Public Health Reports

Vol. 66 • FEBRUARY 9, 1951 • *No. 6*

Cooperation Between Health and Welfare Agencies

—A Health Officer's View—

By LEONARD A. SCHEELE, M.D.*

The cultural lag between the enunciation of a new idea and public acceptance and action based upon it has been estimated as 30 years. In view of this, perhaps it is not surprising to find considerable discrepancy between what health and welfare workers say about cooperation and what they actually do about it. Thirty years ago, there were very few State welfare departments and only a bare patchwork of local programs for aid to mothers and old age pensions. Public health services were limited largely to purification of water supply systems and enforcement of communicable disease regulations.

Health and welfare programs have moved fast and far since that time, until today, from the ideological standpoint, it has become impossible to draw any sharp line between them. All social workers are aware, intellectually at least, that there is a health component in every social problem. All public health workers, worthy of the name, recognize a social component in the health problems that confront them.

At any gathering of health or welfare people, the need for a cooperative attack upon interrelated problems is likely to be discussed. Public health people talked about it extensively at the recent American Public Health Association meeting in St. Louis. There is an equal eagerness among social workers. Yet, after the meetings are over, a cold, analytical look at actual operations in local communities and throughout the Nation shows that the "trend" toward cooperation is painfully slow. From the standpoint of structure for cooperative action, these organizations seem to be almost as far apart as they were in the days when welfare meant an occasional coal or grocery order and when public health meant a red placard on the home of a scarlet fever patient.

Granting that social workers recognize the health implications of the problems they are dealing with and want to work with their

*Surgeon General, Public Health Service, Federal Security Agency. Delivered at the Annual Meeting of the American Public Welfare Association, Chicago, Ill., Dec. 2, 1950.

public health counterparts in attacking them, what agency do they approach? And where? And how? The answer varies, problem by problem, and State by State, for public health services are widely dispersed. Moreover, the dispersion has increased as public health services have expanded. This shows up clearly in the study of distribution of State health services which is conducted at 10-year intervals by the Public Health Service. The 1940 survey [1] revealed that as many as 18 different State agencies administered some type of health program within a single State. Our 1950 study is not yet complete, but a sampling of one State in each of our 10 geographic regions shows that in at least one State, 23 State agencies are administering health programs and that in no State are they administered by less than 9. Nor is there evidence of uniformity in philosophy and approach among these several agencies.

Next to the health department—and in many States even above the health department—the welfare department is the official agency which makes the greatest dollar investment in health services. Since the health and welfare agencies are the largest investors, they have the greatest responsibility to initiate and promote joint planning.

Out of such planning, not only a more soundly structured program but also an enrichment of services in both fields can be expected. The health professions are coming to realize more and more that their best skills and most effective treatments are of no avail in many cases, so long as the patient remains in the same adverse social and environmental situation which contributed to his illness. This is especially true in combating tuberculosis, venereal disease, and many chronic illnesses, and in the promotion of mental health. Health workers need to know people in the welfare field better so that there can be better utilization of their competencies for dealing with these social factors. All too often, we leave it to the patient to find his own solution to the social problems that are inherent in his health problem. And when he is both ill and uninformed about welfare resources, as is frequently the case, the social problems remain unmet and health efforts are wasted.

Conversely, the content of welfare programs can be enriched through better understanding and utilization of public health services. Preventive medicine has made great strides in recent years and can contribute much to the total well-being of the individual. Advances in the field of nutrition, for example, have not only given more knowledge about what the body needs at various age levels to maintain vigorous health but have also improved techniques for getting people to understand and apply this knowledge. Similarly, there have been improvements in techniques for case finding, early diagnosis, and

[1] Mountin, Joseph W. and Evelyn Flook: Distribution of Health Services in the Structure of State Government. Ed. 3. Public Health Bulletin No. 184.

treatment of many of the chronic diseases such as diabetes, cancer, and heart disease with the result that the disabling effects of such conditions can be greatly reduced and, in some cases, eliminated. How many incipient illnesses are there among the clients of welfare agencies, and how often do they receive medical attention before rather than after obvious symptoms appear? There are many people on welfare case loads who could benefit from the preventive and rehabilitation services which could be obtained through closer cooperation of public health and welfare personnel.

Fortunately, in Public Law 734—the 1950 Social Security Amendments—we have a catalyzing agent which both fields have long needed. Its medical care provisions are a challenge to those in the welfare field who are responsible for the well-being of their clients. These amendments are equally a challenge to those who are responsible for the maintenance of public health. Only by working together can the challenge be met successfully. This opportunity must be seized to eliminate the gaps and duplications, the inconsistencies and variations, in existing programs. Otherwise, today's confusions will be compounded in the future as we try to carry out the responsibilities which Public Law 734 has placed upon us.

Many would feel that the first steps must be taken Federally. Already we in the Public Health Service and in the Social Security Administration have been giving much time to the devising of methods to bring together more closely all the Federal grant-in-aid programs that result in medical services to people. We recognize that if these congeries of services are brought together locally a much improved community health and welfare plan will result.

The closely coordinated approach of health and welfare personnel in Washington and in the Federal Security Agency regional offices is one means of fostering local coordination. Consequently, the specialized services which health agencies can be expected to give have been spelled out by the Public Health Service and presented to the Public Assistance Bureau. Plans are being made to set up a joint committee. Regional personnel of both Public Assistance and Public Health have been oriented. These are the steps taken to date—there will be many more in the near future.

Equal desire for cooperation at the State level is evidenced by the fact that the Association of State and Territorial Health Officers, at their recent conference in Washington, passed a resolution strongly recommending health and welfare collaboration at both State and local levels.

The most effective medical care programs will be developed in communities that have adequate health departments, and welfare workers will help to promote the establishment of such departments in the many areas that now lack them. The last 15 years have seen

the development of a Nation-wide network of local welfare agencies and the resulting improvement in services. A Nation-wide network of health services is equally essential to progress in the health field.

In both State and local planning for the implementation of Public Law 734, there is urgent need for advisory committees, broadly representative of both the consumers and providers of health and medical services. Public health is already making effective use of such committees in many of its programs. This is done on the Federal level through nine advisory councils to the Public Health Service. The councils aid in the administration of the hospital survey and construction program as well as in aid to research and training and in control programs in such fields as mental health, cancer, and heart disease. The councils have been tremendously helpful in developing programs and policies that reflect the needs and interests of the Nation. Every State has an advisory body on the hospital program and many States have over-all planning groups for health services. In every instance where citizen groups have been given a real and effective voice in policy, the returns—in terms of public interest and support as well as in terms of sound programming—have been great. Welfare workers have made equally successful use of citizen advisory groups. It seems logical, therefore, to expect that by pooling community organization skills, this type of operation can be carried to an even higher level, gaining stronger community support and interest than either type of agency has hitherto obtained through independent efforts.

