The State of the Nation's public health services

Three key papers from the 52d 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—November 4–7, 1953 . . . a fourth paper, the banquet address of the 11th meeting of the Association of State and Territorial Health Officers . . . notes on the history of the Surgeon General's Conference.

Toward Critical Evaluation Of Federal Participation In State Health Programs

By Nelson A. Rockefeller
Undersecretary of Health, Education, and Welfare

These annual conferences are unique in several ways. They exemplify the most effective type of Federal-State partnership in action. Through this mechanism—established by the wisdom of Congress—you have developed a true forum for the free exchange of ideas and a unified attack upon numerous health problems. You have created an atmosphere of mutual respect and trust which permits frank and open discussion. This history of harmonious Federal-State relationships in public health has not come about by chance. It is the result of a half century of arduous work and firm determination to realize a common goal.

A review of the proceedings of these conferences over the period of years is most revealing—they are historic documents. Surgeon General Wyman in addressing the very first annual conference held under the law—in 1903—evidenced keen insight and a rare gift of prophesy when he said:

"One of the most important features of this assemblage is its official character. All of us are familiar with conventions of similar purpose, productive of much useful information but entirely lacking in official significance. Here, however, are assembled the legalized health authorities of the States, representing the practical administrative experience as well as the theoretical and scientific knowledge required in the consideration of public health affairs.

"[This is] a most noteworthy event. For the first time in the history of the United States there has been placed within its statutes, by the act of Congress . . . a provision looking to harmonious and cooperative efforts in public-health matters between the National Government and the State governments."

As a newcomer to this long-standing and honorable partnership, I have less first-hand knowledge than you of the specific and dramatic gains which have resulted in public health. My long association with the health activities of the Institute of Inter-American Affairs, and for 20 years as a member of the Westchester County Board of Health, has given me considerable experience in this field of public health. In traveling the highways and the byways of Latin America, as the Institute program was developing, I have had a liberal education in the substantial results that can be accomplished through the joint efforts of a variety of organizations. So I share your pride in the progress which has been made here in the United States—progress which has been made possible only through the national and State governments working together as a well-organized team, in full cooperation with local governments, with voluntary health agencies, and with the private physicians of each and every community of this broad land.

Problems of Today

But remarkable as the public health accomplishments of the past fifty years have been, there still remain challenging problems to be solved.

Conditions which at present are the chief causes of sickness, disability, and death may prove more difficult to conquer than those problems to which public health workers first addressed their efforts—and which already have responded to public health measures.

Then, too, there are questions about the particular share of the cooperative job which each of the partners should rightfully assume in meeting today's health needs. What part can best be supplied by the States and localities? What contribution is the Federal Government best equipped to make—and under what circumstances?

One has only to scan the agenda of your working committees to see that these are matters of interest to you in the States, as they are to us here in Washington. It is for the purpose of considering such mutual problems as these—of looking forward rather than backward—that I regard this meeting today with the chief health authority of each State and Territory as a real opportunity.

First, it permits me to comment briefly on the significance of some of the major changes which have occurred in the executive branch of the Federal Government since your last annual conference. With a change in administration comes new leadership—and with new leaders come fresh points of view—perhaps even different goals.

President Eisenhower has a deep personal interest in the health programs of this country. He has abiding convictions concerning the dignity and worth of each individual member of our free society, and steadfastly believes that the individual can develop to his fullest capacity as a productive member of this society only if he enjoys good health—both physically and mentally.

Department Status

The President's first move in reorganizing the executive branch was the proposal to lift the essential health, education, and social welfare functions of the Federal Government to department status. This was accomplished by Congress on April 11 of this year.

For the first time in our national history, these social responsibilities—in the broadest meaning of the term—are represented at the

highest council table of our government—the President's Cabinet. Health, education, and social welfare have become an integral part of the considerations of the President's official family.

There are many facets of the new Department in which you would be interested. Time permits me to mention only a few organizational aspects before passing on to my main topic.

One step toward effective administration of the Department was the establishment by the Secretary of the Departmental Council. Together with the Secretary and other senior officials, the Council is composed of heads of the Public Health Service, Office of Education, Social Security Administration, Office of Vocational Rehabilitation, Food and Drug Administration, and Saint Elizabeths Hospital. An improved interchange of information and closer coordination of the Department's activities through the work of the Council are results already apparent.

The reorganization plan which established the Department provided the Secretary a deputy, the position of Undersecretary, which I have the honor to occupy, two Assistant Secretaries, and a Special Assistant for Health and Medical Affairs. In addition, the Secretary has several staff assistants. All these people make up a corps of associates to aid the Secretary in administering the Department.

The appointment of a Special Assistant, Dr. Chester Scott Keefer, to advise the Secretary on the Department's health programs and activities signifies the importance of health in our affairs. Dr. Keefer is concerned with the total health interests of the entire Department, not just with the Public Health Service's activities alone. One of his functions is to maintain liaison with the leading professional societies and voluntary organizations in the health field. His broad background in research and medical education will be extremely valuable to the Secretary and the Department in reviewing current programs and making plans for the future—plans in which your organization, working with the Public Health Service and Children's Bureau, will play a vital part.

The particular type of Federal-State partnership under which you work as public health officials has an outstanding characteristic; its responsiveness to change. This is inevitable.

Your programs are directly affected by, and must be closely geared to, many types of change: changes in the public health problems you are called upon to solve; changes in populations you serve; changes in broad national and international situations. These last, though not specifically matters of public health, have a strong impact upon the provision of health services.

Because State health officials are sensitive to the importance of and need for continuous evaluation of their programs and because you

The Responsibility of Health Officials in Civil Defense

Midway in his prepared address, Mr. Rockefeller was interrupted by a civil defense air raid drill. On his return to the rostrum he remarked to the State health officials:

I couldn't help thinking, when we were going down to the basement, of the terrific responsibility which you men and women who sit in this room will be carrying if, instead of this being a practice raid, there is a real raid on this country.

One of the things which deeply concerns the Secretary, and with which Dr. Scheele and various others in our Department are preoccupied, is the problem which the United States will face should the tragedy of a bombing occur.

As one studies it, and I am sure that all of you who have State Civil Defense groups know, the problems that we are going to be up against as a Nation are almost inconceivable. And I don't think there is any group in the country assembled, or that could be assembled, which could more importantly carry that responsibility if it comes—and we all pray to God it won't—than you who are sitting in this room.

It has a very sobering and serious impact when one gets to thinking about it. We hope, as the coming year starts, to be able to more effectively than in the past work with you in devising and preparing for that eventuality which, as I say, we hope never comes.

are accustomed to periodically taking stock of your methods of doing business, you will agree, I think, that the beginning of a new administration is a logical time to examine carefully the road we have traveled. Possibly there is need to rechart the course ahead.

The Department of Health, Education, and Welfare is particularly concerned with critical evaluation of Federal participation in State health programs, both through grants-in-aid and through technical assistance.

Grants-in-Aid

One of the basic objectives of the new administration is to achieve greater efficiency and economy throughout government. Not only Congress, but every department and agency head of the executive branch has a strong determination to accomplish this purpose. The force of this broad and desirable objective is felt in the appraisal of all present and proposed activities. The first Presidential message to Congress emphasized that the number one order of business was elimination of the annual deficit. The sacrifices this will entail were clearly recognized.

> "This cannot be achieved merely by exhortation. It demands the concerted action of all those in responsible positions in the Government and the earnest cooperation of the Congress. Getting control of the budget requires also that State and local governments and interested groups of citizens restrain themselves in their demands upon the Congress."

