the maximum weekly allowance for relatively long durations.

No attempt will be made here to outline the details of the claims procedure and the system of medical certification. In brief, the disabled worker is required to file an initial claim which must contain a statement by a qualified physician indicating that he is sick and unable to work. Before the claim can be effective, there is a waiting period of 1 calendar week during which no benefits are paid. Since a calendar week is defined as a period beginning at midnight Saturday and ending midnight the following Saturday, the days of disability prior to Saturday midnight do not count. Therefore, the actual waiting period is 7 to 14 days, depending on when an illness begins. All medical certifications are reviewed by administrative physicians in the employ of the State Unemployment Compensation Board and cases which are doubtful are called before special examining physicians employed by the Board (*4*).

The private physician who signs the initial claim form is expected to estimate the duration of disability. The reviewing physician may then indicate one of the following decisions on the claim: (a) in relation to the diagnosis given, the private doctor's estimate of the duration of disability is sound, and claims should be routinely paid for this period; (b) on the basis of the diagnosis given, a duration of disability is to be allowed different from that indicated by the private physician or for a period specified by the reviewing physician, if the private doctor failed to give an estimate; (c) because of an ambiguous diagnosis or insufficient information, it will be necessary for the claimant to be examined by one of the agency medical examiners before claims are paid.

The unit of disability payment is 1 week, and for each additional week of disability beyond the first, a new claim form must be submitted. Subsequent claim forms may or may not require the repeated certification of the personal physician. If the physician indicates that the worker is to be examined again, let us say, 3 weeks hence, then a new medical certification is not required during this interval.

New certifications by the attending physician are required in all cases, however, at no longer than monthly intervals. If a continued claim form is submitted for a week beyond the original allowance made by the medical director, the claimant is routinely asked to appear for a medical examination by one of the agency physicians. It is difficult to state the exact percentage of claimants called in for a medical examination at some time during the disability, since many of the examinations are rechecks of the same claimant. For the fiscal year April 1945 to March 1946, there were 32,468 initial claims received by the board and 26,885 appointments made for medical examinations by agency physicians (*5*).

Despite the high proportion of cases in which the examination of a private physician is supplemented by that of an agency physician, the administrative costs of the medical certification process are relatively low because the agency medical staff is paid on a part-time salary basis. There are a medical director who reviews all initial claims, four medical examiners working in Providence, and six other examining physicians, located throughout the State of Rhode Island, working chiefly in their offices during regular hours. Allowing for incidental expenses, the cost per examination is about $1.50. In 1945, all operating costs of the disability program, including medical certification and administrative expenditures, were only about 2.8 percent of the total cash benefits paid (*6*).

In order to protect the fund so that benefits prescribed under the law may be paid, recent legislative amendments will restrict benefits to persons actively engaged in the labor market within the past 6 months, reduce abuses associated with simultanous payment of workmen's compensation benefits, and place a maximum of 15 weeks on maternity benefits. Furthermore, the disability fund is to receive an amount equivalent to 1.5 percent of wages.

The medical certification has actually operated smoothly and only a few special problems confront the administrative staff. One of these problems concerns the requirement that the physician estimate an expected period of disability for each case. While this is often omitted or avoided by the private doctor, the medical director simply applies a more or less mechanical rule in making his notation on claim forms, such as allowing 6 weeks post-operatively for an appendectomy, 8 weeks for a hernial repair, 3 or 4 weeks for a case of pneumonia, and so forth, varying the time allowance with the age, sex, and occupation of the claimant. There is naturally bound to be some resentment when the agency physician determines a period of disability different from that certified by the private doctor. Another problem concerns the frequent insufficiency of information on the diagnosis or special circumstances of cases. Early in the program, moreover, there were complaints by members of the organized medical profession that this was "a first step to State medicine" and that it was developed without the approval of the doctors. In response to this complaint, several articles were published in the Rhode Island Medical Journal, describing how the program operates, and a Medical Advisory Committee was set up through the State medical society. Despite this, however, the medical staff of the Unemployment Compensation Board indicates that while the caliber of reports from private physicians has improved, many reports are still very poor.

California program.—The disability insurance program in California differs from that of Rhode Island in a number of respects. Most important, while coverage of workers under disability insurance is compulsory, the workers in a particular plant are allowed to "contract out" of the system by obtaining policies offering comparable benefits through private insurance companies. California's benefits in cash payments and in maximum duration of payments are somewhat higher, but no benefits are paid in maternity cases nor in cases getting awards under workmen's compensation. The waiting period is a flexible week rather

than a calendar week, so that 7 days is always the maximum. Benefits are usually paid in units of 2 weeks rather than 1 week. Because of the large size of the State, in contrast to Rhode Island, administration is highly decentralized (7).

The program is new and the medical certification procedure has not been thoroughly worked out but its main features are as follows: private physicians certify as to disability on an initial claim form. Claims are sent to 1 of 16 district offices throughout the State. Here claims examiners (not physicians) pass upon the certification made by the private doctor. They are guided by a standard insurance company manual on the subject and by indoctrination from the agency medical staff. If they approve of the private physician's estimated duration of disability, claims are paid as long as they are within this limit. If there is any doubt attached to a claim, the claims examiner may authorize an examination by another private physician. This physician is chosen from a panel of names submitted by the local medical society. He is paid according to a liberal fee schedule ranging from $7.50 to $50 per examination, depending on the extent of examining procedure required and whether it is performed by a specialist or a general practitioner.

In the central office of the State Department of Employment, there is a medical director whose principal functions are to develop and supervise the medical certification procedure and to maintain relationships with professional groups throughout the State. There are special delicate problems in professional relationships in California, since the law permits certification by religious healers, osteopaths, and chiropractors as well as doctors of medicine. In each of the two greatest centers of population of the State, Los Angeles and San Francisco, there will be an assistant medical director. The function of these men will, likewise, include the maintenance of professional relations and also the provision of some technical assistance to claims examiners in their review of medical certifications. It is possible that the department of employment may also engage some physicians on part-time salary for check-up medical examinations in the metropolitan centers. Most of the check-up examinations, however, are expected to be done by private physicians on a fee basis.

It is too early to tell how the California program will work out. So far, only a trifling percentage of medical certifications have been challenged by claims examiners. A weekly summary of the decisions of each district office on claims, indicating simply the diagnosis and the number of weeks allowed, is sent to the State medical director for review. In this way glaring errors may be detected, but it would not seem to be the same as competent medical review of all initial claims.

GENERAL COMMENTS

The systems of medical certification being followed involve a combination of certification by the private physician and by agency medical officials. In California and Rhode Island, as in most programs abroad, initial responsibility lies with the private doctor, but power of review and final responsibility lies with agency officials. This combined system is probably best from the point of view alike of the patient, the doctor, and the State agency. The patient is assured of sympathetic attention by a physician who knows his individual case well. The doctor is, in a sense, "protected" from possible pressure by the beneficiary to certify for periods beyond the limit of his own judgment. The State agency is assured of fair handling of claims and of proper protection of the insurance fund.

On the basis of these criteria the medical certification systems are operating in a generally satisfactory manner. Regardless of their efficiency of operation,

however, examination of administrative practices from the point of view of public health administration does not yield favorable answers to the two questions raised above, concerning effective administration and health promotion.

With regard to the first question, it must be stated that little, if any, advantage has been taken of the existing framework of health administration already available in State and local government, through the agencies of public health. Instead of looking to the existing health agencies of the States for technical assistance, the responsible social insurance agencies have established their own independent medical staffs and undertaken their own relationships with private medical practitioners and institutions. This independence is unfortunate not only because many of the disabilities for which claims are paid constitute preventable conditions coming under the control of health departments in one way or another, but more important because the State and local public health agencies offer a ready-made system of skilled personnel in the field of health administration. Despite the noncoverage of many rural counties with full-time public health services, the urban centers, in which practically all beneficiaries of this program are located, are virtually completely covered. It is generally recognized that the wide variety of preventive and therapeutic health functions, dispersed throughout State and local governments, call for integration—preferably under the agencies of public health.

