State of the Nation's Health Services

By Leonard A. Scheele, M. D.

Surgeon General, Public Health Service

As public health administrators, we are increasingly aware of the impact of the Nation's mobilization effort upon our own jobs. We must be alert to the possibility of enemy attack—hence we must devote time and energy to the planning and development of emergency health and medical services for civil defense. Younger members of public health staffs are being drawn into military service. We are called upon to release at least a small portion of our personnel to international health programs. At the same time, the impact of military and industrial expansion for defense is adding to our problems of civilian health. The needed build-up of community health and hospital facilities may be delayed by shortages of materials, supplies, and personnel.

Our health agencies—Federal, State, and local—are struggling with all these problems in an inflationary period. While costs are rising, we are having to operate on somewhat static budgets. In most cases, increases have been slight. No one has yet found a way to make 50 cents do a dollar's worth of work. Even to hold the line at our present level of services, health programs must have budget increases commensurate with increased costs. And to meet the new responsibilities which face all of us, we must have even larger increases in funds.

Our official health agencies are not in a good competitive position to recruit and hold the qualified personnel we require. In the light of the changing economic situation, adequacy of pay and attractive conditions of employment are of paramount importance. The authorization of salary increases is not enough; appropriations must be made to pay for these increases so that the scope of services will not have to be curtailed in order to meet the necessary higher rates.

Maximum utilization of employees' skills by appropriate placement, training, up-grading, and constructive supervision is a must during the coming year. The increased use of administrative, technical, and subprofessional personnel for tasks that do not require full professional training is one means of meeting the shortages. More effective personnel management alone will not meet the basic need for a real increase in the supply of trained persons. However, it should at least free professional staffs for tasks which only they can perform.

Another dilemma of the health agencies is that graduates from basic professional schools do not come to us prepared for public health work. We are not only unable to attract enough recruits, but the personnel we employ usually must be oriented to their jobs and frequently given specialized training in preventive medicine and public health methods before they are fully useful.

The problems of training cannot be solved by the professional schools alone. All of us—Federal, State,

By law, the Surgeon General is required to convene annually "a conference of the health authorities of the several States." The fiftieth conference met in Washington the last week of November 1951. In attendance were the State and Territorial health officers and the State mental health and hospital survey and construction authorities.

An important purpose of the annual conference is to permit the State health authorities to be brought up to date on important national developments in the public health fields. Two general sessions—sponsored jointly by the Public Health Service and the Children's Bureau—were devoted to this purpose.

The fiftieth conference heard from Dr. Scheele on the state of the Nation's health services, and from Mr. Staats on the dollars and cents of health. Dr. Eliot spoke of the children, Mr. Ewing of the aged. Drs. Jones and Potts considered the heart, Dr. Knutson the teeth. The impact of defense mobilization was considered by Dr. Mountin, Mr. Pond, and Miss Arnold. And the implications of malaria infections among servicemen returning from Korea were reviewed by Drs. Myers, Andrews, and Coatney.

Public Health Reports here presents several of these papers in shortened form, and others as news-type summaries.

and local agencies—have a responsibility within our own organizations to develop good training programs if we are to have health manpower with the kinds of skill and experience our programs require.

Partnership and Morale

The Public Health Service and the State and local health departments have a long history of partnership. With the advent of grant-in-aid programs in 1935, we began to create and perfect a kind of teamwork—a mechanism, if you will—that really works. Much more is involved in this relationship than money—much more than the transfer of Federal funds to State treasuries—much more than the increasingly complicated administrative procedures. These business problems plague us all, but as custodians of public funds and public trust, we must accept them.

What is involved is a way of working together as technical experts for the solution of public health problems which affect the entire population. I am bold to say that the people of the United States would lose more in health protection if the teamwork of national, State, and local agencies—voluntary and official—were disrupted, than if all the Federal health grants were wiped out tomorrow.

And yet there comes the suggestion that the States can go it alone in public health work. That there is no need—or less need—for Federal assistance and cooperation; that there is too much Federal action. The complaints are familiar to all of you.

The objective of the Public Health Service is, and will be, to increase the self-reliance of State and local health agencies. If our policies and procedures seem to disregard that objective, if any member of our staff forgets it, the channels are wide open to bring the facts to our attention.

I cannot, however, visualize our Federal, State, and local health agencies getting their respective jobs done effectively without each other's help. It is to the advantage of all of us—and more important, to the health of the American people—that we maintain our working relationships.

The winds of conflicting opinion are high these days. Differences may be political or professional or both. If public health people are to discharge the public trust invested in them, they cannot afford to bend before every partisan blast.

Public health has won and held its place in our democratic society by its single-minded devotion to the public interest. I regret to say that some of us occasionally yield to the temptations put forth by various groups, in the hope of winning a temporary or a personal advantage. In so doing, they are destroying the cause for which they and all the rest of us are working.

This is the time of all times when each and every one of us must stand firm for the principles and concepts of public health. More than ever, public health workers and the practitioners of medicine can and should work side by side with common understanding and purpose. Let it be said of us that "after the whirlwind, the still small voice"—the public interest—has informed and guided our every action.

Adjusting Programs to Needs

The Nation's public health organization is in a period of adjusting programs to needs. Everything seems to be coming at health agencies at once. With one hand, we try to keep up with scientific and technological advances in our traditional programs. With the other, we try to cope with the new problems: health of the aging, chronic disease control, rehabilitation, mental health services, and so on. We are in process of engrafting more individualized services into a program that has been broadly impersonal.

In some areas, we have developed a complementary relationship with the medical profession which makes it possible for the health agency and the private practitioner to carry out their respective functions with little difficulty or friction. If a case of diphtheria occurs, for example, the physician reports it to the health department; the department takes a culture for diagnosis and if need be provides at public expense the antitoxin for the patient and toxoid for susceptible contacts. The physician proceeds to treat his patient, and the health department follows up with another culture before the patient is discharged. In the meantime, the department will have conducted an epidemiological investigation and taken action to prevent spread of the disease. Everyone has known what to do, what to expect, and what the objectives are.

At the present time, we do not have as fully developed a complementary relationship with the medical profession in our programs for heart disease control, cancer, and mental illness. Yet such a relationship can be developed—and should be.

Emergency Resources

The Public Health Service has been working closely with the Health Resources Advisory Committee of the Office of Defense Mobilization—commonly known as the Rusk Committee. We not only have assigned personnel to the committee on a full-time basis, but have undertaken several studies for them to provide the factual bases of planning and programing.

One such study of vacancies in State and local health agencies has pointed up the fact that the numbers of vacant budgeted positions do not provide a full expression of total needs. On the basis of recommended minimum staffing requirements for local health departments operating a limited program, it appears that there are wide discrepancies between vacant positions and actual needs. In our regions II, V, and IX, for example, the number of additional public health physicians needed is 3½ times greater than the number of vacancies. If all local health departments were brought up to the minimum standard of 1 public health nurse per 5,000 population, more than 10 times as many additional nurses would be needed as are indicated by vacancies. The corresponding figure for sanitation personnel is 3½.

The future of public health in a long-term mobilization period de-

pends very heavily on our estimates of need for personnel. If we base such estimates on a narrow view of our responsibilities, our chances of maintaining adequate health manpower will be lessened. The Public Health Service has recommended to the Rusk Committee that some detailed field studies be made for the purpose of re-evaluating the standards now generally in use. Such studies should provide data upon which to base realistic estimates of need.

The Rusk Committee has recently appointed a committee to coordinate the National Blood Program—another field in which health agencies are vitally concerned. The committee is headed by Dr. G. D. Cummings, director, division of laboratories, Michigan Department of Health, and includes representatives of the Department of Defense, the American National Red Cross, the Public Health Service, and the Federal Civil Defense Administration. A small group of specialists in this field will advise on the procurement, allocation, and use of blood and blood derivatives, basic research and clinical testing of blood derivatives and extenders, establishment of standards, storage, reserve, and transportation.

The research and development program now operating in and through the National Institutes of Health will help to solve some of the basic problems which hamper the preservation of blood and the production of blood extenders. We operate on a very limited budget, however, and there are only a few research teams in the country sufficiently well trained to evaluate the effectiveness of the methods employed to preserve blood. Hence, progress may be slow. An immediate need is for the States to come forward and do their share with the Federal and voluntary agencies in the establishment and maintenance of standards for the Nation's blood banks.

The development of sound medical and public health services which can be called upon with assurance for civil defense is of the utmost importance. Certain requirements of civil defense depend primarily on basic public health functions which must be developed, improved, and expanded—regardless of whether we avert war, or whether we must meet it head on next week, or in 2 years or 10 years.

Public Health in Civil Defense

An active, well-planned epidemic intelligence service is one of these first requirements. To achieve an adequate epidemic intelligence service, we need a more efficient nation-wide system of morbidity reporting, a network of laboratories to collaborate in microbiological research and detection of infectious agents, and a field service to assist in the practical control of epidemics or outbreaks of unusual diseases.

Special conferences and discussions have been held during the year on the new plan for morbidity reporting. The plan goes into operation on January 1, 1952.

A coordinated regional laboratory and epidemic intelligence service has been developed by the National Institutes of Health and the Bureau of State Services during the year. If the regional laboratory and epidemic intelligence service are to be of maximum use, especially in emergencies, the State health departments and the Public Health Service staffs will have to develop close coordination and effective teamwork. I hope that this program will be functioning at peak efficiency by the close of the current fiscal year.

Civilian Health Requirements

Still another field of major importance is the strengthening of our Nation's health and hospital facilities. The Public Health Service is claimant before the Defense Production Administration for all health supplies and equipment and for construction of all hospitals, excluding military and veterans' facilities. The problem in civilian health requirements of most immediate concern relates to the allocation of controlled materials for the construction of hospitals and health facilities. In the area of health supplies, we are in a somewhat better position at the moment. Under the Controlled Materials Plan, the Defense Production Administration receives requests from all the claimant agencies, on a quarterly basis, and then proceeds to allocate to them quantities of steel, copper, and aluminum to be used in their respective fields.

The task which confronts the Public Health Service is to determine priorities for the allocation of a limited supply of materials to hundreds of construction projects. Here we turn to the State health and hospital agencies for assistance. We are depending upon you to assist the project sponsors in preparing their requests and to furnish them consultation on the conservation of critical materials. Then, we would like to have you collect and analyze data concerning the requests for construction, appraise the projects with reference to their potential contribution to health and medical care needs in relation to the defense effort, and make recommendations to the Service regarding the essentiality of the projects. Only on the basis of such first-hand information and judgment can the Public Health Service carry out an equitable determination of priorities for scarce materials.