Under this mandate, the Department is giving much thought to the complex question of Federal assistance to States and localities. First let me state, categorically, that grants to health activities will continue. Most people freely acknowledge the necessity of government programs to protect and improve the public health. Indeed, public health services have become an established part of State and local government services.

The issue, then, is not whether a given function should be dropped or continued, but how can it best be performed and supported. It

Is Public Health Too Much "Taken for Granted"?

While discussing grants-in-aid, the Undersecretary interjected some comments about his own personal experiences on a county board of health. Mr. Rockefeller said:

During the twenty-some years during which I have had the privilege of being on the Westchester County Board of Health, I have had the opportunity of tracing the development of many of the programs with which all of you are familiar. One of the problems which we found in Westchester was the fact that the public took for granted many of these services. Many of them they weren't even aware of, and so we took on, just before the war, a job of trying to educate our own citizenry in Westchester as to what they were getting from their county health department.

That had, quite naturally, a relationship to the appropriations which the health department received, or didn't receive, from the Board of Supervisors. We felt—and I think rightly so—that you can't expect an intelligent citizenry to support programs which they don't know about, or don't understand, or don't fully appreciate.

It seems to me this is one of the responsibilities all of us have, particularly in this period when funds are short, when budgets are strained, when taxes are high. The voter and the representatives of the people are bound to look over the items that appear in budgets with great care, and they are going to cut out those that they either feel are less important, or those they don't understand.

It's a lot easier to cut out those you don't know about, because they don't have very much significance. And I think that is something we, frankly, all have to keep in mind at this time.

Our citizens fully appreciate the tremendous heritage they have in this country, and the tremendous asset in these basic health services which, too often, we found in Westchester were taken for granted.

Getting back to the question of grants-in-aid: The public health services have become an established part of State and local government services. And, perhaps, as I look, established too well. They are almost overlooked, at times, which is a serious thing.

would be a happy solution if each separate function could be clearly allocated to one level of government or another. Then there would be no possibility of overlapping authority, duplication of effort, or conflicts of points of view.

In reality, such clear-cut distinctions cannot be made. The States and the Federal Government are interdependent in the fight against health hazards which affect all States.

Since the people of the Nation move freely and frequently from one State to another—and it is a mark of both our freedom and unity that they can do so—and since disease ignores State boundaries, the health and productive capacity of the residents of one State are of interest and concern to all other States.

Financial Interdependence

It is becoming increasingly clear that, in terms also of financial support, complete separation of the health functions of State and Federal governments is impossible. The kind of tax system under which our governments are now financed places much of the total tax-paying ability of the country in a limited number of States. Other States lack the resources to carry on, unaided, some of the most essential services. Bringing the problem to a head is the fact that in those States where the income is lowest, many of the needs for health services are greatest. Here the Nation as a whole has responsibility, particularly for strengthening those State and local public health services of national and interstate significance.

The Federal Government also has a vital role to play in encouraging the development of new programs and techniques designed to overcome major public health problems. When, through research and other scientific investigations, more effective methods become available for combating ever-changing health problems, assistance should be available—at least for a limited period of time—to assist the incorporation of these techniques into public health operations on a nationwide scale.

We believe, too, that it is appropriate for the Federal Government to provide special financial aid to unique projects which give promise of solution to special problems and to a limited number of areas with unusual health problems: areas with exceptionally high incidence of disease; areas with concentrations of Federal activity, such as defense or military installations; areas with major interstate problems, such as health services for migratory labor groups; areas with "pilot plant" operations to develop knowledge or techniques for general application, to name a few.

Technical aid is also an important type of assistance with which the Federal agencies can continue to assist the States. The useful role of the Federal Government in the fields of health and welfare depends, to a considerable extent, on the quality and availability of its technical and professional services.

Maximum Opportunity, Minimum Control

As we administer our grant-in-aid programs, we are aware of the dangers of centralization of control in the Federal Government. But these dangers can be averted if our Federal-State partnership is governed by one simple and historically sound motto, "Maximum opportunity for State decision, and minimum Federal control." As we continue our appraisal of grants-in-aid, we are carefully examining all our requirements in a soul-searching effort to abide by this watchword.

The need for rational solutions to fundamental problems of Federal aid to States was recognized by President Eisenhower early in his administration. He requested Congress to authorize the establishment of a Commission on Intergovernmental Relations to study and to make recommendations to him and the Congress on Federal-State responsibilities and fiscal relationships.

In his message to Congress on the subject, the President said:

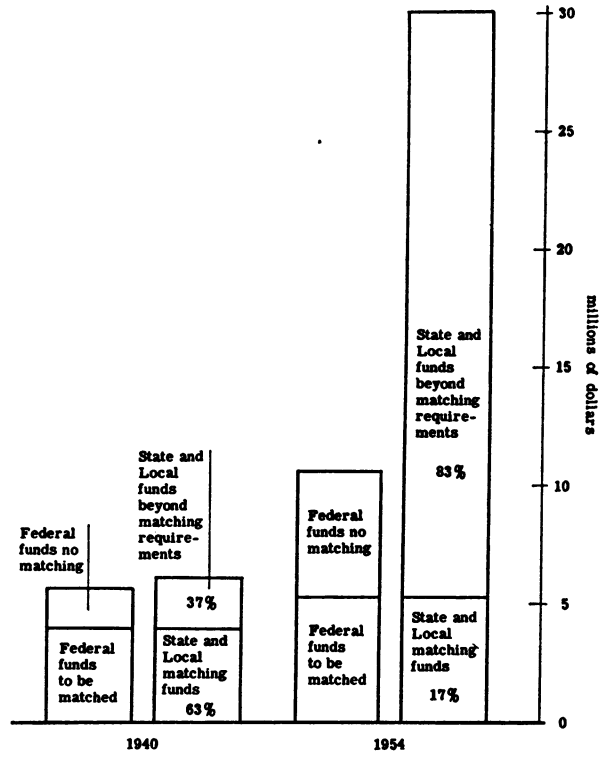
> "The commission should study and investigate all the activities in which Federal aid is extended to State and local governments, whether there is justification for Federal aid in all these fields, and whether there is need for such aid in other fields. The whole question of Federal control of activities to which the Federal Government contributes must be thoroughly examined."

Organization of this commission is now complete. The findings of this commission will undoubtedly make a great contribution to our thinking and understanding of these relationships.

I reiterate that the problems I have mentioned are shared problems—important to the State and Federal groups alike. They are a continuing challenge to the cooperative approach you have taken to similar problems in the past. Keen imagination is called for all along the line if the entire country is to enjoy maximum health services at minimum expense. The good health of our people can never be taken for granted. Vision, vigor, and courage on the part of public health leaders are as necessary today as in the past.

But necessity has always been the spur to ingenuity. I am confident that there are many untapped resources and undevised methods for the provision of better health services. I am hopeful that in your work together here this week you may discover the key to some of them.

State and local funds exceed matching requirements for maternal and child health programs.



NOTE.—No budget reports for 1954 received from California, Connecticut, Massachusetts, New Hampshire, New York.

Child Health Programs: Federal-State Funds And Current Problems

2 **By Martha M. Eliot, M.D.**
Chief of the
Children's Bureau

In some respects this has been a rather special year in the Children's Bureau—one of stock-taking and reviewing many aspects of our work.

We have been giving a good deal of thought to the principles basic to grants-in-aid and to the relationship of Federal grants to the development of State maternal and child health and crippled children's programs. We are asking ourselves and we are being asked such questions as, "What are the appropriate roles of the Federal Government in relation to the work of State health departments?" and "What effect, if any, have the Federal grants had on State and local appropriations for public health activities?" Such questions and others will, of course, continue to be studied by the administration and the Congress.