With regard to the second question, it is clear that little has been done to utilize this program as an instrument for the promotion of better health and more adequate health services for the general population. The general objective of the medical certification system seems to be substantially that which might be pursued by a good commercial insurance company: the desire to protect the fund against abuses and yet to give fair cash awards where they are justified. There appears to be little special interest in what happens to each individual claimant from the point of view of medical care or personal health and nothing in the administrative procedure is designed to encourage such interest. Some might assert that any effort along these lines would constitute interference with the private practice of medicine, but such a claim would reflect ignorance of well established principles of cooperation between public health administration and private professional practice.

Likewise, numerous opportunities are presented under these programs for the provision of preventive services to beneficiaries. The number of people who might be offered such services is of no small proportion. In Rhode Island, for example, during the 1945–46 benefit year, there were some 210,000 persons covered by the disability insurance program, representing more than 40 percent of all persons 18–65 years of age in the State. In that year, there were over 32,000 initial claims for cash benefits in cases of disability stated to be of at least 1 week's duration. In other words, through this program an official State agency made contact with about one out of six or seven covered employed persons in connection with a serious health problem. Some of the ways in which advantage might be taken of this relationship are presented in the following section.

PUBLIC HEALTH ASPECTS

If responsibilities for the medical certification aspects of disability insurance programs were assigned to State and local departments of health, either directly or on a basis of cooperative working agreements, some of the following benefits could be realized:

Utilization of health department staff and facilities.—The task of initial review of the disability certifications by private physicians could be handled by medical personnel already on the health department staff—either full-time or part-time. This is not a serious problem in a State as small as Rhode Island, where one part-

time physician is able to do the entire job, but in larger States the administrative problem would be considerable. Assignment of the initial responsibility to lay claims examiners, as in California, is in a sense only an adjustment to the lack of a proper professional staff throughout the State.

Medical examinations, when required, could likewise be performed by doctors on the health department staff or by private physicians already serving in public health clinics. State and local public health officials are in a good position to know the local physicians best qualified for carrying out this type of function. Necessary administrative supervision over medical procedures could be more effective on this basis.

The physical facilities of the local health department, where available, could be used as the place for examining claimants when necessary. If a local health department is lacking in a particular area, the State health department could establish a special local facility for this purpose. Having examinations performed in health department facilities would provide a fitting background for promoting health education activities at a time when the worker would be more than ordinarily health-conscious.

The laboratory services available through laboratories of the department of public health could be used when necessary to establish or confirm the diagnosis in a claimant.[2] It would save the worker money at a time when he has little to spare. Since accurate diagnosis under this type of program serves a public function by protecting the insurance fund, it would seem fair to undertake such services at public expense.

The public health nurses of the health agency could be utilized to investigate the status of certain cases in their homes. This would avoid the occasional unfortunate situation in which a worker is asked to report for an examination (often because the private doctor gave inadequate information on the claim form) when he is, in fact, sick in bed. During such home visits, of course, the public health nurse would have the usual opportunities for educational work which constitute the central feature of her program.

Disabled workers could go to established clinics of the health department when not able to go to a private physician for financial or other reasons. This would apply particularly to cases of tuberculosis or venereal diseases and to women requiring prenatal and postpartum care (when maternity care is covered). The usual follow-up services of these clinics would be available to assure the continued care of persons using them.

Epidemiological functions.—The control of communicable and occupational diseases by appropriate divisions of the health department could be facilitated by the prompt reporting of claimants with such conditions.[3] Tuberculosis, for example, was reported as the cause of disability in Rhode Island in 341 cases during the 1944–45 benefit year. How many of these cases were already known to the health department and how many were unknown cannot be stated. This represents a probable loss of opportunities for examinations of contacts and other measures of tuberculosis control.[4] With regard to occupational diseases the

[2] This has, in fact, been done to some small extent in Rhode Island, especially in connection with cases diagnosed as anemia.

[3] It is a matter of historic interest that this point was recognized in 1915 by a medical officer of the U. S. Public Health Service who wrote in a study involving disability insurance: "The provision that no cash benefit be paid until the cause of sickness or death is reported would in time bring an accumulation of records of diseases which would be of tremendous value in the search for preventive measures." From: Warren, B. S., "Sickness Insurance: Its Relation to Public Health and the Common Welfare." *Pub. Health Rep.*, vol. 30, (January 8) 1915.

[4] Steps have recently been taken to arrange for the referral from the Rhode Island Unemployment Compensation Board to the State Health Department of the names of all claimants diagnosed as cases of tuberculosis.

diagnosis may often be ambiguous, but it would seem advisable for the health department to be informed of cases such as dermatoses or anemias, that might be suspected of having occupational origin.

Outside of the officially reportable diseases, an analysis of disability records could give public health officials valuable information on over-all community health problems. Here is, in fact, a comprehensive morbidity reporting system on serious illnesses and accidents causing extended disability. Significant epidemiological information might be discovered regarding the distribution of certain chronic diseases or physical impairments throughout the State, by areas, by age groups, by sex, by occupation, by income, by race, or by other demographic features. This information could provide an invaluable basis for specific control programs designed at prevention, where possible, or early diagnosis and prompt treatment of heart disease, diabetes, cancer or other conditions of high prevalence.[5]

Educational activities.—The health education services of the department of health could be utilized to explain to the workers of the State the meaning and mode of operation of the entire program. Disability insurance, moreover, presents a great opportunity to educate workers about the general importance of obtaining proper medical care. With partial compensation of wage loss during periods of disability, the worker is in a better economic position to obtain needed medical care.

One of the principal problems in a program of this type is the need for constant, active education of the physicians of the State on how the program operates, the obligations of the doctor under it, and how it can be used to promote the health of the beneficiaries. Among other things, it would seem helpful—in view of experience so far—to provide physicians with information on the actual average durations of different classes of disability, to help guide them in making estimates on their cases. A department of health which is engaged in many different programs of professional education, in cooperation with professional societies, seems to be in a good position for this activity.

Facilitation of medical care.—As important as any other health opportunity presented by a disability insurance program, is the chance to advise the disabled worker concerning his specific medical needs. This is a delicate issue since the health department is not engaged in the practice of medicine. A proper system of offering medical advice, however, would not in the least constitute competition with private medical practice, but rather would promote the utilization of such service. Disabled persons could be advised to obtain the necessary treatment for their conditions not merely by telling them to "see your family doctor" but rather by discussing with them the specific problem and advising them how to get care. In many conditions causing extended disability, the care of a specialist is required; yet the average worker is not in a position to know either the class of specialization or the name of a specialist whom he should consult. Lists of specialists of different types, as well as general practitioners from which the worker could make an intelligent choice could be made available. If workers indicate that they cannot afford to obtain the kind of medical service required, the public health worker could explain the steps necessary to obtain services through a public clinic or in some other way. In some cases, the assistance of the health agency might be valuable in arranging for needed hospitalization. Medical social workers could complement the services of public health nurses in this field.

[5] In California, steps have already been taken by the State Department of Employment to provide the State Department of Health with complete morbidity reporting on all claims. The *Manual for Coding Causes of Illness* of the U. S. Public Health Service is to be used. This data will be analyzed by the Bureau of Chronic Disease Control in particular.

