The State of the Nation's public health services

Reports from the 51st annual conference of the Surgeon General of the United States Public Health Service and the Chief of the Children's Bureau with the State and Territorial health officers, mental health authorities, and hospital survey and construction authorities.

Report on Programs and Problems, 1953

Excerpts from a statement by LEONARD A. SCHEELE, M.D. Surgeon General of the Public Health Service

Our country is still in a period of international emergency and national mobilization. The development of strong defense against the spread of aggression necessitates continued sacrifices by every American.

As public health workers, we have had an important share, from the beginning, in the program for economic and technical assistance to underdeveloped areas that need help to become strong allies. In sharing our knowledge and skills, real progress has been made in the control of disease and the promotion of health.

Many State and local health agencies have joined with the Public Health Service in staffing these overseas health programs. Despite the general shortage of public health personnel, and although we have not been able to provide all the personnel our own Government and the struggling health agencies of underdeveloped countries have asked for, we have made a very good showing. These programs are so vital to the survival of a free world that the Public Health Service intends to tighten its belt even more so as to help meet their minimum staff requirements. We will continue to call on health agencies for help. (See report by Dr. Hyde, page 188, this issue.)

Health Material Requirements

During the past year, the Public Health Service has developed a smoothly running

organization to handle allocation of critical metals for construction of hospitals and health facilities. We are now concerned with the specialized technical staff work that must be done if civilian health supplies are to be available in the event of full mobilization.

This means that experienced and technically competent personnel must be available to work with industry in projecting potential demands and productive capacity 4 or 5 years ahead. The Defense Production Administration has delegated this responsibility to the Public Health Service. With the active cooperation of the health and medical supply and equipment industries, and the military forces, our Division of Civilian Health Requirements has made good progress in developing the basic data.

We expect in the immediate future to begin making similar estimates of facility requirements that would come with full mobilization. It will be important for State hospital survey and construction agencies to participate. We shall need to know what it takes to keep the existing hospital and health plant going; and what will be needed 4 or 5 years ahead for renovation and repair of buildings, replacement of equipment, maintenance of supplies, and so on.

Of special concern are items already in short supply, as well as those that would become critical under full mobilization. For example, already completed is a study of penicillin requirements, and our proposals for increased production have been approved by the Defense Production Administration. Recommendations soon will be completed on such items as surgical bandages, sutures, dental supplies and equipment, hypodermic needles and syringes, X-ray film and machines.

With these and to-be-developed data, the Public Health Service intends to keep abreast of the production situation so that civilian needs may be safeguarded in the face of increased demands and heightened competition for essential supplies and equipment.

Environmental Health

There are many encouraging signs of the emergence of practical solutions to some of the critical problems created by new environmental factors in our rapidly changing society, at the same time that substantial progress is being made in long-established sanitation activities.

Radioactive Hazards

Steady progress has been made in the public health control of hazards incident to the use of radioactive materials and radiation-producing machines. Several State health departments already are operating radiological health programs—in recent months, for example, pilot programs have been initiated by the New Jersey and the California health departments. Progress also has been made on the Colorado Plateau in controlling radiation hazards inherent in the mining and milling of uranium.

"ONCE MORE the conference of the Surgeon General of the United States Public Health Service with the State and Territorial Health Officers—established by Congress as a statutory function 50 years ago—has assembled. In recent years, the effectiveness of this annual exchange of views has been strengthened by the companion conference of the Chief of the Children's Bureau and by concurrent conferences with the State hospital and mental health authorities. These actions testify to the common interests of health administrators from all parts of the country and to their desire to work together as a united force for the protection and promotion of the Nation's health."

Thus the Surgeon General opened the 51st conference of State and Territorial health authorities held in Washington from December 8 to 11, 1952.

One of the important purposes of these meetings is to bring the health authorities up to date on important health developments and prospects on the national scene. Several reports which have more than transient interest are presented in these pages in abbreviated form. Other material stemming from these discussions will appear in later issues of Public Health Reports. Included here are excerpted reports from—

Interstate Milk Shipping

The program for the certification of interstate milk shippers—recommended by the State and Territorial health officers for the past 8 years—has reached a point where additional support for the Public Health Service's share in these joint activities is essential. Despite lack of adequate funds, the Service has conducted during the past year a highly successful demonstration project. It has been shown that effective certification of interstate milk shippers can be achieved with the active participation of State and local health departments, agricultural agencies, and the dairy industry. If this modern method for the marketing of safe milk is to be extended beyond the limited area covered by our demonstration, all of the States, as well as the Public Health Service, will have to increase their activity.

Poultry Sanitation Code

The development of a poultry sanitation ordinance and code is going forward satisfactorily. This project is being conducted with full participation by the poultry industry and by law enforcement agencies.

Raw Garbage Feeding of Swine

The Executive Committee of the Association of State and Territorial Health Officers has been considering the need for appropriate legislation and supporting control measures in connection with the practice of feeding raw garbage to swine. The Public Health Service has been cooperating closely with the U. S. Department of Agriculture, and we believe that joint planning and action in this field will bring about better control of many swine diseases, including trichinosis and others of public health importance.

Up to now, our mutual efforts in this field have made headway slowly, because of lack of clear epidemiological data demonstrating the importance of trichinosis as a public health problem. Last summer's rapid spread, from coast to coast, of vesicular exanthema in swine, traced to the feeding of raw garbage, illustrates the hazards of the practice and its role in the transmission of disease both to man and to domestic animals. This vesicular exanthema outbreak has stimulated reconsideration and brought forth new support from all quarters. Now is the time for State health departments to renew their cooperative efforts with their State agricultural agencies in legislation and control. The Public Health Service is tightening up its interstate action in this field, and we are prepared to provide States with technical and consultative service for their intrastate operations.