Facilities and Services

Perhaps no other recent event is of such immediate interest to health agencies as the approval, on September 1, of the Defense Housing and Community Facilities and Services Act of 1951 (P. L. 139, 82d Cong., 1st sess.). The law places additional—but not unfamiliar—responsibilities on the Public Health Service and State health and hospital construction agencies. The provisions which directly concern us are similar to those of the Lanham Act of World War II.

In the administration of this program, the Public Health Service will turn to the State agencies as we have in the past. We expect to use the services of the State sanitary engineers to the fullest extent possible. When and if appropriations are made under Public Law No. 139 for hospital construction, we shall turn to the State health and hospital agencies. Funds are available only for water and sewage treatment plants and interceptor sewers within the range of operation of the Public Health Service program.

Mobilization requires a tremendous output of the Nation's physical, mental, and spiritual energies. We must use more fully and more efficiently the capacities of our older citizens and of the handicapped. The development of our chronic disease control programs, occupational health, and rehabilitation services is of the utmost importance. As new programs related to the health and greater productivity of the Nation come into being, our Federal, State, and local health agencies must be at the forefront—ready and willing to take on their share of new responsibilities in a positive way.

America's enormous material resources are but the product of her human resources. The martialing of the Nation's power against the threat of aggression is dependent—utterly dependent—upon the physical, mental, and spiritual vigor of the people. The Nation's health services—official and voluntary—were created and are maintained to contribute to the vigor of each individual. A narrower view of our goal and our mission will only lead to failure in the hour of crisis. Our long-standing alliance for the health of the American people leads me to believe that our organizations together will take the leadership in the efficient operation of programs that seem difficult to groups less skilled in the ways of public health and teamwork.

Dollars and Cents of Health

Health and Hospital Programs In the Federal Budget

By Elmer B. Staats

Assistant Director, Bureau of the Budget

In the field of public health the three levels of Government—local, State, and Federal—are engaged in an extensive cooperative enterprise, providing health services which contribute toward the common goal of better health for the individual, the family, and the community.

In the scale of values of the American people, health is recognized as a basic resource, essential for immediate military security as well as for our longer-term economic growth, social development, and individual well-being. Since the fiscal year 1946, expenditures by the United States Public Health Service alone have expanded from a level of $118 million to an estimated level above $300 million for the present fiscal year of 1952. This rapid increase has occurred in a period when other imperative needs are straining the fiscal resources of the Nation.

Outlines of Federal Budget

Before discussing with you the current status of Federal hospital and health programs, I should like to indicate briefly the broad outlines of the Federal budget. Of expenditures totaling approximately $70 billion in this fiscal year, about $60 billion, or 85 percent, are required solely to meet the needs of our national security programs, the interest on the national debt, and commitments for veterans' services and benefits. This means that for the current fiscal year, only about $10 billion is included to finance most of the domestic or civilian activities of the Government, and even within this segment of the budget, less than two-thirds is subject to reallocation or reduction through the normal budgetary process. Much of it is committed for meeting such relatively fixed and predetermined obligations of the Government as the contributions to retirement funds for railroad workers and Government employees, the recurrent postal deficit, and subsidies to merchant shipping. This part of the budget provides also for practically all the $2.7 billion of grants to State and local governments under existing laws. Moreover, this $10 billion for civilian domestic programs includes numerous items which have direct and obvious relationships to the defense effort, including defense power projects, internal security, and protection of harbors and ports. Yet, paradoxically enough, this is the area against which the charges of "big Government" are most frequently hurled. This is generally the area where those who would balance the budget usually direct their attention.

Postwar Problems

We emerged from World War II with a relatively large military program and new international responsibilities, both designed to preserve our national security in the uncertain postwar world. We emerged with a debt more than six times greater, costing us more than $5 billion annually in interest alone. We emerged with 15 million new veterans, many needing hospitalization and eligible for readjustment training and education benefits. These new and enlarged responsibilities created a large new hard core for the Federal budget—four times greater than it had been a decade before.

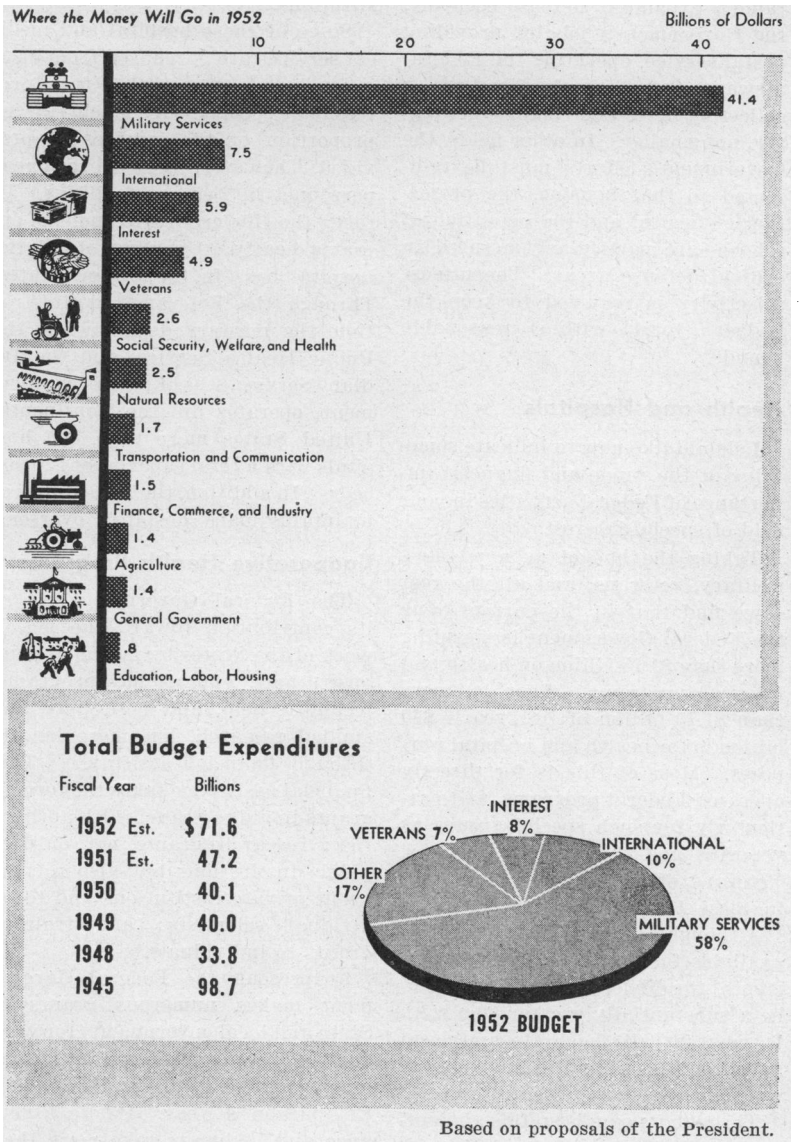
We emerged also from a period during which our domestic programs had been virtually closed down. Our economy had been expanding, science

and technology had made tremendous strides, and our population had grown, but during these years we had been building up an ever-increasing backlog of needs—needs for more housing, for improved highways, for increased medical research and training, for new natural resource developments, for more adequate measures of social welfare and security.

One of the great problems facing the Federal Government during the postwar years has been the achievement of a balanced domestic program within the limited number of available dollars.

Furthermore, that problem has been immeasurably heightened, not lessened, since the outbreak of the Korean conflict and the immediate steps taken to expand our armed forces and our mobilization base. In July 1950, the President took steps to curtail, defer, or redirect the nondefense programs in the budget by calling upon all executive agencies to defer or curtail public works construction, to reduce credit activities, and to restrict Government purchasing. The Congress also, in the General Appropriation Bill for 1951 several months later, directed the Bureau of the Budget to reduce the appropriations voted in that bill by $550 million "without impairing the national defense." Under that directive, all Federal programs were carefully screened, particularly those in the construction field where there was particular competition for men, materials, and supplies. The Federal-aid hospital program was one of the programs slowed down.

1952 Budget for the United States



Based on proposals of the President.

Again today the outlook is not bright for any material easing of the restrictions applied to domestic programs. The momentum of the defense program authorized during the last two sessions of Congress is only now beginning to exert its full impact on budget expenditures. Since Korea the Congress has authorized appropriations totaling more than $170 billion. By the end of this fiscal year only some $100 billion of that total will have been spent. That means that we will enter the fiscal year 1953, next July 1, with billions of dollars of goods on order for which expenditures will be made in 1953 and later. These expenditures, together with those for pay and maintenance of our men in uniform, will cause direct defense and other national security expenditures to rise to a substantially higher level in the fiscal year 1953. Thus, even if we merely maintain our domestic expenditures at the same level in 1953 as in 1952, the total of Federal budget expenditures will exceed $80 billion. Even after allowing for the higher receipts arising from the Revenue Act of 1951 and a higher level of economic activity in the months ahead, we face a sizable and sobering deficit for 1953 and perhaps even beyond.

In referring to the limited funds available for civilian or domestic programs in the budget, I do not mean to imply that there is any fixed or arbitrary total available for these programs from year to year. Nothing could be further from the truth. Each individual program must be weighed and compared with a multitude of other programs in terms of its potential importance to the Nation as well as its short-run contribution to defense needs and essen-

tial civilian requirements. In our rapidly expanding defense economy, the Government's jobs of providing postal service, operating the Federal airways, patrolling the borders, or collecting taxes and customs get bigger, not smaller. In other fields, the Government's efforts must be redirected so that housing, the protection of health, and the operation of schools are particularly assured in critical defense areas. The utmost selectivity is required to keep the budget total within reasonable bounds.

Health and Hospitals

I should like now to indicate something of the range and financial importance of Federal activities in your field of special interest.

Taking the budget as a whole—military, veterans, and all the rest—we find that in the current year the Federal Government is spending more than $1.75 billion on health and hospital programs. That is, more than $1.75 billion of this year's $70 billion is for health and hospital purposes. Most of this is for directly operated Federal programs, and particularly for such special groups as veterans and the military services. Veterans, of course, are predominant in these Federal totals.

Although only a rough estimate is available for State and local governments, the Federal total appears to be a substantially greater sum than is spent by all the State and local governments on health and hospital programs, including mental care.

Through its own hospitals and outpatient clinics, the Federal Government provides medical services and hospital care that are available in some measure to more than 25 million people. Included in this eligible group are the 18.5 million war veterans; the 3.5 million officers and enlisted personnel of the Army, Navy, and Air Force, and certain of their dependents; 400,000 American Indians and the Eskimos and other natives of Alaska; some 2 million civilian Federal employees, in the event of injury or illness in line of duty; 100,000 American merchant seamen; 30,000 Coast Guardsmen and their dependents; 50,000 civilians in the Panama Canal Zone; and nearly 20,000 persons in Federal institutions.