Administrative procedure in the medical certification system could be effective in other ways in encouraging needed medical care for cases drawing disability benefits. Thus, it would seem wise to be assured that an individual drawing weekly checks is in continual receipt of medical service. This is accomplished in some foreign disability insurance programs by requiring, with certain exceptions, a new medical certification of disability about once a week. In the Rhode Island program, a worker can be disabled for as long as 4 weeks without being definitely required to see a physician. In California, the continued claim forms can be signed by a physician, a hospital representative, or an authorized representative of the department of employment. In certain types of cases, such as chronic orthopedic conditions, it might perhaps be permissible to require a medical examination only once every 2 weeks or thereabouts. In most conditions even of the most chronic type, however, serious enough to be disabling from work, a medical examination would seem to be desirable at least weekly. With regard to prenatal cases, good medical care dictates the advisability of an examination at least once a month. Workers may object to a requirement of repeated medical certifications as a compulsion on them to assume the expense of a medical fee which they cannot easily afford. The worker will in the end profit, however, from maximum protection of his health and prompt return to regular employment, which always yields him higher income than do cash disability benefits.

The workmen's compensation program in Rhode Island happens to demonstrate another device that might be used to foster improved medical care under the disability insurance program. This is through the establishment of what is called a "Curative Center" to which difficult chronic cases are referred. At this center, intensive services in the form of physiotherapy, occupational therapy, and psychotherapy are given by highly skilled salaried personnel—physicians and others—to help rehabilitate injured workers who have not responded to ordinary medical management. In the workmen's compensation program, the costs of this center are defrayed by setting aside a small percentage of the insurance premiums; the same might theoretically be done with disability insurance contributions. The task of arranging for referrals of difficult cases to a center should, indeed, be easier under the disability insurance program than under the workmen's compensation program; in the latter case, the private physician loses certain assured private medical fees by referring a patient to the center, while under disability insurance, there is no fund specifically guaranteeing the payment of the physician.

Specific preventive services.—The requirement that certain workers claiming disability benefits must present themselves for examination by an agency doctor provides a valuable opportunity for organized case-finding and preventive procedures. Why should it not be possible, for example, for every person coming for an examination to have the benefit of a chest X-ray or a serological test for syphilis as a routine matter? Likewise, in epidemic situations, this opportunity might be used for offering immunizations against influenza or typhoid fever or other conditions in which the protection of adults might be indicated. If examinations are performed in a public health facility, such routine measures could be easily provided.

Coordination with other health agencies.—Through a health agency, it might be possible to coordinate the medical care aspects of the disability insurance program with the medical services available through State and local welfare departments. Many workers at the time of their disability might have been unemployed for several months and might be eligible for public assistance, including welfare medical services. A unified health agency could arrange for proper referrals to obtain these services.

Another area for coordination is in connection with the medical aspects of workmen's compensation administration. It would seem wise for the certification of disability under these two programs to be unified so that, in applicable cases,[6] both systems would certify cases for the same period of disability. However, much remains to be done before health departments are integrated with the administration of the medical aspects of workmen's compensation.

The medical services available through the Federal-State vocational rehabilitation program present a special opportunity for disabled workers. This program offers financial resources with which to pay for needed medical services to correct static physical or mental defects impairing a worker's employability. An active referral system under the disability insurance program could facilitate the recovery of certain disabled workers and reduce the drain on the insurance fund. The numerous cases getting cash benefits for disability related to elective surgical operations represent additional instances in which the two programs may concern the same individuals.

In States like Rhode Island, where medical licensure is a responsibility of the health department, or even where it is in a separate unit, another opportunity for coordination is presented. While the exercise of licensure authority would seldom be invoked, it might have the effect of encouraging proper standards of performance in this program. It might be possible, moreover, to cope with the problem of nonmedical practitioners more effectively under a health agency than elsewhere.

Doubtless, other illustrations of benefits that might be derived by the administration of medical certification through a health agency could be shown, but these may be enough to make the point. As experience developed in such a program, new opportunities for coordinated administration and for health promotion would undoubtedly appear.

IMPLICATIONS FOR THE FUTURE

It should be clear that under the administrative pattern suggested here, the agency supervising the general disability insurance program would retain ultimate responsibility for all aspects of it. The maintenance of wage records, determinations of eligibility, payment of disability cash benefits, and all such functions would, of course, remain under this agency. Some might say that it is unsound to separate in this way responsibility for medical certification from responsibility for the payment of benefits based upon this certification. Actually, the separation need be no greater than it is by the establishment of a separate medical divison within the social insurance agency. The department of public health would, in effect, operate essentially as a technical arm of the insurance agency. Reports to the social insurance agency should be periodically required and the health department should be responsible for accepting criticisms and suggetions from the insurance agency. The dependence of the health department on the insurance agency, moreover, for administrative funds would constitute another appropriate control over health department activities by the agency footing the general bill.

There are many critical issues in the field of disability insurance beyond the question of medical certification discussed here. One of these which impinges directly on the health aspects of the program is the question of allowing workers to "contract out" for their disability protection through private insurance companies. This is, at present, allowed in California and is being considered as the exclusive method of operation in current discussions regarding a program in New Jersey. Social insurance experts offer numerous objections to this policy which

[6] In the 1943–44 benefit year, when a study was made, about 8 percent of the disability claimants in Rhode Island were also claiming workmen's compensation benefits.

cannot be reviewed here, but purely from the point of view of health opportunities it would, likewise, seem to be objectionable. The integration of the disability-insurance program with the activities of State and local health departments would probably be extremely difficult with respect to those workers who are insured by independent private companies. Each company has its own certification system and neither the claim form nor the individual worker makes direct contact with a public agency.

It is claimed by some that a disability insurance program actually operates to increase sickness. What probably happens, of course, is that disability insurance tends to expand our knowledge of sickness and to make it statistically evident (*8*). There is, nevertheless, impressive evidence that disability insurance can have the effect of increasing absenteeism and at least one paper on this point has been published by an industrial physician in Rhode Island. How valid this experience may be is not clear, especially since there were coincident reasons why absenteeism might have increased following the introduction of the disability insurance program in Rhode Island (employment during the wartime period of more women workers and older men, longer hours, night shifts, higher wages with greater savings to buffer wage loss, wartime emotional stresses, etc.). Even if there is a real increase in absenteeism because of disability insurance, however, one must ask the meaning of this in terms of the individual's health and well-being.

There is a great deal of talk about "positive health" these days; yet we know that thousands of workers do not enjoy such positive or optimal health, even while they are carrying on their usual occupation. If workers are enabled by a disability insurance program to enjoy relatively thorough periods of convalescence, they are surely returning to their usual occupation in a state of considerably higher positive health than if they were prematurely compelled to "get back on their feet" because of the necessity of earning a living. While there are a certain number of unjustified claims arising in these and perhaps in any disability insurance program, their proportion—according to the staff physicians in the Rhode Island program—seems relatively small. When allowance is made for fundamental psychosomatic factors in disability, the proportion of truly unwarranted claims is doubtless smaller.

The entire question of disability insurance in relation to public health takes on special importance today because of the likelihood of new programs developing in several additional States in the very near future. Because of an amendment to the Social Security Act, passed on the last day of the Seventy-ninth Congress in 1946, at least seven other States outside of Rhode Island and California have a special financial inducement to undertake disability insurance programs. This amendment provides that in any State in which an employee contribution has been made to the State unemployment compensation fund, the sums so collected since the beginning of this program may now be set aside for a disability insurance program (*9*). The States involved are Massachusetts, New Jersey, Alabama, New Hampshire, Indiana, Kentucky, and Louisiana. In New Jersey, for example, a reserve fund of $185,000,000 is available with which to begin a disability insurance program. This would be sufficient to carry along such a program for several years, even if there were no current contributions; with current contributions, this reserve fund would help to insure the stability of an especially liberal sickness benefit program. In addition, other States like Washington and New York are seriously contemplating disability insurance programs on the basis of new taxes.

The main points of this analysis may be summarized in the following way: The medical certification requirement in a disability insurance program raises, on the one hand, a large task of medical administration and, on the other hand, it

presents valuable opportunities for promoting improved health services for the public. Administration of these medical phases of disability insurance by or through departments of public health would present a way in which fullest advantage might be taken of the resources of public agencies in the field of health administration. At the same time, it would provide maximum opportunities for promoting the health of the public and, indeed, ultimately the solvency of the disability insurance fund.