"Fringe Area" Housing

There is still a large residuum of substandard housing which presents basic sanitation problems—chiefly in urban and suburban areas, and not limited to "rural slums." "Fringe areas" still are growing faster than are our efforts to forestall serious health problems. Mobilization has brought with it a variety of housing sanitation problems. More than this, the morbidity and mortality rates from home accidents, the relation of housing conditions to cardiovascular disease, to arthritis and rheumatism, to the aging, and to many other conditions that stand among the Nation's unsolved health problems point day after day to the health agency's responsibility for action in the hygiene of housing.

Accidents in the Home

In home accident prevention, the Public Health Service and participating States have made some progress in developing the basic data essential for planning in this field. In fact, the time has come to pull together the recently acquired knowledge and experience and to evaluate what we have learned. Such an effort is planned for January when representatives of State, county, and municipal health agencies, voluntary organizations, and Federal agencies meet at Ann Arbor for a conference on home accident prevention.

Our Chemical Environment

The report of the House Select Committee to Investigate the Use of Chemicals in Foods and

Cosmetics focuses attention on the growing importance of the chemical environment as it affects human health. Much remains to be learned about the potential hazards, as well as the potential benefits, that may be inherent in the introduction and use of many new chemical compounds. With respect to our knowledge of the health effects of the chemical environment, we are just about at the same level of understanding as public health pioneers were three-quarters of a century ago in their knowledge of bacterial causes of disease. Our first steps, therefore, must be thorough research programs aimed at finding answers to fundamental questions.

Fluoridation Programs

In the advancement of dental public health, the fluoridation of public water supplies needs to be skillfully interpreted to the people of our communities. Although more than 500 towns are now benefiting from fluoridation, progress in applying this preventive measure has been impeded in some communities by misinformation. There have been some court actions, referendums, and opposition by groups and individuals.

Such situations are not uncommon in the history of public health progress. The early efforts to install chlorination of water supplies met with opposition, sometimes with unfounded fears of "poisoning." Again, we are called upon to exercise a high degree of public health statesmanship. The skeptics must be convinced that our epidemiological and laboratory studies are valid and that the benefits of fluoridation are not to be discarded lightly in the face of uninformed opposition.

Communicable Disease Control

New disease entities are being identified; new agents for prevention and control of well-known infections are being tested; and the problems of identifying the etiologic agents in unusual outbreaks are increasing—in short, future progress in the control of communicable disease depends upon the efficiency of our epidemiological and research techniques. In disasters or enemy attack, success in protecting large populations from rapid spread of disease depends upon a well-organized, highly efficient, nation-wide epidemiological service.

During the past few years, the Public Health Service has been emphasizing the epidemiological approach in its communicable disease control and microbiological research undertakings. The sectional research program in microbiology set up in the National Microbiological Institute and the epidemic intelligence service set up in the Communicable Disease Center are the two major contributions of the Public Health Service to the attainment of such an organization. The institute and the center are, of course, developing their programs together as a team.

Emergency Reserves

The Public Health Service has made repeated attempts to build up a more extensive and vital inactive Reserve Corps, particularly for active duty in the event of full mobilization or disaster and to provide officers for assignment to the States for duty in defense-impacted areas. We have been handicapped by lack of funds.

We are, however, about to launch an experimental expansion of the inactive Reserve Corps in the engineer component. The idea is to have available a reserve of engineers who could be called to duty in the vicinity of their usual place of employment. Recruitment will be largely from sources other than State and local health departments—industries, public utility companies, universities, and units of governments having engineering personnel.

We plan to use our present engineering staff as recruiting agents and to keep inactive reservists informed on developments in environmental and general public health fields. Engineer reservists are expected also to have opportunities for active duty—from a few weeks as special consultants, to a year or two on special missions. Later we hope to conduct special training along the lines employed by military reserve organizations. This demonstration effort should provide experience that will be of value in the eventual development of an expanded inactive Reserve in components other than engineering.

Sectional Research Program

The aim of the sectional research program is to encourage laboratory and epidemiological research on infectious agents through the operation of a nation-wide network of regional and coordinating laboratories especially skilled in microbiological investigations.

At present, 98 laboratories, organized in 11 sectional groups, are participating. More than 10 percent are in State and local health departments, and representatives of several State laboratories are on the advisory committee helping us to develop this program. The Public Health Service has awarded research grants to those laboratories requiring aid in order to participate, and next year we hope to increase the amount available for these grants.

Epidemic Intelligence

The companion epidemic intelligence service has completed its first full year of service. We have been encouraged by the results and by the cooperation which has been extended by the State and local health departments, the schools of public health and medicine, and others who have teamed up with us. A second group of epidemiologists have completed their initial training at the Communicable Disease Center and are now in the field, bringing the number of medical officers in the intelligence service up to 32. By expanding this corps, and by stepping up various types of laboratory and field research, the Public Health Service is better prepared to discover and combat disease outbreaks, whatever their origin and wherever and whenever they occur. We stand ready to answer the call for epidemic aid from any quarter of the Nation.

Disease Reporting

Efficient morbidity and mortality reporting is a fundamental requirement in the investigation and control of communicable disease. The increasing strength of State activities in vital statistics and morbidity reporting is evidence of progress in this field.

Plans are going forward for an expansion of State and national reporting of animal diseases. Although collection of data on animal diseases is a function of the United States Department of Agriculture, the Public Health Service has offered consultative assistance in the planning stages because of its many years of experience in the reporting of human diseases. I hope that the State health departments will offer similar assistance to their State agricultural agencies.