The urgency of immediate transition from talk to action must again be stressed. The need for streamlined operations which will deliver the utmost in health and welfare services to the individual at a minimum cost of money and manpower is growing day by day as more staff is drawn into the Armed Forces and as health and welfare take on the added functions of civil defense.

At the State and community levels, health and welfare agencies have already begun to demonstrate ability to get together promptly and effectively, in a truly cooperative way, for the development of civil defense plans. This response to the stimulus of an emergency situation will carry over into all endeavors.

Such an outcome is not only logical but also essential, for emergency services, to be effective, must be based upon and flow from soundly structured, well-administered normal services. We in public health and public welfare are striving toward common goals. As public servants, we have also a common responsibility to close ranks and move forward toward those goals, rendering services efficiently and effectively through cooperative planning and operations.

Résumé of Public Health Service Grant-in-Aid Programs Providing Medical Services

By Estella Ford Warner, M.D., and Evelyn Flook*

With the introduction of legislation to broaden the Federal Social Security Act—providing, in addition to other changes, more medical care for the needy—the Social Security Administration established the Committee on Inter-Agency Relationships in Grant-in-Aid Programs Providing Medical Care. The committee was composed of representatives of the Bureau of Public Assistance—one of whom served as chairman—the Children's Bureau, Office of Vocational Rehabilitation, and Public Health Service. Purposes of the committee were: (*a*) consideration of the statutory bases and regulations, similarities, and differences in the various existing grant-in-aid programs; (*b*) review of services available and coverage of existing programs to identify the gaps and overlaps; (*c*) identification of points of contact in operation; (*d*) consideration of State problems and opportunities to take full advantage of the Federal provisions governing existing grant-in-aid programs; (*e*) exchange of information to fill the great gaps in knowledge of the various programs; and (*f*) consideration of the principles developed under each program to guide agencies in dealing with the States.

As background material for deliberations of the committee, this résumé of grant-in-aid programs administered by the Public Health Service has been prepared.

BACKGROUND INFORMATION

Description of Programs

General Health Programs

Grants-in-aid for general health purposes are designed to assist States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public health services. This includes: grants to State health departments to supplement State and local appropriations for basic State and local health services not provided for through categorical grants, such as public health nursing, laboratory services, communicable disease control, collection, analysis, and dissemination of vital statistics, health education, nutrition services, dental services, and environmental sanita-

*Chief, Division of State Grants, and Chief, Program Evaluation and Records Section, Division of State Grants, Bureau of State Services, Public Health Service.

tion; provision of technical assistance to State and local health departments through consultation and demonstrations; training of personnel for State and local health work.

Categorical Health Programs

(Tuberculosis, venereal disease, cancer, heart disease, mental health, and dental health.)

Categorical grants are made available for selected purposes in order to assure that they receive particular emphasis in the total State and local public health programs.

All categorical programs include assistance to States and local communities for case finding, diagnosis, and epidemiological follow-up; training of personnel for State and local health work in the designated category; education of the lay public; and research to improve methods of diagnosis and treatment.

In addition, the following services are also included for the programs indicated:

Tuberculosis and venereal disease. Provision of appropriate facilities for care and treatment (venereal disease—both in-patient and out-patient; tuberculosis—out-patient only).

Cancer. Federal funds may be used to purchase in-patient hospital care for diagnostic purposes for a period not to exceed 3 days. All other hospital care must receive prior approval. Expenditures for surgical or radiotherapeutic procedures requiring hospitalization are not permissible when unfavorable prognosis exists.

Heart. Establishment and operation of organized community programs of heart disease control and cooperation with public and private agencies in demonstration of improved techniques and procedures.

Mental health. Assistance in the development and maintenance of preventive, diagnostic, and out-patient clinical services (none of the services provided are for patients who are in hospitals) and coordination of all research and other activities conducted by both public and private agencies.

Dental health. Assistance to States and to local communities in planning, organizing, developing, and maintaining modern dental health services; demonstration of new and improved dental public health procedures for prevention and treatment of dental caries; and promotion of widespread use of latest professional techniques.

State Agencies Administering Programs Utilizing Grant-in-Aid Funds From the Public Health Service

General health, tuberculosis, and venereal disease. All State health agencies utilize Federal grants for these three purposes.

Cancer. All States except New Hampshire utilize Federal cancer funds. In each instance, Federal funds are made available through the State health department. However, the Arkansas program is administered by the State Cancer Commission.

Heart. Plans for heart disease control programs of varying scope have been approved for all States but Wyoming. All programs are organized under the State health department.

Mental health. In 17 States, an agency other than the health department is the officially designated State mental health authority. All States utilize mental health funds.

Dental health. Forty-eight of the 53 State health departments conduct or financially support dental activities. General health, cancer, or Children's Bureau funds are used in these programs.

Method of Administration

The State health agency—or, in the instance of mental health, the officially designated State mental health authority—may provide services by direct operation or may provide financial support of services operated by another agency or organization. Full responsibility for services may be placed with local health departments, aid being given by the State agency through funds, personnel, equipment, or contributed services.

Extent of Programs

Federal Appropriations Available for Grants to States, Fiscal Year 1950

General health	[1] $14,200,000
Venereal disease:	
Regular	7,757,000
Projects (rapid treatment facilities; case finding)	4,500,000
Tuberculosis	6,790,000
Mental health	3,550,000
Heart disease	2,000,000
Cancer:	
Regular	3,500,000
Projects	1,000,000
Total Public Health Service grants	43,297,000

(There is no categorical grant for dental services as such. However, dental services constitute one of the purposes for which general health, maternity and child health, or cancer funds may be used. It is estimated that about $150,000 of the $14,200,000 available for general health grants during fiscal year 1950 was expended for dental health. In 1949, the total from all sources expended for dental health was $1,839,133. This included $998,681 of Federal funds. In 1948, $1,473,259 was expended for dental health.)

[1] Approximately $1½ million of this was budgeted for State sanitation activities which are not directly related to medical care.