There is an obvious connection between disability insurance and the various programs for improving the distribution of medical care now developing or being planned throughout the country. Even with coincident programs of medical care—voluntary or government-sponsored—medical certification remains a large problem, but the central issue of assuring medical care to the disabled worker is better met. This relationship, of course, gives health departments a special interest in the medical aspects of disability insurance.

It is relevant that in California bills for compulsory health insurance have been introduced into the State legislature for the past several years. In February 1947, a new bill providing for compulsory hospitalization insurance, including protection for the services of the physician in the hospital, was introduced (*10*). It is quite significant that in that State the notion is common that operating responsibility for health insurance should be vested with the Department of Employment, since that agency is already handling disability insurance. It can be readily appreciated that by this logic the State and local health agencies of California would be barred from administrative responsibility even for a program whose direct and primary purpose is the maintenance of health.

The closest possible relationships between the health departments and the emerging State programs of disability insurance are dictated, therefore, not only by current considerations of sound public health practice, but also by recognition of likely medical care responsibilities in the future.

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VACANCIES FOR FULL-TIME PUBLIC HEALTH PERSONNEL IN STATE AND LOCAL HEALTH DEPARTMENTS, JUNE 1947

As of July 1945, 38 State and 930 local health departments reported to the Surgeon General's Committee on Postwar Training of Public Health Personnel, a total of 2,593 vacancies in full-time positions in 19 types of public health personnel.[1] These figures did not include 144 vacancies for "other technical" and "unspecified types of personnel" and approximately 2,000 positions vacant or filled by temporary appointees, which were being held for persons in the armed services.

In order to appraise further the situation, in February 1946, the Committee wrote follow-up letters to the State health officers of California, Georgia, Kentucky, New York, North Carolina, Michigan, and Missouri asking what changes, if any, had taken place in the medical officer vacancies in each State since July 1945. The substance of the replies was that there was little if any improvement. Mention was made of the fact that the impact of medical men returning from the military forces had not yet been felt. One State replied that none of the vacancies listed in 1945 had been filled. Another State reported that medical vacancies were approximately 15 percent worse than in June 1945, and that while all former health officers had been released from military duty, only 3 had returned to the State Health Department. The failure of local and State health departments to establish salary ranges attractive to physicians was mentioned by one State as a factor affecting the recruitment of medical personnel.

While complete statistics were not submitted in every case, 6 States reported a total of 117 vacancies in the category of medical officer and epidemiologist. This was 27 more physician vacancies than were reported by these same 6 States in June 1945.

In April 1947, the Public Health Service Committee on Training Public Health Personnel requested detailed vacancy information from 12 State health departments. With 8 States supplying incomplete data, a total of 1,847 vacancies were reported in the same 19 types of public health personnel reported on in 1945. This constitutes an increase of 590 vacancies over the 1945 report from the same 12 States. The detailed 1947 report by States compared with the 1945 report appears in the accompanying table. It should be noted that the figures for New York for 1947 are exclusive of New York City, which fact should be borne in mind when making comparison with the complete return for 1945.

[1] Pub. Health Rep. 60: 1253 (1945).

TABLE 1.—*Number of vacancies for full-time public health personnel in State and local health departments, 1945 and 1947*

Type of position	State																									
	Minnesota		Texas		New York		Illinois		Georgia		Louisiana		California		Kentucky		Colorado		Michigan		North Carolina		Massachusetts		Totals	
	1945	1947	1945	1947	1945	1947[1]	1945	1947	1945	1947	1945	1947	1945	1947	1945	1947	1945	1947	1945	1947	1945	1947	1945	1947	1945	1947
Health officer	1	6	4	12	0	4	0	(2)	13	28	(2)	5	1	5	18	31	1	3	9	6	5	13	3	4	55	117
Epidemiologist	-----	1	1	1	10	1	1	(2)	1	6	(2)	1	2	(2)	-----	1	(3)	1	1	1	1	2	-----	(2)	17	15
Other medical officers	-----	1	5	5	35	48	1	4	14	63	(2)	3	24	23	3	6	2	3	3	8	13	12	1	10	101	186
Graduate nurse	5	23	35	(2)	181	203	7	22	57	238	(2)	33	96	61	71	60	11	(4)	159	241	29	59	3	(2)	654	940
Sanitary or public health engineer	1	7	2	2	2	9	1	9	17	37	(2)	(2)	4	5	2	1	1	1	3	5	3	5	(3)	(2)	36	81
Dentist	-----	1	1	3	-----	1	1	3	1	5	(2)	(2)	2	9	3	2	-----	(2)	3	1	1	7	2	(2)	14	32
Health educator	-----	1	1	1	4	2	2	3	2	8	(2)	(2)	1	1	-----	1	1	1	5	1	3	4	2	(2)	21	23
Nutritionist	(3)	2	-----	-----	3	-----	-----	(2)	1	7	(2)	(2)	6	2	1	2	1	1	2	2	-----	2	1	(2)	15	18
Medical social worker	(3)	1	(3)	(3)	(3)	(2)	(3)	(2)	-----	-----	(2)	(2)	2	5	(3)	1	(3)	3	-----	(2)	(3)	1	2	(2)	4	11
Inspector	2	(2)	-----	8	12	-----	-----	(2)	5	12	(2)	(2)	21	(2)	-----	2	1	(2)	19	(2)	2	19	2	(2)	64	41
Sanitarian	-----	(2)	5	8	12	1	1	(2)	7	47	(2)	14	32	55	13	6	2	4	4	3	15	(2)	1	(2)	92	138
Veterinarian	-----	(2)	-----	-----	4	1	-----	(2)	1	1	(2)	(2)	1	1	-----	2	-----	1	5	1	-----	(2)	-----	(2)	11	7
Statistician	(3)	(2)	-----	-----	17	12	1	5	1	1	(2)	1	8	6	-----	-----	-----	(2)	1	(2)	1	(2)	-----	(2)	29	25
Bacteriologist, serologist	-----	(2)	8	12	18	3	-----	18	2	12	(2)	(2)	3	2	-----	-----	-----	1	8	6	2	2	1	(2)	42	56
Chemist	-----	(2)	1	2	2	1	(3)	1	1	-----	(2)	1	1	2	1	1	1	(2)	2	2	3	2	1	(2)	13	12
Laboratory technician	1	(2)	2	5	21	7	-----	5	15	51	(2)	(2)	8	11	4	1	1	(2)	10	(2)	2	2	3	(2)	67	82
X-ray technician	-----	(2)	1	3	4	(2)	(3)	1	8	27	(2)	2	1	1	3	1	-----	(2)	1	(2)	1	3	-----	(2)	19	38
Dental hygienist	(3)	(2)	-----	-----	-----	(2)	(3)	(2)	-----	-----	(2)	(2)	2	2	(3)	-----	(5)	(2)	(3)	(2)	(3)	(2)	-----	(2)	2	2
Venereal disease investigator	(3)	(2)	1	1	(3)	(2)	-----	1	(3)	(4)	(2)	(2)	-----	2	-----	-----	(3)	1	-----	1	-----	3	(3)	(2)	1	9
Other professional personnel [6]	(2)	(2)	(2)	(2)	(2)	(2)	(2)	4	(2)	(2)	(2)	(2)	(2)	6	(2)	(2)	(2)	(2)	(2)	(2)	(2)	4	(2)	(2)	-----	14
Total	10	43	67	63	325	293	15	76	146	543	-----	60	215	199	119	118	22	20	235	278	81	140	22	14	1,257	1,847

[1] Exclusive of New York City.
[2] Not reported.
[3] No such position.
[4] Position classified but no funds allocated.
[6] Includes: Occupational therapists, psychiatric social workers, consultants in hospital administration, informational personnel, physical therapy technicians.

NOTE: Statistics for 1945 taken from Public Health Reports, Reprint No. 2656: *Number of Vacancies for Full-Time Public Health Personnel in State and Local Health Departments*, July, 1945. Statistics for 1947 submitted by State health departments as of spring, 1947.