Poliomyelitis Prevention

Reports by several investigators within the past few months indicate that we may be on the threshold of development of one or more useful immunization agents for poliomyelitis (see *Public Health Reports* for January 1953, pp. 105–107). Much research remains to be done, but the immediate potentialities of gamma globulin pose major practical problems for Federal, State, and local health agencies and the medical profession. Close and active cooperation in the development of policies and procedures relating to blood collection, serum processing, and allocation are required of all hands.

Venereal Disease Control

By the middle of 1953, venereal disease control programs will have attained almost complete conversion to out-patient treatment of syphilis. This is indeed a triumph and one in which all of us share. It is the result of research, pharmaceutical production, and public health and private medical practice. Now every private physician can be an efficient venereal disease control officer, giving ambulatory treatment to patients in his office, while State and local health departments maintain the important supporting services of case finding, contact tracing, referral, treatment of many patients unable to pay for private care, and education.

State health departments are establishing about 70 prevention and control centers in strategically located urban clinics. They aim to provide the best in venereal disease diagnosis, treatment, epidemiological services, and education. From them will radiate services to physicians, local health centers, hospitals,

and social agencies in the area. There are here, also, opportunities for professional training in cooperation with universities and medical schools.

Chronic Disease Control

In tuberculosis, cancer, heart disease, diabetes, arthritis, and other chronic diseases we might well aim for levels of control that involve every practicing physician giving ambulatory treatment, either preventive or curative, in his office. Thus as a key element in its chronic disease effort, the Public Health Service continues to support an unremitting search for case-finding techniques that may be applied on a wide scale and for therapies that may ultimately be placed in the hands of the general practitioner as well as the specialist.

Certainly, facing up to the problems of chronic disease and an aging population, public health agencies need to encourage and develop many new types of partnership. There is strong support for chronic disease control and for health services to the aging. Yet State and local health services in most of these fields are scanty and scattered.

While new techniques for chronic disease control and hygiene of the aging remain in a twilight zone between experiment and widespread use, it may be that a "bridge" type of community institution with research, educational, and limited service functions is needed to speed the sound application of scientific advances. (See description of this type of institution in *Public Health Reports* for January 1953, pp. 8–9.)

Rheumatic Fever Prevention

All interested in health have long looked forward to the day when a sound preventive program against rheumatic fever could be proposed and endorsed. Recently, the American Heart Association and its affiliated Council on Rheumatic Fever and Congenital Heart Disease formed a committee on prevention of rheumatic fever. This group proposes, essentially, two main lines of action: (1) early and adequate treatment with penicillin of all cases of streptococcal infections; and (2) long-term prophylactic use of sulfadiazine or oral penicillin in rheumatic patients. (See *Public Health Reports*, January 1953, pp. 12–15, for the full text of the statement.)

These recommendations of the leading specialists in this field represent a milestone on the road to control of rheumatic fever and its crippling companion, rheumatic heart disease. Implementation of the community programs which makes such control possible should be given high priority.

Rehabilitation

At the 1950 meetings of this conference it was recommended that the Public Health Service and the State health agencies undertake studies of the public health aspects of rehabilitation. We are now preparing the final report of a Public Health Service committee and task force on rehabilitation which was formed last year with the cooperation of the Office of Vocational Rehabilitation.

Community action for the improvement of rehabilitation facilities and services is widespread. Spurred by Federal aid for the permanently and totally disabled, many communities are planning and developing service programs with a minimum of health department participation. Unless State health officials move quickly and think through their responsibilities in this field, they stand to lose opportunities for significant leadership in improving health services generally and particularly in the fields of chronic disease and impairment where we already have operating programs.

Hospital Licensure

State health and hospital agencies increasingly are involved in the licensure of hospitals and related institutions. At their request, the Public Health Service has undertaken a compilation of existing regulations for institutional licensure. Guide materials for the development of licensing procedures and techniques are being prepared.

Licensure as a phase of hospital and related institutional care is destined to come into greater prominence as programs for the aging,

for convalescent care, and for rehabilitation expand. The subject requires a great deal more study, but such study requires more funds than the Public Health Service yet has had to devote to it.

Manpower Shortages

The shortage of professional and technical personnel which has engaged our attention for two decades continues to be a serious problem. Trained workers, never available in numbers adequate to meet the needs of organized services and institutions, are in steadily increasing demand from a number of sources. We must, therefore, make strenuous efforts toward more effective utilization of our present supplies of professional and auxiliary health personnel. It is highly probable, for example, that a number of duties now performed by physicians could be delegated to nonmedical personnel.

Critical evaluation of all activities, constant and intensive recruitment, in-service training, careful consideration of salary levels, opportunities for advancement, and satisfying work experiences—taken together—constitute main weapons against the current shortage. Essentially, this means that we must try to get well-qualified workers into public health, or workers with the potentiality for high qualifications, and we must make our field a career service for them—one which they need not and will not leave for another.

In nursing—a particularly difficult area—several State health agencies during the past year have been active in the conduct of nursing surveys. Some hospital divisions in State health departments also have taken the initiative in stimulating hospitals to evaluate the utilization of nursing personnel. The coming year should see increased activity in both these fields.

Re-examining Local Services

We in the Public Health Service believe that the time has come to re-examine carefully the entire concept of, and structure for, the delivery of community health services. The present pattern has served its purpose well. However, new forces have emerged in the total social fabric. We are confronted with may new problems. Marked changes have occurred in the physical environment. The general standard of living has improved markedly. There are better means of communication and transportation. New scientific bases are available for prevention, diagnosis, and treatment of illness. There is a wider public understanding of personal and community health problems.

