

# Public Health Reports

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## **NEW PUBLIC HEALTH LAWS**

Several laws were enacted during the closing days of the second session of the 80th Congress which will have an important bearing not only on the future activities and functions of the Public Health Service, but also on the general health and well-being of the entire American people during the coming years.

The most noteworthy pieces of new legislation affecting the public health placed on the statute books by the 80th Congress are Public Laws 655 and 755, establishing within the Public Health Service, respectively, a National Heart Institute and a National Institute of Dental Research; Public Law 845, providing for a national water pollution control program; and Public Law 643, authorizing participation by the United States in the World Health Organization.

### **National Heart Act**

By enacting Public Law 655, known as "The National Heart Act," Congress has enabled the Public Health Service to launch a full-scale attack on the Nation's Number 1 destroyer of life—cardiovascular diseases. The passage of the Act marked a recognition on the part of the members of the national legislature that the general public was becoming increasingly concerned over the growing incidence and mortality rates of cardiovascular diseases in the United States. In response to similar public interest in the cancer and mental health problems, Congress has, within the past few years, passed legislation authorizing the Public Health Service to undertake training, research, and control activities in the fields of cancer and mental diseases.

That the problem of cardiovascular disease in this country is of serious enough proportions to warrant the undertaking of special measures for its control is evident from the following statistics.

Diseases of the heart and circulatory system have accounted for more than one of every three deaths in the United States during the

last decade. They are the principal cause of death and a major cause of disability today. In 1946, 588,000 persons died from diseases of the heart, and it is estimated that close to 60 million Americans now living will die of illnesses of this type unless new treatments and cures are discovered. In addition, about one in every 16 persons, or about 9 million people, are estimated to be disabled in varying degrees by diseases of the heart and circulation. Moreover, unless effective control measures are developed immediately, these diseases can be expected to take an even greater toll as the average age of our population increases. This is so because cardiovascular diseases, while ranking high as causes of death among all age groups, count most of their victims among persons who have reached or passed middle age; they cause nearly one out of every two deaths among persons over the age of 45.

In sharp contrast to the staggering amount of death, suffering, and disability for which this group of diseases is responsible are the meager facilities and funds which have been available, up to now, to combat them. Current research in heart disease is limited and fragmentary. It suffers from a shortage of funds and a paucity of special laboratory and clinical facilities. In addition, there are far from enough medical and other scientific personnel devoting their attention to research in this field. Application of the medical knowledge which has already been attained about diseases of the heart is even less widespread than research on them. Heart disease prevention and control programs on a community-wide basis are virtually nonexistent.

With the passage of Public Law 655, it will be possible, for the first time, for the Service to take real national leadership in organizing heart disease research and control programs on a scale commensurate with the gravity of the heart disease problem.

The National Heart Act (S. 2215 before enactment) authorizes a broadly conceived, well-balanced program of research, training, and control activities in the field of cardiovascular disease comparable to those already undertaken for cancer and mental diseases. The major provisions of the Act include:

1. Establishment of a National Heart Institute in the Public Health Service.

2. Authorization for the Surgeon General of the Service, through the Institute, to make grants to institutions and individuals for research projects in heart diseases and to States, their political subdivisions, and other organizations for the purpose of assisting them to establish organized community programs of heart disease control; to set up research fellowships and traineeships in the Institute and elsewhere; and to organize an information center on heart disease research, prevention, diagnosis, and treatment.

**3. Creation of a National Advisory Heart Council to advise the Surgeon General on activities undertaken by him in connection with the heart program, and to review and make recommendations to him on requests for grants-in-aid for research and training projects in the cardiovascular field.**

More specifically, the Heart Act, which amends the basic Public Health Service Act (42 U.S.C. ch. 6A), gives the Surgeon General the following responsibilities, which he is expected to exercise through the Heart Institute and in cooperation with the Advisory Heart Council:

*a.* To conduct, assist, and foster research, experiments, and demonstrations on the cause, prevention, and methods of diagnosis and treatment of heart diseases;

*b.* To coordinate research and control programs carried on by the National Heart Institute and similar programs conducted by other agencies, organizations, and individuals;

*c.* To make research facilities of the Public Health Service available to public authorities, health officials, and scientists engaged in special studies related to diseases of the heart;

*d.* To make grants-in-aid to universities, hospitals, laboratories, other public or private institutions and agencies, and individuals for research projects relating to heart diseases which are recommended by the National Advisory Heart Council—including grants for the acquisition, construction, equipping, and maintenance of hospital, clinic, and laboratory facilities and for the care of patients in these facilities, insofar as such activities are necessary to the carrying out of the specified research projects;

*e.* To establish an information center on research, prevention, diagnosis, and treatment of heart diseases, and to disseminate information on the research and other activities carried on under the provisions of the National Heart Act;

*f.* To obtain advice and assistance from heart disease experts both in the United States and abroad;

*g.* To establish and maintain research fellowships (with appropriate stipends and allowances) in the National Heart Institute and elsewhere, and to provide for the establishment of similar fellowships through grants to public and other nonprofit institutions, upon recommendation of the Advisory Heart Council;

*h.* To provide training and instruction and establish traineeships, in the Institute and elsewhere, in matters relating to the diagnosis, prevention, and treatment of heart diseases, and to provide for similar training and instruction facilities and traineeships, upon recommendation of the Advisory Heart Council, through grants to public and other nonprofit institutions.

In addition, the Surgeon General is directly empowered under the Act to make grants to States, counties, health districts, and other

political subdivisions of the State, and to public and nonprofit agencies, institutions, and other organizations for the purpose of assisting them to establish and maintain organized community programs of heart disease control, including conducting of demonstrations and training of personnel.

The appropriation of sufficient sums for the carrying out of these purposes is specifically authorized. The Surgeon General is required to determine for each fiscal year, with the approval of the Federal Security Administrator, the total amount to be made available for allotment among the States for heart disease control. This money must then be allocated on the basis of (1) the population and (2) the financial need of the respective States.

Any money granted for carrying out heart disease control programs must be expended in accordance with plans submitted by the State health authority and approved by the Surgeon General. The Surgeon General is also authorized, however, to make direct payments from any State's allotment to a political subdivision of that State or to any public or nonprofit organization within it, upon recommendation of the State's health authority, if (1) the State health authority concerned is not authorized to make such payments to its subdivisions or to other organizations, or (2) the State health authority concerned has not had a control plan approved by the Surgeon General prior to August 1 of the fiscal year for which the State allotment has been made.