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Direct Operations by Public Health Service, Fiscal Year 1950

Tuberculosis (X-ray surveys in large cities)	$1, 171, 396
Venereal disease:	
Rapid treatment facilities	1, 307, 211
Case finding	40, 000
Mental health (demonstration project in a local health department)	45, 000
Dental health (studies and demonstrations)	947, 371

State and Local Appropriations, Fiscal Year 1950

Reported by State health departments and 17 separate State Mental Health Authorities

Total (approximate)	$303, 000, 000
State appropriations	[1] [2] 180, 000, 000
Local appropriations	123, 000, 000

[1] This does not include expenditures for mental hospitals, except ½ of 1 percent which may be used for matching Federal mental health grants.

[2] Approximately 6½ million dollars of State funds was budgeted for State sanitation activities which are not directly related to medical care.

Type and Scope of Services

a. Grant programs

A wide variety of services significant to medical care programs are provided by State and local health departments. These may be grouped as immunizations, diagnostic laboratory services, clinical diagnostic services, diagnosis through X-ray, treatment clinics of various kinds, in-patient treatment of various kinds, medical and dental corrective services for school children, home and clinic nursing services, psychiatric and psychological services, administrative supervision of hospitals providing care for the several special programs, bedside nursing services, nutrition services, and medical social services. To a varying degree, State health departments, through the use of grant funds, either provide such services directly or financially support the services operated by local health departments.

Information on volume of service provided by State and local health departments is not available to the Public Health Service. However, some indication of the frequency with which State agencies directly provide or financially support designated types of services may be obtained from the pamphlet, Variations in State Public Health Programs (*1*), prepared annually by the Division of State Grants of the Service.

In the grant programs of the Public Health Service, reporting of activity by a State agency does not imply State-wide coverage. When a State agency reports participation in a particular type of service, only one county or one city in the State may be receiving such service; the entire State may be covered; or the service may fall between these two extremes. This situation is in sharp contrast to most of the welfare programs which must be State-wide in coverage.

A general idea of the extent to which selected types of services in-

volving some element of medical care are available in local health departments may be gained from Mountin's article, Changing Concepts of Basic Local Public Health Services (*2*). Since health departments may support services and facilities operated by some other agency, total community health resources are of interest also. For description of coverage see, Public Health Personnel, Facilities, and Services in Local Areas Having a Full-Time Health Officer (*3*).

b. Direct service by the Public Health Service

Services furnished directly by the Public Health Service to States or their political subdivisions are limited in scope. The more outstanding ones are:

Tuberculosis. Direct case-finding program (estimated number of persons X-rayed by small films during the fiscal year 1950—2,479,362).

Venereal disease. Direct case-finding program, including: development of new and improved case-finding techniques; development and dissemination of media for professional and public education; development and evaluation of time dose schedules of therapy utilizing penicillin and other antibiotics.

Mental health. Demonstration operation of a mental health clinic in a local health department, Prince George's County, Md. (During 1949, 486 persons were given consultation or treatment services. Of these, 281 were children and 187, adults.)

Dental health. Studies and demonstrations. Topical fluoride demonstration program initiated July 1, 1948—units operating in 40 States; 200,000 children had received treatment by January 1, 1950. Defluoridation of a communal water supply (Britton, S. D., and Bartlett, Tex.). Fluoridation of a communal water supply (Grand Rapids, Mich.). Determining the effectiveness of topical agents (Wilmington, Del.). Dental needs of children (Richmond, Ind. and Woonsocket, R. I.).

How Services Are Provided

a. By salaried personnel

(1) Medical (or dental) administration of the program.
(2) Laboratory services.
(3) Home and clinic nursing services.
(4) Mass radiography services.
(5) Case finding.
(6) Medical social services.
(7) Services of psychologists.
(8) Nutrition services.
(9) Corrective dentistry, prophylaxis, oral examinations.
(10) Maintenance and operation of hospitals for venereal disease, tuberculosis, cancer, etc.

b. By purchase (including contract)

(1) Services of professional personnel for providing corrective measures on an individual basis (rates vary from locality to locality).
(2) Services of medical clinicians including psychiatrists (usually paid on a clinic session basis—rates vary).
(3) Hospitalization—contract with a general hospital or a fixed remuneration per diem for each occupied bed (particularly for venereal disease and cancer patients).
(4) Services of readers of small X-ray films (average rate $10 per roll).
(5) Purchase of care in nursing homes (particularly for heart disease).
(6) Services of consultants.
(7) Pathological service.
(8) Corrective dentistry, prophylaxis, oral examinations.

PROGRAM RELATIONSHIPS WITH OTHER AGENCIES

A close working relationship is maintained between the Public Health Service and the Children's Bureau in all grant-in-aid operations, since both Federal agencies are dealing with the same State agencies and with many of the same persons.

Continuous mutual consultation and exchange of information are carried on by the Public Health Service and the Office of Education in planning school health programs. The Children's Bureau also is represented on a committee charged with developing a program of school health.

A close working relationship is maintained between the Public Health Service and several offices of the Federal Security Agency: the Office of Federal State Relations, particularly the Divisions of State Grant-in-Aid Audits and State Merit System Services; the Office of Field Services; and the Office of General Counsel.

The Public Health Service and the Office of Vocational Rehabilitation are holding joint planning conferences in connection with development of chronic disease services.

The Public Health Service, the Department of Agriculture, and the Children's Bureau are engaged in cooperative work with respect to problems of nutrition; the Public Health Service and Department of Agriculture, with respect to matters of veterinary medicine.

A close working relationship is maintained between the Public Health Service and the Office of Indian Affairs with respect to the provision of all types of health services to the Indian population.

(Committee work will result in further program relationships).

LEGISLATIVE BASE

Legislative Requirements for State Plan

For All Programs Except Cancer

The basic Public Health Service law specifies that "the moneys so

paid to any State shall be expended solely in carrying out the purposes specified and in accordance with plans approved by the Surgeon General which have been presented by the health authority of such State." The basic law makes no provision as to the content of the State plan.

For heart disease only. Upon recommendation of the State health authority, payment may be made direct to political subdivisions of a State or to nonprofit organizations if the State health authority has not, prior to August 1 of any fiscal year, presented and had approved a plan.

For Cancer

The basic Public Health Service law does not require a State plan. Hence, State plans for cancer grant-in-aid programs are required by regulation only.

Determination of Allotments

For All Programs Except Heart Disease and Cancer

The Surgeon General, with the approval of the Administrator, is empowered to determine annually from appropriations for the respective purposes the total sum which shall be available for allotment, and, in accordance with regulations, make allotments to the several States on the basis of:

The population.
The extent of the several problems (venereal disease, tuberculosis, mental health, etc.).
The financial need of the respective States.

For Heart Disease

The same legislative provisions as above apply except that only two factors can be considered in determining allotments:

The population.
The financial need.