Are we taking advantage of these many new technological, social, and economic forces to make available the best possible health services at the lowest per capita cost? Are we organizing and administering programs that merely maintain the status quo, or are we getting down to the "grass roots" and finding out what precisely are the health needs and the best means of meeting them? Are we experimenting with new techniques?

To illustrate: In approaching a study of the amount and kinds of nursing service required to meet the minimum needs of local health departments, the Public Health Service has run head on into the basic fact that to consider the needs of a single type of service is not enough. The fact is, we have too long fractionated our approach. It is not enough merely to extend the study to cover other types of public health personnel. We must go much deeper.

Today's public health problems require a wide range of professional skills, facilities, and services. We have become increasingly aware that the newer programs do not always fit into the traditional structure. Many local health organizations as now constituted cannot cope with the problems. Local health organization is indispensable, and it must be strengthened. We must learn new ways of organization as well as new operating techniques.

Any new approach to local health services must be carefully planned after well-conducted studies. Such studies must be so designed as to yield results applicable to the whole field of public health, not merely to the solution of discrete problems. They must be of sufficient scope and longitude to insure valid conclusions. They must be focused more upon the human community than upon the professions which serve the community. They must draw upon the social sciences for their design, methodologies, and conduct.

The need for such appraisal of current practices and for the development of more effective and economical methods for different types of communities is of vital concern to all health workers. The Public Health Service hopes to begin the difficult first step of such studies—the planning—in the near future. But we cannot, and we will not, promise any hasty "appraisal" or quick results. But we shall do our best to add some useful knowledge to the science and art of public health.

Report on Federal-State Relations, 1952

2

Excerpts from a statement by JOHN W. THURSTON Deputy Administrator of the Federal Security Agency

This meeting is significant because it is indicative of growth in health programs and responsibilities. It is also significant because it demonstrates maturity in Federal-State relations—serious, cooperative consideration of nation-wide health problems.

Back of the growth lies a long history of cooperation, the development of a system for recognizing, meeting, and solving health problems. We have created a structure that is enduring and that has met the test of time. The machinery for action-in-partnership is here and it works. It has become a part of our social heritage, extending beyond individuals and beyond shifts in political alinements. The only real danger we face is to fall victims of the twin evils of arrogance and complacency—to lose that sense of hopefulness and vision and hard work that brought us where we are today.

Results of Partnership

The results of the partnership have been substantial. Even as we reflect on the achievements of the past, however, we are wrestling with the problems of the present, in part created or intensified by earlier victories. The changing environment, the general aging and mobility of our population, the swift pace of industrial expansion bring us face to face with new problems. Health problems today are much more subtle and complicated than they were in the past.

The greater the awareness of the new factors, the more effective will health services be. Health workers must ally themselves with other social forces in the local and national community. The partnership must not only grow stronger between the various levels of government—local, State, and Federal—but must also branch out laterally. Adequate health services in the future call for genuine integration with related social programs, such as welfare and rehabilitation and education, and for close rapport with other community services that affect health, such as housing and community planning.

The Federal-State partnership is based on respect and trust, on the recognition of individual rights and mutual responsibilities. The flow of power is a natural one, from the individual citizen to his local community and then to his larger community, the State and the Nation. The interrelationship between the citizen and his government, and within the various levels of government, is delicate and subtle, yet strong, like a fine fiber.

An American Invention

The structure that binds us together is, in fact, unique in man's governmental efforts. It is an American invention, rooted in our social fabric and peculiarly suited to our geographic needs. It has developed out of a combination of circumstances—our pioneering traditions, our strong community bonds, our patterns of emerging social obligations. At its base is a federated system of government—a system of local, State, and Federal authorities—with each member of the partnership having its own set of duties, powers, and obligations.

The American federated system is also unique in its sources of strength and its possibilities for action. It preserves and extends

local independence and at the same time permits national concentration on national problems. Our citizens have different loyalties without necessarily having conflicting loyalties. We meet national needs best when local resources are strongest.

It is true that problems may not always be the same. The needs of some States may differ somewhat from the needs of other States, and local problems may not always be comparable to those of the State. But there is a core of problems that require joint undertaking, that confront all the people of the United States. And these problems demand the united efforts of our Federal-State-local system.

The result of the system then has been a fusion of effort which helps us to pull together our resources instead of scattering them or instead of quarreling over them. It is this kind of teamwork that has enabled us to undertake cooperative endeavors, to share ideas, resources, and facilities for a common national goal.

Unity and Responsibility

This is not to imply that all our endeavors have been marked by complete harmony. Nor would we want to pay the costs of such a harmony, the costs of smugness and stagnation. We have had differences, but they have been honest differences. But from these differences, from the hammering out of compromises, has come greater understanding and a higher kind of unity.

When we come to the differentation of responsibilities, we find that certain broad categories of responsibility fall, quite typically and quite naturally, to the Federal partner, just as others fall to the States and the communities. For example, it is an accepted obligation of the Federal partner to conduct research and experimentation in new health techniques; to develop and set nation-wide standards; to collect national statistics of various kinds; and to meet problems which are interstate, international, or so new or so fluid that no State or local agency could possibly undertake them.

Financial aid is, of course, an important type of assistance offered by central to local governments. But it is by no means the only, or even the most important, kind of aid. I think the grant-in-aid principle is firmly established in this country; it is one of the buttresses of our federated system of government. It is to be expected, however, that at any particular time one member of the partnership may be stronger in resources than another, and that there will need to be a continual balancing of forces in the interests of greatest economy and productiveness.

More important than the financial aid is the necessity for all groups to do their share in a unified, constructive way. The Federal-State health system is not a matter of giving but a process of sharing.