I would like to report to you some statistics which we have recently put together related to the maternal and child health programs. They show the growth of these programs in States and localities in the past 14 years, and illustrate what can happen when Federal, State, and local governments combine their resources to meet child health needs. Let me tell you just what has happened.

State Funds Increase

In 1940, the State and local maternal and child health programs were financed by a budget of about $11.5 million. Of this, $6 mil-

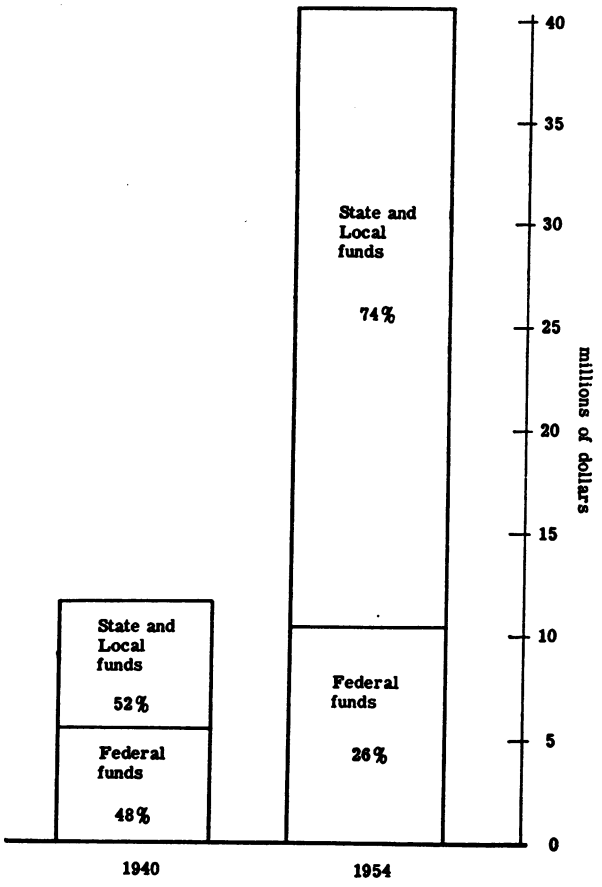
lion were from State and local funds, $5.5 million from Federal funds.

For 1954, the total amount budgeted is $40.5 million, or nearly four times as much as for 1940. The States today put up more than $30 million, the Federal Government $10.5 million.

Clearly the expansion of State and local funds for child health has been much more rapid than that of Federal funds. From the beginning of this cooperative program the States have put up, in the aggregate, more than enough to match the required amount of Federal funds. By 1940, State and local funds were 37 percent in excess of the amount needed for matching. This year, 1954, 83 percent of the State and local funds is over and above what is required for matching.

We can contrast the contributions from Federal and State sources in still another way.

State and local funds have increased more than Federal funds for maternal and child health programs.



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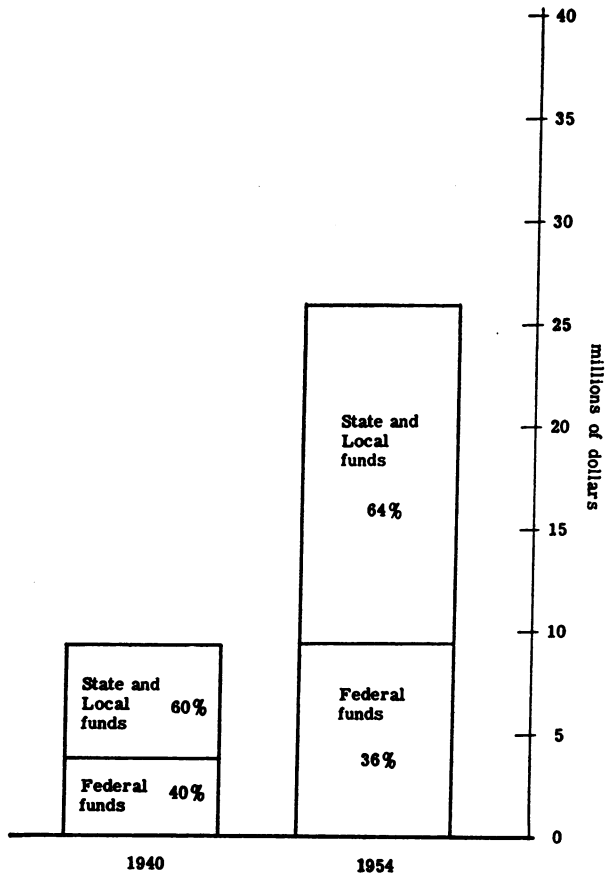
State and local funds have increased more than Federal funds for crippled children's programs.



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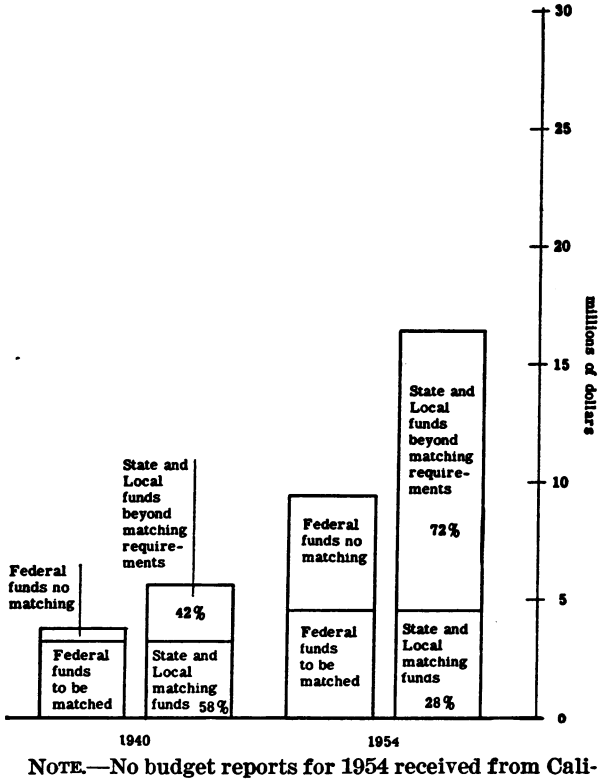
In 1940 the Federal contribution to the combined budget amounted to 48 percent of $11.5 million. Today, 1954, the Federal contribution is only 26 percent of $40.5 million.

The conclusion that we draw from this is that Federal grants have clearly served to draw out additional State and local funds. Similar data have been prepared on the crippled children's program and similar conclusions can be drawn here as in the maternal and child health program. In the crippled children's programs the differences are not so striking since local funds play a less prominent role in this more highly centralized State program.

Of course these statistics represent totals of all the States and do not, by themselves, bring out the considerable variations that exist from State to State with respect to fiscal ability. The fact that the fiscal capacity of the States

vary, together with the fact that the poorer States have relatively more children, suggest that the Federal Government can help reduce the inequities in opportunity for children to receive needed health services. By distributing grants so as to help equalize the opportunities for health services within the Federal-State grants-in-aid programs, the Federal Government is making a significant contribution to children and recognizing that their health and welfare is of national concern and interest.

State and local funds exceed matching requirements for crippled children's programs.



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Progress of the Programs

During these years State health departments and crippled children's agencies have used their funds with great imagination and insight. Let me give you an example. As infant mortality has declined and as the leading causes of death in infancy have changed, the health departments have increased their services to infants in the neonatal period, particularly those for prematurely born infants. The majority of the States are now assisting hospitals in improving their maternity and newborn infant services and facilities. They are loaning incubators to hospitals and local health departments. They are enabling nurses and physicians to receive additional training in the care of newborn and premature infants. Some are making special studies of prematurity. In many other types of activities, the States are emphasizing the importance of this aspect of the maternal and child health program. The medical and hospital care programs for premature infants which 16 States have developed are of particular interest. As a result of all these activities, greater attention is again being given to prenatal care, particularly for mothers with complications of pregnancy, in an effort to reduce the incidence of premature birth. A number of health departments are now studying the problems of fetal deaths as well.