As in other control programs authorized under the Public Health Service Act, the granting of funds to States, their subdivisions, or other organizations for heart disease control purposes is conditioned upon compliance by the grantees with the general provisions of the Heart Act, the provisions of their own approved control plans, and the regulations established under the Act by the Surgeon General. Similarly, recipients of Federal grants for heart disease control must spend for the same general purpose an amount from their own funds to be determined by regulations.

In defining the structure of the National Advisory Heart Council, the Heart Act provides that, unlike previously established advisory councils to the Public Health Service, the new Council may include nonprofessional persons among its members. Of its twelve appointed members, to be chosen by the Surgeon General with the approval of the Federal Security Administrator, six are required to be persons who are outstanding in the study, diagnosis, or treatment of heart diseases; the other six may be chosen from among leading authorities in the general fields of basic and medical sciences, education, or public affairs. In addition to its 12 appointed members, the Council has four *ex officio* ones—the Surgeon General of the Public Health Service,

the Surgeons General of the Army and Navy, and the chief medical officer of the Veterans' Administration, or their representatives.

Each member of the Council holds office for four years, but replacement of the entire Council every four years is avoided by the provision that three of the members first appointed shall hold office for one year, three for two years, three for three years, and only three for the full term. No member of the Council is eligible for reappointment until a year after his term of office has expired. Every two years, the Council elects one of its members as chairman for the succeeding two-year period.

The Council is authorized to carry out the following specific functions:

*a.* To review research projects in the cardiovascular diseases, applications for grants-in-aid for heart disease research projects, and applications for grants for training, instruction, and traineeships in the heart field; and to certify approval to the Surgeon General of those projects or applications which it believes will make significant contributions to human knowledge of diseases of the heart or will best carry out the purposes of the Act.

*b.* To collect information on studies being carried on in this country or abroad on diseases of the heart and, with the approval of the Surgeon General, make this information available to physicians, scientists, public and private health and welfare organizations, and the general public.

*c.* To recommend to the Surgeon General acceptance of conditional gifts.

*d.* To advise, consult with, and make recommendations to the Surgeon General with respect to carrying out the Act's provisions.

Also contained in the Heart Act are provisions which (1) raise to \$50 a day the compensation rate for appointed members of all advisory councils of the Public Health Service while they are performing their duties as council members and (2) change the term "National Institute of Health," whenever it appears in the Public Health Service Act, to "National Institutes of Health."

## Dental Research Act

A great stride toward meeting the vast backlog of dental care needs in the United States was made by the 80th Congress with the passage on June 12, 1948, of the Dental Research Act (Public Law 755).

As in the case of the National Heart Act, Congress found ample justification for the enactment of this law in the widespread existence of untreated oral conditions among the American people. Data presented at the hearings on H. R. 6726 (which became Public Law

755) and on other bills<sup>1</sup> with similar objectives reported out during the second session of the 80th Congress demonstrated conclusively that the oral health of the Nation could be improved appreciably within the foreseeable future only by the discovery, through research, of new and improved techniques for preventing and treating dental illness.

The two major causes of oral ill health, according to the evidence presented at the hearings by authorities in the field of dentistry, are dental caries and pyorrhea. Dental caries is the destroyer of most of the teeth lost by persons before their middle thirties. About 90 percent of American children have one or more decayed teeth by the time they enter school, and at 16 most of them have lost one or more of their permanent teeth. After the age of approximately 35, pyorrhea—a disease affecting the supporting tissues around the teeth—becomes the chief menace to oral health. Persons older than 35 who retain a usable number of natural teeth are, apparently, in the minority throughout the Nation. In addition, malocclusion occurs in between 35 and 40 percent of the population, and is prevalent in all age groups; while arthritis, neuritis, neuralgia, heart disease, and other ailments may be caused, directly or indirectly, by neglected, diseased, or untreated teeth and gums.

The volume of needed dental treatment is so large nationally as to exceed by far the man-hours of dental skill available at present for meeting it. Only through extended research in the field of dentistry, therefore, can new techniques be developed which may compensate, to some extent, for the lack of dental manpower. Dental research, adequately financed, may reasonably be expected to discover, ultimately, the causes of and preventives for dental caries, pyorrhea, and other diseases of the oral cavity.

It is generally agreed, however, that at present the amount of money being devoted to dental research—although not exactly known—is disproportionate to the established size of the dental need problem. Only \$150,000 a year is currently expended on dental research by the Public Health Service—one of the Nation's largest investors in this field. Additional amounts totaling perhaps \$500,000, it is estimated, are being spent on research by dental schools and other interested groups. Calculations made on the basis of these figures show that the annual investment in dental research is only *one-tenth of one percent* of the amount spent for dental treatment in a year. In other words, for each \$10 spent in treatment of dental ailments, less than one cent is expended on attempts to find ways of reducing the need for treatment.

**Lack of facilities is fully as important as meagerness of funds in**

<sup>1</sup> H. R. 574; H. R. 4200; and S. 176. A good many of the provisions of these bills and some of the suggestions made for improving them in the course of testimony on them were incorporated in H. R. 6726, as passed.

handicapping effective dental research. There is no large dental research center comparable to the medical centers which exist in many cities of the United States. The dental research section of the National Institutes of Health, though one of the largest organizations of its kind in the world, has less than a dozen investigators devoting their full time to research activities. Dental schools are not, in general, well endowed with research facilities.

Nevertheless, even the present dental research program—small as it is—is cramped by a shortage of trained personnel. The number of recent dental graduates who intend to make a career of teaching or research is extremely small. Only if greater incentives are offered to them will their number increase.

In the face of these facts elicited at committee hearings on proposed dental research legislation, Congress, after having given careful consideration to the other bills with similar purposes presented during its 1948 Session, enacted H. R. 6726 into law. Designed to lay a sound basis for a dental research program, the Dental Research Act closely parallels the National Heart Act in many of its provisions.

It amends the Public Health Service Act by establishing within the Service a National Institute of Dental Research, occupying a position similar to that of the Cancer and Heart Institutes. The Institute is empowered, in general, not only to conduct basic and applied research in the dental field, but to make grants-in-aid to public and private institutions for research projects which, in the opinion of the Surgeon General and the National Advisory Dental Research Council, promise to make valuable contributions to the knowledge of oral diseases and conditions. The Act also provides for the establishment of fellowships and traineeships in the Dental Research Institute, and for the setting up of traineeships in other public and nonprofit institutions through grants given by the Institute.