Trail Blazing by States

Sometimes it is charged that the Federal Government dominates the States. I know something about the Federal regulations governing grants for health purposes. And I see nothing in the Federal-State system that prevents any State from seizing the initiative and blazing the trail in new health programs. I do not think the States have been stifled because they have been the recipients of Federal grants. I do not know of many bold experiments or new programs that have been vetoed in Washington.

Certainly there have been experiments, new programs, new techniques. There will be more. There must be more if there is to be real progress. The flexibility of the Federal-State structure, its adaptability for many kinds of uses, leaves room for a wide variety of new programs, for administrative and technical pioneering.

This very meeting is evidence not of Federal coercion, but of healthy give-and-take discussion and of general agreement on goals to be reached and methods to be followed. Here we find a core of dedication, of good will, of social conscience, and professional competence that will enable this Nation to attain new levels of health.

I think we can all take pride in the health structure we have built, in our strong chain of health defenses. It has carried us a long way in a relatively short span of years. Despite calumnies, despite set-backs, despite the fears of some, it will carry us much further. I am

confident that the people, as well as the health professions, will be satisfied with no less in the future.

Report on Child Health And Welfare

3

Excerpts from a statement by MARTHA M. ELIOT, M.D. Chief of the Children's Bureau

The United States is becoming a nation of old people. While it is true our aged are increasing in number, as a nation we are maintaining our youth. We are actually growing younger faster than we are growing older.

During the past decade, while the population over 65 years of age increased 37 percent, the population under 5 grew 55 percent. These children now are increasing our elementary school population in great numbers. Soon the effect of this increase will be felt in the high schools.

This fact has many implications for health, welfare, and education programs for children and youth. It means that during the current decade, we will be facing new and ever greater responsibilities in providing services for them.

Today in the United States there are nearly 48 million children under 18 years of age. The characteristics of this child population are of significance to us.

In rural areas live 43 percent of our children. Almost one-half of all children belong to families with incomes of less than $3,000 a year.

An impressive reduction has taken place in infant and maternal mortality for the country as a whole. There are, however, many counties, largely rural, which lag a decade or more behind the more metropolitan counties. The majority of the counties where higher infant mortality rates prevail are in the southeastern and southwestern parts of the country, where some of our most economically depressed families live, many of them migratory workers, Negroes, Spanish-speaking people, Indians. These people are living under serious disadvantages. They need our continuing help.

The needs in such areas are basic in character—adequate nutrition, housing, sanitation, public health services, maternal and child health services. Equally important are the acceptance and utilization of these services by a population which often does not understand too well what they are.

The Premature Infant

The leading cause of infant mortality throughout the Nation is prematurity. At least 7 percent of all live-born infants are premature, and about 60 percent of deaths in the first month of life are associated with prematurity. The inclusion of birth weight on birth certificates by the States is now making it possible, through the matching of birth and death certificates, to increase greatly our information about prematurity.

For over a decade health departments have done considerable educational work in the area of prematurity, lending incubators, providing consultation to hospitals, giving nursing care in the home, and providing opportunities for nurses and physicians to obtain additional training in this field. These efforts have been accelerated and extended in the past 5 years.

Among the newer significant developments has been the increase in the number of State health departments which are working with hospitals and medical schools in developing centers for the care of premature infants—centers which serve as the focal point of community programs for premature infants. Such programs are demonstrating that mortality among prematures can be reduced appreciably. These good results are even being extended to infants weighing less than 2 pounds.

The birth of a premature infant constitutes a serious economic problem for almost every family when it happens. The average duration of hospitalization is 30 days and the average cost per infant is almost $500, and, naturally, the smaller the premature, the higher the cost. Clearly such a cost added to the cost of maternity care is often calamitous to families with low incomes.

That 16 State health departments are assisting families in bearing the costs of medical and hospital care, at least in demonstration areas, is encouraging. The development of such programs, though still in their inception, is among the outstanding accomplishments of health departments in recent years.

The increased knowledge about prematurity gained from these programs, together with an appreciation of what the financial burden of premature birth means to families, is leading State health departments to give more consideration to the possibilities of reducing the incidence of prematurity.

This involves, in the first place, extending prenatal care facilities so that women can have good care during pregnancy. Women who have poor care or none are about three times as likely to have a premature baby as those who have good prenatal care. The major known causes of prematurity are complications of pregnancy, which are prone not only to cause premature labor, but also to decrease the chances of survival of infants born prematurely. For these reasons, several States which have been active in caring for premature infants are also directing their attention to maternity programs, increasing prenatal care services, and providing medical and hospital care for women with complications of pregnancy. Herein lies the greatest possibility of reducing the incidence of prematurity, of lowering the costs of care for premature infants, of reducing the number of blind infants with retrolental fibroplasia, and of lowering fetal and infant mortality.

School Health Services

Health services for children of school age constitute a considerable proportion of the maternal and child health programs of many States. Health and education departments are giving greater attention to the use of screening techniques for finding children in need of medical attention and to assisting these children in securing the services they need. If less time were spent on frequent examinations of children in the schools and more time on screening and follow-up, on medical consultation to the school, and on the utilization and development of local resources for diagnosis and treatment, most school health programs would undoubtedly be more productive of good results.

The pamphlet "Better Health for School Age Children," prepared by a committee of staff members of the Children's Bureau, the Office of Education, and the Public Health Service, has been widely distributed. Through its clear and specific statements on the subject (summarized in the November 8 issue of the *Journal of the American Medical Association*), it makes a real contribution to the literature in the field.

The Rural Problem

Earlier I referred to the fact that children living in rural areas are at a disadvantage in some respects. Medical specialists are for the most part concentrated in urban areas. Children in rural counties, moreover, receive considerably less medical supervision than those in or near cities. But it is particularly with regard to specialized services, such as those for premature infants and crippled children, that rural children are at a disadvantage. With our greatest medical skills concentrated in the teaching medical centers, one of our major problems is to help children in rural areas have the benefit of such skills.