Some of these hospital and medical services are purchased from local and private contractors or from professional people. A much larger proportion of the services is provided, however, by Government personnel in Federal facilities. In fact, the Federal Government operates nearly 20 percent of all the hospital beds in the United States. Through the Veterans Administration, the military departments, the Public Health Service, and the Indian Service, the Federal Government operates in the continental United States more than 500 hospitals with a total capacity of 220,000 beds. In addition, the Armed Forces maintains many hospitals overseas.

Cooperative Health Programs

The Federal Government makes its contribution toward the health work of the States by means of demonstrations, educational programs, technical help, and both pure and applied research, but more largely through financial assistance. This financial assistance takes the form of grants-in-aid to State health authorities; research grants not only to public institutions but also to nonprofit private institutions and to individual scientists; and training grants to individuals.

At present, the Federal Government makes numerous grants to State and local governments for various kinds of governmental activities, amounting for all purposes to about $2.7 billion a year. Public assistance and highways take more than 60 percent of the grants, and the remainder is distributed under 44 separate grant programs. There are 10 separate grant programs directly in the field of health, including not only the hospital survey and construction program, on which Federal expenditures in the current fiscal year may exceed $150 million, and the general health grants to States, amounting this year to $14 million, but also five programs directed to specified categories of disease—venereal disease, tuberculosis, heart disease, cancer, and mental illness. Other grants are provided for maternal and child welfare (administered by the Children's Bureau), disease and sanitation control in Alaska, and water pollution control. For the current fiscal year, grant expenditures under the 10 health programs are estimated at $233 million.

Closely related to these health grant programs are selected phases of some other Federal grant programs, such as civil defense contributions of medical supplies and equipment to State and local governments and direct Federal expenditures for procuring and stockpiling additional medical supplies and equipment. Another defense-related grant program in the health field was authorized at the last session of Congress for the provision of community facilities and services in critical defense housing areas. An appropriation of $4 million was voted to cover, during the fiscal year 1952, the functions and duties of the Public Health Service with respect to health, refuse disposal, sewage treatment, and water purification, as well as other functions of the Federal Security Agency in these critical defense areas.

The vocational rehabilitation, school lunch, and public assistance grant programs also have health and medical aspects, but I have not included these programs among health grants.

The Role of Federal Grants

Without entering into an evaluation of each of the 10 health grants, several general observations may be made about Federal grants-in-aid generally which might point the way toward basic improvements of Federal policy for the health grants.

The role of the grant-in-aid in our governmental system is often misunderstood. The grant is often described as an instrument of centralization. Actually, it is a partnership arrangement. In fields where it is practicable, the Federal grant stands midway between direct Federal operation with complete Federal financing of a service at one extreme, and complete State (or State and local) financing and operation at the other. As a cooperative device, the grant helps to preserve the vitality of our Federal system of Government.

Inequalities are bound to occur

between the needs of the people of a State or local community for governmental services, on the one hand, and the ability of that area to finance those services from locally available taxes, on the other. Some States can support a high standard of public service with a low tax rate; others have to skimp on services despite high tax rates.

The Federal grant-in-aid helps to reduce somewhat these interstate inequalities. The basis and the justification for a Federal grant is that there is a national interest in the services being financed. In contrast, a complete separation and sharp division of tax sources and functions between the Federal and the State governments, such as is occasionally proposed, would constitute, in effect, a denial of any national interest in the services to be rendered by the States. In the field of health and in such other fields as highways, public assistance, and education, the existence of that national interest cannot be denied. The need, therefore, is for policy in the use of grants-in-aid which will give proper recognition to the appropriate contributions of the Federal and the State levels of government.

To serve national objectives effectively at reasonable cost, each grant needs to be so distributed that the share for each State will reflect its need for the particular service and also its capacity to finance the minimum level of service from its own taxable resources.

At the same time that the Federal grant provides national assistance in financing a service, it leaves to State or local governments actual administration of the program. Thus the State has—or should have—a substantial measure of discretion in adapting the program to local needs and customs. The States do, of course, operate within a framework of broad national policies for the grant program. But within these policies the States decide how far to go with a particular program, and they determine the day-to-day content and quality of the operations.

Grant-in-aid programs have sometimes been too narrowly defined; that is, their content and direction in some cases have been too precisely and specifically set forth in Federal law or regulation. When federally aided programs are defined too narrowly, the State may have no direct incentive to economy and efficiency in the use of Federal money, since any savings it makes on the aided program ordinarily are not available for other use by the State.

This problem of overly narrow grant categories is particularly present in the field of health. It creates difficulties in budgeting, but even more important, it may hamper flexible and efficient administration by State and local officials. At the outset, a narrow definition of purpose may be adopted because a particular disease is the subject of special public concern or because of a widespread belief that a concerted, dramatic, Nation-wide effort on a cooperative basis may conquer the disease. But laws and programs tend to stay on the books and continue in operation even after needs have changed. The use of broad categories instead of narrow, selective ones permits the redirection of money and effort as needs change. Particularly, it permits individual States and communities to adjust their current programs to new conditions, including the possibility that a successful attack on a particular disease may actually reduce the need for the specific categorical grant in varying degrees in different areas.

New health problems created by the defense effort especially point up the desirability of flexible budgeting and programing for health services. It may be that limitations contained in some Federal grant statutes are interfering with that reorientation of activities which will assure highest priority to the needs of the defense effort.

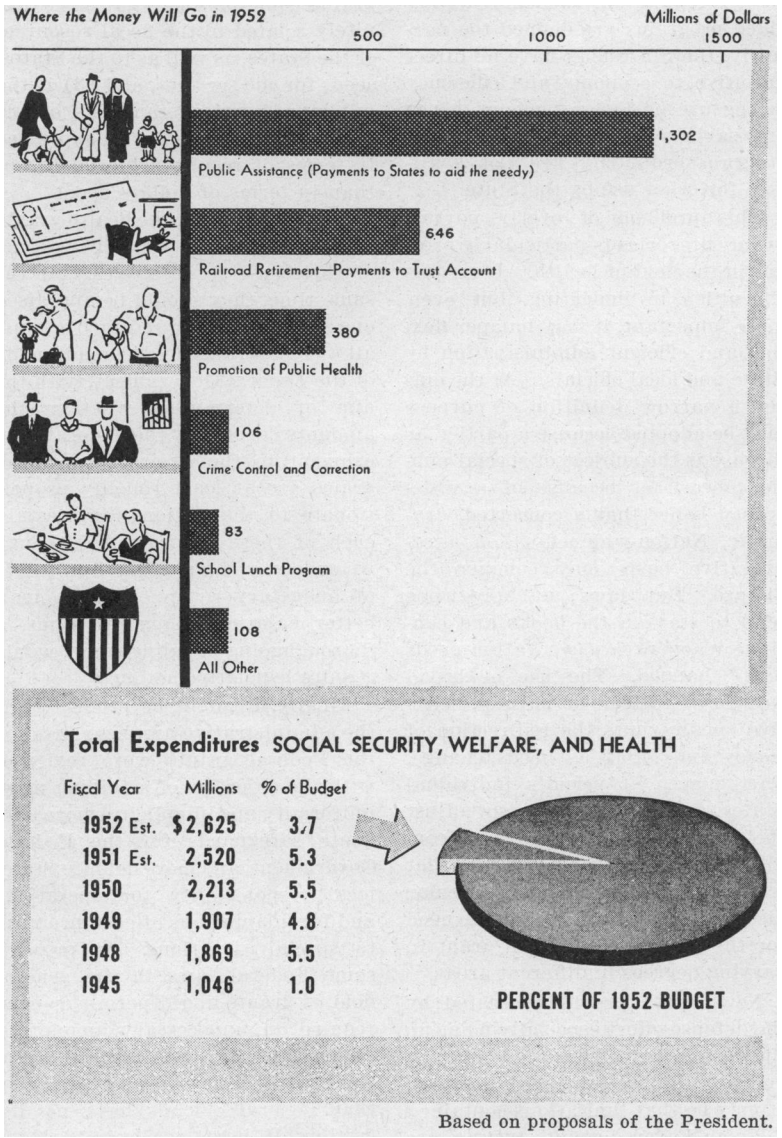
These considerations raise the question whether it might be timely to undertake a complete and systematic review of all the Federal grants for promoting health, reconsidering the scope or subject matter of each program, and the conditions attached to the grant. Possibly the grant-in-aid system for health would be more effective and economical if certain basic changes were made—for example, (1) if existing piecemeal programs were consolidated into broader programs, (2) if the grants could be somewhat more definitely related to the fiscal resources of the States, as well as to the States' needs for the services, and (3) if the minimum service standards or objectives could somehow be expressed in terms of results achieved rather than in terms of dollars spent.

In such a review, the health grants might well be re-evaluated in terms of their specific objectives. At the same time, they should be appraised one against another and each against all the programs and commitments of the Federal Government, with the aim of determining whether the amounts devoted by the Federal Government to the several grant programs are at least roughly proportionate to the national interest in each of these programs. Although we endeavor in the normal processes of budgetary review to promote a better balance among programs, a thoroughgoing realinement would require legislative action.

Finally, it might be productive if the administrative arrangements for the Federal grants were reviewed with the objective of attaining more uniformity and simplicity, more adequate safeguards for the Federal Government, and more definite State-local responsibility for operations and for adaptations of each program to special situations. At present, some Federal laws in the general field of grants-in-aid permit or even require an unnecessary amount of Federal interference in State operations, while others are so restrictive that Federal officials have no discretion. I have not examined the health grants closely enough to know whether they now exhibit such variations. But, in general, it can be suggested as a good principle that the Federal administrator should have enough authority to make sure that the national interests are protected, but not so much authority that coercion is substituted for cooperation.

Uniformity among Federal grant programs is by no means an end in itself, since the purposes of the grants and the conditions under which they must apply are themselves varied. But sometimes there are procedural variations between

Federal Budget for Social Security, Welfare, and Health, 1952



Based on proposals of the President.

laws which entail extra cost and introduce complexities without serving major purposes. If such differences exist in the health grants, they might well be identified and corrected as one result of a comprehensive review.

The kind of review I am suggesting would look toward the long-run improvement of the entire Federal program in the field of health grants. Its principal results, therefore, would presumably be reflected in legislation and administration, but the conclusions of any such study would have a direct bearing also upon the programing and budgeting of health activities, both for the long run and from year to year.