Vacancies reported in 1947 were greater than in 1945 in 13 of the 19 categories of positions. There were reductions in total vacancies reported for chemists, epidemiologists, inspectors, statisticians, and veterinarians. Vacancies for two dental hygienists were reported for both years.

Official health agencies will have to face in a realistic fashion the continued scarcity of trained personnel indicated in these reports, if the public is to receive the kind of public health service recommended by competent authorities as a necessary minimum for human welfare.

Some of the reasons for this shortage—low salaries, lack of prestige, lack of job security—are known. Possibly there are other less obvious reasons. It would seem that the time has come for all concerned to study thoughtfully the problem of recruitment and training of public health personnel with a view to taking definite action to correct the situation.

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 NOVEMBER 1, 1947

Summary

Following decreases in each of the past 6 weeks, a net increase was reported in the incidence of poliomyelitis, although sharp declines occurred in a number of States. A total of 351 cases was reported, as compared with 333 last week, 564 for the corresponding week last year, and a 5-year (1942–46) median of 390. Of the 8 States reporting more than 10 cases, 4 showed increases. States showing increases of more than 4 cases are as follows (last week's figures in parentheses): New York 47 (39), Ohio 62 (50), Nebraska 7 (2), Tennessee 10 (4), Idaho 25 (10), Utah 8 (1), California 18 (11). Since March 15, the approximate average date of lowest weekly incidence, 8,934 cases have been reported, as compared with 22,474 for the same period last year and an average of 15,780 for the corresponding periods of the 4 epidemic years 1943–1946. The corresponding figure for 1942 was 3,358.

Of 1,438 cases of influenza (last week 1,576, which was the same as the 5-year median), 1,088 cases, or approximately 76 percent, occurred in 3 States—Virginia 250 (last week 267), South Carolina 328 (384), and Texas 510 (last week 605). These States reported 80 percent of last week's total. Of the total of 13,233 cases (last year 12,627) reported during the 14 weeks since July 26 (the approximate average date of seasonal low incidence), the same States have reported 10,891 cases, last year 10,299, approximately the same percentage (82 percent) for both years.

No occurrence of smallpox was reported during the week. Of 3 cases of Rocky Mountain spotted fever (last week 1, 5-year median 3), 2 cases occurred in California, the first reported in that State this year, and 1 case in Maryland. The total for the year to date is 538, as compared with 552 for the same period last year, and a 5-year median of 449.

Deaths recorded during the week in 93 large cities of the United States totaled 8,880, as compared with 8,675 last week, 8,616 and 9,023, respectively, for the corresponding weeks of 1946 and 1945, and a 3-year (1944–46) median of 8,969. The total to date is 403,352, as compared with 397,205 for the same period last year. Infant deaths in the same cities totaled 689, last week 702, 3-year median 671. The cumulative figure is 32,475, as compared with 28,928.

Telegraphic morbidity reports from State health officers for the week ended Nov. 1, 1947, and comparison with corresponding week of 1946 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	Week ended—		Median	Week ended—		Median	Week ended—		Median
	Nov. 1, 1947	Nov. 2, 1946	1942–46	Nov. 1, 1947	Nov. 2, 1946	1942–46	Nov. 1, 1947	Nov. 2, 1946	1942–46	Nov. 1, 1947	Nov. 2, 1946	1942–46
NEW ENGLAND												
Maine	1	1	1	-------	-------	-------	1	114	5	0	1	1
New Hampshire	0	0	0	-------	-------	-------	4	9	9	0	0	0
Vermont	0	0	0	-------	-------	-------	1	47	19	0	0	0
Massachusetts	10	15	2	-------	-------	-------	24	139	157	0	2	4
Rhode Island	2	0	1	-------	1	1	2	2	-------	0	0	0
Connecticut	1	1	1	-------	1	1	7	33	18	0	0	2
MIDDLE ATLANTIC												
New York	24	11	11	[1] 1	[1] 7	[1] 5	79	91	91	8	9	15
New Jersey	0	13	4	1	3	4	47	14	14	3	5	5
Pennsylvania	10	9	8	[2] 1	[2] 4	[2] 3	44	182	143	2	2	4
EAST NORTH CENTRAL												
Ohio	17	18	18	3	6	6	63	69	26	3	2	5
Indiana	10	1	8	-------	-------	12	6	4	6	0	1	2
Illinois	2	5	5	-------	5	4	130	6	38	0	3	7
Michigan [3]	2	1	10	2	-------	-------	346	36	117	2	0	3
Wisconsin	0	4	4	11	27	27	49	47	47	0	1	2
WEST NORTH CENTRAL												
Minnesota	6	13	9	-------	-------	-------	132	7	5	1	0	2
Iowa	6	3	8	-------	-------	-------	10	8	8	1	3	1
Missouri	4	4	4	6	1	-------	2	2	6	0	0	1
North Dakota	1	2	3	-------	9	-------	17	-------	1	0	0	
South Dakota	0	0	2	-------	-------	-------	8	1	2	0	0	0
Nebraska	1	1	3	-------	5	1	4	3	4	0	1	1
Kansas	6	8	4	3	2	2	2	5	5	1	0	0
SOUTH ATLANTIC												
Delaware	1	0	0	-------	-------	-------	-------	-------	-------	1	0	0
Maryland [3]	8	11	7	1	1	1	1	6	6	2	0	5
District of Columbia	0	4	0	1	-------	-------	2	6	2	1	0	1
Virginia	1	13	15	250	203	187	10	7	7	1	0	1
West Virginia	5	10	10	30	4	4	32	6	6	1	1	1
North Carolina	33	14	29	-------	-------	-------	5	55	17	2	1	3
South Carolina	32	7	19	328	130	285	4	2	3	1	0	0
Georgia	24	12	25	16	12	25	1	13	8	0	0	0
Florida	2	6	8	2	7	3	4	1	2	0	4	2
EAST SOUTH CENTRAL												
Kentucky	11	31	13	2	-------	2	1	-------	5	1	2	2
Tennessee	10	7	8	24	3	16	12	3	3	0	0	1
Alabama	20	13	33	44	28	32	1	1	3	0	0	1
Mississippi [3]	13	10	17	12	-------	-------	1	-------	-------	0	0	1
WEST SOUTH CENTRAL												
Arkansas	5	12	19	70	19	31	11	26	2	0	0	0
Louisiana	7	7	12	1	-------	2	4	-------	1	1	2	1
Oklahoma	1	8	13	20	16	22	1	-------	9	0	1	1
Texas	30	29	63	510	750	750	24	48	34	6	8	8
MOUNTAIN												
Montana	1	1	1	-------	4	4	40	49	17	0	2	0
Idaho	0	0	0	3	8	-------	3	3	3	0	0	0
Wyoming	0	0	0	-------	1	1	4	3	3	0	0	0
Colorado	3	6	6	5	8	29	6	4	11	1	1	1
New Mexico	3	0	1	3	2	-------	2	34	1	0	0	0
Arizona	0	2	2	67	86	60	2	8	4	2	0	1
Utah [3]	6	2	0	15	-------	-------	1	9	11	0	0	0
Nevada	0	0	0	-------	-------	-------	-------	-------	2	0	0	0
PACIFIC												
Washington	2	13	6	-------	-------	-------	29	17	26	0	0	2
Oregon	1	2	2	3	2	5	10	8	22	0	0	1
California	9	19	27	3	11	20	72	40	53	4	3	7
Total	331	349	518	1,438	1,366	1,576	1,261	1,168	1,363	45	55	88
44 weeks	9,809	13,263	12,408	314,746	202,824	92,654	192,520	647,020	554,188	2,977	5,134	7,103
Seasonal low week [4]	(27th) July 5–11			(30th) July 26–Aug. 1			(35th) Aug. 30–Sept. 5			(37th) Sept. 13–19		
Total since low	3,512	4,635	5,059	13,233	12,627	12,581	7,018	6,935	7,597	336	468	608

[1] New York City only. [2] Philadelphia only. [3] Period ended earlier than Saturday.
[4] 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 Nov. 1, 1947, and comparison with corresponding week of 1946 and 5-year median—Con.