State maternal and child health and crippled children's programs have pioneered in bringing to rural areas specialized services for certain groups of children, such as premature infants and children with orthopedic and other handicaps. In recent years, in addition, several health departments have developed pediatric consultation clinics in rural areas which bring at regular intervals the services of a well-trained pediatrician associated with a teaching hospital to the area. Not only are significant services thereby provided children who are referred for consultation by physicians in private practice and by public schools and other community services, but the clinic also serves a teaching purpose in the consultative relationship between the pediatrician and local practitioner. Children in need of further diagnostic work or treatment which cannot be obtained locally are provided these services in an urban teaching hospital which in this respect takes

on a regional function. This relationship of the local pediatric or special clinic with the teaching hospital is a most important factor in raising the quality of care. Extending arrangements such as these would greatly improve the quality of care for children throughout the country.

Crippled Children

State agencies have continued to make gains in the past year in extending services for crippled children, a group for whom there is much support from the public. Parents' groups particularly have become much more active in recent years in supporting these services. Although some of these groups have tended to emphasize certain conditions, they are nevertheless a constructive force which can be of great assistance to all of us in program development.

States are experimenting, too, with new types of services. Since the beginning of the epilepsy demonstration program in Maryland in 1950, some seven or eight other States have also begun epilepsy programs. Other States are planning them. Through the active participation of organized public health services, the benefits of research in therapy can be brought to epileptic children all over the country.

Progress is also being made in the further development of the regional congenital heart disease program. California's program is now in operation serving the far West, Alaska, and Hawaii. The program centering in Illinois is under way and plans for Texas and Maryland have been approved. Programs such as these are representative of the dynamic nature of public health today and its readiness to experiment with new methods of providing service.

Interesting developments are also taking place in services for children who have cleft palate. This group of children has been included in virtually all of the State crippled children's programs since the passage of the Social Security Act, but recently, in a number of States, some of the traditional concepts of treatment are being questioned and modified. Again, the necessity of considering the child first as a growing individual and second as one with a defect in a particular part of his body is being emphasized.

Surgery for cleft palate is not the solution for all children. For those who do need surgery, careful consideration must be given to the age at which this will be done. Many children, without surgery, have satisfactory speech with the aid of a prosthesis. Too many children who have had several operations still do not have a closed cleft or satisfactory speech.

One of the most encouraging aspects of the newer concepts in this field is the recognition that the care of the child with a cleft palate is not the province of the surgeon alone. Some of the best work is being done in those centers where each child is carefully studied by a team—the plastic surgeon, pediatrician, orthodontist, prosthodontist, speech therapist, medical social worker, public health nurse, and others—which considers all the aspects of the situation and reaches agreement on what is the best procedure to be followed for this particular child. Such teamwork offers new opportunities for greatly improved services in a technically difficult area. Opportunities for training in this field are being offered through the University of Illinois Medical School and services for crippled children in Illinois.

Children of Migrants

A different problem, that of children of migratory agricultural workers, demands attention. Their number varies with the season of the year, but it ranges from 250,000 to 1,500,000. These children are, economically and socially, the most depressed group of children in the whole country. Few stay long enough in any one place to call it home. They grow up without having enough of anything. They lack food. They lack adequate shelter, clothing, medical care, and education. Sickness and mortality rates are high among them. These children contribute to the high infant mortality rates in the Southeast and the Southwest. The problem of the families to which these children belong is fundamentally an economic one. Its solution lies in some far-reaching social and industrial measures. Until these measures are undertaken, attention must be directed to the serious health problems of the children. Some States are already helping these families, but in many localities their needs are still unmet.

To be effective, not only must the several agencies involved within a State make a concerted effort; there must also be cooperative interstate efforts. Among the measures that need to be taken are: adequate housing; environmental sanitation; health and medical care services for infants, young children, and expectant mothers; health education that will reach the different cultural groups; and interstate cooperation.

One of the principal causes of death among infants and children of migratory workers is dysentery, a fly- and water-borne disease. Adequate sanitary engineering, fly control, and screening of houses will do much to reduce this mortality. Even as we help peoples in Europe, Asia, and Latin America to adopt sanitary measures, we must help people in some sections of our own country to do the same.

Bringing adequate health services to these families is not a simple matter. One of the basic problems in providing services for migrants is the lack of coverage by local health units. When we have the basic services in public health that we need in rural areas, at least some of the migrant's health problems will be solved, or the mechanism will be available for solving them. I would give the strengthening of the local health units a very high priority among our public health needs but even with basic coverage attained, the job of increasing services suddenly for large numbers of people for a short period of time is a difficult one.

Mobile units may have to be considered. Probably additional staff—physicians, nurses, medical social workers, nutritionists, health educators—will be needed to provide individual services and to make arrangements with social agencies for child welfare services. In view of the poor resources these families have, the provision of medical and hospital care must be included.

Provision of day-care centers would constitute another constructive health, as well as welfare, measure. Since both parents and older children in these families usually work, young children are commonly left pretty much on their own. In a few States, day care is being provided, but additional financial support is needed if any headway is to be made in the provision of this service.

State and local health and welfare departments which have the basic organization to do the job must take the responsibility for the administration of health and welfare services to meet the needs of migrants. Migrants should not be set off from the rest of the population but should be enabled to participate in all community services to the fullest extent possible.