Unlike the Heart Act, however, the Dental Research Act contains no specific authorization for grants-in-aid for the establishment of control programs in States and communities; furthermore, in contrast to the Heart Act, it provides for a definite ceiling on the appropriation authorized for carrying out the purposes of the Act—\$750,000 for each fiscal year, beginning with the year 1948-1949.

In general, the duties given to the Surgeon General by the Dental Research Act are quite similar to those he is required to perform under the National Heart Act. These duties include: conducting and fostering research on oral diseases and conditions; coordinating such research both within and outside the Institute of Dental Research; obtaining consultation services for the Institute's staff from experts in dental diseases; providing fellowships; cooperating with State health agencies in the prevention and control of dental diseases; and providing training and instruction and establishing traineeships

in the Institute and, through grants, in public and nonprofit institutions.

The structure and functions of the National Advisory Dental Research Council are parallel in every respect to those of the National Advisory Heart Council, except that, with regard to the makeup of the former, it is specified that of the six members to be appointed from among persons who are outstanding in the study, diagnosis, or treatment of dental diseases four must be dentists.

Finally, the Dental Research Act authorizes the appropriation of not more than \$2,000,000 for the construction and equipping of the Dental Research Institute. The Federal Works Administrator is empowered to acquire a suitable site for the Institute in or near the District of Columbia, selected with the advice of the Surgeon General, and to erect and furnish appropriate buildings and facilities.

## **Federal Water Pollution Control Program**

An important step has been taken in the abatement of pollution of our water resources by domestic sewage and industrial wastes with the passage in the final days of the second session of the 80th Congress of the Water Pollution Control Act. The act became Public Law 845 when signed by the President on June 30, 1948.

The new law authorizes the Federal Government to help individual States control pollution of watercourses by providing technical and financial aid. It is the first specific Federal legislation aimed at cleaning up our streams. The Surgeon General, in cooperation with other Federal agencies, with State water pollution control agencies and interstate agencies, and with the municipalities involved, is authorized to make joint investigations and to prepare or adopt comprehensive programs for eliminating or reducing water pollution.

The act authorizes the Federal Works Administrator to make loans to any State, municipality, or interstate agency for preparation of plans and construction of necessary treatment works to prevent the discharge by such State or municipality of untreated or inadequately treated sewage or other waste into interstate waters. The loans made can cover up to one-third of the estimated cost of such plans and construction but are limited to \$250,000 for each project. No loan can be made unless the project is approved by the State water pollution control authority and the Surgeon General, and is included in a comprehensive program developed under the act. The act authorizes \$22,500,000 to be appropriated for each of the five fiscal years, beginning with July 1, 1948, for making these loans.

The Act authorizes the appropriation of up to one million dollars a year to the Federal Security Agency for the next five fiscal years



to be used as grants to State water pollution control agencies and to interstate agencies in the conduct of investigations, research, surveys, and studies related to control of water pollution caused by industrial wastes. Another million dollars a year for the next five fiscal years is authorized to be appropriated to the Federal Works Agency. This money is to be used for grants to municipalities to aid them in preparing plans and specifications preliminary to the construction of treatment works.

Section 8 of the Act authorizes an appropriation of \$800,000 a year for the next 5 years to the Federal Works Agency to erect, furnish, and equip such buildings and facilities as may be necessary for the use of the Public Health Service at Cincinnati in connection with research and study of water pollution and the training of personnel. There is also authorized to be appropriated \$2,000,000 a year for the next 5 years to the Federal Security Agency and \$500,000 a year for the next 5 years to the Federal Works Agency to carry out the functions authorized under the act.

The Act establishes in the Public Health Service an 11-man Water Pollution Control Advisory Board. The Surgeon General or a sanitary engineer officer designated by him is to be chairman. The members of the Board are to include one representative each of the Federal Works Agency, Department of the Army, Department of the Interior, and Department of Agriculture.

The remaining six persons are to be appointed by the President and are not to be officers or employees of the Federal Government. One of the persons appointed by the President shall be an engineer who is expert in sewage and industrial waste disposal, one shall be a person who has shown an active interest in the field of wildlife conservation, and, unless the President determines otherwise, one shall be representative of municipal government, one a representative of State government, and one a representative of affected industry.

The Act declares that the pollution of interstate waters which endangers the health or welfare of persons in a State other than that in which the discharge originates is considered to be a public nuisance and subject to abatement. Under the law, whenever the Surgeon General, on the basis of reports, surveys, and studies, finds that any pollution declared to be a public nuisance is occurring, he is to notify the person or persons causing such pollution. Also to be notified of this fact is the State or interstate water pollution control agency in the State or States where such pollution is originating.

The notification may outline recommended remedial measures which are reasonable and equitable and shall specify a reasonable time to secure abatement of the pollution. If action calculated to secure abatement of the pollution within the time specified is not commenced, a second notice is to be sent calling upon the State or interstate agency

to act. The law provides for public hearings at this point and the submission of recommendations by a hearing board. Only after the Federal Security Administrator makes such reasonable efforts, is he authorized to initiate suit on behalf of the United States and then only with the permission of the State or interstate water pollution control agency.

The comprehensive program of water pollution control will be administered on the basis of major river basins. Fourteen offices will implement the pollution control program in their respective areas. These offices will be the field operating centers and will cooperate with State and interstate agencies, and through them, with the municipalities and industries.

Supporting the river basin offices will be the water pollution control headquarters office of the Public Health Service in Washington, and the research, technical service, and field investigations facilities at the water and sanitation investigations station in Cincinnati.

The pollution control program is not aimed at restoring our streams to their pristine purity of a hundred years ago, and will not require the indiscriminate building of elaborate treatment works. All water uses of the stream will be considered and the treatment recommended will be based on these uses. Due regard will be given to the health, welfare, and economic considerations of the local situation and their effect upon the national welfare.

As envisioned by the Public Health Service the act will be instrumental in launching a systematic program of pollution abatement with the cooperation of State and interstate agencies.

## **Hospital Survey and Construction Act Amendments**

Three amendments to the hospital survey and construction provisions of the Public Health Service Act (Title VI) were also passed during the second session of the 80th Congress. They make changes of some importance with respect to: (1) applicability of those provisions to the Virgin Islands (Public Law 713); (2) the minimum amount of Federal funds allotted to States for hospital construction (Public Law 830); and (3) the eligibility of States to participate in the hospital construction program after July 1, 1948 (Public Law 723).