For Cancer

There is no legislative basis for determining allotments. Basis is determined by regulation only.

Matching Requirements

For All Programs Except Cancer

The basic law provides that the amount of State and local funds to be expended for each purpose shall be determined in accordance with regulation.

For Cancer

There is no legislative basis for determining matching requirements. Basis is determined by regulation only.

ADMINISTRATIVE BASE

Regulations

All regulations and amendments thereto regarding grants to States shall be made after consultation with State health authorities or, in the case of regulations or amendments which relate to or affect grants for mental health, the State mental health authority.

Programs Supported by Grants Subject to Allotment

Requirements for State Plans (All Programs)

Program purpose

(1) Each State making application for grants shall submit, through its State health authority—or, in the case of mental health, the State mental health authority—plans for each fiscal year for carrying out the several purposes.

For heart disease only. Plans of cooperating agencies for heart disease control programs, in lieu of State plans, shall be submitted through the State health authority.

(2) A State making application for Federal funds for more than one of the purposes authorized may consolidate its plan: *Provided*, that the information specifically required for a State plan is distinguished with respect to each purpose.

(3) Plans shall be prepared in accordance with forms supplied by the Public Health Service and may be amended with the approval of the Surgeon General or his designee.

Plan content

A plan with respect to any program shall include:

(1) A description of the current organization for and health services included in the program and the proposals for extending, improving, and otherwise modifying such organization.

(2) Provision for health services in substantial accordance with nationally accepted standards.

(3) A budget by project totals for carrying out the services described.

(4) A statement that the plan, if approved, will be carried out as described and in accordance with applicable provisions of the Public Health Service Act and regulations prescribed thereunder.

Time of submittal and approval

(1) For a continuing program an annual plan shall be submitted at least 45 days prior to the beginning of the Federal fiscal year to which the plan relates.

(2) A plan or amendment thereto shall not be approved for any

period antedating receipt of such plan by the Public Health Service: *Provided,* that exceptions to this rule may be made by the Surgeon General when necessary to meet emergencies.

(3) The budget for health services shall not be approved unless each item thereof relates to activities described in the plan.

(4) For heart disease only—A plan for a heart disease control program submitted by a cooperating agency shall not be approved unless recommended by the State health authority.

Basis of Allotment

For general health

Of the amount available for allotment for general health purposes other than mental health:

From 90 to 95 percent on the basis of population weighted by financial need;

From 5 to 10 percent on the basis of the extent of special health problems.

For venereal disease, tuberculosis, and mental health

From 20 to 40 percent on the basis of population weighted by financial need;

From 60 to 80 percent on the basis of the extent of the problem (venereal disease, tuberculosis or mental health, as the case might be).

For cancer

Sixty percent on the basis of population weighted by financial need;
Thirty-five percent on the basis of the extent of the cancer problem;
Five percent on the basis of relative population density.

For heart disease

A portion on the basis of a uniform per capita allotment not to exceed 10 cents per capita for the first 100,000 population or part thereof of each State. The remaining amount on the basis of the remaining population of each State weighted by financial need.

Matching Requirements

The expenditure of at least one State or local dollar for each two Federal dollars is required for all programs.

Programs Utilizing Project Grants

Venereal disease

Any State or, with the consent of the State health authority, any county, health district, or other political subdivision of a State, making application for project grants shall submit applications for grants setting forth a proposed plan for the operation of a project, including proposed budgets, and reports on official forms prescribed by the Surgeon General.

State health agencies, universities, hospitals, laboratories, institutions, or professional nonprofit organizations will be eligible to apply for funds for projects relating to cancer control. The applicant shall submit plans for such projects through the State health authority.

Required Reports

The Surgeon General may require the submission of information pertinent to the operation of the plans and to the purpose of the grants, including the following:

1. A certification from the State health authority on an official form as to the amount of State and local funds available for carrying out the State plan.

2. A statement from the State health authority showing on an official form the estimates of need by fund and functional activity for the second succeeding year.

3. Quarterly reports on official forms showing total receipts, expenditures, unliquidated encumbrances, and balances of Federal funds; and for the first three quarters, total quarterly expenditures from Federal grants and other sources for each activity shown in the budget for health services.

4. A report on an official form showing personnel, facilities, and services for each local health organization included in the current State plan.

5. The following reports on official forms shall be submitted by the State health authority with respect to tuberculosis control activities:

a. A semiannual report on mass chest surveys, and tuberculosis morbidity and mortality, with separate report for cities of 500,000 population or over.

b. An annual report on clinic and nursing services.

6. The following reports on official forms shall be submitted by the State health authority with respect to venereal disease activities:

a. A quarterly report on laboratory activities, drug distribution, and fees to private physicians.

b. A quarterly activity report for each cooperative health unit or a summary of such activities by the State health authority.

c. A quarterly morbidity report with separate report by each city of 200,000 population or over.

Audit

1. Audit of the activities and programs described in the plan may be made after prior consultation with the State health authority or the cooperating agency.

2. Records, documents, and information available to the State

health authority or cooperating agency pertinent to the audit shall be accessible for purposes of audit.

Conditions of Eligibility

From the Federal standpoint

There are no restrictions on eligibility for service by virtue of the grant funds involved, except that:

(1) Federal funds for cancer may be used to purchase in-patient hospital care for diagnostic purposes for a period not to exceed 3 days. All other hospital care for cancer must receive specific prior approval. Expenditures for surgical or radio-therapeutic procedures requiring hospitalization are not permissible when *unfavorable* prognosis exists.

(2) None of the tuberculosis, heart disease, or mental health services provided are for patients who are in hospitals.

From the State and Local Standpoint

Restrictions on eligibility for the several types of service vary. For instance:

Venereal disease

No limitations on provision of diagnostic services. Eligibility for treatment varies with the State or local community.

Tuberculosis

As a rule, anyone is eligible for mass radiography and diagnostic laboratory services, whereas, in some States, complete clinical diagnosis and pneumothorax refills may be available only to those who cannot afford the services of a private physician. There is greatest variability with respect to financial and residence requirements for admission to State and county tuberculosis hospitals.

Cancer

Some States limit detection center service to those referred by a private physician or to those in good health. Some centers are available to female applicants only or to those over 35 or 40 years of age. The States are more likely to limit diagnostic and/or treatment clinic service to those claiming medical indigency—some require certification of this fact—and to those with a "danger signal" referred by a physician. Pathological service in some States is provided only for clinic patients. In other States the service is available to all physicians and is free only for their indigent patients; other patients pay a set fee ranging from $3 to $6. In some States there is a volunteer pathological service for indigent cases. State-financed hospitalization of those with cancer is most often limited to the indigent. The majority of States require that the case be remediable, though a few

do not. Legal residency in the State is a specified requirement in several States.