Juvenile Delinquency

One of the most serious byproducts of the general insecurity brought about by periods of national and international unrest is the marked increase in juvenile delinquency. Adolescence is a period when youth is naturally in revolt against the adult world. In seeking their own place in the world and establishing their identity, adolescents tend to band together. They may easily fall into antisocial patterns of behavior with which we are familiar in this country. They may also be exploited as in totalitarian countries. It is our responsibility to understand the behavior of adolescents and to help direct it into constructive channels.

Because this problem is becoming increasingly serious, the Children's Bureau during the past year has been giving a majority part of its attention to it. We have established in the division of social services a newly organized juvenile delinquency branch. A special juvenile delinquency project is being financed through private contributions to the Child Welfare League of America. This special project is working closely with the Children's Bureau. We have had a series of conferences with many leaders in this field and with public and private agencies, one of the most recent being with the National Health Council. The Children's Bureau has published several factual pamphlets about juvenile delinquency, and the December 1952 issue of *The Child* is entirely devoted to this subject.

These are a few of the facts we have brought to public attention:

About 350,000 children were referred to the juvenile courts in this country in 1951. Most of these boys and girls are 15 to 17 years of age.

About 1,000,000 were picked up by the police for delinquent behavior.

The number of delinquent children seen in

juvenile courts has increased 19 percent between 1948 and 1951.

Some 50,000 to 100,000 children are detained each year in local jails, often with adult criminals.

As a result of the increased birth rate, it is expected that by 1960 there will be 45 percent more children between 10 and 17 years of age than there were in 1950. Even if the rate of delinquency does not increase, the number of children picked up by police may rise to 1,500,000 by 1960.

We can do much to prevent delinquency, and we can provide juvenile delinquents with the treatment they need, much better today than in the past.

The Mentally Retarded

Another important problem is becoming of increasing concern to public agencies, that of the mentally retarded. The parents of these children are increasing their efforts to secure help for them. In public programs, when both funds and personnel are short, priorities must be given to some activities. Unfortunately, the mentally retarded are not high on the priority list. Yet as we learn more about these children and their problems, we find that many with help need not be nonproductive nor a financial drain. Access to good diagnostic services is a first step in a constructive approach to the problem. Let us hope that in the near future, health, education, and welfare agencies can give consideration to how their resources can be utilized best in helping these children and their families.

Personnel Shortages

The need for personnel continues to be a major problem and probably will continue to be for some time. Progress, I believe, is being made in improving the teaching of preventive medicine and public health in medical schools so that more medical students will be graduating with some knowledge of the modern concepts and services of public health agencies and an increased respect for public health. Because of this shortage of personnel we continue to emphasize the need for increasing opportunities for training. The principal means of doing this is through the provision of adequate stipends for fellowships. There is need to give some long-term fellowships—2 or 3 years—to assure fuller training in the many aspects of child health that will be required by future leaders in our maternal and child health programs. This is essential if we are to maintain our gains of the last few years.

Evaluation of Services

Large sums of money are spent by Federal, State, and local governments to promote children's health and welfare. The needs of children and their parents for aid in these respects are great, and it is to the advantage of all that the physical and emotional health and social functioning of children and youth be the best possible. That evaluation of health and welfare programs and practices is needed is obvious.

To carry on evaluation studies is a huge and long-range task. The Children's Bureau plans to provide research consultation to those States requesting it in one or another of the following program areas in 1954:

1. Foster care of children who are homeless, neglected, or for some other reason need care outside their own homes.
2. Adoption services.
3. Delinquency control and services to delinquents.
4. Health supervision of children through child health conferences or school health programs.
5. Services to crippled children, especially those services that are not medical.

There is a limit to the amount of consultation services the staff can give. As a first step in undertaking such studies, a report on the methodology of research is being prepared.

The various subjects touched on here, though briefly, demonstrate the broad interest of the Children's Bureau in children and the close relationship between child health and child welfare. The physical, social, and emotional problems of children are inseparable. Only as all the professions involved work together in a genuine spirit of service can the interests of children be served in the way we all want them to be served—to the highest degree possible.

Report on International Staffing

4 **Excerpts from a statement by HENRY van ZILE HYDE, M.D. Technical Cooperation Administration**

The resolution of the Association of State and Territorial Health Officers (see page 189) constitutes clear recognition of the fact that from now on the United States is inextricably involved in the health problems of the world. It further recognizes that this is a phase of public health which is not exclusively a Federal responsibility—not solely a responsibility of the Public Health Service, nor of the Department of State nor any other Federal agency. This statement gives clear recognition to the fact that American health leaders, at all levels, must from now on encompass a world responsibility while discharging their domestic responsibilities.

Your resolution is encouraging not only to the Federal agencies concerned with international health, but to the World Health Organization, the Pan American Sanitary Bureau, and, more particularly, to those countries that need your leadership and assistance in improving their health. It will serve as a beacon to them in searching the way out of the morass of ill health.

Mobilizing State Leadership

For some time we in the national agencies have been seeking ways whereby the full force of American public health leadership could be brought to bear upon the problems of health abroad. We are well aware that leadership in public health in this country resides to a very large degree in the State and local health departments. A practical question is: How can we avail ourselves of your leadership and the leadership under your influence in tackling international health problems?

The Public Health Service is taking a first step toward an answer. Taking into account that the international phase of public health is a long-term responsibility with workaday aspects, the service is transferring its Division of International Health to the Bureau of State Services. This move should integrate more closely and bring into proper balance within the Service the domestic and international phases of its total public health responsibility. It is hoped that this move will strengthen the intimacy of the relationship of the Service to the State health officers in discharging international responsibility. It will provide, likewise, opportunity for full utilization of the regional offices in international work.

Approaches and Principles

How can we mobilize full strength in this program? How can we bring it fully to bear on the international problem? We need to seek new ways and to seek these together. The problem has been discussed with a number of State health officers. In every case we have found enthusiasm and interest, with reservations only concerning ability to contribute as largely as the State would wish.