School Health

Much progress has been made in the provision of health services for school-age children. Many of you can recall the dreary wholesale medical inspections which not so long ago constituted this program. We have broken away from tradition in school health services to a healthy degree. Emphasis is now on appropriate screening methods, especially for hearing and vision, on teacher observation and public health nurse consultation, on health education, and upon using the skills of the physician for examining selected children or those in a few selected grades, and for consultation. There is less emphasis today on whether it is properly the school's program or the health department's and more emphasis on the community's program for children, bringing together the public and private resources of the community.

Crippled Children

During the first few years of the Social Security Act, the crippled children's program was virtually synonymous with orthopedics. Perhaps in the last few years we may have let the pendulum swing too far the other way with the result that not enough attention has been given to new developments in the orthopedic program. The progress that has been made in orthopedic services and in research in this field

has been great, stimulated in part by the war. Of much current interest is the renewed attention being given to children who have limb amputations. The National Research Council has a Joint Committee on Artificial Limbs which is working with the Michigan Crippled Children's Program to develop a plan for making new types of prosthetic appliances available to children in the program.

Hearing Aids

I am reminded, too, that during the war great progress was made in the new science of audiology and in the development of new hearing aids. I think it quite probable that children have been more greatly benefited than adults by this research in audiology. We are looking forward to similar benefits for children from the research now in process on the structure of artificial limbs and braces.

But the crippled children's program is today more inclusive than orthopedics or plastic surgery. As the programs have broadened, the proportion of children with orthopedic conditions has declined. During 1952, about one-half of the 238,000 children receiving physicians' services in the crippled children's program had orthopedic diagnoses. The other half includes those having cerebral palsy, ear conditions, rheumatic fever, cleft palate, and other conditions requiring plastic surgery, eye conditions, epilepsy, and other neuromuscular conditions. The greatest relative increase in the past few years has been in the number of children with eye conditions, and children who have epilepsy.

Team Concept

One of the great contributions the crippled children's program has made to medicine and public health is the team concept in the care of children, particularly those who have long-term handicapping conditions. The recognition of the essential contribution made, not only by the physician, but by the nurse, the medical social worker, the nutritionist, physical and occupational therapist, constitute a landmark in interprofessional relationships. And closely associated with the staff of crippled children's programs are the staffs of the welfare, vocational rehabilitation and special education agencies. In fact, at certain times in the care of crippled children, these workers virtually become members of the team.

Personnel Resources and Education

A few words about the increase in specialized personnel over the past decade or more will, I think, be of interest, particularly to those of you who have been associated with these programs for a long time.

In 1947 there were 20 specialized maternal and child health consultant nurses in health departments in 19 States; in 1952 there were 81 such consultants in 44 States.

At the beginning of the program in 1936, there were 9 nutritionists in 3 States' health departments; in 1953 there are 202 nutritionists in 41 States and Territories.

In 1936, only 2 departments employed medical social workers for their maternal and child health and crippled children's programs; today there are 375 medical social workers in 48 State health departments and crippled children's agencies.

In 1937, 3 State crippled children's agencies employed 5 physical therapists; in 1953 there are 147 in 40 States and Territories.

Growth of Training Programs

Much of this progress has been made possible by a remarkable growth in training programs and by changes in curriculums in academic institutions. The schools of public health are all now offering courses in maternal and child health and some of them offer majors in maternal and child health. In addition to the many courses offered for the training of the specialists I have just mentioned, there are new training opportunities for workers in such specialized fields as audiology, prematurity, rheumatic fever, epilepsy, cerebral palsy, children's dentistry, many of which are supported by the States with funds granted by the Children's Bureau. Most of these courses give particular emphasis to the community or public health aspects of these programs.

Public Health Influence

The influence of public health programs is also being felt in medical schools. A major

development in the training of medical students which has significant potentialities for public health is the concept of "comprehensive medicine." This concept includes consideration of the patient as an individual who has family and community relationships which have a bearing on his health. Some of the schools are assigning a family to each student for his 4 years of medical training and he learns to serve as a family health adviser. These students are supervised by the faculty and are assisted in understanding the social and emotional components of health and illness by medical social workers. Community health facilities, such as prenatal clinics and child health conferences, are being used in this training plan. Such students will graduate with a far better understanding of public health and preventive medicine than the graduates of even a decade ago.

Unfinished Business

This is necessarily a very sketchy summary of some of the highlights of progress you have made in the maternal and child health and crippled children's programs. We can all of us be justifiably proud of this record, in which the facts speak for themselves. But there is no room here for complacency, or for a feeling that the job of protecting and promoting the health of mothers and children is just about done, or at least well on its way. We have, in fact, made an excellent beginning, but not much more than that. There is an enormous amount of unfinished business that lies before us.

Infant Mortality

Consider for example, some problems of infant mortality. A recent analysis of vital statistics tells us the neonatal mortality rate for full-term newborn infants is less than 8.0 per 1,000 live births. But for premature infants the rate is 174.0 per 1,000 live births or more than 20 times as great. It is easy to see why so much emphasis is being placed on prevention of prematurity. As impressive as the decline in infant mortality has been, we must keep in mind that 10,000 infants could be saved each year if all counties had rates as low as those with cities of 50,000 population or more. This illustrates again the need for our maintaining a special interest in children in rural areas. The disparity in maternal mortality between high and low income States is excessive, being 5.9 per 10,000 live births for the former, and 13.0 for the latter. Whereas for the United States as a whole, 5 percent of births in 1950 were unattended by a physician; 15 percent of the births in the low income States took place without a physician.

Premature Births

The major problem in the maternal and child health program, prematurity, looms larger as we find out more about it. In about half of the mothers who have premature infants, the cause is obscure. But we do know that mothers in poor social and economic circumstances are more likely to go into labor prematurely than others. The average duration of hospital care for a baby in premature centers is about 30 days and the average cost of hospital care in voluntary hospitals is about $19 a day. Prematurity is, therefore, a very costly business. Only an occasional hospital insurance plan provides for the newborn infant. Undoubtedly early hospitalization of mothers who have complications of pregnancy, as is advocated by Taylor at the University of Colorado and others, does prolong gestation and reduce prematurity, but few States are providing such care even for mothers lacking other resources.

In the crippled children's program, services for children with other than orthopedic handicaps are being provided for the most part in demonstration programs which have a sharply limited geographic basis. The orthopedically crippled are not the most numerous among children who are handicapped. Yet about one-half the children who receive physicians' services are orthopedically handicapped. It is usually estimated that children who have rheumatic fever are as numerous, and there are more who have serious hearing or visual impairment. Twenty-eight States have rheumatic fever programs, for the most part demonstrations, which together provide services for only about 10,000 children a year. Services for children with other less visible handicaps are just as limited or more so. Yet these handicaps may be just as crippling as the more obvious orthopedic handicap. The job that lies before us is the translation of these

well-established demonstration programs into service programs with the same geographic coverage as the orthopedic services.

The Expense of Neglect

The problems hindering such a development are chiefly financial. We have to contend not only with the added costs of extending or developing such programs, but also with the increasing population and the increasing costs of living. There were, in 1952, 50 million children under 18 years. This child population increased 25 percent between 1940 and 1952. Costs have increased too. Hospital expenses per patient day went up 118 percent between 1945 and 1952, and close to half the expenditures in the crippled children's program are for hospital care. In the same period salaries for county public health nurses rose 60 percent and salaries of medical personnel, 52 percent. Yet, I am convinced that together we will gradually go ahead and find the ways to meet these problems and provide the services our children need. We cannot afford not to do so. The cost of neglect is too great, not only in terms of human values, but of money as well.