Dental health

As a rule, topical fluoride applications and other services for school children are available to all. Other services may be limited to indigents only.

Mental health

Diagnostic and child guidance services are most commonly made available without limitations. Admission to State mental hospitals may be on either a free, part-pay, or full-pay basis. In the majority of States, fees are not collected from the patients.

Limitations Because of Shortages of Funds or Personnel

General Health

Personnel

Personnel shortages exist in both State and local health departments. Many programs in State health departments are without full-time directors. Many other essential positions are vacant in State health departments.

Of the 1,291 full-time organizations providing local health service, 299 had vacancies in the health-officer position in June 1949. At the same time only 65 counties of 1,636 reporting to the Public Health Service and 8 of 237 independent cities reporting had sufficient personnel to meet the established minimum staffing standards in all four classes (physicians, nurses, sanitation personnel, and clerks). A breakdown of the number of counties and cities having sufficient personnel in each class to meet the minimum staffing standards follows:

	Counties	*Cities*
Physicians	769	80
Nurses	148	25
Sanitation personnel	956	192
Clerks	774	103

It is estimated that to meet minimum staffing requirements, the Nation would virtually have to double the number of personnel now employed in these four classes. Additional personnel are also needed in other categories, such as dentists, dental hygienists, nutritionists.

Lack of local organizations

In June 1949, between 35 and 40 million people were residing in areas without full-time health organizations.

Many States lack enabling legislation for the establishment of local health units.

Funds

The tremendous shortage of funds available for providing adequate public health services is reflected in the personnel situation and in the number of areas without full-time local health organizations, which form the basic structure for carrying out not only the general health services but the specialized programs represented by the categorical grants.

Venereal Disease Case Finding

Acquired syphilis. With reduction in the annual incidence there has arisen a need for the development of case-finding techniques which will make it economically feasible to reach that segment of the infected population which has not responded to present-day case-finding activities.

Congenital syphilis. The discovery of early congenital syphilis is handicapped by the difficulty of securing serological samples from infants and young children. The recent development of a reliable serological test using capillary blood applied on a filter paper from a needle prick rather than venous blood promises to facilitate the finding of congenital syphilis.

Tuberculosis

Many State and local tuberculosis programs are seriously handicapped because of their inability to obtain sufficient medical clinicians and public health nurses for follow-up. Less frequently, but even more seriously, perhaps, the position of full-time medical director of the program is vacant. Occasionally there are also shortages of X-ray technicians, health educators, medical social workers, and clerical personnel. Personnel shortages are largely attributed to salaries which are too low to attract qualified professional workers.

Diagnosis, treatment, and follow-up services are limited in almost every State because of shortages in funds and personnel. Because of insufficient funds, hospital beds, diagnostic and treatment clinics, and X-ray facilities are still acutely inadequate in most places. Because of insufficient nursing personnel, follow-up of cases discovered through surveys, and of their family contacts, has lagged far behind the case-finding program.

Cancer

Several States have very limited cancer control programs because of shortages of funds or trained personnel. They are able to provide little more than a partial educational program and perhaps a few other central office services. In 1948, only six States completely lacked clinic service. However, in very few of the remaining States is the clinic coverage adequate geographically. The lack of a full-time program director is one of the major handicaps in about half of

the States. Several States are hampered because they must rely on volunteer clerical, pathological, or clinical personnel. Elsewhere, State funds are eaten up providing hospitalization. In few States would program expansion be possible with present funds and personnel.

Heart Disease

Most State programs are not handicapped because of lack of funds at this time. However, trained personnel in this comparatively new public health program are difficult to obtain and many State programs are seriously handicapped due to lack of personnel.

Dental Health

Dental health programs in most States are handicapped by lack of funds and especially by shortages of dentists and dental hygienists. In 1948, 19 States had no full-time public health dentist serving local areas with full-time health organization.

Mental Health

Both State and local activities are seriously handicapped because of the severe Nation-wide shortage of mental health workers, particularly psychiatrists, clinical psychologists, psychiatric nurses, and social workers. A sizable proportion of grants is therefore being used for training such personnel. As in other health fields, low salary scales have hampered recruitment of personnel for expanding and improving mental hygiene activities in many States. The most serious limitation to some programs is the amount of funds available.

PENDING OR PROPOSED LEGISLATION

General Health

Status

Three local public health services bills—H. R. 274, H. R. 913, and S. 445—were introduced in the Eighty-second Congress, on January 3, 4, and 11, 1951, respectively. The House bills were referred to the Committee on Interstate and Foreign Commerce and the Senate bill to the Committee on Labor and Public Welfare. Reports from both committees are pending.

Purpose

To assist the States, through grants, in developing and maintaining local public health units organized to provide essential full-time public health services in all areas of the Nation, particularly in national defense areas, and in the training of all types of personnel for local public health unit work.

Implementation

Essentially the bills do not create a new program. They would

merely implement principles of extending local public health services provided in the Public Health Service Act. This is to be effected by amendments to and substitutions for sections 314 and 315 of the current act.

Major Provisions of Senate Bill

Regulations which the Surgeon General shall prescribe with respect to local public health units:

a. The minimum population to be served by each unit in different areas.
b. The minimum number and types of personnel which units in different areas must employ.
c. Methods of administration including the merit basis of personnel administration.
d. The types of service for which Federal funds provided under this section may be expended under State plans, which may include:
   (1) Diagnosis and prevention of disease.
   (2) Control of communicable disease.
   (3) Health education.
   (4) Demonstrations.
   (5) Sanitation.
   (6) Vital statistics.
   (7) The training of personnel for State and local public health work.
   (8) Other aspects of preventive medicine.
e. Federal funds provided under this section may not be expended for medical, dental, or nursing care except in:
   (1) The diagnosis or prevention of disease.
   (2) The control of communicable disease.