There are certain underlying principles governing the program that should be understood:

1. It is truly a joint endeavor with each country, not a unilateral effort.

2. The specific content of each country's program is determined jointly with the ministry of health in the country concerned. It is not laid out in Washington nor by the Americans in the field.

3. Program can be influenced most effectively in the field, by field visits, when the annual program is being developed. It would be brash to attempt to mold or veto programs at great distances, particularly when they are to be carried out in a foreign setting.

4. The United States is furnishing leadership, not the mass of workers. Quality, not quantity, is required—competent, experienced public health leaders to give direction to pro-

Whereas, the Association of State and Territorial Health Officers recognizes the importance of improving world health as a sound basis for insuring world peace, and

Whereas, the United States of America has achieved pre-eminence and leadership in the field of public health, largely due to the training and experience of all public health personnel in State and local health departments and the U. S. Public Health Service, and

Whereas, by cooperation in the extension of modern public health services to other countries in the world, as well as the interchange of views and experience through the assignment abroad of trained United States personnel there has developed a better mutual understanding of the problems concerned and distinct improvement in local and domestic health conditions: And, therefore, be it

RESOLVED, That the Association of State and Territorial Health Officers, assembled in annual sessions at Washington, D. C., December 8–11, 1952, hereby pledges its continued interest and support to the international health programs now being carried out and strongly recommends that State and Territorial health officers encourage and, by active participation wherever possible, extend this great movement in international health, and thereby help to promote the spirit of good will and peace throughout the peoples of the world.

gram development and to train and direct indigenous workers.

Personnel and Objectives

In the 18 countries in Latin America, where the program is most advanced, there are fewer than 100 American technicians directing programs involving over 6,000 native personnel. In the Near East, African, and Asian areas, there are now in the field of health and sanitation about 95 technicians under an authorized budget providing for 158 positions. Although some increase of the authorized budget might be forthcoming, it is not expected that the number of personnel required will skyrocket.

The object of the program is, of course, to build strong, permanent, self-supporting national and local health services. It is necessary first to create widespread public demand for such services—a demand sufficiently strong and clear to constitute effective political pressure. Such a demand can be generated through sufficiently widespread, successful demonstrations of effective health services. At the same time, it is necessary to train indigenous technicians, both professional and subprofessional, and to develop true public health leadership within the country. The program is, thus, basically one of demonstrations and training. It is a program that requires competent, experienced leadership abroad working under the stimulation and broad guidance of the best at home.

A Pioneering Step

In seeking means for full participation in this program, an important pioneering step has recently been taken in the signing of a contract between the Commonwealth of Massachusetts and the Technical Cooperation Administration of the Department of State. This contract establishes the principle of cooperation and sets up a working method that is already providing action. The principles inherent in it are important.

The contract establishes a special relationship between the Department of Public Health of the Commonwealth of Massachusetts and the Technical Cooperation Administration, with particular reference to the Point IV health program in Pakistan. The contract, in its preamble, recognizes the fact that the personnel and facilities of the Department of Public Health of Massachusetts are particularly well suited for participation in the activities contemplated under the program for the improvement of public health and sanitation in a rela-

tively underdeveloped country. The Commonwealth on its side recognizes that its personnel under such an arrangement will gain invaluable training and experience in work abroad.

Article I defines the functions of the Department of Public Health of the Commonwealth as follows: (1) to make available the ability and services of the commissioner of public health as chief consultant to the Government of Pakistan and the Technical Cooperation Administration in the development of cooperative programs of public health in Pakistan; (2) make available the abilities and services of such specialized personnel of the Department of Public Health as the commissioner may consider advisable to serve as additional consultants; (3) be responsible, in cooperation with the appropriate officials of the Government of Pakistan or other participating countries and the directors of United States technical cooperation in such countries, for the planning of cooperative programs for the development of public health; (4) endeavor to provide, as expeditiously as is practical, technicians to perform services as the needs of the cooperative public health and sanitation programs in Pakistan or other participating countries require and as requested by the Technical Cooperation Administration; (5) assume responsibility for participating in the selection of candidates for Technical Cooperation Administration grants for training.

Certain funds are transferred to the Commonwealth of Massachusetts in order to enable it to carry out these functions.

TCA-Massachusetts Team

It is important to notice that this contract sets up a partnership between the Technical Cooperation Administration and the Commonwealth of Massachusetts' Department of Public Health—a partnership dedicated to assisting a specific country through a cooperative program. The State will have a major voice in the form that such a program might take. It will give intellectual leadership, stimulation, and direction. Staffing will be only a part of the job. Under such a contract State personnel can be assigned to foreign duty without loss of rights within the State service. Such personnel can continue to grow under the leadership and direction and observation of the State health officer.

The contract is not so rigid as to exclude other methods of employment. Particularly, when it is advantageous to do so, the personnel may be commissioned in the Reserve Corps of the Public Health Service. Whether in the employ of the State or commissioned, personnel when on assignment to the foreign country will work as an integral part of the Point IV mission to the country, receiving technical stimulation, guidance, and leadership from the State health officer in close conjunction with the Technical Cooperation Administration and the Division of International Health of the Public Health Service.

A contract such as that which has been entered into with Massachusetts may be applicable in the case of other States which wish to participate in this program. In some States quite a different pattern might be required. It has been suggested that in certain States it might be desirable to establish a new, separate entity of government under the State health officer. In a number of States specific legislation may be required in order to provide for leave of absence or to encompass service abroad within the framework of State service. The matter needs to be explored on a State-by-State basis because of the variations in legislation and resources.