The Senate Committee on Labor and Public Welfare, which reported out the bill (H. R. 6339) that became Public Law 723, considered its enactment necessary to the proper completion of the hospital construction program authorized by the 79th Congress. The hospital construction provisions of the Public Health Service Act require that a Federal allotment to a State for hospital construction can be made only if the State's construction plan has been approved by the Surgeon General

prior to or during the fiscal year for which the allotment is made. Each State construction plan must include, by law, minimum standards of maintenance and operation for all federally aided hospitals. Before the passage of Public Law 723, a State lost its right to further Federal allotments for hospital construction if it had not enacted, by July 1, 1948, legislation requiring the observance of minimum standards of operation and maintenance by hospitals receiving Federal aid. The new Act, however, entitles a State, so long as it complies with other requirements of the law, to receive a grant for both the fiscal year in which it enacts appropriate legislation on standards of maintenance and operation and the preceding year. This retroactive feature of the Act is designed to avoid penalizing States whose legislatures do not meet during the fiscal year 1949, but which enact appropriate legislation at the first opportunity.

Since such legislation ordinarily takes the form of hospital licensure laws, the Act also gives the States concerned sufficient time to set up necessary administrative machinery, make investigations and studies, formulate suitable standards, and bring the operations of existing hospital institutions into conformity with those standards.

Actually, only three States and one Territory had failed to establish eligibility for hospital construction grants by July 1, 1948. Of the three States, two have legislation already on the books which may be adequate to fulfill the requirements of the law.

Public Law 713, also passed on June 12, 1948, amends Title VI of the Public Health Service Act so as to make the Virgin Islands eligible for Federal grants for hospital construction purposes.

Although the Virgin Islands are included in the definition of the term "State" for all other purposes under the Public Health Service Act, they are not so included, as are the other Territories, with respect to the original hospital survey and construction provisions of that Act.

The Senate Committee on Interior and Insular Affairs, in reporting favorably on the bill (H. R. 5889), felt that, in view of the low economic status of the Virgin Islands and their great need for hospital and other health facilities, they should not be excluded from any national health program except for special reasons.

Also included in Public Law 713 is a provision allotting the Islands the maximum Federal grant which can be given, under Title VI, to any State in terms of its population and per capita income.

Public Law 830 (H. R. 4816 before enactment), passed by Congress on June 18, 1948, further amends Title VI of the Public Health Service Act to provide for a minimum annual Federal allotment of \$100,000 to all States and Territories (excluding the Virgin Islands) for hospital construction purposes. It also authorizes increased appropriations to be made under Title VI for fiscal year 1948 and the

three succeeding years to permit payment of increased allotments to those States which were receiving less than \$100,000 annually in Federal grants under the original formula included in the Hospital Survey and Construction Act. This formula provided for a minimum Federal allotment of 33½ percent of the cost of approved hospital projects within each State but set no minimum in dollars. Under it—before the passage of Public Law 830—Nevada, Delaware, and Alaska would each have received annual grants of less than \$100,000.

## Membership in World Health Organization

On June 14, 1948, the President signed a Joint Resolution of Congress authorizing acceptance by the United States of membership in the World Health Organization.

The constitution of the Organization, adopted July 22, 1946, by the International Health Conference, came into force April 7, 1948, when the 26th member of the United Nations deposited its instrument of acceptance with the Secretary General of the United Nations. On June 15 the Organization had 41 members, 9 of which were non-members of the United Nations. On July 10 the President of the first World Health Assembly, meeting at Geneva, announced that the Organization then had 54 members. Additional acceptances are coming in steadily.

The United States may send three delegates, designated by the President, to Assembly sessions. One of these will serve as chief delegate. The number of alternates is to be consistent with the rules of procedure of the Assembly.

Whenever the United States becomes eligible for representation on the Executive Board, the President, acting on the advice and consent of the Senate, is to designate a representative, with one alternate, to attend the Executive Board sessions. The representative must be a graduate of a recognized medical school and have spent at least 3 years in active practice as a physician or surgeon. An amendment introduced by the House would have required 10 years of practice. There was no corresponding provision in the Senate Joint Resolution. The Committee of Conference reduced the requirement to 3 years.

A House amendment which the Conference agreed to omit provided that no United States' citizen or resident could participate in any session or work of the Organization without the consent of the Secretary of State. Another House provision, however, was retained, requiring investigation as to loyalty and security by the Federal Bureau of Investigation prior to appointment of any person as a representative, delegate, or alternate.

An annual appropriation, limited to \$1,920,000, is authorized for the payment of the United States' share of the Organization's expenses.

Such additional sums are authorized, not to exceed \$83,000 for the fiscal year beginning July 1, 1947, as may be necessary to pay the expenses incidental to participation by the United States. This latter item includes salaries, and travel and office expenses of the representative and alternate serving on the Executive Board. Congress imposed a similar limitation in the case of the Food and Agriculture Organization for which the authorized annual appropriation of the United States is limited to \$1,250,000.

At its fifth session the Interim Commission of the World Health Organization recommended a budget of \$6,300,000 for the first financial year of the Organization. If this is adopted by the Assembly the maximum proportion which can be paid by the United States will be 30.5 percent.

There is no provision for withdrawal in the constitution of the World Health Organization. The Joint Resolution reserves the right of the United States to withdraw from the Organization on a one-year notice provided that the financial obligations of the United States are met in full for the Organization's current fiscal year. This is a safeguard against embarrassment in the event that the constitution should be amended in a manner prejudicial to the interests of the United States. Amendments to the constitution come into force upon acceptance by two-thirds of the members.

Finally, the Resolution expresses the understanding of Congress that nothing in the constitution of the World Health Organization in any manner commits the United States to enact any specific legislative program relative to any matters referred to in the constitution. It is considered that existing national legislation is adequate to permit the United States to fulfill its obligations under the constitution.

### **Miscellaneous Legislation**

Two other bills affecting the Public Health Service were passed by the 80th Congress in the closing days of the second session—Public Law 882 (S. 1969 before enactment) and Public Law 781 (H. R. 4114 before enactment).

The former, passed on June 19, 1948, extends the terminal date for training Filipinos in public health methods and administration under the Philippine Rehabilitation Act of 1946 (Public Law 370, 79th Cong.). The 1946 Act originally specified January 1, 1948, as the closing date for this training program; Public Law 882 advances the date to July 1, 1950.