Major Provisions of House Bills

a. *State plans must provide for:*
   (1) Local public health unit coverage as soon as practicable of all defense areas, and extension of local health units to other areas at the maximum rate consistent with the availability of personnel and facilities.
   (2) Evidence of authority of the State health agency and all local public health units covered to carry out the plan.
   (3) Inclusion of sufficient population and financial resources in each local public health unit to assure continuing financial support for efficient and economic administration.
   (4) Employment of full-time personnel of such types and in such numbers as are required to render minimum basic public health services to the population served by each local public health unit.
   (5) Allocation of all funds to local health units by methods which will assure their equitable distribution and effective use in extension and expansion of basic public health services.
   (6) Methods of administration which include establishment and maintenance of personnel standards on a merit basis.
   (7) Submission of reports required by the Surgeon General.

b. *Types of services for which Federal funds may be expended*

Federal funds provided under this pending legislation may be expended for:

(1) Health education and information.
(2) Laboratory services.
(3) Vital statistics.
(4) Communicable disease control.
(5) Environmental sanitation.
(6) Maternal and child health.
(7) Demonstrations related to public health.
(8) Training of personnel for local public health work.
(9) Other aspects of preventive medicine.

c. *Types of services for which Federal funds may not be expended*

Federal funds provided under this pending legislation may not be expended for:

(1) Industrial accident prevention programs.
(2) Medical or dental treatment, except in:
    (a) Communicable disease control.
    (b) Epidemic or other emergency situations.
    (c) Activities for which Federal aid is authorized under other provisions of the law.

Limit of Federal Aid

Federal funds would be provided to meet approximately one-third of the State expenditures for the Nation as a whole, within a limit of $1.50 per capita. A sliding-scale matching ratio is provided, with low-income States receiving a relatively higher Federal share, but never to exceed 66⅔ percent.

REFERENCES

(1) Campbell, Josephine, Mullins, Rubye F., and Kennedy, Marion: Variations in State Public Health Programs as Portrayed by the Annual Combined Report and Plan for Fiscal Year 1948. Federal Security Agency, Public Health Service, January 1949.
(2) Mountin, Joseph W.: Changing concepts of basic local public health services. Am. J. Pub. Health **39:** 1417-1428 (1949).
(3) Flook, Evelyn, Gill, Arthur P., and Dubber, Bessie Patrick: Public Health Personnel, Facilities, and Services in Local Areas Having a Full-time Health Officer, as Reported for the Year 1947. Federal Security Agency, Public Health Service, June 1949.

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 Ending January 20, 1951

Except for Gordo, Ala., there were no reports of the occurrence of influenza in epidemic form in the United States. The outbreak in Alabama should be regarded as an "influenza-like disease" until presence of influenza virus can be confirmed by laboratory tests.

Reports of Epidemics

Typhoid fever. Dr. G. W. Cox, Texas State Health Officer, has reported 17 cases of typhoid fever within recent weeks from a single county. These cases were principally in children who had attended a banquet. The vehicle of infection is thought to have been food. Only four cases of the disease had been reported in this county over a period of 6 years prior to the present epidemic.

Streptococcal sore throat. Dr. R. M. Albrecht, New York State Department of Health, has reported an outbreak of streptococcal infection in one ward of one building in an institution for mentally defective children. There were 15 cases with a rash (1 on January 12, 1951; 6 on January 13; 4 on January 14; and 4 on January 15). Many other children had fever and sore throat. Spread of infection was not considered to be by food but by contact. The mother of the first case visited the child on January 7. Apparently another case of scarlet fever had occurred in the family.

Influenza in Europe. From reports of the World Health Organization and of other sources, the incidence of influenza has been highest in northern England. Incidence in Scotland has been relatively low, but A-prime virus has been isolated in Edinburgh. Of the influenza deaths reported, 85 percent are in persons over the age of 55.

Influenza has been present in the Netherlands and Belgium and has reached Iceland. The disease is progressing through France from the north and south. A clinically mild type of influenza is prevalent in Spain.

Influenza Information Center [1]

The strain study center in the laboratory of Dr. T. P. McGill, State University Medical Center, Brooklyn, N. Y., has received the influenza virus from throat washings from three cases in London.

[1] National Institutes of Health, Bethesda, Md.

This is reported to be A-prime. This laboratory has also received the A-prime isolated in Sweden earlier in the season and A-prime virus isolated in Leyden, Holland. These strains all appear to be similar in antigenic characteristics.

Dr. J. E. Salk, University of Pittsburgh, reports the recovery of influenza virus isolated from a patient who was ill on December 27, 1950. Antigens in influenza vaccine, especially the A-prime component, match the Pittsburgh strain. At the present time there is no indication of an outbreak of influenza in Pittsburgh.

The Division of Preventive Medicine, Office of the Surgeon General, Department of the Army, reports serologic diagnosis of type B influenza virus from a case in military personnel in Dayton, Ohio. The onset of illness was approximately January 5.

The Department of Virus and Rickettsial Diseases of the Army Medical Service Graduate School has examined the Swe–3–50 influenza virus isolated in Sweden during June 1950 and the London 1–51 strain from the current English outbreak. Tests with human sera showed that both viruses belong to the general A type. Tests with strain-specific rooster antisera indicate that the Swedish and London viruses are similar though not identical to the 1950 Cuppett virus. Neither virus showed a significant reaction with PR8 (type A) nor FM1 (type A-prime) antiserum.

Comparative Data For Cases of Specified Reportable Diseases: United States

[Numbers after diseases are International List numbers 1948 revision]

Disease	Total for week ended—		5-year median 1946–50	Seasonal low week	Cumulative total since seasonal low week		5-year median 1945–46 through 1949–50	Cumulative total for calendar year—		5-year median 1946–50
	Jan. 20, 1951	Jan. 21, 1950			1950–51	1949–50		1951	1950	
Anthrax (062)	3			(1)	(1)	(1)	(1)	4	1	2
Diphtheria (055)	85	149	252	27th	3, 209	4, 791	7, 087	302	520	729
Encephalitis, acute infectious (082)	11	13	8	(1)	(1)	(1)	(1)	25	35	22
Influenza (480–483)	2. 097	4. 563	4, 585	30th	20, 276	43, 495	49. 077	5, 734	12, 965	12, 965
Measles (085)	9, 020	4, 329	5, 490	35th	50, 278	31, 449	39, 697	21, 577	12, 319	13, 573
Meningitis, meningococcal (057.0)	116	106	100	37th	1, 280	1, 186	1, 186	319	273	266
Pneumonia (490–493)	1, 511	2, 274		(1)	(1)	(1)	(1)	4. 744	6, 746	
Poliomyelitis, acute (080)	164	116	69	11th	32, 668	41, 834	25, 036	449	363	239
Rocky Mountain spotted fever (104)				(1)	(1)	(1)	(1)		4	2
Scarlet fever (050)	2, 307	1, 649	2, 428	32d	21, 288	20. 745	29. 754	5, 597	4, 306	6, 844
Smallpox (084)		2	2	35th	11	12	30	3	4	9
Tularemia (059)	18	32	32	(1)	(1)	(1)	(1)	46	83	87
Typhoid and paratyphoid fever (040, 041) [2]	35	46	46	11th	3, 051	3, 487	3, 520	136	114	117
Whooping cough (056)	1, 890	2, 192	2, 192	39th	26, 808	27. 547	30, 919	5. 206	6. 011	6. 011

[1] Not computed.
[2] Including cases reported as salmonellosis.