Division and State	Poliomyelitis			Scarlet fever			Smallpox			Typhoid and paratyphoid fever		
	Week ended—		Median	Week ended		Median	Week ended—		Median	Week ended—		Median
	Nov. 1, 1947	Nov. 2, 1946	1942–46	Nov. 1, 1947	Nov. 2, 1946	1942–46	Nov. 1, 1947	Nov. 2, 1946	1942–46	Nov. 1, 1947 [5]	Nov. 2, 1946	1942–46
NEW ENGLAND												
Maine	1	2	2	13	15	19	0	0	0	0	0	0
New Hampshire	1	7	2	4	0	7	0	0	0	0	0	0
Vermont	2	1	1	3	7	6	0	0	0	0	0	0
Massachusetts	6	19	8	71	58	107	0	0	0	3	2	3
Rhode Island	2	2	1	6	6	6	0	0	0	0	0	0
Connecticut	0	6	6	11	19	23	0	0	0	0	0	0
MIDDLE ATLANTIC												
New York	47	39	39	113	208	185	0	0	0	3	5	6
New Jersey	9	10	10	28	55	48	0	0	0	6	1	1
Pennsylvania	15	12	12	87	77	161	0	0	0	6	3	3
EAST NORTH CENTRAL												
Ohio	62	17	11	176	218	230	0	0	0	2	5	4
Indiana	1	13	5	30	34	62	0	0	0	4	0	1
Illinois	13	72	23	55	78	127	0	0	0	4	8	2
Michigan [3]	16	30	7	77	141	118	0	0	0	2	6	2
Wisconsin	9	41	8	21	55	78	0	1	0	0	0	0
WEST NORTH CENTRAL												
Minnesota	5	32	8	38	19	46	0	0	0	1	0	0
Iowa	7	29	6	43	18	53	0	0	0	0	0	0
Missouri	2	17	13	9	14	46	0	0	0	2	1	3
North Dakota	0	5	0	5	4	9	0	0	0	0	1	0
South Dakota	0	8	1	9	1	19	0	0	0	0	0	0
Nebraska	7	17	3	7	11	23	0	0	0	0	0	0
Kansas	0	33	8	21	27	73	0	0	0	0	0	0
SOUTH ATLANTIC												
Delaware	3	0	0	1	4	4	0	0	0	0	0	0
Maryland [3]	4	7	7	21	18	54	0	0	0	3	2	2
District of Columbia	1	0	0	7	9	14	0	0	0	1	0	0
Virginia	10	6	3	33	34	72	0	0	0	5	3	3
West Virginia	6	0	1	17	58	70	0	0	0	2	0	2
North Carolina	12	5	2	26	31	106	0	0	0	1	1	1
South Carolina	8	1	1	4	1	12	0	0	0	3	1	1
Georgia	0	1	1	13	13	32	0	0	0	3	1	1
Florida	0	3	3	0	3	8	0	0	0	0	0	1
EAST SOUTH CENTRAL												
Kentucky	6	1	2	55	41	64	0	0	0	1	2	5
Tennessee	10	1	1	43	18	59	0	0	0	1	1	1
Alabama	0	0	0	17	16	29	0	0	0	1	1	1
Mississippi [3]	3	9	2	3	9	20	0	1	0	3	0	2
WEST SOUTH CENTRAL												
Arkansas	0	8	3	5	8	11	0	0	0	3	2	2
Louisiana	2	10	3	3	6	9	0	0	0	3	1	1
Oklahoma	5	3	3	7	9	28	0	0	0	0	0	3
Texas	5	7	8	22	28	48	0	0	0	4	11	11
MOUNTAIN												
Montana	[6]0	4	1	9	3	9	0	2	0	0	0	0
Idaho	25	0	0	12	4	14	0	0	0	0	2	0
Wyoming	1	5	0	2	3	3	0	0	0	0	0	0
Colorado	2	6	4	23	26	28	0	0	0	0	0	1
New Mexico	3	2	2	0	3	3	0	0	0	2	0	1
Arizona	1	4	1	5	8	7	0	0	0	4	0	1
Utah [3]	8	7	7	8	15	15	0	0	0	0	0	0
Nevada	0	0	0	0	0	1	0	0	0	0	0	0
PACIFIC												
Washington	8	17	9	30	36	39	0	0	0	1	3	1
Oregon	5	4	2	18	19	20	0	0	0	0	2	1
California	18	41	36	59	78	148	0	0	0	7	2	3
Total	351	564	390	1,270	1,566	2,556	0	4	4	81	67	94
44 weeks	[6] 9,546	22,941	12,342	70,223	97,673	116,334	152	310	340	3,415	3,602	4,881
Seasonal low week [4]	(11th) Mar. 15–21			(32nd) Aug. 9–15			(35th) Aug. 30–Sept. 5			(11th) Mar. 15–21		
Total since low	[6] 8,934	22,474	11,945	8,120	11,378	16,875	5	31	33	2,930	3,127	4,065

[3] Period ended earlier than Saturday.
[4] Dates between which the approximate low week ends. The specific date will vary from year to year.
[5] Including paratyphoid fever reported separately, as follows: Massachusetts 3 (salmonella infection); New Jersey 1; Michigan 1; Minnesota 1; Georgia 2; Arkansas 1; Texas 1; California 2.
[6] Correction (deducted from cumulative totals): Poliomyelitis, Montana, week ended Oct. 11, 0 cases (instead of 1).

Telegraphic morbidity reports from State health officers for the week ended Nov. 1, 1947, and comparison with corresponding week of 1946 and 5-year median—Con.

Division and State	Whooping cough			Week ended November 1, 1947							
	Week ended—		Median 1942–46	Dysentery			Encephalitis, infectious	Rocky Mt. spotted fever	Tularemia	Typhus fever, endemic	Undulant fever
	Nov. 1, 1947	Nov. 2, 1946		Amebic	Bacillary	Unspecified					
NEW ENGLAND											
Maine	15	16	23								
New Hampshire	4										
Vermont	20	10	24								4
Massachusetts	131	155	155		45						
Rhode Island	32	18	24								
Connecticut	49	25	65	1							5
MIDDLE ATLANTIC											
New York	204	205	254	10	1					1	1
New Jersey	145	145	145	1							
Pennsylvania	137	97	167								3
EAST NORTH CENTRAL											
Ohio	139	72	124	1							
Indiana	19	7	28				1				4
Illinois	65	110	110	2	1		1		1		10
Michigan [3]	125	145	122								9
Wisconsin	140	182	151				2				4
WEST NORTH CENTRAL											
Minnesota	71	3	40								8
Iowa	17	7	7								21
Missouri	15	12	12						3		6
North Dakota	11		6			1	1				
South Dakota	10		5								
Nebraska	8	4	4				1				1
Kansas	21	15	21	1							4
SOUTH ATLANTIC											
Delaware	5	2	2								
Maryland [3]	93	30	40			7	1	1			1
District of Columbia	19	5	6						1		
Virginia	41	73	44			27	3			2	1
West Virginia	35	5	13								
North Carolina	40	24	57				1				
South Carolina	62	22	31	1	7						
Georgia	14	3	11		2				1	12	
Florida	24	20	20	2						4	
EAST SOUTH CENTRAL											
Kentucky	22	32	30		1						
Tennessee	54	4	14			8	1				2
Alabama	13	8	8							1	
Mississippi [3]	2				1					3	1
WEST SOUTH CENTRAL											
Arkansas	43	22	22	7	1		1		5	1	
Louisiana	3	3	2	6			1			3	2
Oklahoma	5	7	2	1	2						4
Texas	195	136	98	6	321	26			2	9	8
MOUNTAIN											
Montana	21	1	7								
Idaho	18		5				1				2
Wyoming	5		2								
Colorado	47	9	14								5
New Mexico	10	5	5		1	4					
Arizona	13	8	5			23					
Utah [3]	1	6	11			1			1		2
Nevada			1								
PACIFIC											
Washington	19	14	15								1
Oregon	9	15	9	1							
California	98	60	94	2	6		4	2			6
Total	2,289	1,742	2,055	42	389	97	19	3	14	36	115
Same week: 1946	1,742			39	234	44	13	3	9	61	92
Median, 1942–46	2,055			39	255	82	12	3	7	128	[7] 90
44 weeks: 1947	133,713			2,505	13,643	8,560	560	538	1,220	1,731	5,322
1946	83,800			2,051	14,002	5,602	556	552	784	3,003	4,468
Median, 1942–46	106,880			1,663	14,237	6,756	564	449	706	3,716	[7] 4,263

[3] Period ended earlier than Saturday.
[7] 2-year average, 1945–46.