Public Law 781, passed on June 12, 1948, provides permanent legislative authority, through various amendments to the Public Health

Service Act, for certain miscellaneous expenditures by the Service previously authorized only in appropriation acts.

In addition, two acts of interest to the Service were passed earlier in the second session of the 80th Congress.

Public Law 425, signed by the President on February 28, 1948, contains amendments to the Public Health Service Act relating to certain personnel and administrative procedures, including the promotion and training of commissioned officers of the Service and the definition of various categories of commissioned officers.

Public Law 402—the “United States Information and Educational Exchange Act of 1948,” signed by the President January 27, 1948—includes authorization for the establishment of an educational exchange service to cooperate with other nations in (1) the international exchange of professional personnel and knowledge; (2) the rendering of technical services to foreign countries; and (3) the interchange of information on developments in the fields of education, science, and the arts. The Act provides, among other things, for interchanges on a reciprocal basis between the United States and other countries of students, trainees, teachers, guest instructors, professors, and leaders in fields of specialized skill and knowledge; and for reciprocal interchanges of books and periodicals, their translation into other languages, and the preparation, distribution, and interchange of other educational materials. It also authorizes the Secretary of State to assist schools, libraries, and community centers abroad which have been founded or are being sponsored by citizens of the United States and are serving as “demonstration centers” for “methods and practices employed in the United States.” Public health personnel and public health methods and techniques are expected to play an important role in the progress envisaged by this act.

# INCIDENCE OF DISEASE

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

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## UNITED STATES

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### REPORTS FROM STATES FOR WEEK ENDED JULY 24, 1948

#### Summary

The incidence of poliomyelitis increased from a total of 717 cases last week to 982 for the current week, as compared with 668 for the corresponding week of 1946, the largest number reported for a corresponding week of the past 5 years, and a 5-year (1943-47) median of 369. The 12 States with reports of more than 18 cases each, aggregating 722 cases (last week 549), all except Texas showing increases, are as follows (last week's figures in parentheses): North Carolina 206 (196), California 192 (164), Texas 68 (75), Ohio 48 (25), South Carolina 35 (8), New York 33 (19), Oklahoma 27 (13), New Jersey 23 (9), Iowa 23 (2), Nebraska 23 (15), Illinois 22 (14), Minnesota 22 (9). Eleven other States reporting 11 to 18 cases each showed a combined increase of 53 cases. Since March 20 (average date of seasonal low incidence), 3 States (North Carolina 868 cases, Texas 857, and California 771), have reported 2,496 cases, or approximately 59 percent of the total of 4,235 cases reported for the period. For the corresponding period of 1946 the total was 2,789 and the 5-year median 1,653.

Of 34 cases of Rocky Mountain spotted fever reported currently (last week 36, 5-year median 27), 23 occurred in the South Atlantic area, 3 each in Tennessee and Alabama, and 1 each in New York, New Jersey, Pennsylvania, Illinois, and Colorado. The total to date is 286, as compared with 244 for the same period last year and a 5-year median of 256. One case of smallpox was reported, in Nebraska.

Deaths recorded during the week in 93 large cities in the United States totaled 7,992, as compared with 8,648 last week, 8,113 and 8,266, respectively, for the corresponding weeks of 1947 and 1946, and a 3-year (1945-47) median of 8,266. The cumulative total is 284,564 as compared with 284,008 for the corresponding period last year. The total of infant deaths recorded was 625, as compared with 639 last week and a 3-year median of 652. The total to date is 20,132, as compared with 22,750 for the same period last year.

Telegraphic case reports from State health officers for week ended July 24, 1948

[Leaders indicate that no cases were reported]

Division and State	Diphtheria	Encephalitis, infectious	Influenza	Meningitis, meningococcal	Pneumonia	Polio-myelitis	Rocky Mt. spotted fever	Scarlet fever	Tularemia	Typhoid; paratyphoid fever <sup>d</sup>	Whooping cough
NEW ENGLAND											
Maine.....				2	7			3			8
New Hampshire.....	2				1	3		1		4	1
Vermont.....											1
Massachusetts.....	4	2		1	12	2		40			25
Rhode Island.....	1				1						
Connecticut.....	1			1	32	3		4		1	7
MIDDLE ATLANTIC											
New York.....	6		b 2	7	18	33	1	c 44		2	64
New Jersey.....	2		1		26	23	1	17		2	47
Pennsylvania.....	6	1	(b)	6		15	1	34		13	56
EAST NORTH CENTRAL											
Ohio.....	8				28	48		45		7	28
Indiana.....	1	1		1	7	11		9		1	9
Illinois.....	2	1	1	5	37	22	1	24	1		47
Michigan <sup>a</sup> .....		3		1	20	12		24		2	26
Wisconsin.....		1	2	3	5	11		22			34
WEST NORTH CENTRAL											
Minnesota.....	2				7	22		6		1	3
Iowa.....		1		4		23		5			6
Missouri.....	1				15	9		2		1	11
North Dakota.....				2		2					8
South Dakota.....	3				1	4		1			
Nebraska.....						23					4
Kansas.....	4	1			5	9		9			12
SOUTH ATLANTIC											
Delaware.....						17	1				1
Maryland <sup>a</sup> .....	1	1		1	24		5	e 5		1	9
District of Columbia.....					12	4		1			4
Virginia.....	6		131		22	18	5	62	3	2	74
West Virginia.....			5	1	3	2	3	3		3	3
North Carolina.....	9	1		2		206	8	13	2		59
South Carolina.....	2	2	92			35	1	4	2	3	57
Georgia.....	1		11		2	9	1	7		17	12
Florida.....	1			1	7	16		1			7
EAST SOUTH CENTRAL											
Kentucky.....	5				13	13		4	1	4	17
Tennessee.....	1		10	3	39	8	3	9		4	23
Alabama.....			2	2	26	14	3	2		1	20
Mississippi <sup>a</sup> .....	1			2	8	11		2	1		2
WEST SOUTH CENTRAL											
Arkansas.....	3		5	1	12	13		e 6	6	1	13
Louisiana.....	1		25		38	1		1		5	
Oklahoma.....	1		1	1	12	27		4	1	2	13
Texas.....	9		292	2	65	68		4	3	8	123
MOUNTAIN											
Montana.....						6			1		1
Idaho.....			5		3	4		e 6		1	4
Wyoming.....						7		1	2		2
Colorado.....	3		7		12	6	1	5		1	15
New Mexico.....					9	7		2			10
Arizona.....	3		6		16	5		1			13
Utah <sup>a</sup> .....	1			1	3	3		3			5
Nevada.....											
PACIFIC											
Washington.....	3		2		2	8		13		2	7
Oregon.....	4		1		14	7		3		1	23
California.....	9	1	1	5	15	192		33	1	3	56
Total.....	107	16	602	54	577	982	34	485	24	93	969
Median, 1943-47.....	169	13	492	114		369	27	807	16	129	2,924
Year to date, 29 weeks.....	4,806	264	138,124	2,069		4,585	286	54,550	592	1,753	53,386
Median, 1943-47.....	6,615	304	189,694	5,770		2,048	256	94,785	534	2,133	73,290
Seasonal low week ends {	July	{	July	Sept.	{	Mar.	{	Aug.	{	Mar.	Oct.
Since seasonal low week.....	196		181,682	2,851		4,235		77,039		1,280	84,652
Median, 1943-47.....	351		333,917	8,222		1,653		133,106		1,509	95,337