Reported Cases of Selected Communicable Diseases: United States, Week Ended January 20, 1951

[Numbers under diseases are International List numbers, 1948 revision]

Area	Diphtheria (055)	Encephalitis, infectious (082)	Influenza (480–483)	Measles (085)	Meningitis, meningococcal (057.0)	Pneumonia (490–493)	Poliomyelitis (080)
United States	**85**	**11**	**2,097**	**9,020**	**116**	**1,511**	**164**
New England	**3**	**2**	**6**	**251**	**5**	**77**	**5**
Maine			1	6		14	
New Hampshire			2		1	1	
Vermont				80			
Massachusetts	3	2		149	2		4
Rhode Island				7	1	4	
Connecticut			3	9	1	58	1
Middle Atlantic	**8**	**2**	**6**	**1,842**	**24**	**158**	**25**
New York	5		[1] 4	538	6	41	18
New Jersey		1	2	301	5	61	3
Pennsylvania	3	1		1,003	13	56	4
East North Central	**4**	**2**	**39**	**1,795**	**18**	**160**	**13**
Ohio	1		11	363	11		2
Indiana	1		27	68		16	2
Illinois	2			362	6	82	3
Michigan		2	1	284		62	5
Wisconsin				718	1		1
West North Central	**5**	**1**	**20**	**668**	**10**	**25**	**5**
Minnesota	1		1	58	3	4	
Iowa	1			5		2	
Missouri	2		7	282	5	2	2
North Dakota			11	16	1	5	
South Dakota		1		15			1
Nebraska							2
Kansas	1		1	292	1	12	
South Atlantic	**26**		**733**	**487**	**18**	**228**	**24**
Delaware				10			
Maryland	2		1	12	1	38	1
District of Columbia				33	2	30	
Virginia	4		454	132	4	98	2
West Virginia			171	15	5	24	
North Carolina	8			91	2		2
South Carolina	9		67	5	1	18	3
Georgia	2		40	171	3	20	8
Florida	1			18			8
East South Central	**7**		**306**	**533**	**14**	**45**	**6**
Kentucky	3		1	382	1		
Tennessee	2		43	74	5		2
Alabama	2		250	6	4		3
Mississippi			12	71	4	45	1
West South Central	**21**	**2**	**682**	**1,762**	**16**	**686**	**22**
Arkansas	3		515	231		66	1
Louisiana	6	1	3	172	1	40	5
Oklahoma	3		164	109	2	36	5
Texas	9	1		1,250	13	544	11
Mountain	**2**		**285**	**586**	**1**	**73**	**9**
Montana	1		54	11			1
Idaho				34			
Wyoming				23			
Colorado			27	334		18	6
New Mexico	1		2	28		7	
Arizona			202	101		48	2
Utah				55	1		
Nevada							
Pacific	**9**	**2**	**20**	**1,006**	**10**	**59**	**55**
Washington	4		4	512	2	8	9
Oregon			6	34	1	23	5
California	5	2	10	550	7	28	41
Alaska			1			1	
Hawaii						2	1

[1] New York City only. *Anthrax:* New Jersey, 2 cases; Pennsylvania, 1 case. *Psittacosis:* Illinois, 1 case.

Reported Cases of Selected Communicable Diseases: United States, Week Ended January 20, 1951—Continued

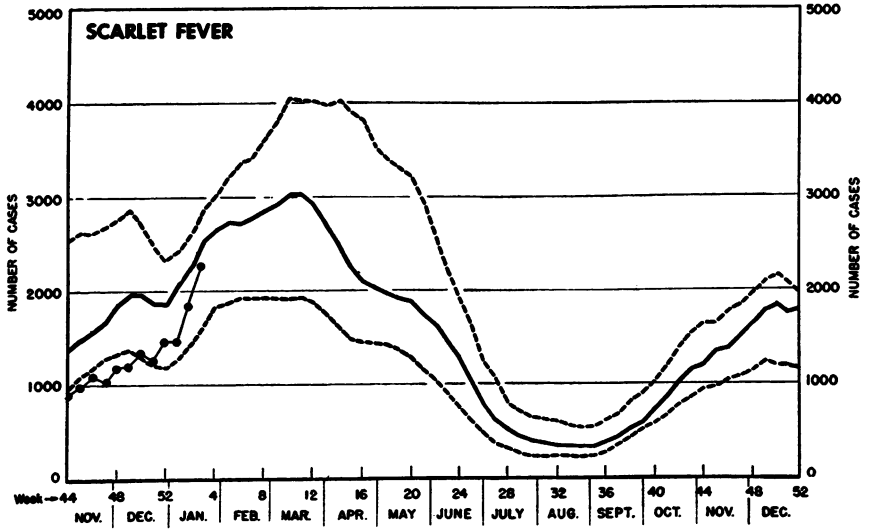
[Numbers under diseases are International List numbers, 1948 revision]