I have discussed thus far only some of the problems of the maternal and child health and crippled children's programs. But there are others just as pressing in which health departments and crippled children's agencies have as yet been involved only to a slight degree. I am referring to the serious situation which faces us with regard to children who are delinquent, children who are mentally retarded, and the children of migratory agricultural workers.

Juvenile Delinquency

I am sure that all of you have been hearing and reading much about the reported increase in juvenile delinquency and I am also sure that many of you have been actively working in your States and communities trying to do something about this situation.

Juvenile delinquency is not the product of any one social or personal factor, but of many. You and I know that the child's own personality, the effect of his family relationships and cultural patterns, the neighborhood in which he is raised, the economic situation, the tensions of the times, the lack of an appealing school program, various forms of discrimination, bad housing, broken homes, all these contribute to the making of a juvenile delinquent. To reduce the number of delinquent children will require great extension and improvement in many of our social institutions, and a major change in the economic and social situation in many well-defined urban neighborhoods. Health agencies have a real role to play in preventive maternal and child health services.

Mental Retardation

Each year the Bureau receives many requests for help with problems growing out of mental retardation in children. Groups in local communities and professional workers are becoming more outspoken about what they want for mentally retarded children and are taking leadership in attempts to get better facilities, training, and treatment programs for these children.

Of particular interest to all of us is the period of infancy and the preschool years when parents begin to realize that they have a retarded child. The family physician is usually the one who has the responsibility of informing the parents that they have a retarded child. This is a critical occasion, one which most physicians would rather not face. How it is done is important. The physician frequently needs psychological assistance in reaching a diagnosis. This problem is seen, of course, in your child health conferences. The parents need a great deal of help in coping with such a situation. The Children's Bureau hopes to be able to make available to you some consultation service in this field in the not too far future.

Migratory Workers' Children

The problem of the migrant agricultural worker has been with us for a good many years now and I know many of you have struggled with it. One of the major blocks to picking up on this responsibility seems to be a feeling of helplessness in doing it alone. A number of health officers have indicated the willingness of the States to do their share but have expressed their feeling of bafflement about how to deal with a group of people, present in the locality

for only a few weeks or months, who receive little or no care before coming and little or none in the places to which they go. If a group of States could get together on a coordinated plan, with the State of origin doing its part and the States along the migratory route picking up theirs, all of the States would be helping one another. We believe such a plan is possible and will be wanting to talk with some of you, particularly those from the States on the eastern seaboard, about your interest in such a project. To you who know the problem so well I need hardly add that welfare and education, along with health, must be intimately involved.

Cooperative Efforts

In working out some of these problems, particularly those involving several State agencies, many States have found it helpful to organize State committees on children and youth. Similarly, the Children's Bureau participates in the Interdepartmental Committee on Children and Youth. This Federal committee has 30 members, representing government departments, agencies, and bureaus whose work in some way relates to children and youth. Many of you, or your staff, are members of State committees on children and youth. In most of the State committees, the lay participation has been especially helpful in getting citizen support. The Federal interdepartmental committee has just entered into an agreement with the organization to which these State committees belong—The National Advisory Council on State and Local Action for Children and Youth. The agreement makes provision for an exchange of information about what is going on in the various States and between the States and the Federal agencies. We believe this will be beneficial both to State committees and to the Federal agencies. We believe it will further all our objectives.

You can see that I am greatly impressed with the progress that has been made in the programs for children and that I am equally impressed with the magnitude of the job that lies before us. I am confident that just as we have come this far together, so will we continue this highly satisfactory method of working together and continue to extend and improve services for mothers and children. Literally millions of children are depending on us.

Federal-State Partnership: Problems in Administration, Research, and Practice

3 By Leonard A. Scheele, M.D.
Surgeon General of the
Public Health Service

This Conference of the Public Health Service and the Children's Bureau with the States and Territories will go down in history as a momentous one. For the first time, the many governmental activities which concern you and us directly or indirectly have been brought together in an executive department of the Federal Government. For the first time, our mutual aspirations for the health of people everywhere, and our mutual problems are represented in the President's Cabinet by our first Secretary of Health, Education, and Welfare.

The completion and operation of the Clinical Center of the Public Health Service set another landmark in public health since last we met. I would predict that the nationwide research effort, in which the Center is destined to be a dynamic force, will produce, sooner than we think, findings capable of turning public health work upside down. The great revolutionary findings of the nineteenth century in the field of bacteriology and related disciplines brought public health into being as a scientific profession, and those same findings revolutionized the practice of medicine. Medical research is on the verge of remarkable advances in our knowledge of chronic diseases, viral diseases, and mental diseases, as well as in our basic understanding of the human organism and its functioning.

I predict that the new findings will give preventive medicine a greater force in the medical arts and sciences than it has ever had in the past. At the same time, the new findings will turn public health practice as we know it today—upside down. Our role of supporting clinical practice will take on new significance.

There are many interesting new features in the Clinical Center's physical plant, as well as many challenging research studies. Each project is designed to throw new light on some facet of diseases which are killing or disabling large numbers of people everywhere. The studies on metabolic balance in rheumatoid arthritis, on hypertension, and on hormone-producing tumors may seem remote from the activities of a public health department. The end results, however, may be of immediate concern to you and your staffs.

The mass cripplers and killers must ultimately be prevented by simple methods. Some may criticize this concept, but I insist that this is the goal of research and of medicine. Let us take, for example, certain common forms of arteriosclerosis: If we find that certain alterations in metabolism lead to arteriosclerosis—as studies reported by the National Heart Institute suggest—and if we can then find a chemical means of blocking such metabolic dysfunction, we may have a preventive technique as important to medical and public health practice as was the discovery of vitamin C in the prevention of scurvy and of vitamin D in the prevention of rickets. This may seem like a dream, but I believe we are on the threshold here at the Clinical Center and elsewhere in the United States of just such important discoveries.

Control of Noninfectious Diseases

We may also find methods capable of mass application for the prevention of some noninfectious diseases. Who would have thought, in 1943 for example, that a technique for treating the water supply to control a noninfectious disease would be discovered, developed, and put to work in nearly 800 American communities within a decade? I refer, of course, to the fluoridation of public water supplies for the reduction of dental caries in children. During the past year, the eighth annual examination of school children in Grand Rapids, where fluoridation was first applied, showed the same excellent results of past years.

The significance of the fluoridation story is this: By a single method we are able to combat a noncommunicable disease that currently costs the Nation at least half a billion dollars annually in dental bills plus untold amounts in lost time and in the ill effects of dental decay on personal health. The fluoridation of public water supplies does not prevent all caries, but it will eliminate a major segment of the problem. A goal of public health in communicable disease control has been at least to reduce a specific infection to manageable proportions. We are now learning how to accomplish the same goal in noncommunicable diseases.

It is not only possible, but probable, that the greatly intensified research program throughout our Nation will produce new, simple, and relatively inexpensive methods for community-wide attacks on far more serious diseases than dental decay. The work on environmental factors in the causation of cancer, for example, may one of these days produce the evidence and the methods we need for a forthright attack on cancerigenic agents in the environment. By this means, we might directly prevent the occurrence of a significant number of cancer cases.