<sup>a</sup> Period ended earlier than Saturday. <sup>b</sup> New York City and Philadelphia only, respectively. <sup>c</sup> Including cases reported as streptococcal infections and septic sore throat. <sup>d</sup> Including cases reported separately as paratyphoid fever and salmonella infection, as follows: New Hampshire 4; New York (salmonella infection) 1; Pennsylvania (salmonella infection) 2; Virginia 1; Georgia 11; Texas 1; Washington 1.

Smallpox: Nebraska 1.

Alaska: Typhoid 1; Chickenpox 6; Mumps 1; Measles 3.

Territory of Hawaii: Lobar pneumonia 2; Whooping cough 3; Measles 6 (last week 3).



## Poliomyelitis Cases Increase

As the graph for poliomyelitis on page 1077 indicates, the reported incidence of this disease for the country as a whole has been higher in 1948 than in corresponding weeks of the preceding 7 years for the last 11 weeks shown. The excess was first seen in the early part of May of this year and since that time the cases reported have been consistently about twice as high as the median frequencies for the period. Such an excess could arise merely as a result of an earlier peak in the normal seasonal cycle of the disease. But examination of the geographical distribution of the cases suggests that this could not be the only cause. During the 4-week period ending July 17, 638 cases of poliomyelitis were reported from the South Atlantic States (from Delaware to Florida), about a third of the total for the entire country during this period. In the South Atlantic region the seasonal peak usually occurs in the beginning of September, occasionally later and rarely earlier. Yet the total of 638 cases is higher than that for the peak 4-week period in all but one of the last 10 years. (In 1944 there were 801 cases in the South Atlantic area between August 13 and September 9.) The great majority of the cases (483) in that area during the current 28-day period occurred in North Carolina. No other State in the area had as much as a tenth as many cases.

From the Pacific region (California, Oregon, and Washington) there was also an excess of poliomyelitis reported in the 4-week period ending July 17. Of the total of 409 cases recorded in that area all but 17 occurred in California. Although California has not had in any recent year as many cases of poliomyelitis in the corresponding 4-week period, there were 712 cases reported from that State during the 28 days ending September 14, 1946. Hence, it is possible that the excess of cases there will not be as great as in the 1946 epidemic.

There was also evidence of fairly high incidence of poliomyelitis in the North Central and West South Central regions. In Texas, 309 cases were reported in the 4 weeks under consideration. Texas has not had as many cases in any 4-week period since the one ending on July 31, 1943, when 393 cases were reported.

Since about 62 percent of all the cases brought to the attention of health authorities during the current period occurred in three States and since, as yet, there is no clear evidence that States adjoining these three have become heavily involved, the present epidemic appears to be fairly well localized at the time of writing.

### Explanation of the Graphs

The accompanying graphs are presented in order to show the trend of reported cases for the current year in relation to the corresponding weeks of preceding years. They relate to the entire United States and for that reason may sometimes conceal important differences from one part of the country to another.

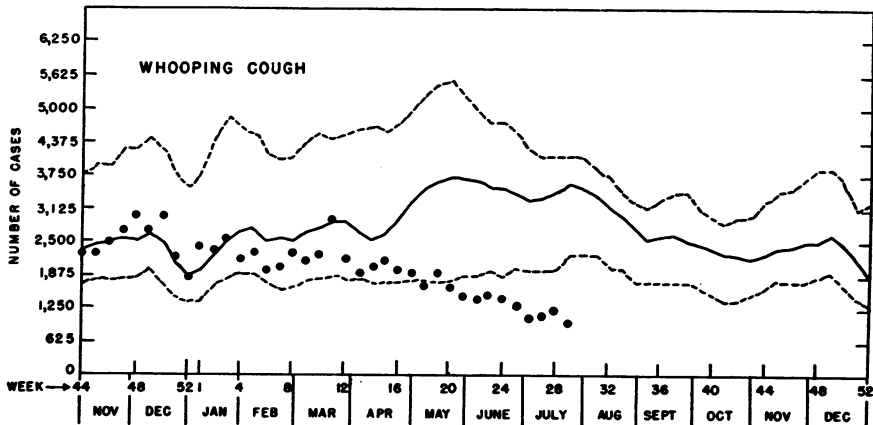
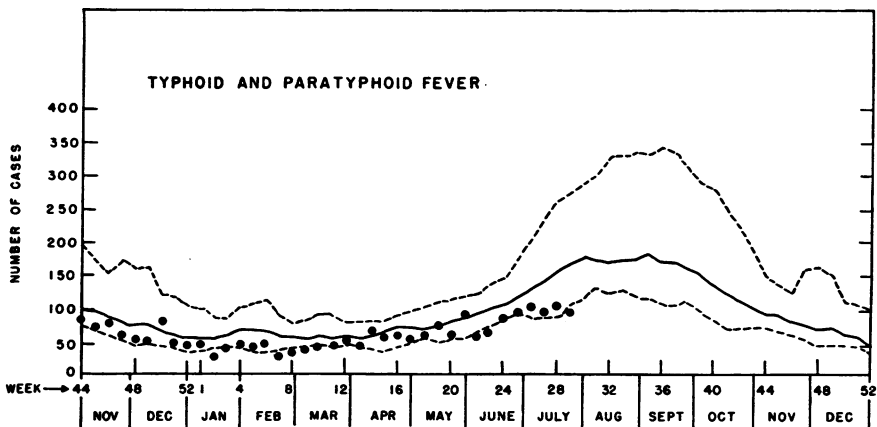
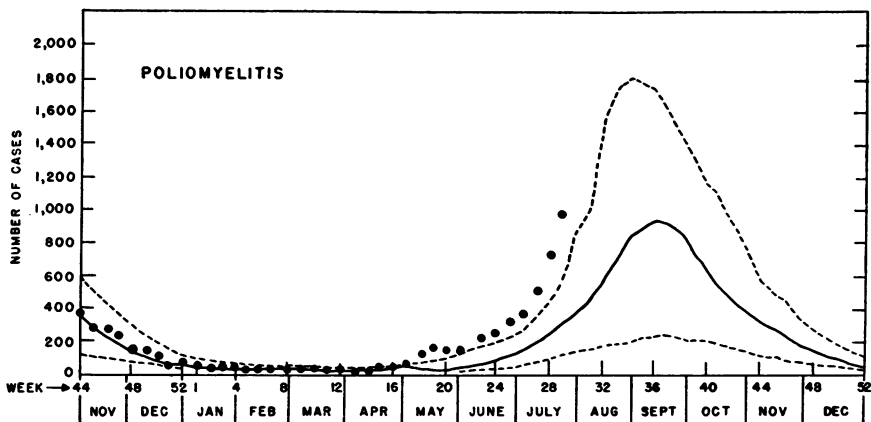
The two broken lines and the solid line are formed in the following manner. By examining the statistics of cases reported for the first week of January in each of the 7 years in the period, 1941-1947, there is found the highest value, the lowest value, and the median value recorded for the first week in January. This process is then repeated for each of the remaining 51 weeks of the year. Next, all of the 52 high values are smoothed by a 3-week moving average and plotted. The plotted points are then connected by a broken line. The low and median values are treated in the same manner, except that a solid line is used to connect the median values. The heavy dots represent the numbers of cases being reported for each week of the current year through the latest week for which statistics are available.