Leprosy: New York 1, Minnesota 1.
Territory of Hawaii: Bacillary dysentery 2, measles 1, endemic typhus fever 1, whooping cough 19.

WEEKLY REPORTS FROM CITIES [1]

City reports for week ended Oct. 25, 1947

This table lists the reports from 88 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	------	0	-------	0	2	0	2	0	0	6
New Hampshire:												
Concord	0	0	------	0	-------	0	0	0	0	0	0	------
Vermont:												
Barre	0	0	------	0	1	0	0	0	0	0	0	------
Massachusetts:												
Boston	3	0	------	1	38	1	1	6	13	0	1	11
Fall River	0	0	------	0	-------	0	0	0	0	0	0	10
Springfield	0	0	------	0	1	0	0	0	0	0	0	4
Worcester	0	0	------	0	-------	0	5	0	4	0	1	2
Rhode Island:												
Providence	0	0	1	0	-------	0	2	0	1	0	0	21
Connecticut:												
Bridgeport	0	0	------	0	-------	0	0	0	0	0	1	2
Hartford	0	0	------	0	5	0	1	0	2	0	0	16
New Haven	0	0	1	0	-------	1	1	1	1	0	0	13
MIDDLE ATLANTIC												
New York:												
Buffalo	0	0	------	0	1	0	0	0	4	0	0	13
New York	22	1	3	0	58	3	40	11	26	0	2	72
Rochester	0	0	------	0	-------	0	2	4	7	0	0	8
Syracuse	0	0	------	0	-------	1	2	3	1	0	0	14
New Jersey:												
Camden	1	0	------	0	1	1	2	1	1	0	0	------
Newark	0	0	2	1	1	0	0	0	2	0	0	18
Trenton	0	0	------	0	-------	0	0	0	0	0	0	4
Pennsylvania:												
Philadelphia	4	0	------	0	3	2	23	0	19	0	1	32
Pittsburgh	2	0	1	1	-------	1	16	1	3	0	0	26
Reading	0	0	------	0	4	0	1	0	0	0	0	3
EAST NORTH CENTRAL												
Ohio:												
Cincinnati	7	0	------	0	------	0	5	6	9	0	0	2
Cleveland	1	0	------	0	2	2	7	21	11	0	0	53
Columbus	6	0	------	0	4	0	4	2	6	0	0	------
Indiana:												
Fort Wayne	0	0	------	0	-------	0	1	0	2	0	1	------
Indianapolis	0	0	------	0	-------	0	2	1	2	0	0	15
South Bend	0	0	------	0	-------	0	0	0	0	0	0	1
Terre Haute	0	0	------	0	-------	0	1	0	0	0	0	3
Illinois:												
Chicago	0	0	------	1	34	3	29	10	14	0	0	16
Springfield	0	0	------	0	1	0	5	0	3	0	0	3
Michigan:												
Detroit	0	0	1	0	2	0	7	5	32	0	0	52
Flint	0	0	------	0	------	0	0	0	2	0	0	1
Grand Rapids	0	0	------	0	4	0	0	0	2	0	0	10
Wisconsin:												
Kenosha	0	0	------	0	1	0	0	0	1	0	0	1
Milwaukee	0	1	------	0	-------	0	1	0	6	0	0	30
Racine	0	0	------	0	-------	0	0	0	1	0	0	1
Superior	0	0	------	0	-------	0	0	0	1	0	0	5
WEST NORTH CENTRAL												
Minnesota												
Duluth	0	0	------	0	2	0	0	0	3	0	0	16
Minneapolis	1	0	------	0	60	1	4	1	29	0	0	20
St. Paul	0	0	------	0	1	0	5	1	2	0	0	30
Missouri:												
Kansas City	0	0	10	1	-------	0	3	0	2	0	0	1
St. Joseph	0	0	------	0	-------	0	0	2	1	0	0	------
St. Louis	2	4	------	0	-------	1	7	1	1	0	0	9

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

City reports for week ended Oct. 25, 1947—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	1	1	2	0	0	------
Kansas:												
Topeka	0	0	------	0	-------	0	0	0	0	0	0	2
Wichita	0	0	------	0	-------	0	3	0	0	0	0	5
SOUTH ATLANTIC												
Delaware:												
Wilmington	0	0	------	0	-------	1	0	0	0	0	0	6
Maryland:												
Baltimore	0	0	1	1	1	0	5	2	11	0	1	64
Cumberland	1	0	------	0	-------	0	2	0	0	0	0	3
Frederick	0	0	------	0	-------	0	1	0	0	0	0	------
District of Columbia:												
Washington	0	0	------	0	4	1	1	0	12	0	0	27
Virginia:												
Richmond	0	0	------	0	2	0	2	0	6	0	0	5
Roanoke	0	0	------	0	-------	0	0	0	0	0	0	------
West Virginia:												
Charleston	0	0	------	0	-------	0	0	1	0	0	0	------
Wheeling	0	0	------	0	-------	0	1	0	0	0	0	------
North Carolina:												
Raleigh	0	0	------	0	-------	0	1	0	0	0	0	------
Wilmington	3	0	------	0	-------	0	1	0	0	0	0	------
Winston-Salem	0	0	------	0	-------	0	0	0	1	0	0	2
South Carolina:												
Charleston	0	0	24	[illegible]	-------	0	1	0	0	0	0	2
Georgia:												
Atlanta	0	0	5	0	1	0	4	0	2	0	0	6
Brunswick	0	0	------	0	2	0	0	0	0	0	0	------
Savannah	0	0	1	0	-------	0	0	0	0	0	0	2
Florida:												
Tampa	0	0	------	0	-------	0	1	0	0	0	0	1
EAST SOUTH CENTRAL												
Tennessee:												
Memphis	2	0	------	0	2	0	3	0	1	0	0	4
Nashville	1	0	------	0	-------	0	0	0	4	0	0	2
Alabama:												
Birmingham	0	0	2	0	-------	0	2	0	2	0	1	------
Mobile	0	0	3	0	-------	0	2	0	1	0	0	------
WEST SOUTH CENTRAL												
Arkansas:												
Little Rock	0	0	2	0	1	0	0	0	0	0	0	------
Louisiana:												
New Orleans	0	0	------	0	-------	0	6	0	1	0	0	1
Shreveport	1	0	------	0	-------	0	0	0	0	0	0	------
Oklahoma:												
Oklahoma City	1	0	1	0	-------	0	1	0	2	0	0	4
Texas:												
Dallas	1	0	------	0	-------	1	2	0	3	0	0	7
Galveston	0	0	------	0	-------	0	0	1	0	0	0	1
Houston	3	0	------	0	-------	0	2	0	1	0	1	1
San Antonio	1	0	------	0	-------	0	4	0	1	0	0	------
MOUNTAIN												
Montana:												
Billings	0	0	------	0	9	0	2	0	0	0	0	9
Great Falls	0	0	------	0	1	0	0	0	0	0	0	------
Helena	0	0	------	0	1	0	0	0	0	0	0	------
Missoula	0	0	------	0	-------	0	0	0	0	0	0	------
Colorado:												
Denver	2	0	------	0	1	0	2	0	10	0	0	3
Pueblo	0	0	------	0	-------	0	1	0	0	0	0	5
Utah:												
Salt Lake City	0	0	------	0	1	0	3	1	3	0	0	2