Applying Principles of Prevention

We sometimes find it difficult to realize that the broad principles of prevention, environmental control and preventive therapy, may be just as applicable to the chronic diseases, mental illness, and traumatic causes of death and disability, as to dysentery, diphtheria, and whooping cough. At a recent staff meeting in the Public Health Service, we heard that a case of hoof-and-mouth disease had been reported from one of the States. All the machinery of diagnosis, confirmation, and search for the source of infection had, very properly, been set in motion. Eventually, the resources of other State health departments, the Public Health Service, and Federal-State departments of agriculture also will be drawn into the search and control effort.

I could not help remembering that every day nearly 2,000 people in the United States die of cardiovascular diseases; 575 others die of cancer; and 240 more die in accidents. Yet the combined daily loss of some 2,800 lives from these 3 major causes alone all too often creates no such surge of concern and action as does the occurrence of a few cases of a rare infectious disease.

Control of Chronic Diseases

Actually, some of the available methods for the control of chronic diseases are far less crude and costly than are the available methods for preventing the spread of hoof and mouth disease. The prevention of rheumatic fever—especially of its cardiac sequelae—is a case in point. The preventive therapy now available with sulfa drugs and antibiotics is certainly more effective and less expensive than earlier methods of controlling scarlet fever, for example. The channels for its application are the very ones that public health officers and private physicians together opened for the application of immunization against diphtheria, smallpox, and typhoid fever 50 years ago; and again for the diagnosis and treatment of syphilis 35 years ago.

Channels of Cooperation

The precise techniques and the division of labor in the control of chronic diseases may be different. The channels of cooperation between the health agency and the practicing physicians, and between them and the voluntary agencies, the hospitals, the schools, and other community facilities, however, are the same. And it is the foremost challenge to the State and local health departments to pick up the spade and do the ground breaking in opening up these channels of cooperation.

The health officer and his staff cannot take over the practice of medicine, nor is it their desire to do so. Ours is the challenge, however, to work with our colleagues in private practice, in medical organizations and specialty societies, so that a higher level of national health can be attained. Cooperation and teamwork for health should be the watchwords of all members of the health professions, regardless of the setting in which they work. Learning how to cooperate is one of the great problems before us and the extent to which we seriously explore and develop techniques of cooperation will be the real measure of our fulfillment of the trust we hold. This is true for all of us, whether we be general practitioners, specialists in private practice, hospital administrators, dentists, nurses, or public health administrators.

There should be no conflict of interests. Rather there should be harmony of interest. This assignment calls for developing our skills in the art of cooperation to the highest possible degree. It calls for imagination, persistence, and patience. All of the health professions need especially to bring to bear creative thinking on how to go about developing cooperative action for the prevention of chronic disease. We in public health and our colleagues in private practice have grown up professionally with certain established patterns of organization and operation.

The problems which confront us today cannot be solved in an identical framework in all communities. Perhaps what we need most at the present time is some communities with bold thinkers who will dare to conceive and test new patterns of organization and operation for the control of chronic disease. The communities that can come forward with such thinking may well be the pacesetters for future progress in public health.

Federal-State Relations

Consideration of the Nation's major health problems invites consideration of the future relations of the Public Health Service with the State and Territorial health officers and their staffs, the hospital, and the mental health authorities. The issue of Federal financial grants to the States in all fields is receiving the most serious attention at the highest levels of our Government. Mr. Rockefeller has described the Commission on Intergovernmental Relations, which will be concerned with governmental functions and fiscal resources, established by Congress last July. The Department of Health, Education, and Welfare also has set

up a special intradepartmental task force to cooperate with the staff of the commission. All of us are working to the end that the President's aim may be reached: namely, that the programs "be made more effective instruments serving the security and welfare of our citizens."

The question of financial grants is only one of many to be considered by the commission. However, it is certainly one of transcendent importance to the States and communities who will have to make the final decisions as to whether the services now supported in part by Federal grants are to be continued and maintained at effective levels.

If the Nation's health authorities will reflect on these developments, they will find that it requires a fresh look at the purpose of Federal grants and at the means for implementing health programs in the States and local communities. The tendency in the past has been to expect the continuation of a given grant program, whatever its category, general health, maternal and child health, venereal disease control, and so on. More and more the States should try to provide funds to cover programs once aided by Federal grants. This will free Federal funds for new programs.

Venereal Disease Control

Many of the State health officers will recall that Congress developed the very first "categorical grant" program—venereal disease control—on the principle of increasing State responsibility. The war period and the subsequent addition of other categorical programs have tended somewhat to obscure that principle. Many officials in public health, hospital construction, and mental health programs have not realized that the time would come when definite program appraisal and planning for the assumption of financial responsibility would be in order.

Our cooperative venereal disease control activity provides an example of what can be done to keep a categorical program dynamic—moving toward the goal for which it was created. In 1938, the Nation's health and medical authorities assured Congress that it was possible to bring venereal disease under control throughout the United States in a generation, or about 25 years. World War II with its accompanying increased spread of venereal infections would have set back the schedule many years had it not been for two fortunate situations: first, the swift action on the part of Federal, State, and local health agencies to set up a going program; and second, the advent of penicillin, which climaxed many years of research.

Timetable for Control

The State and the Public Health Service have never lost sight of the original goal. When the project grant program was initiated, State and Federal staffs jointly worked out a timetable for bringing venereal disease under control in each State. Twenty-four States had attained their goal by the close of the fiscal year 1953.

The timetable calls for control in the remaining States by the close of specific years, up through 1963. The Public Health Service and the armed services hope to provide continuing resources for handling the venereal disease problem in areas where direct Federal responsibility is clearly indicated. After 1963, the target year for control of venereal disease throughout the United States, the Federal Government's responsibility should be limited to surveillance against the interstate spread of disease, as in other infections under control.

This goal can be reached, but only if the States pick up their share of the burden. It will be a tragedy—nay, a disgrace—if after so many years of successful cooperative effort, after the pledge of public health to the Nation to control venereal disease, we do not attain this goal.

It may be that we cannot at the present time "pinpoint" the attainment of other public health goals with the precision we have achieved in venereal disease control. But the States and the Public Health Service should make it their joint concern and persistent effort. Your responsibility and ours is to render an account to the public of what we expect to accomplish, how we expect to attain the goals, and when. We need clear delineation of Federal and State responsibilities, including delineation of the need for Federal financial aid and State support.

Finances and Practical Appraisals

All of us realize that the combined current expenditures, Federal, State, local, and voluntary, for public health work in the United States falls far short of the amount needed to provide health services which will give the people the full advantages of modern medical and public health science. In looking ahead, therefore, we must go beyond the static concept of maintaining State and local health services at the current level. The public health, hospital construction, and mental health authorities will need to make it clear to their legislatures and their citizens that a mere replacement of reductions in Federal health grants will not be enough. More than replacement is needed if the American people are to attain higher levels of health in the future.

Additional expenditures of themselves, however, do not insure progress. Of equal importance is a more effective use of funds. Last year, I emphasized the need for a comprehensive appraisal of current public health practices, with a view to providing more effective local health services.

Inventory Studies

Many States and communities have inventoried their resources and activities from time to time; but few have measured the results of specific practices and procedures. Only by careful observation and study of local programs in various community settings will it be possible to develop reliable criteria for the improvement of current practices. Only through such studies can we test the comparable effectiveness of new and old procedures.

The Public Health Service has made tentative plans for such a study, and it is gratifying that some States and communities are preparing to inventory their programs in terms of current needs and to appraise their administrative practices. The data from these new-type inventories will be useful in connection with our study of public health practices. A complete stock-taking of Public Health Service activities and operations in the Federal-State cooperative programs also is underway. As we anticipated, the job is not easy. Our guideline is: how to get more for each tax dollar in a reduced budget, without sacrificing quality of service.