Hence, if the dots appear to be falling consistently above the upper broken line, it can be said that the reported incidence of the disease is higher than it has been in any of the preceding 7 years. If they fall below the lower broken line, the incidence can be said to be unusually low, while if they fall between these two, in the neighborhood of the solid line, the incidence is then about average in relation to experience for the 7 preceding years.

The numbers along the base of each chart represent the week of the year to which the statistics apply. For example, the graphs show the last 9 weeks of 1947 on the left-hand side. (The three reference lines for this portion of the graph are computed from data for the 7 years, 1940-1946). The reference lines, having been constructed in advance, run through the last week of 1948, while the dots show current numbers of reported cases through the 29th week of the year.

## Communicable Disease Charts

All reporting States, November 1947 through July 24, 1948



The upper and lower broken lines represent the highest and lowest figures recorded for the corresponding weeks in the 7 preceding years. The solid line is the median figure for the 7 preceding years. All three lines have been smoothed by a 3-week moving average. The dots represent numbers of cases reported for the weeks of 1948.

**PLAGUE INFECTION IN NEW MEXICO AND WYOMING**

Under date of July 20, plague infection was reported proved in pools of fleas from ground squirrels and prairie dogs collected in New Mexico and Wyoming as follows:

**NEW MEXICO**

*Rio Arriba County.*—A pool of 40 fleas from 35 prairie dogs, *Cynomys gunnisoni*, shot July 8 on a ranch 3 miles northeast of Brazos, and a pool of 22 fleas from 11 prairie dogs, same species, shot July 9 along the Chama River 1 mile south of Park View.

**WYOMING**

*Albany County.*—A pool of 40 fleas from 15 ground squirrels, *Citellus richardsonii elegans*, trapped July 6 at a location 9½ miles southeast of Laramie on U. S. Highway No. 30 and thence 4 miles east on Ft. Warren Target and Maneuver Reservation road.

*Laramie County.*—A pool of 7 fleas from 16 ground squirrels, *Citellus richardsonii elegans*, shot July 1 on a ranch 15 miles west of Cheyenne.

**TERRITORIES AND POSSESSIONS**

**Puerto Rico**

*Notifiable diseases—4 weeks ended June 26, 1948.*—During the 4 weeks ended June 26, 1948, cases of certain notifiable diseases were reported in Puerto Rico as follows:

Disease	Cases	Disease	Cases
Chickenpox.....	26	Syphilis.....	129
Diphtheria.....	33	Tetanus.....	9
Dysentery.....	15	Tetanus, infantile.....	1
Gonorrhea.....	182	Tuberculosis (all forms).....	778
Influenza.....	7	Typhoid fever.....	5
Malaria.....	108	Typhus fever (murine).....	8
Measles.....	516	Whooping cough.....	47
Poliomyelitis.....	2		

**DEATHS DURING WEEK ENDING JULY 17, 1948**

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

	Week ended July 17, 1948	Corresponding week, 1947
<b>Data for 92 large cities of the United States:</b>		
Total deaths.....	8,603	8,250
Median for 3 prior years.....	8,050	
Total deaths, first 29 weeks of year.....	274,804	274,198
Deaths under 1 year of age.....	637	649
Median for 3 prior years.....	648	
Deaths under 1 year of age, first 29 weeks of year.....	19,338	21,885
<b>Data from industrial insurance companies:</b>		
Policies in force.....	70,995,420	67,258,171
Number of death claims.....	13,061	10,580
Death claims per 1,000 policies in force, annual rate.....	9.6	8.2
Death claims per 1,000 policies, first 29 weeks of year, annual rate.....	9.7	9.6

## FOREIGN REPORTS

### CANADA

*Provinces—Communicable diseases—Week ended July 3, 1948.*—During the week ended July 3, 1948, 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.....		35		89	284	77	18	41	74	618
Diphtheria.....		1		15	2	1				19
Dysentery:										
Amebic.....				1						1
Bacillary.....				2						2
German measles.....		5		12	13			5	7	42
Influenza.....		18		10	10	1			2	31
Measles.....			3	293	714	24	1	77	109	1,221
Mumps.....		37		56	135	19	27	35	8	317
Poliomyelitis.....				4	4			2	1	7
Scarlet fever.....		2	1	39	33	4			3	82
Tuberculosis (all forms).....		2	3	62	45	19	6	4		141
Typhoid and paratyphoid fever.....		1		4	1				2	8
Undulant fever.....				1	1					2
Veneral diseases:										
Gonorrhoea.....		8	5	100	69	18	14	30	62	306
Syphilis.....		2		49	37	1	5		14	110
Whooping cough.....				37	9	2		24		73