Budgetary Outlook

I indicated earlier that I would try to comment on the implications of our present budgetary outlook for Federal health and hospital programs in 1953. The general objective which guides our current review of budget requests for 1953 is that the over-all size of the budget—which means the aggregate use of goods and services by the Government—shall be held to the minimum level that will assure adequate national defense, an expanding volume of essential production, and a strong and stable economic system for the Nation. The detailed recommendations in the 1953 budget, to be transmitted to Congress in January 1952, will have to be grounded on this basic purpose.

To make the general policy effective, certain specific rules have been spelled out. For example, new civil public works construction projects will be recommended only if they contribute to meeting defense needs. Similarly, other new activities will be restricted to those which contribute directly to defense or toward sustaining a continued defense economy and military effort. Moreover, all existing programs are being reexamined in the light of the unprecedentedly heavy peacetime demands of national defense and international security. The broad implications for public health programs may be summarized in this way:

First, the expansion of basic health programs of the Federal Government will be limited to those contributing directly to national defense.

Second, the States should continue their efforts to reorient health programs to needs arising from the emergency. In our governmental system, public health is basically a State and local responsibility, and it is through the State and local health services, whether assisted by Federal funds or not, that the Nation will have to meet the challenges created by the defense emergency.

Third, it seems inevitable that the continued growth and development of health services that might have been possible under more favorable conditions will be slowed down considerably. This is one of the many serious losses that we have to sustain in these troubled times.

Need for Program Review

The last decade has witnessed a great expansion not only in the direct Federal programs serving specific groups, but also in the cooperative Federal-State programs in the field of health. At this time, we need to re-evaluate the whole range of

these governmental health programs, to be sure that they are the right programs for today's needs, that they are economically and effectively administered, that they add up to a balanced program in the local communities and States and for the Nation, and that our health services as a whole are in proper proportion to other essential services. Such a reevaluation is difficult, but it is necessary. Under our system of government, all public programs quite properly must undergo constant and complete reconsideration. It is important that this reappraisal be based on informed judgment as to needs, objectives, and available resources.

Above all, whether as budget makers, professional workers in the field of health, public administrators and legislators, or just plain citizens, all of us have an interest and an obligation in this matter. Together we must see to it that the preservation and promotion of the people's health takes its proper place among our public objectives in this difficult period—this period when the attention and energies of the Nation are primarily devoted to meeting the urgent and unavoidable demands of national defense.

The Children

New Horizons for Child Health

By Martha M. Eliot, M. D.

Chief, Children's Bureau

The States have every right to be satisfied with the way the infant mortality rate for the Nation has been reduced from 100 deaths per 1,000 live births in 1915 to 29 in 1950. To some nations around the world where infant mortality rates are 10 times as high, this is a phenomenal record. But those of us who are close to the situation in this country know how much more we could do to reduce even this figure of 29. There are areas in our country where the rate is twice the national average. In 1949, this rate was 63 percent higher for nonwhite than for white babies. Babies are dying needlessly in many places, particularly in the Southwest and Southeast.

To save more babies, we will have to work on many fronts, not all of them strictly in the field of public health. The health officer and his staff of nurses and sanitarians will need the help of such special health and allied workers as health education specialists who can help in community planning, nutritionists who can advise on food for both mother and child, medical social workers and child welfare workers who are especially skilled in helping families with their social problems, teachers who can work health education into their courses wherever appropriate, economists and social scientists to interpret the problems related to income and cultural patterns.

Causes of death associated with premature births are still responsible for a third of the infant deaths occurring in the first year of life. In the last 20 years we have cut nearly in half the proportion of all reported deliveries ending in fetal death, but even now the rate of fetal deaths remains at about 2 percent of deliveries.

Much more research is needed if we are to get at the causes of premature birth and fetal death and, therefore, to be better able to prevent them. We already know from studies that mothers who have good diets during pregnancy have fewer premature deliveries than mothers who have poor diets.

It is good to know that in 1950 only 7 mothers died in childbirth for every 10,000 live births, compared with 58 in 1939. But we cannot take pride in the fact that the rate for nonwhite mothers is more than three times what it is for white mothers. Nor is mere survival all that we want for mothers. Every mother should come through her maternity experience with abounding health, both physical and emotional.

The great reduction, since the last war, in the number of days that mothers stay in hospitals raises some new problems. What happens to mothers who go back to their housework 3 or 4 days after delivery? This is something that needs study. Should we not examine our maternity facilities and see if they are as simple and flexible as is compatible with maternity care of high quality?

Much needs to be done, too, to improve standards of care in maternity and children's hospitals. Hospital practices should be examined to make sure they do not unnecessarily create emotional problems but do contribute positively to the emotional as well as the physical health of both mother and child. The growing interest in rooming-in arrangements is one sign of an improved attitude toward the mother's and the infant's psychological needs.

For many years one of the major tools of the maternal and child health program has been the child health conference. Its original purpose was, of course, to reduce infant mortality. Today, the work of the child health conference is directed more toward helping parents with normal everyday problems in the growth and development of their children. It is time we should ask whether the child health conference is still an effective tool for this purpose. Does it need revamping? What staffing patterns are desirable today? These are things that need study.

In recent years much progress has been made in evaluating health services for the child of school age, both the services within the school itself and those provided by the community. The new statement sponsored jointly by the National Council of Chief State School Officers and the Association of State and Territorial Health Officers on "Responsibilities of State Departments of Education and Health for School Health Services" will certainly help to focus attention on how these services can go forward. The Federal Security Agency Committee on Health Services for School-Age Children, on which the Public Health Service, the Office of Education, and the Children's Bureau are represented, is about to issue a publication called "Better Health for School-Age Children." It includes practical suggestions on how communities can figure out for themselves which things most need doing.

Health Services for Children

As communities give more careful and inclusive consideration to the problems of providing day-care centers for children of working mothers, foster family care, adoption services, institutional care, and services for juvenile delinquents, they are sure to find that health services and medical care are essential to well-rounded programs in these fields. It is my understanding that State and local health agencies are cooperating increasingly with State and local education and welfare agencies, with State youth authorities, and with law enforcement agencies, such as the juvenile courts, on the physical and mental health aspects of their programs. But only a beginning has been made. In many institutions for children, including training schools for delinquent boys or girls, health services are inadequately provided. In this connection, may I remind you that funds for maternal and child health and crippled children's services may be used to assist other State and local agencies in developing adequate health and medical services for children and young people coming within their scope.

Undoubtedly the Mid-Century White House Conference on Children and Youth did much to stimulate widespread consideration of the multi-professional approach to the needs of children and increased cooperation among public and voluntary agencies. In many States committees on children and youth will continue to provide the opportunity for such joint planning. State and local health agencies can do much to stimulate the work of these committees.

Handicapped Children

With respect to the State programs for care of crippled children, I believe that you have reason to be gratified by recent developments. The improvements are of many kinds. All together, 215,000 children were cared for in 1950, an increase of 18 percent over the number the year before. Although children with orthopedic conditions still make up a large proportion of the total number treated under the State programs, it is heartening to see the way State agencies are broadening their programs beyond orthopedic services to include care for many different kinds of handicapping conditions.

Epileptic children are among the most recent to be included in crippled children's programs. Services for these children offer a very good example of the importance of close teamwork between health services and the community. To develop better community understanding and to train more workers in this field, two States are assisting medical schools in providing courses for physicians, nurses, social workers, and others. As workers are trained, services for epileptic children can expand.

Some States are doing fine things for children with impaired hearing. So much can be done for these children now that was never possible before. Already a few States are assisting universities to train more audiologists.

A vast majority of the 175,000 children with cerebral palsy can benefit enormously from skilled assistance, but so far as anyone can tell only a fraction are now getting it. About a dozen State agencies have developed comprehensive programs for these children, usually geographically limited, but they include physician's care; physical, occupational, and speech therapy; medical social services; public health nursing; and special teaching arrangements. Comprehensive programs such as these are needed in many other States.

At present, 26 State health departments and crippled children's agencies have programs for the care of children with rheumatic fever. The fact that so many States have undertaken to demonstrate care shows how wide the interest in this is. As you know, it is now the policy of the Children's Bureau gradually to withdraw from these programs the funds that have been especially reserved. However, it is hoped that States having these projects will carry them on and expand them by seeking State funds as well as by using some of their regular Federal funds.

Regional Programs

New methods of diagnosis and treatment are being developed on all sides. One such development is in the field of congenital heart disease. Not every State has the highly trained surgical and pediatric specialists needed to give care to children with this condition. So that States without facilities can refer their children to an outstanding center nearby, a regional program has been developed. Connecticut has set up the machinery for the first of such regional programs. California will probably be next. When the nationwide planning is complete there should be five or six such regional programs strategically placed so that children with congenital heart disease in every State in the Union may have access to specialized diagnosis and surgery.

This device of pooling resources on a regional basis has large promise, too, for the care of children with other types of handicaps which call for highly skilled treatment, such as cleft lip and palate. It also has great significance for other types of regional planning: for example, the establishment and use of education and training programs; the sharing of special consultants; and the use

of special diagnostic and treatment facilities by two or three States.

Cutting across all phases of both the maternal and child health and crippled children's programs is the question of recruiting and training more and better personnel. This, I believe, is the number one problem in advancing child health work.

We need a long-range plan of work with universities and colleges, with schools of medicine, nursing, and social work, to recruit personnel to enter the child health field. Joint planning between undergraduate and graduate schools is necessary. Undergraduate curriculums should be developed to attract new students to prepare themselves for graduate work. Economic, racial, and sex barriers will have to be broken down. Pay and working conditions will have to be made more attractive. More funds will have to be made available to enable educational institutions to strengthen their faculties with competent teachers in maternal and child health and in the related fields.

Professional schools are realizing the need for including instruction on child growth and development to give all types of workers with children the newer concepts of physical, mental, and social health. New recruits to the field of child health must be as sensitive to the emotional needs of children as they are to their physical management.

Second only to a satisfactory program of recruitment and training is the research necessary to obtain new facts on which new or modified programs can be based, and to evaluate the progress, quality, effectiveness, and cost of on-going work. Increasingly, State agencies are becoming interested in studying and evaluating their own programs. Within its resources the Children's Bureau stands ready to assist and to advise on ways and means of making such evaluations.

The strength of the Children's Bureau and its greatest value lie in the fact that our concern is with all of child life and that we work across the board with the States on all the health and welfare aspects of this business of growing up. As long as I am with the Bureau I shall no doubt keep on reminding you that you can't split up a child; that children with health problems also have social and emotional problems; that children who are neglected, delinquent, and dependent also have health problems. I shall probably keep hammering away, too, on the old theme that all professions working with children should know about the way normal children grow if they are to do a good job either with normal or sick children. I shall urge constantly close teamwork between all professions working with children.

Older Citizens

Aging—Weakness or Strength?