The new Hoover Commission, the Commission on Organization of the Executive Branch of the Government, is a second high policy-level group that will be concerned with health programs and organization. The commission will have eight task forces, including the following of special interest to you, the Public Health Service and the Children's Bureau; water and power resources; Government medical services; personnel and Civil Service; and accounting and budget procedures. Mr. Hoover has appointed Chauncey McCormick of Chicago as chairman of the Government Medical Services Task Force.

The scope of the second Hoover commission's mandate is considerably wider than that of the first. The first commission was restricted to proposals for reorganization and realignment of existing functions. The second is authorized to recommend abolishment of functions and activities not considered necessary to the Government, and the elimination of nonessential services, functions, and activities which compete with private enterprise. It may also recommend specific legislation.

Mr. Hoover has set December 31, 1954, as a target date for completion of the commission's legislative recommendations. Some of these may be ready early in 1954, however.

Water Resources and Pollution Control

The proposals of the commission on water resources will be of special interest to health officials. The critical situation which now faces the entire country is familiar to all of you. In a special message to Congress, July 31, the President emphasized the need for a sound national program of conservation, improvement, wise use, and development of both land and water resources. He also stated his belief that such a program can be achieved through cooperation among the States, local communities, private citizens, and the Federal Government.

The States have made impressive advances in water pollution control in the past 5 years, but even greater accomplishments are needed if the Nation is to keep pace with the demands of in-

creasing population and industrial production. By far the largest and most serious pollution problem is that of industrial wastes. We do not yet know the precise effects of chemicals in water on human health. We have not yet developed sufficient methods for eliminating these waste products. The production and use of chemicals—new and old—have vastly increased in recent years. The Nation's health authorities are in a position to aid water conservation programs, as well as the control of pollution, by increasing their vigilance over water uses and practices which impair the basic sources of supply and at the same time are potential hazards to public health.

Radiation Problems

We are making progress in the study of radiation problems. Two State health departments, California and New Jersey, in particular are going forward with pilot programs for the control of radiation hazards. Several cooperative programs have been established between the Atomic Energy Commission and the Public Health Service. The Service has recently had a special team which maintained liaison with the Atomic Test Group and the States. A public health team has done a most creditable job this year in monitoring fallout of atomic debris in areas up to 200 miles from the test site.

Home Accident Prevention

I am especially pleased to report progress in yet another "new" public-health program—home accident prevention. The W. K. Kellogg Foundation has awarded grants to eight States for the conduct of statewide demonstrations in this field, on recommendations of the Public Health Service. The Foundation based its extension of support on the success of the 4 local demonstrations initiated 2 years ago. The Service will cooperate with the States in their demonstrations, as we have in the local projects.

The Public Health Service has been fostering this interest in home accident prevention for the past 3 years. We have been able to assemble an enthusiastic and well-qualified team to assist in the design and conduct of demonstrations. The activity is giving our organization and State and local health departments valuable experience in how to develop needed new programs through cooperation with voluntary agencies, private foundations, and universities.

The Public Health Service has been the catalyst and technical consultant. The States and communities participating in the program have recognized a need and want to do something about it. A private foundation has provided the funds for finding out how to do the job. The National Safety Council has been an active participant and a valuable spearhead. The University of Michigan School of Public Health played host to the first National Conference on Home Accident Prevention, sponsored by the council and the Public Health Service, last January. Perhaps this is a design for public health progress in some other areas, and a role that the Service should play in other new and challenging fields in the years ahead.

Highway accidents also maim hundreds of people and take a major toll in lives every day. Voluntary and official agencies are deeply concerned with this problem, yet few official health agencies serve as consultants to the interested groups, or play any role in helping stem the tide of accidents. Technical advice on physical standards for drivers' licenses and on safety engineering is a fertile field for health department cooperation.

Other Environmental Programs

For the first time, the Public Health Service has a small sum allocated in the 1954 appropriations for assisting the States in the certification of interstate milk shippers. During the past 2 years, 395 shippers, representing 30,000 producers in 33 States and the District of Columbia, have been certified by the States. A year from now we expect that approximately 600 shippers, representing 50,000 producers, will be participating in this program.

Work has been completed on the first section of the Poultry Ordinance and Code, which we have been developing with the States and representatives of the poultry and poultry-products industries. The industries are concerned, as we health workers are, that about one-fourth

of all reported outbreaks of "food poisoning" are traced to poultry or poultry products. This fact tends to cause some communities to adopt regulations that serve, in effect, as trade barriers, but not always as adequate protection for the public. A guide to regulations that will both safeguard public health and permit the widest possible distribution of essential foods should be a good springboard for improvement in this area.

Emergency Activities

One of the most important events of the past year was the adoption of a formal agreement by the Public Health Service and the American Red Cross regarding cooperation in time of disaster. A copy of the agreement was forwarded to you with the agenda of this conference and will be a subject of further discussion tomorrow. The Service and the Red Cross recognize that really effective handling of disaster problems can be accomplished only by the State and local people. The State health officers can do more than any other single group to promote such effective handling of disasters in their jurisdictions.

I wish to commend the State and Territorial health officers—each and every one—for the highly successful operation of the emergency gamma globulin distribution program this summer. Between May 15 and October 1, nearly 3,750,000 cc. of gamma globulin for polio were allocated to the States under policies established by the Office of Defense Mobilization, on recommendation of the National Research Council, the Association of State and Territorial Health Officers, and other national groups and individuals. Mass prophylaxis programs, requiring more than 1,600,000 cc. of gamma globulin, were conducted in 23 local communities in the continental United States and in Juneau, Alaska. Approximately 231,000 children were inoculated in the mass programs.

Whatever epidemiologic investigation and scientific appraisal may indicate regarding the effectiveness of gamma globulin in the control of paralytic poliomyelitis, we can feel real gratification that national, State, and local agencies have demonstrated their ability to apply new operating procedures to a traditional public health problem—epidemic control.

In the gamma globulin program, the health officer found himself in a position opposite to his usual role. He had to restrict the use of the material rather than devote his efforts to the promotion of increased application of a public health measure. Despite the difficult, controversial, and potentially unpopular nature of the assignment, no health officer declined to take the responsibility. The Public Health Service's civilian requirements staff functioned effectively in meeting the requirements of the States. There was marked improvement in the reporting procedures.

Antipoliomyelitis Vaccine

Our success in jointly conducting such a "different" nationwide activity has proved again that Federal-State-voluntary cooperation in the health field is strong, reliable, and able to take new responsibilities in stride. The National Foundation for Infantile Paralysis is now asking your cooperation in large-scale testing of a killed-virus antipoliomyelitis vaccine. If studies to date are confirmed in a larger test series, the vaccine may provide an effective immunizing agent which will eliminate large-scale use of gamma globulin against paralytic polio.

Health of Migrant Workers

There are plenty of unresolved problems on our doorstep that need joint action among ourselves and with our colleagues in related fields, such as education, welfare, vocational rehabilitation, law enforcement, agriculture, and others. We need the help of our colleagues especially in solving such problems as health services for migrant workers. Doctor Eliot has discussed this problem with you. She and I are particularly gratified at the interest and constructive thinking demonstrated by a number of State health officers with respect to migrant worker's health.

Hospital Construction

You will recall that, in the approval of projects under the Hospital Survey and Construc-

tion Act, the so-called "split project" technique has been utilized for several years. The technique was designed to permit the approval of large projects, which because of their high cost, would absorb all of a given State's annual allotment, or even exceed it. By spreading the Federal participation over successive fiscal years, it was believed that such projects could be financed without jeopardizing the intended initiation of new construction throughout the country.