### JAMAICA

*Notifiable diseases—4 weeks ended May 29, 1948.*—For the 4 weeks ended May 29, 1948, cases of certain notifiable diseases were reported in Kingston, Jamaica, and in the island outside of Kingston, as follows:

Disease	Kingston	Other localities	Disease	Kingston	Other localities
Chickenpox.....	6	12	Puerperal fever.....	1	1
Diphtheria.....	1	2	Tuberculosis (pulmonary).....	25	61
Dysentery, unspecified.....	2		Typhoid fever.....	6	67
Erysipelas.....		2	Typhus fever (murine).....	2	
Leprosy.....		1			

## NEW ZEALAND

*Notifiable diseases—4 weeks ended June 26, 1948.*—During the 4 weeks ended June 26, 1948, certain notifiable diseases were reported in New Zealand, as follows:

Disease	Cases	Deaths	Disease	Cases	Deaths
Cerebrospinal meningitis.....	8	2	Poliomyelitis.....	91	3
Diphtheria.....	27	1	Puerperal fever.....	1	-----
Dysentery:			Scarlet fever.....	105	-----
Amebic.....	3	-----	Tetanus.....	1	-----
Bacillary.....	5	-----	Tuberculosis (all forms).....	179	53
Erysipelas.....	16	-----	Typhoid fever.....	2	1
Food poisoning.....	3	-----	Undulant fever.....	3	-----

## NORWAY

*Notifiable diseases—April 1948.*—During the month of April 1948, cases of certain notifiable diseases were reported in Norway as follows:

Disease	Cases	Disease	Cases
Cerebrospinal meningitis.....	14	Measles.....	825
Diphtheria.....	24	Mumps.....	2,678
Dysentery, unspecified.....	16	Paratyphoid fever.....	3
Encephalitis, epidemic.....	4	Pneumonia (all forms).....	2,751
Erysipelas.....	375	Poliomyelitis.....	7
Gastroenteritis.....	3,430	Rheumatic fever.....	125
Gonorrhoea.....	496	Scabies.....	2,566
Hepatitis, epidemic.....	164	Scarlet fever.....	120
Impetigo contagiosa.....	2,390	Syphilis.....	147
Influenza.....	2,643	Tuberculosis (all forms).....	404
Laryngitis.....	10,932	Typhoid fever.....	3
Malaria.....	1	Whooping cough.....	451

### 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

*China—Kwangtung Province.*—Information released May 7, 1948, reports an outbreak of plague in Chan Chiang Municipality and Lien Chiang District, Kwangtung Province, China. Figures available are as follows: March 11–20, 1948, 14 cases, 12 deaths; April 1–30, 34 cases, 20 deaths; May 1–10, 19 cases, 3 deaths.

*Java.*—Plague has been reported in Java as follows: January 1948, 79 cases with 65 deaths; February, 78 cases with 69 deaths; March, 240 cases with 222 deaths; April, 203 cases with 173 deaths.

**Smallpox**

*Arabia.*—Information from Dhahran, Arabia, dated July 7, 1948, reports a mild epidemic of smallpox at Safwa, a small town in the northern part of the Quatif Oasis. Cases are reported confined for the most part to children. Necessary precautions had been taken.

*Sumatra.*—During the period June 1–18, 1948, 1,472 cases of smallpox with 49 deaths were reported in Sumatra. Of these, 1,175 cases, 42 deaths, were reported in Sumatra Barat Residence.

**Typhus Fever**

*Great Britain—Ireland (Northern).*—Information dated July 19, 1948, states that during the week ended July 10, 1948, 2 cases of typhus fever were reported in Tyrone County, Northern Ireland. These cases were in brothers, aged 7 and 16 years. The last case was admitted to the hospital on July 7, and the diagnosis was confirmed as louse-born typhus. Necessary precautions were stated to have been taken, and investigation as to origin was proceeding.

*Japan—Kyoto.*—For the week ended June 12, 1948, 26 cases of typhus fever with 1 death were reported in Kyoto, Japan.

**—Announcement—****Course in Laboratory Diagnosis of Parasitic Diseases**

A 6-week refresher course for laboratory personnel in the laboratory diagnosis of parasitic diseases will be offered at the Laboratory Division of the Communicable Diseases Center from October 11 to November 19. The second 2-week course this year for laboratory directors, senior staff members, and physicians will be given from September 13 to 24 on parasitic diseases.

This training is open to all grades of employed laboratory personnel. Although first consideration will be given to personnel from the laboratories of State and local public health departments, applicants from hospitals and private laboratories will be considered when vacancies occur. Laboratory directors and senior staff members wishing to attend the 6-week course may do so.

There is no tuition or laboratory fee, but the individual or his employer must pay for travel and living expenses.

Applications for the courses should be made as soon as possible to Seward E. Miller, Senior Surgeon, Chief, Laboratory Division, 291 Peachtree Street, Atlanta, Ga. Students will be notified of acceptance, and will receive a list of hotels and rooming houses.

Planned for students taking the 6-week course are 3 weeks of instruction in laboratory diagnosis of intestinal parasites, and 3 weeks in diagnosing blood parasites. Special emphasis during the first half will be placed on diagnosing amebiasis, hookworm, echinococcosis, and schistosomiasis; and in the second half, on diagnosis of malaria, filariasis, leishmaniasis, and trypanosomiasis.

The tentative outline includes:

*First week*—intestinal protozoa (amoebae, flagellates, cultivation and concentration techniques).

*Second week*—intestinal protozoa and helminths (ciliates, coccidia, nematodes, staining and concentration techniques).

*Third week*—intestinal helminths (cestodes, trematodes, and concentration techniques).

*Fourth week*—hemoflagellates, filarial worms, arthropods of medical importance (leishmaniasis, trypanosomes, filarial worms, arthropod vectors and staining of blood films).

*Fifth week*—malarial parasites in thin and thick blood films (four species of plasmodia).

*Sixth week*—malarial parasites in thin and thick blood films (malarial unknowns and finals).

Instruction for laboratory directors, senior staff members and physicians taking the 2-week course will cover intestinal parasites the first week and blood parasites the second.