By Oscar R. Ewing

Federal Security Administrator

The changing age distribution of our population is emerging as an overriding challenge of our time. It is a challenge to all of the social sciences; certainly to public health.

By and large, the later years do not fulfill the promises that we traditionally attach to them. In all too many instances, instead of bringing fulfillment of hopes they are barren and empty. In a nation still fundamentally oriented to youth, older people become bewildered, confused, and insecure.

Even if the world were at peace with itself, this would present a major challenge. Against the backdrop of the greatest test that this country has ever had to face, it becomes a matter of deep national concern.

The United States is stronger today than ever before in its history, but the demands upon it have increased accordingly. How much stronger we shall have to become to stand up to the trials ahead no man can say.

This much, however, seems clear: Not one of us can take an easy breath until every segment of our society is in a position to put forth its full quota of productive effort—and that includes the older members of our society.

Whether our older citizens become a national asset in the trial of strength that we are now in, or whether they become a serious drain on our economy could well make the difference between success and failure in the times ahead.

I should like to suggest that one of the most important things that we have to do at this point is to re-examine our attitudes, as a people, toward our older citizens.

We have fallen into the habit of judging the worth of people by the number of birthdays they have had. Ultimately, I suppose, the calendar rules our lives. But it can play tricks on us, if we let it.

Can Play Tricks

This habit of looking at a person's age instead of at the person is, it seems to me, but part of a larger tendency which is somehow characteristic of these days and times—that is, the tendency to throw everything into the discard which is old, simply by reason of its age, and to admire and respect that which is

new, simply by reason of its newness.

That applies not only to material things; unfortunately, it applies to some extent also to people.

I venture to say that the discarding of people who for one reason or another have gone out of "style" represents today our greatest single national waste; that a reversal of this attitude would point the way toward development of our greatest single idle asset.

Revision of Attitude Needed

We don't have to wait for a big formal program to revise our attitudes toward the phenomenon of aging. We can start doing something about it now.

Let me be a little more specific.

A good many people go into the discard every year, not through their own choice but through forced retirement—in many instances, years before their productive capacities have been exhausted or even seriously impaired.

They are shunted off by society into the valley of lost men—not because they have nothing more to contribute to society and to their own happiness but simply because the earth has made so many revolutions around the sun since they were born.

This alone constitutes a serious loss to society.

A companion problem is that represented by the uncounted numbers of perfectly capable men and women who, for one reason or another, find it necessary to seek new employment relatively late in the period of life that we call the working years—when they are 45, say, or 50. Many companies will not even consider the applications of persons 45 or over. But even if the employer doesn't have a set rule about it, age is a handicap. Regardless of the applicant's real abilities, his judgment, his experience, his emotional stability, his wisdom even, he is under a cloud—simply by reason of having lived so long.

In addition to these very considerable groups, there are the thousands upon thousands of workers—or would-be workers—whose capacities have clearly been changed by age but who, given the right encouragement, the right guidance, the right tasks, the right working environment could be productive and useful members of society but who, in the absence of these things, slip little by little into the discard.

Actually, in a good many jobs older workers not only perform as well as younger, less experienced workers—they perform better. . . .

Finally, there are the ever-increasing numbers of older people who, through apparent or real disability, are forced to eke out the remainder of their days in mental institutions, hospitals, and nursing homes—burdens to themselves and burdens to society. There is a growing realization, and some significant evidence, that a good many of these unfortunate people can be cared for better—even, perhaps, less expensively—in their own homes, in foster homes, under the family-care plan, or in residence clubs.

The large components of the older population that I have cited represent but a few examples of the problem of aging. I recognize, too, that they are vastly oversimplified examples.

I don't suppose we have ever been confronted with a problem that has crossed so many professional boundary lines or that has so deeply involved our social and economic institutions. What the older members of our population do with their time is not a matter of concern to them alone; it is a matter of concern to all society.

It seems to me that the key to this whole situation is simply this: Let us make up our minds to go to work on this problem with what we now know and with the resources that we now have. In other words, let's start from where we are.

We need not wait until we have all the answers. While there is much that we do not yet know, many things about the phenomenon of aging are already clear. Among other things, some myths about the aging process already have been exploded. We know, for instance, that older people *can* learn new things. And we know that while the aging process does impair certain of our capacities, it can actually strengthen others. In short, we know enough to be doing much more than we are now doing in this whole area, both as individuals and in our official capacities. And believe me, I include myself in that.

Public Health Should Lead

Certainly no program on aging, whether it be Federal, State, or local, can be entirely successful without the full and active assistance and the leadership of the public health profession. Yet I would hazard the guess that there are many significant activities relating to aging going on in your own States and your own communities which have not so far had the benefit of that counsel and leadership.

I suspect that there is not a person here who in a few minutes could not come up with a list of several things that could be done within his present program which would contribute significantly to the betterment of conditions for older people.

Perhaps it would be nothing more than talking about aging and its problems with some of the people who come to see you in connection with other health matters, and with State and community leaders with whom your work brings you in touch. I hardly need to point out that a good many important programs have started just as simply as that.

Perhaps it would be a re-examination of the laws of your State which directly or indirectly affect older people. It goes without saying that not all our State laws are geared to the changes that are taking place in the age distribution of our population.

Perhaps it would be the establishment of closer working relationships with institutions, agencies, and organizations which have to do in one way or another with older people—infirmaries, nursing homes, adult education centers, community centers, and recreation groups, to name a few of the more obvious ones. It should be pointed out in this connection that, in Public Law 734, the Congress has placed specific responsibility on health and welfare agencies for supervision of old-age homes,

nursing homes, and infirmaries. And it is worth noting also that already in 15 States, public health authorities are working with nursing home operators on the establishment of standards for these institutions.

Certainly, any such list ought to include making a little extra effort to keep up with the rapidly growing body of knowledge about older people themselves, their hopes and fears, their weaknesses and their strengths. This should be a must for everyone in the public health professions.

Once we understand the problem in its true perspective, we will find ways to put our knowledge to work. If we believe that the problem of our older people is in part a matter of attitude—if we agree with Shakespeare that "there is nothing, good or bad, but thinking makes it so"—then, I am sure we will be on the right track.

The Nation needs its older people. The need for their combined strength, their experience, their judgment, their wisdom will become more and more urgent as time goes on. It is urgent now. Each of us—each according to his individual capacities—has an obligation to himself and to his country to do his part in this great human undertaking.

There is not one of us here present—and let me emphasize again that I include myself in that—who cannot start tomorrow—today—to do more than he is now doing to turn what *could* become a great national liability—our older people—into one of our greatest national assets.

Health in Defense Impact Areas, I

Inventory of Health Needs

By Joseph W. Mountin, M. D.

Chief, Bureau of State Services, Public Health Service

The Public Health Service, during both World Wars I and II, assisted States and communities to meet emergency needs. This was done by strengthening health organizations around military installations, by improving facilities for the prevention and control of epidemics, and by giving special attention to industrial and other groups important in the war effort.

We are now confronted with a situation similar in many respects to the period preceding World War II. In preparation for the special needs, the Public Health Service, a little over a year ago, established in the Bureau of State Services a unit known as the Special Projects Branch. This branch has three major purposes: (1) to assemble data on developments and needs in critical areas; (2) to act as a focal point for the collection and dissemination of information on defense-impact activities; and (3) to assist the divisions of the Public Health Service in carrying out their regular and special programs as they relate to defense work.

Area Surveys

Our first objective is to obtain basic data for critical areas and to devise a mechanism whereby health problems in these areas might be anticipated in advance of their development. Specifically, the purpose of the inventories is threefold: First, to gain a clear understanding of the nature and extent of the health problems which these communities will have to face when the defense program swings into high gear; second, to evaluate the resources available locally for dealing with the problems; and third, to determine what additional resources in the way of manpower, physical facilities, and health organization may be necessary.

We are studying the situation in three types of critical areas—military, industrial, and target. Most of the areas which have been surveyed exhibit two or more of these characteristics; they also contain interdependent population groupings. Beginning with a training camp, for example, we have surveyed not only the areas immediately surrounding the camp, but also communities within commuting distance. Such an area might have additional military installations, industrial plants, and large-scale housing developments. The surveys have covered existing facilities for health and medical care, water supplies, sewage disposal, refuse collection, housing, hospital beds, health organization, and special health problems.

To date, some 97 military areas have been studied and evaluated. Over half of these appear to warrant further attention from the standpoint of public health. More recently, over 100 industrial localities have been surveyed; these are now being evaluated.

In general, the surveys have shown: (1) an acute shortage of public health personnel in critical areas; (2) lack of essential physical facilities, especially hospitals, health centers, improved and extended systems of water supply, and refuse and sewage disposal; (3) a need for improved sanitation of eating and drinking establishments; (4) a need for safe milk supplies; and (5) housing facilities in many areas that present public health problems. In this connection, it should be noted that there is a growing number of trailer camps, especially in areas adjacent to military installations. Many of these trailer camps are substandard and constitute a health problem of some magnitude, particu-

larly where they are located in unincorporated places.

Two points should be stressed in connection with these surveys. First, the problems are of the same general type that normally confront health departments. However, they are intensified because of the lack of personnel to cope with them and because of the urgency of the need. Second, the critical areas are by no means fixed or static. Our military and industrial establishment is growing, and an area which is not critical today might well be an important problem spot tomorrow.

Some New Services

The Public Health Service has also expanded existing activities relating to defense and has developed certain new programs. These activities are designed primarily to augment the services of State and local health departments. In the past year, for example, approximately 50 venereal disease investigators were assigned, through the States, to areas where Army, Navy, and Air Force installations are located. These investigators are conducting interviews in the camps and follow-up case-finding activities in surrounding areas, in cooperation with the health departments involved.

Our expanded epidemiological services are designed to help meet new health problems in critical areas and to perfect a mechanism which would be available immediately to spot and arrest epidemics, both natural and man-made. The service consists of at least four important elements: effective reporting; provision of epidemiologists for on-the-ground study; laboratory diagnostic services; and personnel to institute control measures. We are concentrating now on tightening and improving the disease reporting system.

For example, it is most important that we know promptly of any unusual rise in the incidence of malaria. While the necessity of reactivating an extensive malaria control program is not anticipated, there has been some increase in this disease, occurring mainly among troops returning from Korea. Through effective epidemiological intelligence and through alert surveillance, the problem can be closely watched, and more vigorous control measures can be instituted as circumstances warrant.

In order to help State and local health departments investigate outbreaks of disease, a corps of medical epidemiologists is being recruited, intensively trained, and attached to Public Health Service field stations for immediate deployment to areas of need. An initial staff of some 20 young epidemiologists in training has already been assigned to this program; further expansion is anticipated in the future.