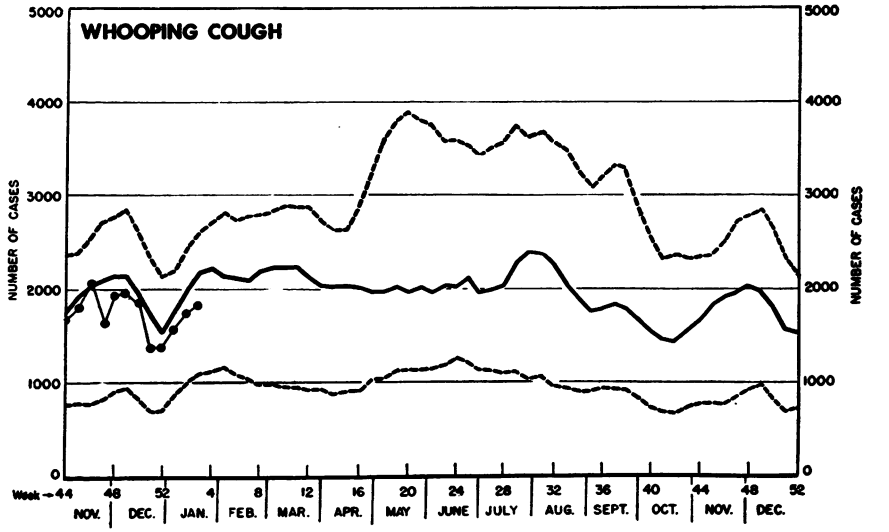
Area	Rocky Mountain spotted fever (104)	Scarlet fever (050)	Smallpox (084)	Tularemia (059)	Typhoid and paratyphoid fever [1] (040, 041)	Whooping cough (056)	Rabies in animals
United States		**2,307**		**18**	**35**	**1,890**	**127**
New England		**199**			**1**	**250**	
Maine		9				70	
New Hampshire		7					
Vermont		3				60	
Massachusetts		157			1	61	
Rhode Island		2				35	
Connecticut		21				24	
Middle Atlantic		**456**			**8**	**409**	**17**
New York		[2] 253			3	134	16
New Jersey		40			2	128	
Pennsylvania		163			3	147	1
East North Central		**510**		**2**	**1**	**310**	**15**
Ohio		146			1	37	4
Indiana		45		1		23	
Illinois		86				25	
Michigan		193				153	9
Wisconsin		40		1		72	2
West North Central		**130**		**3**	**5**	**78**	**15**
Minnesota		29				30	3
Iowa		5		1	1	3	12
Missouri		43		1	2	11	
North Dakota		3				5	
South Dakota		4			1	2	
Nebraska		5			1		
Kansas		41		1		27	
South Atlantic		**215**		**6**	**3**	**227**	**19**
Delaware		5				8	
Maryland		32				25	
District of Columbia		14				11	
Virginia		46		3	1	44	1
West Virginia		17				52	
North Carolina		67			1	62	
South Carolina		1				5	9
Georgia		20		3	1	15	6
Florida		[2] 13				5	3
East South Central		**128**		**4**	**3**	**67**	**23**
Kentucky		41				7	12
Tennessee		67		1	2	24	2
Alabama		10				33	7
Mississippi		10		3	1	3	2
West South Central		**138**		**2**	**3**	**293**	**36**
Arkansas		6		1		15	5
Louisiana		10				1	
Oklahoma		30		1		21	1
Texas		92			3	256	30
Mountain		**197**		**1**	**3**	**182**	
Montana		5		1		79	
Idaho		39				8	
Wyoming						6	
Colorado		23				18	
New Mexico		3			3	27	
Arizona		21				39	
Utah		[2] 106				5	
Nevada							
Pacific		**334**			**8**	**74**	**2**
Washington		117				25	
Oregon		25				2	
California		[2] 192			8	47	2
Alaska						6	
Hawaii		3				1	

[1] Including cases reported as salmonellosis. [2] Including cases reported as streptococcal sore throat.

Communicable Disease Charts

All reporting States, November 1950 through January 20, 1951





The upper and lower broken lines represent the highest and lowest figures recorded for the corresponding weeks in the 5 preceding years. The solid line is a median figure for the 5 preceding years. All three lines have been smoothed by a 3-week moving average. The dots represent numbers of cases reported weekly, 1950–51.

FOREIGN REPORTS

CANADA

Reported Cases of Certain Diseases—Week Ended December 30, 1950

Disease	Newfoundland	Prince Edward Island	Nova Scotia	New Brunswick	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	British Columbia	Total
Brucellosis							3			1	4
Chickenpox			12	2	77	538	52	63	69	59	872
Diphtheria					2						2
Dysentery, bacillary						6				6	12
Encephalitis, infectious								1			1
German measles	1		8	1	5	55		12	9	7	98
Influenza			15			2					17
Measles	16		12		73	1,055	87	51	12	10	1,316
Meningitis, meningococcal			2			4					6
Mumps	7		18		53	388	20	78	154	54	772
Poliomyelitis								1			1
Scarlet fever					39	63	7	4	57	37	207
Tuberculosis (all forms)				12	51	27	29	5	2	86	212
Typhoid and paratyphoid fever					2			1			3
Venereal diseases:											
Gonorrhea	5		9	8	47	41	20	12	35	51	228
Syphilis	2		2	4	13	17	2	4		3	47
Primary					3	3		2			8
Secondary						2					2
Other	2		2	4	10	12	2	2		3	37
Whooping cough	2		5	4	12	93	21		2	11	150

CUBA

Reported Cases of Certain Diseases—4 Weeks Ended November 25, 1950

Disease	Pinar del Rio	Habana		Matanzas	Santa Clara	Camaguey	Oriente	Total
		Habana City	Total					
Brucellosis					1			1
Cancer	2		37	14	24	8	12	97
Chickenpox						1	3	4
Diphtheria		3	8	5		1	5	19
Hookworm			13					13
Leprosy	1		4		1	3		9
Malaria	5	1	4	1	4	4	124	142
Measles		1	1				1	2
Poliomyelitis		1	2				1	3
Tuberculosis	2		19	11	11	19	7	69
Typhoid fever	7	7	22	4	13	6	28	80
Whooping cough			4					4

FINLAND

Reported Cases of Certain Diseases—November 1950

Disease	Cases	Disease	Cases
Diphtheria	90	Scarlet fever	3,548
Dysentery	3	Typhoid fever	4
Meningitis, meningococcal	10	Venereal diseases:	
Paratyphoid fever	65	Gonorrhea	554
Poliomyelitis	33	Syphilis	38

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

The following reports include only items of unusual incidence or of special interest and the occurrence of these diseases, except yellow fever, in localities which had not recently reported cases. 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

Burma. During the week ended January 13, 1951, 29 cases of cholera were reported in Bassein, compared with 8 for the previous week. For the week ended January 13, three cases were reported in Akyab.

India. For the week ended January 13, 1951, 41 cases of cholera were reported in Calcutta, compared with 52 for the previous week. During the week ended January 6, 41 cases were reported in Nagpur.

Smallpox

Dahomey. During the period January 1–10, 1951, 45 cases of smallpox were reported in Dahomey.

Egypt. For the week ended December 16, 1950, three cases of smallpox were reported in Suez.

India. For the week ended January 13, 1951, 294 cases of smallpox were reported in Calcutta and 33 cases were reported in Bombay. For the week ended January 6, 423 and 19 cases were reported in Calcutta and Bombay, respectively.

Iran. During the week ended January 13, 1951, eight cases of smallpox were reported in Iran, of which one was in Teheran.

Pakistan. Four cases of smallpox were reported in Karachi for the week ended January 13, 1950.

Yellow Fever

Colombia. Two fatal cases of jungle yellow fever were reported in Puerto Lopez, Territory of Meta for the period December 17–25, 1950.