City reports for week ended Oct. 25, 1947—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	3	0	1	1	7	0	0	8
Spokane	0	0	------	0	1	0	0	1	0	0	0	------
Tacoma	0	0	------	0	1	0	0	0	1	0	0	------
California:												
Los Angeles	5	0	------	1	8	0	0	2	8	0	0	13
Sacramento	0	0	---	0	3	0	2	0	0	0	0	------
San Francisco	0	1	1	0	27	0	2	0	6	0	0	13
Total	70	7	59	7	293	20	238	87	301	0	10	742
Corresponding week, 1946[1]	90	------	64	9	191	------	256	------	377	0	14	505
Average, 1942-46[1]	86	------	55	[2] 13	[3] 341	------	[2] 292	------	551	0	17	647

[1] Exclusive of Oklahoma City.
[2] 3-year average, 1944-46.
[3] 5-year median, 1942-46.

Anthrax.—Cases: Philadelphia 2.
Dysentery, amebic.—Cases: New York 6; Chicago 1; Flint 1; Baltimore 1; Charleston, S. C. 1; Nashville 1; New Orleans 1; San Francisco 2.
Dysentery, bacillary.—Cases: Worcester 1; Providence 1; New York 1; Philadelphia 1; Chicago 1; St. Paul 4; Memphis 2; Nashville 1; Billings 1; Los Angeles 1.
Dysentery, unspecified.—Cases: Baltimore 1.
Typhus fever, endemic.—Cases: New York 1; Atlanta 1; New Orleans 2; Shreveport 1; Galveston 1; Houston 1.

Rates (annual basis) per 100,000 population, by geographic groups, for the 88 cities in the preceding table (latest available estimated population, 34,537,800)

	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	7.8	0.0	5.2	2.6	118	5.2	31.4	18.3	60	0.0	7.8	222
Middle Atlantic	13.4	0.5	2.8	0.9	31	3.7	39.8	9.3	29	0.0	1.4	88
East North Central	8.5	0.6	0.6	0.6	29	3.0	37.7	27.4	56	0.0	0.6	117
West North Central	6.0	8.0	20.1	2.0	127	4.0	46.3	12.1	80	0.0	0.0	167
South Atlantic	6.6	0.0	51.3	1.7	17	3.3	33.1	5.0	53	0.0	1.7	195
East South Central	17.7	0.0	29.5	0.0	12	0.0	41.3	0.0	47	0.0	5.9	35
West South Central	17.8	0.0	7.6	0.0	3	2.5	38.1	2.5	20	0.0	2.5	36
Mountain	16.5	0.0	0.0	0.0	107	0.0	66.1	8.3	107	0.0	0.0	157
Pacific	7.9	1.6	1.6	1.6	68	0.0	7.9	6.3	35	0.0	0.0	54
Total	10.6	1.1	8.9	1.1	44	3.0	36.0	13.2	46	0.0	1.5	112

TERRITORIES AND POSSESSIONS

Virgin Islands of the United States

Notifiable diseases—July—September 1947.—During the months of July, August, and September 1947, cases of certain notifiable diseases were reported in the Virgin Islands of the United States as follows:

Disease	July	August	September
Filariasis	3	1	
Gonorrhea	11	15	17
Hookworm disease	4	2	5
Influenza			22
Pneumonia (lobar)		1	
Schistosomiasis		1	1
Syphilis	28	13	21
Tuberculosis	1	1	1
Typhoid fever		1	
Whooping cough		1	1

DEATHS DURING WEEK ENDED OCT. 25, 1947

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

	Week ended Oct. 25, 1947	Corresponding week, 1946
Data for 93 large cities of the United States:		
Total deaths	8,675	8,739
Median for 3 prior years	8,814	
Total deaths, first 43 weeks of year	394,472	388,589
Deaths under 1 year of age	702	789
Median for 3 prior years	629	
Deaths under 1 year of age, first 43 weeks of year	31,786	28,181
Data from industrial insurance companies:		
Policies in force	67,097,868	67,334,484
Number of death claims	11,766	10,846
Death claims per 1,000 policies in force, annual rate	9.1	8.4
Deaths claims per 1,000 policies, first 43 weeks of year, annual rate	9.2	9.5

FOREIGN REPORTS

CANADA

Provinces—Communicable diseases—Week ended October 11, 1947.—During the week ended October 11, 1947, 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				32	54	4	42	31	58	221
Diphtheria			1	9	6	3	4	3		26
Dysentery, bacillary				2	1					3
Encephalitis, infectious						8	4			12
German measles		3		2	13		2		1	21
Influenza		22			3	1			8	34
Measles				74	26	13	10	10	25	158
Meningitis, meningococcus				1	1	1				3
Mumps		12		30	77	4	22	7	15	167
Poliomyelitis		2	1	3	44	5	13	2	7	77
Scarlet fever		4	32	29	31	1	2	7	6	112
Tuberculosis (all forms)		3	1	89	28	27	29	7	37	221
Typhoid and paratyphoid fever				5	2		1			8
Undulant fever				11	1			3	5	21
Venereal diseases.										
Gonorrhea		10	6	143	101	37	33	53	58	441
Syphilis		5	2	77	61	13	14	12	27	211
Other forms									5	5
Whooping cough				38	41	14	4	15	51	163

NOTE.—Report for the period from Prince Edward Island not received.

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.

Cholera

Egypt.—The following daily reports of cholera in Egypt have been received: October 19, 1947, 659 cases, 279 deaths; October 20, 753 cases, 366 deaths; October 21, 769 cases, 341 deaths, including 6 cases in Alexandria, 3 cases with 1 death in Cairo, 5 cases in Damietta, 2 cases with 3 deaths in Ismailiya, 1 case in Suez; October 22, 786 cases, 353 deaths, including 3 cases with 1 death in Alexandria, 4 cases in Cairo, 1 case in Damietta, 3 cases with 1 death in Ismailiya, 1 case in Port Said, 3 cases in Suez; October 23, 876 cases, 446 deaths, including 4 cases with 1 death in Alexandria, 2 cases with 4 deaths in Cairo, 2 cases with 1 death in Damietta, 1 case with 2 deaths in

Ismailiya; October 24, 903 cases, 418 deaths, including 10 cases with 8 deaths in Alexandria, 4 cases with 2 deaths in Cairo, 2 cases in Damietta, 1 case in Ismailiya, 1 case in Suez; October 25, 880 cases, 496 deaths, including 7 cases with 4 deaths in Alexandria, 2 fatal cases in Damietta, 3 cases in Ismailiya, 1 case in Port Said. Total officially reported, September 23–October 25, 11,495 cases, 5,213 deaths.

Siam (Thailand).—For the week ended September 27, 1947, 99 cases of cholera with 75 deaths were reported in Siam (Thailand).

Smallpox

Mexico.—For the month of September 1947, 135 cases of smallpox were reported in Mexico.

Rhodesia (Southern).—For the week ended October 25, 1947, 24 cases of smallpox with 12 deaths were reported in Southern Rhodesia.

Tunisia.—Smallpox has been reported in Tunisia as follows: September 11–20, 1947, 41 cases, September 21–30, 1947, 39 cases.

Typhus Fever

Mexico.—For the month of September 1947, 149 cases of typhus fever were reported in Mexico.

Yellow Fever

Sudan (French)—Bamako.—On October 21, 1947, 1 case of yellow fever with 1 death was reported in Bamako, French Sudan.

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