The Public Health Service has also furnished consultation and assistance on specific health problems important in the defense effort. Among these are fly and other insect and rodent control measures around military and industrial areas.

Mobilization and speedy industrial expansion often create new hazards to the health of industrial workers, especially when new substances and materials are used. The Public Health Service has been studying particular industrial situations, such as the mining and milling of uranium ore and the production of jet fuels, with a view to correcting or eliminating the industrial hazards involved.

In an effort to relieve shortages, but more especially to develop additional competencies on State and local health department staffs, refresher training programs have been expanded at the Communicable Disease Center and at the Environmental Health Center in Cincinnati.

Gaps to be Filled

Perhaps the weakest link in our efforts to meet health defense problems is the most important one—the basic local health structure. Unfortunately, there are still approximately a thousand counties without even the most rudimentary organization for the provision of local health services. Many more have only skeleton staffs; hence are equipped to furnish only limited services.

The Community Facilities and Services Act authorizes the development and construction of necessary physical facilities. When appropriately implemented by funds, this measure should furnish a mechanism for providing physical facilities important to health. The term "services" as mentioned in the act appears to be limited to the ordinary operating requirements of such facilities. Other measures will be required to meet the needs for general public health activities.

Supplementary appropriations under the Community Facilities and Services Act did not include funds for hospital construction. However, a request for funds for this purpose—based on current survey data—will probably be made in the near future. It is well to remember that appropriations obtainable under this act are intended for use only where Hill-Burton funds are not available.

In addition to filling the gaps in our general health organization, it is necessary to build the structure for planning the health and medical aspects of civil defense. It is axiomatic that we cannot have an alert system ready to spring into immediate action in the event of attack unless we carefully plan and prepare such a system. The health department's chief need here, again, is for the personnel to plan and follow through on the civil defense measures which are assigned to them.

Other important needs are for occupational health services, especially in small industrial plants producing critical defense materials, and for programs of health maintenance and rehabilitation for older people.

Pending Proposals

Some of the gaps can be closed by a redirection of effort and by increased attention to problem areas. Others call for concerted action on a community basis. Several proposals are now pending which would help localities alleviate some of their critical needs.

For example, in the last session of Congress, the Local Health Services Bill was amended to pinpoint health needs in defense areas and to strengthen services and programs in these areas. Favorable action on this bill was taken by the Senate, but it has not been reported out of Committee by the House.

Increases in general health grants have been proposed, with the specific purpose of weighting these increases in favor of defense impact areas. This would make possible a concentration of effort in critical military, industrial, and target areas. Another proposal would authorize the Public Health Service to recruit, train, and assign personnel to areas requiring special technical assistance from the Federal Government. Recognized Federal-State channels would be maintained in providing this assistance.

Planning for defense calls for the closest kind of teamwork and cooperative effort. Joint planning at all levels of government will help build the foundation of sound health defense programs suited to these trying times.

Health in Defense Impact Areas, II

Planning for Community Facilities And Services Program

By M. Allen Pond, M. P. H.
Chief, Division of Engineering Resources, Public Health Service

The President approved the Defense Housing and Community Facilities and Services Act of 1951 (P. L. 139, 82d Cong.) on September 1, 1951. Limited funds to carry out the provisions of the act were contained in the Second Supplemental Appropriation Act of 1951, approved November 1, 1951. However, construction funds at present are available only for sanitary engineering works, and for streets and roads.

Responsibilities for the administration of the new community facilities program are divided between the Housing and Home Finance Agency (HHFA) and the Federal Security Agency. In Executive Order 10296 the President, on October 2, 1951, assigned to the HHFA the responsibility for programing, making loans or grants for, and (where needed) the direct Federal construction of all community facilities authorized in the act except hospitals, health centers, water-purification plants, interceptor sewers, sewage-treatment plants, refuse-disposal facilities, child day-care centers, recreation facilities, and libraries.

The responsibility for programing and making loans or grants for the latter facilities rests in the Federal Security Agency, and the Surgeon General of the Public Health Service is specifically responsible for that part of the program involving hospitals and health centers, water-purification plants, sewage-treatment plants, including interceptor sewers, and refuse-disposal facilities. The Housing and Home Finance Administrator must obtain the approval of the Surgeon General for all water-source development projects to receive assistance under the act, and he must consult with the Surgeon General on projects involving water distribution or sewerage systems.

The act provides not only for Federal financial assistance in providing facilities, but it also makes possible Federal financial assistance in the operation of community facilities. The legislative history clearly indicates that Congress did not intend that funds appropriated under this act should be used for the staffing of local health agencies such as was done during World War II under the Emergency Health and Sanitation Activities program. The loan and grant funds available to the Public Health Service can be used to assist in the operation only of water-purification plants, sewage-treatment plants, and refuse-disposal facilities.

Responsibility of HHFA

The Housing and Home Finance Agency is the Federal agency primarily concerned with the national housing program. It is the parent agency for the Public Housing Administration, the Federal Housing Administration (FHA), and the Home Loan Bank Board. Furthermore, the Community Facilities Service, formerly a part of the old Federal Works Agency, somewhat more than a year ago was transferred to the Office of the Administrator of HHFA.

Criteria For Critical Areas

Responsibility within HHFA for its part of the community facilities program will rest in the Office of the Administrator and his regional representatives. There must be the closest possible relationship between the defense housing aspects of HHFA's program and the community facilities activities, especially as the latter involves water lines and sewers. HHFA regional representatives are responsible for both activities.

Within the Federal Security Agency the Assistant Administrator for Defense Activities coordinates all aspects of the Agency's community facilities program. In addition to the Public Health Service role, described more fully below, the Children's Bureau and the Office of the Administrator are concerned with child day-care centers and recreation facilities, respectively.

At present, the major function of the Office of the Administrator in connection with Public Law No. 139 involves representation on the Office of Defense Mobilization's Interagency Committee on Critical Defense Housing Areas, and its regional counterparts. Before Federal assistance authorized in Public Law No. 139 can be made available in a community, that community must be found to be a critical area for the following reasons: (1) A defense plant or installation must exist or be proposed; (2) substantial in-migration must have occurred or must impend; and (3) there must be a substantial shortage of housing and/or community facilities or services. In Executive Order 10296, the President placed in the Office of Defense Mobilization the responsibility for such determinations. Representation on the Interagency Committee is held by the Office of Defense Mobilization, Department of Defense, Economic Stabilization Administration, Federal Security Agency, Department of Labor, and Housing and Home Finance Agency.

Delegation of Responsibilities

Within the Public Health Service all operating responsibilities in the community facilities program have been delegated to existing organizational units. The Division of Water Pollution Control is responsible for the sanitary engineering aspects of the program, the field part of which will be directed by Public Health Service regional engineers. Although no funds are yet available for hospital or health center programing and construction under the terms of the new act, the Division of Hospital Facilities is carrying out essential planning functions at headquarters, and the regional hospital consultants are responsible for field work currently needed. Field contact by State and local health officials and hospital authorities with the Federal agencies on this program will be through the Public Health Service regional medical directors who are responsible for coordinating the various field activities within their respective jurisdictions.

All aspects of the Service's community facilities program, including the maintenance of liaison with the Housing and Home Finance Agency, are coordinated in the Office of the Surgeon General.

Loan Steps Listed

It might appear to be simpler—at least on paper—if one unit were responsible for all aspects of the program. However, by integrating this defense activity through existing operating units we are convinced that less violence will be done to our continuing programs than if a new organization were created.

What steps must be taken before loans or grants can be made for community facilities?

1. Responsible local public officials, usually the mayor, county commissioners, or common council, will make an official request to the chairman of the Advisory Committee on Defense Areas to have the community declared a critical defense housing area. Based on analysis of data submitted—and supplemental facts collected as needed—the advisory committee will make findings and recommendations for action by the Director of Defense Mobilization.

2. In an area found to be critical, the Housing and Home Finance Agency will program the construction by private enterprise of essential rental and sale dwelling units, relaxing regulation X to assist builders to proceed. (The act provides that no permanent public housing can be programed until the end of a waiting period of 90 days, and then only if it is clear that private capital cannot meet the housing shortage.)

3. A community in need of expanded facilities will ask HHFA or the Federal Security Agency for Federal financial assistance. First notice of the need for Federal assistance will probably come through personal inquiries or a letter from a responsible local official to the Housing and Home Finance Agency, the Federal Security Agency, or directly to the Public Health Service. At that stage we will request certain minimal information from the municipality before an application blank is furnished to it. The purpose of this is to make it possible for municipalities to save the substantial sums of money that would be required to file formal applications. Formal applications will be requested only if it appears on the basis of this preliminary screening that the community will qualify for Federal financial assistance.

4. Once application forms are submitted to the community, the Public Health Service regional medical directors will inform State health officers that the municipality is planning to make application for a loan or grant or for direct Federal construction, and will ask the State health agencies at that time to make recommendations with respect to the project in question.

5. Completed application forms will be sent to FSA (PHS) regional offices or those of HHFA where they will be carefully screened. Regional officials will then make their recommendations to headquarters for final action. With limited funds, it obviously will be necessary to handle applications on a priority basis.

6. When an application is finally approved, advances of funds will be made to the municipality which thenceforth will be responsible for carrying out the job. During the construction period, periodic inspections of the project will be necessary but primary responsibility for project inspection will rest with the community unless the job is a direct Federal construction operation.

Two Key Problems

Immediate problems associated with the inauguration of this program are numerous, but two stand out above all others. In the first place, there must be prompt determinations, with respect to priorities, of need for assistance in several communities where practically the only question is that Federal financial assistance must be made available forthwith. We are confronted with the question: Should we try to give token assistance in a large number of places, or should we assign priorities in terms of relative need in the defense effort? It is our considered judgment that Congress intended us to meet the real emergencies, which means that we must establish a list upon which com-

munities will be graded in terms of their relationship to the defense effort. In connection with establishing such a priority list, the advice of State health officers and their staffs will be of major importance.

The second outstanding problem that we see arises from the legislative history of the Second Supplemental Appropriation Act. At hearings last fall, Congress asked for factual information on needs of community facilities in critical defense housing areas. Studies are being made in those communities that appear to have the most critical needs, and information is being gathered on the other designated areas.

Health in Defense Impact Areas, III

Day-Care Services for Children Of Employed Mothers

By Mildred Arnold

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If the defense and mobilization effort continues for any period of time, the problem of caring for children whose mothers work may become an urgent one. This is an area where State health and welfare agencies can work together profitably.

The problem of day-care services for children of working mothers has been with us for many years. The Federal Government entered the picture for the first time in World War II when an unprecedented number of women entered industry. Over 3,000 day-care centers were developed during that war with funds appropriated under the Lanham Act. At the peak of this program, in 1944, these centers were caring for 105,000 children. During the entire history of the Lanham Act, over $51 million of Federal funds were used for this purpose.

Because of the limitations of that act, there never was a full program of day care. Federal funds could be used only for group care of children. Little provision was made for infants, and no resources were developed through Federal funds for foster-family day-care homes for very young children. Nor was it possible to use these funds to develop much needed counseling services to help mothers plan for their children. Following the war, practically the entire program developed under the Lanham Act disappeared.

Now we are seeing the same problems emerge as appeared during World War II. At the height of employment, 20.4 million women were working. Now there are 19½ million women in the civilian labor force. Some 10 percent of these women have children under 6 years of age. It is anticipated that an additional 1,400,000 workers will be needed in 1952, and a great many of these will have to be women because available labor from other groups is about exhausted.

Long Waiting Lists

Voluntary agencies and commercial centers are attempting to meet the present need for day-care services. Some voluntary agencies report waiting lists longer than enrollments. Fees charged by commercial centers are often prohibitive for many working mothers, and standards in many are low.

Possible Expansion

The Defense Housing and Community Facilities and Services Act (P. L. 139, 82d Cong.) authorizes Federal funds for day-care centers in critical defense housing areas, but no appropriation has been made either for operation or administration of day-care centers. If the problem becomes great enough to command Federal funds, I hope two things will happen: First, that we will have a much more adequate and well-rounded program than we have had in the past, one that includes not only group centers but also foster-family day-care homes for the very young child, and counseling services for mothers; second, in the development of any day-care program, I hope there will be a very close working relationship between health and welfare departments so that the entire needs of these children will be met.

Education Needed

At present, 27 States and the District of Columbia have laws relating to the licensing of day-care centers. Health and welfare agencies should work closely together in developing standards for the licensing of such centers and supervising these facilities. There should be close working relationships with educators, too, so that these centers do not become merely custodial places but provide sound education and training experiences for children.

As one boy once said, "I am just nobody's nothin'." While mothers are making their contribution to mobilization, we certainly do not want their children to feel that they are "nobody's nothin'."

MALARIA FROM KOREA

Army Giving Primaquine Treatment To All Returning Servicemen

Only one civilian case of malaria so far reported in this country is suspected of having been transmitted from Korean returnees, Lt. Col. Donald S. Myers, of the division of preventive medicine, Office of the Surgeon General of the Army, told the health authorities.

About 9,000 among the 145,000 American servicemen who had left Korea between July 1950 and mid-October 1951 were known to have malaria, Colonel Myers reported. Since it became apparent, in April 1951, that the military "had a problem on our hands," steps were taken to see that all returnees—irrespective of a malarial infection record—were given a preventive treatment course.

The preventive treatment series consists of a single dose of 1 gm. of chloroquine and 15 mg. of primaquine a day for 14 days. The chloroquine is given as soon as possible, the primaquine regimen is started whenever the servicemen reach an accessible port of embarkation in the Far East, and is continued aboard ship on the way to the west coast.

Experiments Started in 1945

Some of the background of primaquine was given on October 16, 1951, by Maj. Gen. George E. Armstrong, Army Surgeon General, when he announced that all servicemen returning from Korea would receive the new antimalarial drug.

Experimentation with primaquine dates from the end of World War II when it was included among many thousands of drugs marked for testing as antimalarial agents, General Armstrong said. Primaquine was first synthesized in 1945 by Dr. Robert Elderfield of Columbia University, working under a grant from the Office of Scientific Research and Development.

Commercial synthesis was first effected by Dr. Elderfield in March 1950, under a United States Public Health Service grant, the Army Surgeon General continued. Early toxicity and neuropathology studies of the drug were begun in December 1947 by Dr. Leon Schmidt of the Institute for Medical Research, Christ Hospital, Cincinnati, also under Public Health Service auspices.

Human toxicity studies and clinical investigations were begun in March 1948 among prisoner volunteers in Stateville Prison, Joliet, Ill., by Dr. Alf S. Alving of the University of Chicago, General Armstrong reported. Dr. Alving was assisted in his work by Army physicians and supported by a Public Health Service research grant. Subsequent research has been extended to the Federal Penitentiary at Atlanta. This work is under the direction of Dr. G. Robert Coatney of the National Institutes of Health, Public Health Service. It is a joint project of the Public Health Service and the Bureau of Prisons of the Department of Justice, and is financially supported by the Army Research and Development Board. The Army has also conducted an extensive project among malarious sections of Nicaragua, General Armstrong said.

Testing among military personnel began when twin projects were established at Fort Benning, Ga., and Fort Knox, Ky., to determine how effective the drug was in the treatment of the Korean strain of malaria, and also, General Armstrong noted, to investigate the possibility of undesirable side effects when primaquine was administered to healthy men engaged in normal activities. In October, 2,700 soldiers returning from Korean duty were administered the 14-day series, aboard transport, by Navy physicians of the Military Sea Transport Service.

General Armstrong said that the Fort Benning studies were supervised by Dr. Coatney, serving as a consultant to the Army Surgeon General. Dr. Alving initiated the Fort Knox tests, now under the supervision of Dr. Ralph Jones, Jr., of the University of Pennsylvania, and supervised the transport series.

During their annual meeting, the State and Territorial health authorities were brought up to date on the military, civilian, and research aspects of malaria control in light of infections and relapses developing among United States troops returning from Korean duty.

In August of 1951—following discussions in Washington among the Armed Forces, the Public Health Service, and the National Research Council—the Public Health Service advised State and Territorial health authorities and editors of medical journals of this potential hazard to civilian health, pointing up the need for diagnostic facilities, drugs and treatment schedules, and methods of preventing the spread of malaria. Even prior to this, however, work had been intensified by the Army and the Public Health Service on development of the new antimalarial drug, primaquine. In November 1951, Young and Burgess reported on the susceptibility of Anopheles quadrimaculatus to Korean vivax malaria (Public Health Reports, January 1952, pp. 14–16). On page 200 of this issue appears a chart showing the current trend in malaria morbidity in the United States.

In addition to the malaria reports, two condensations of reports on the heart and one on fluoridation are presented in the following pages.

Primaquine Not a Preventive

The Army Surgeon General emphasized that primaquine is not a preventive for malaria. Neither is it a substitute for chloroquine as a suppressant in malarious areas. Instead, he said, it is an effective therapeutic agent against malaria when the parasites which cause the disease have lodged in the liver or

other body organs. It is therefore expected that the serviceman who has been exposed to malaria will be cured before an attack of malaria or before relapses of the disease can occur.

Although field trials have been limited, it seems probable that malaria incidence in returnees to the United States can be sharply reduced with primaquine, General Armstrong felt. In addition, it should be possible to avoid relapses in cases where an acute attack has already taken place, he said.

General Armstrong said that the move to administer primaquine to all returning Korean servicemen had been endorsed by both the Subcommittee on Malaria of the National Research Council and by the Armed Forces Medical Policy Council. He predicted that the program being put into operation would prove effective but emphasized that further research would be necessary to determine finally the dose needed for the most rapid cure. Investigation of the drug is continuing at a number of Army posts and under Public Health Service auspices.

CIVILIAN CONTROL

Possibility of Malaria Endemicity Much Less Than in 1945–47

Reviewing the potential impact on civilian health of the introduction of malaria from Korea, Justin M. Andrews, Sc. D., of the Communicable Disease Center, Public Health Service, said that up to late October there had been some 5,127 cases of malaria reported from all the States except New Hampshire and Vermont.

About 70 percent of these were military cases, Dr. Andrews noted. Of the 1,233 civilian and unknown cases, about half have been appraised by State and Federal epidemiologists, and 424 were found to be parasite-positive cases. Almost all of the cases were *vivax* infections.

Dr. Andrews said that most of the military personnel who were not under military supervision when they had their attacks or relapses sought treatment from private clinicians. He estimated that only about half of the cases which have occurred, according to military records, have been reported through civilian health channels.

Even so, a number of authorities have agreed, according to Dr. Andrews, that the possibility of re-establishing malaria endemicity now is not great in comparison with the situation of 1945–47 when more than 100,000 infected persons with symptoms of malaria returned from overseas to the United States.

"This and subsequent influxes of malaria-parasitized personnel can be contained without the re-establishing of malaria endemicity," Dr. Andrews maintained, (1) "if blood from suspected cases is examined in competent laboratories to determine whether or not it is malaria parasite positive"; (2) "if patients believed to have malaria are treated energetically with effective antimalarials"; (3) "if cases are reported promptly to local health authorities"; (4) "if these cases are investigated and appraised epidemiologically"; and (5) "if in cases found parasite positive DDT spraying or mosquito-proofing is done on all premises within a mile of the home of these persons."

Dr. Andrews pointed out that the systematic investigation and appraisal of reported or other suspected cases of malaria, and the entomologic and spraying activities carried on around confirmed cases is known as the malaria surveillance and prevention program.

It was Dr. Andrews' belief that "this procedure, if faithfully followed, will prevent the establishment once more of malaria endemicity of this country. The States and the Federal Government have invested something more than $50 million between them in malaria control and eradication since 1942. Proved malaria as a public health problem has disappeared—and in some States the malaria eradication criterion of the erstwhile National Malaria Society has been fulfilled. Laxity in preventing the return of this disease after so much has been accomplished would be costly and disastrous."

MALARIA RESEARCH

Primaquine 15 mg. for 14 Days Cures "High Percentage"

The new antimalarial primaquine in a dose of 15 mg. daily for 14 days has cured "a very high percentage of relapsing Korean *vivax* malaria" cases, G. Robert Coatney, M. D., of the National Microbiological Institute, Public Health Service, reported.

Dr. Coatney described primaquine (SN 13,272) as an 8-aminoquinoline compound which belongs to the pamaquine (plasmochia), pentaquine, and isopentaquine group of compounds, the members of which differ only in the characteristics of the terminal amino group.

Primaquine was first tested against malaria in men by Alving and his coworkers in 1948, who have shown that on an equal weight basis primaquine is approximately four times as active as the best of the other members of the group, and the

toxicity on a quantitative basis is about equal.

However, Dr. Coatney pointed out, there was not by the winter of 1950 sufficient information to allow for the use of the drug on a large-scale basis. This was the situation when an ad hoc committee of the National Research Council met to discuss the status of antimalarial drugs, with a forward look as to what might be needed as a result of the Korean developments.

It was decided then (December 29, 1950) to bend research efforts toward the complete documentation of certain 8-aminoquinolines in terms of their military application. Work has gone forward, Dr. Coatney said, at the University of Chicago installation at Joliet, Ill., and at Atlanta, Ga.—the work being spread out because one installation working by itself could not turn out the data in the time allotted.

In addition to toxicity studies, it was decided to evaluate three regimens in the treatment of relapsing cases at Fort Knox and Fort Benning. Tests were later made aboard transports returning from Korea. On the basis of these studies it was concluded, Dr. Coatney said, "that it was practical and safe to administer primaquine at 15 mg. single dose daily for 12 or more consecutive days to men of different races."

DENTAL HEALTH

Tasks of State Health Departments In Developing Fluoridation

At the present rate of progress in the fluoridation of public drinking water supplies it will take 150 years to complete the task ahead, John W. Knutson, D. D. S., chief, Division of Dental Public Health, told the State health authorities.

There are approximately 16,750 public water supplies in this country, of which some 15,000 do not contain natural fluorides. At present, 138 of these 15,000 communities have controlled fluoridation programs. However, only 80 of them started their programs within the last 12 months, Dr. Knutson reported.

Ninety-three percent of all public water supplies are in communities of 10,000 population or less, he pointed out, which means that in 9 out of every 10 cases a trained water works engineer probably will not be operating the local plant. This is of importance to State health departments, said Dr. Knutson, for they will have to provide dentists and engineers to participate in public discussions of fluoridation and to establish on-the-job training or training centers for water-works operators. They will also have to be a source of competent technical advice to help communities solve installation and operational problems. Dr. Knutson felt that this was an unusual opportunity for State health departments to offer an important service unit to virtually every community in the State.

The basic minimum fluoridation staff, according to Dr. Knutson, would include at least one dentist, one sanitary engineer, one chemist, and one subprofessional technician. They would be occupied to a large extent with training local personnel and in assisting them in getting ready for the fluoridation job.

Tasks For Staff Dentists

Dr. Knutson outlined the following jobs on which an additional staff dentist is needed to assist the State dental director in laying the groundwork and establishing a smooth-running fluoridation program:

1. Collect, analyze, and organize all scientific data relating to controlled fluoridation, and maintain a current file, including background material, technical bases of operations, results of pilot projects, types of fluoride-feeding equipment, fluoride compounds available for use, and costs.

2. Supervise the development of education materials for dentists, other professional personnel, and the lay public.

3. Encourage the dentists of each community to plan and schedule a meeting of local dental, medical, and other professional health personnel to discuss all aspects of fluoridation and consider the formulation of recommendations for its use.

4. Encourage and assist representatives of local service organizations in planning and scheduling meetings for public discussion of water fluoridation and provide for the participation of informed dental and other technical personnel.

5. Provide for a preliminary survey of the community's water supply so that useful estimates of equipment needs and costs can be made available for use at meetings scheduled for discussion of fluoridation.

6. Provide expert technical services to communities which have formally decided to fluoridate their water supplies.

7. Provide expert advisory and emergency services to communities after fluoridation has been initiated and as operational, fluoride-testing equipment, and supply problems arise.

8. Provide for the collection of baseline data on dental caries so that a periodic evaluation of the effects of fluoridation can be made in each community. Promote the use of standard record forms and provide advisory services relating to the processing, analysis, and utilization of the data collected.

9. Coordinate all promotional efforts relating to fluoridation and assume responsibility for establishing and maintaining a close and effective working relationship with the sanitary engineering and laboratory divisions of the Department.

Other Services Needed

Without essential chemical and engineering services, the fluoridation program can be seriously ham-

pered and delayed, said Dr. Knutson. He listed the following as services which the additional personnel should be able to provide:

1. Chemical analysis of the drinking water supply, including fluoride determinations.

2. Study and analysis of sources and capacity of water supply, consumption rates, purification methods, types of distribution systems, and population trends.

3. Determination of the point in the water-processing system where fluoride compounds can be added most effectively and efficiently, the compounds most suitable, the type of fluoride-feeding equipment to be installed, and the effectiveness of proposed controls for maintaining the proper fluoride concentration.

4. Determination of storage facilities necessary for maintaining an adequate supply of the fluoride compound and the needs for auxiliary equipment to insure adequate protection of operators who handle the fluoride compound.

5. Determination of points in the distribution system where samples should be collected for testing, and training water-works personnel to make tests for determining fluoride concentration.

6. Specifications for equipment, approval of plans, and inspection of completed installations.

7. Orientation and training of water-works operators and personnel in the hazards of handling fluoride compounds, how the hazards can be eliminated, and how to feed fluorides properly.

8. Periodic determinations of fluoride concentrations at the State health department laboratory so as to check the results of tests made by local water-works personnel.

HEART DISEASE

Diagnostic and Surgical Services Suggested on Regional Basis

Cardiovascular surgery has reached a point where at least five types of heart defects present at birth can be corrected by the surgeon's knife, Willis J. Potts, M. D., chief surgeon of Children's Memorial Hospital, Chicago, and associate professor of surgery, Northwestern University School of Medicine, said in reviewing progress in heart surgery. He pointed out, however, that the diagnostician still played the key role in moving such patients along toward surgery and correction.

Need Central Services

Citing increasing survival rates, Dr. Potts underscored the need for further development of diagnostic and surgical services for children. While a heart surgery center in every city would not be feasible, he felt the establishment of regional centers in major universities and large clinical centers would provide a means for effectively bringing such skills within the reach of every patient who needed them. Such centers, he said, also would serve to maintain the interest and skills of the specialists.

Listing the diagnostician as most essential in the staffing of such centers, Dr. Potts stated that, in addition to congenital heart disease, the diagnostician should be familiar with rheumatic heart disease and functional murmurs, and should be able to differentiate operable from inoperable cases. Ideally, he said, the diagnostician should be a pediatrician, for murmurs and heart conditions in children may differ considerably from those in adults.

Obtaining suitable surgical skill by comparison is not too great a problem, he said. A well-trained surgeon can acquire more quickly the new surgical techniques than a physician can acquire the experience necessary for expert diagnosis.

A roentgenologist acquainted with heart disease and interpretation of electrocardiographic film (particularly in children) and an anesthesiologist who is also a physician and certified by the Board of Anaesthesiology were listed as other necessary team members.

Experience Cited

He stated his Children's Memorial Hospital team alone performed over 500 congenital heart operations, with the most common group that of patent ductus arteriosus (where the prenatal shunt has failed to close off at birth) and tetralogy of Fallot (involving a stricture of the pulmonary artery). The latter type is popularly known as the "blue baby."

Three other types of congenital defects corrected by his group are: (1) coarctation of the aorta (involving a narrowing of the principal artery); (2) the aortic ring (several types which include deformities of the aorta and its branches); and (3) pulmonary stenosis (malformation of the heart valves, also producing a "blue" effect).

"In the approximately 168 cases operated upon for patent ductus by us, we have had no deaths," he reported. "The blue babies, however, represent an altogether different problem. In the children below 3 years of age, operated upon because they cannot live without surgery, the mortality continues at about 22 percent.

Low Mortality Rate

"In approximately 200 cases between 3 and 16 there have been only 4 deaths, or a mortality of a little over 2 percent. If the child can reach the age of 3 years, his chances of surviving surgery for pulmonary stenosis are approximately 97 percent."

Dr. Potts cautioned that not all such heart defects are amenable to surgery. Two out of five "blue babies" had to be turned away by his surgical team because operating technique has not advanced to a stage where their defects can be corrected.

Community Requirements for Developing Heart Programs

The difficult task of translating our present knowledge of the heart diseases into action presents a challenge and an opportunity, declared T. Duckett Jones, M. D., medical director of the Helen Hay Whitney Foundation.

Tracing a history of significant events in the heart disease field, Dr. Jones stated that a strategic position in progress in community heart programs has been reached. To the fund of knowledge already available, research is rapidly adding new knowledge. Also, important general recommendations have been formulated as guiding principles in the development of control programs.

Integrated Approach

Dr. Jones noted four viewpoints common to planning and advisory groups in both public and private programs at the national level which he felt offer great reassurance to those developing community heart programs and to citizens in general. First, he said, there has been no tendency to direct or to be mandatory, but rather an attempt to achieve general helpfulness and mutual cooperation. Second, all groups have stressed the importance of local initiative and local decision concerning plans and programs. This is considered essential, Dr. Jones pointed out, because of the varying needs in the individual States and communities.

Third, there is a desire to be certain that whatever is done is in addition to and not a substitution for what already exists, so that improvement and not replacement will result. Fourth, he said, a strong feeling is held that it is necessary to bring together at the State and local levels individuals with broad professional training and interests, and many of the prominent laymen, as members of advisory committees.

Main Requirements

Dr. Jones stressed the importance of thorough orientation with regard to local conditions, facilities, and needs, and an awareness of available resources, public and private, which can be pulled together through good leadership and utilized to meet the total disease problem. With such intimate knowledge, he stated, it is possible not only to begin intelligent action to meet the gaps and needs, but also to set the mark for high standards and quality of services.

Education and training—for physicians and other professions, for the patient, and for the layman—are activities of the highest importance. Pointing out that difficulties are often caused when lay education exceeds professional education, Dr. Jones advocated special emphasis on the latter. The chief problem in professional education has been difficulty in reaching physicians who need it most. It is hoped, he said, that the *Heart Bulletin* which is expected to appear in 1952 will serve a tremendously useful function. Slanted toward the general practitioner, the *Bulletin* is expected to have content of a very high order, in such form as to "catch the physician's eye."

Case finding is another essential part of a community heart program, Dr. Jones stated. Many methods exist: first the physician and the patient; then nurses, social workers, clinics, schools, teachers, school physicians; industrial, insurance, and selective service examinations; and multiple screening. With regard to selective service, pre-employment and insurance examinations, which are confidential, Dr. Jones urged that some way be worked out whereby the individual examined can be informed of abnormal findings and directed to his physician.

Other points stressed were that supplemental clinics, important as a part of care service as well as case finding, should be used in connection with much broader opportunities for service; and that arrangements for definitive care and service must be made in the local community, notwithstanding where the responsibilities lie. Dr. Jones also emphasized the importance of prevention and the vital necessity of attention to the problem of rehabilitation. He further suggested that a register of heart cases could serve a useful purpose if used as a means to make sure that individuals receive needed services at a given time, rather than merely as a device to collect statistics.

PHS Epidemiologists Aid States

During 1951, the Public Health Service's Communicable Disease Center at Atlanta, Ga., expanded its epidemiological assistance to the States by establishing an epidemic intelligence service, a special corps of 21 communicable disease investigators. During the year, Public Health Service epidemiologists aided State and local health departments in dealing with 88 epidemics and disease outbreaks and one disaster, the Kansas flood. The epidemics included 16 outbreaks of poliomyelitis, 11 of infectious hepatitis, 6 of gastroenteritis, and 55 epidemics or individual cases of 25 other diseases.