At the last session of Congress, there was adverse comment regarding the split project technique. As a result, with the approval of the Secretary, the Public Health Service is issuing a revised split project policy. The effect of the revision will be to limit the approval of such projects to sums not to exceed two-thirds of the equivalent of the Federal appropriation for 1954 in the fiscal year 1955, and to one-third of the same in 1956. In addition, applicants for split projects will hereafter be required to demonstrate their ability to complete a usable facility in the event of reductions in, or failure of, Federal appropriations. Members of the Public Health Service are discussing this new policy with State health and hospital authorities during this meeting.

Personnel Problems

Personnel shortages continue acute in many categories. I regret to say that the shortage of medical public health administrators has grown more critical during the past year. Clinical practice continues to attract most young physicians. I hope that our colleagues in private practice and in the medical associations will increasingly recognize the serious problems which face public health and that they will join us in an aggressive campaign to fill some of the gaps.

Sanitary Engineers

In the fields of sanitary engineering and nursing resources, several interesting projects have been completed. They will be useful in helping meet some of the shortages in these categories. The Public Health Service, for example, has completed a study designed to discover why such a high proportion of the sanitary engineers leave the field for which they were trained in college. It now appears that the majority who leave the field do so immediately after graduation; that is, they fail to enter the field. They lack information about specific job openings. We hope that some way will be found to inform the college seniors of all the jobs available to them in sanitary engineering.

Nursing Aides

The American Hospital Association, the National League for Nursing, and the Public Health Service have prepared a manual of simple nursing procedures for the training of nursing aides. Originally, the Health Resources Advisory Committee of the Office of Defense Mobilization urged the Service to investigate the need for training of these hospital workers. As you know, there are more than 200,000 auxiliary nursing personnel employed in the Nation's hospitals. Most of them have had no preparation. The "learn-as-you-go" training they get is time consuming, as is the constant supervision they require from professional nurses.

The new Handbook for Nursing Aides in Hospitals will be off the press about December 1. At that time, the National League for Nursing will begin a series of regional institutes to teach key nurses in local areas how to use the handbook and to apply the methods of instructing nursing aides which it introduces. I hope that the State health officers and hospital authorities will help extend the training of nursing aides by sending one or more of your nursing consultants to the regional institutes when they are announced in your areas.

The need for health manpower in the United States technical assistance programs overseas also continues to be acute. President Eisenhower has emphasized the importance of these programs, and we call on all of you to rotate some of your staff through tours of duty in international health services.

Last year, we solicited your cooperation in having State health departments sponsor health missions overseas. We realized that there would be many legal and regulatory difficulties to overcome, so we are pleased that three States have taken definite action.

Urges Critical Appraisal

We also wish to express our gratitude, and that of our colleagues overseas, for the splendid work the State health officers, their staffs, and local health authorities have done this year for the thousands of foreign students and visitors in our country. You have contributed immeasurably to our Nation's foreign relations by your warm and continuing interest in these neighbors from the free world who came to study and observe our American health services. I assure you that your understanding and friendship are sincerely appreciated by the men and women whom you have helped.

I am sure that many public health workers in the States and Territories, as well as in the Federal services, are wondering how they can make the admittedly inadequate nationwide expenditure for health purposes do a bigger job and a better job in the face of rising costs, some reductions in financial support, and continuing personnel shortages.

I am sure that we can do a bigger job in spite of some adversity, and I believe that all of us can do a better job. The people in our States and communities must learn to look to their State and local governments and their voluntary agencies for additional support of the services which reach them directly. All of us must learn how to be more efficient in the utilization of available funds. We all need to do a little soul searching. Critical appraisal of our practices and projects may well reveal economies that will make it possible to do a better job in our traditional public health activities, as well as to start some new programs. It will help us eliminate repetition of long-outmoded programs and practices. In so doing, we will be able to launch a successful attack on the major causes of ill health; an attack planned and carried out in an atmosphere of full cooperation and trust by all professional groups, official and voluntary—and without official control and dictation. Such an attack will bring us closer to our great goal—higher levels of health for the American people in their communities.

The Impact of Research And Medical Education On Public Health

By Chester Scott Keefer, M.D.
Department of Health, Education, and Welfare

The impact of research and education on the public health has been so great in the past 50 years that its full measure cannot be taken in a few minutes. However, I want to reflect a little about it tonight and to take a long look ahead. Permit me to start with your first conference.

Changing Health Problems

When the first conference of State and Territorial health officers and the Public Health Service was called, shortly after the turn of this century, the major health problems in the United States resembled those of many underdeveloped areas of the world today. The average life expectancy at birth was about 49 years. Infant and maternal mortality rates were high; communicable and infectious diseases were prevalent and were frequent causes of death; relatively little was done to prevent pollution of water supplies and food, and many large cities had open sewer systems.

I am told that the discussions in the first conference and in those of many subsequent years were an exchange of knowledge and experience on ways of improving these conditions, since our country—already embarked on the transition from an agricultural to an industrial econ-

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omy—recognized human resources as its most precious national wealth. This shift from an agricultural to an industrial economy carried with it an increasing number of health problems. High priority was given in the early years of public health and preventive medicine to bacteriological research, training and demonstrations in environmental sanitation, and interstate cooperation in combating the spread of infectious diseases.

The contrast between the questions considered in your present conference and in that of some 50 years ago is a dramatic proof of the success of research and education in the health services. Specialists in bacteriology, immunology, epidemiology, sanitary engineering, pediatrics, and obstetrics have greatly extended our knowledge of the causes of infectious diseases. The public health profession has developed techniques that, in conjunction with improved standards of living and advances in the practice of medicine, have almost eradicated the sources of many communicable diseases. Nearly 20 years has been added to life expectancy at birth. This achievement has resulted largely from declines in the death rates for diphtheria, streptococcic diseases, diarrhea and enteritis, tuberculosis, pneumonia, and other infectious diseases which formerly took the lives of many young children.

Primary emphasis in the early attack against infectious diseases was on prevention and detection. These preventive measures served to reduce the number of cases and carriers, thus decreasing the threat of epidemics. These measures for the prevention and detection of infectious diseases must continue with intensity since they are still with us. Overall death rates do not tell the whole story.

Specific Therapy

Specific therapy is a more recent development, stemming from laboratory and clinical research and the development of anti-infective drugs which have further reduced death rates and lessened the hazards of serious and prolonged illness from infections. The use of anti-infective agents has also aided in the prevention of certain diseases.

These successes are at once a source of pride in achievement and a source of confidence in health progress for the future. They are not cause for relaxation of efforts, however, for in many parts of the United States infectious diseases such as tuberculosis and dysentery are still prevalent, and tuberculosis is one of our important chronic diseases. Efforts must be continued on a selective basis to reach the irreducible minimum incidence of morbidity and mortality from infectious diseases in each area and to hold our past gains throughout the Nation. We must also find ways of using and extending our knowledge and experience in an attack against chronic and prolonged illness. The art and science of medicine and public health face the complex problem of preventing, diagnosing, treating, rehabilitating, and minimizing the effects of the chronic conditions that are now leading causes of death and disability.

In the early 1900's heart disease, arteriosclerosis, cancer, diabetes, and mental disorders received scant attention as public health problems, since only about 18 percent of the population survived the hazards of acute infectious diseases to reach age 45. Only an extremely hardy 4 percent lived to celebrate their 65th birthday. These chronic diseases, though found at all ages, strike hardest in the later years of life. The proportion of the aged has now doubled and is still increasing, while well over 25 percent of our population has reached or passed age 45, and half of the deaths in this country occur in the age group of over 65 years.

Research Needs

With the past as prologue in public health, a conference of State and Territorial health officers 50 years hence will unquestionably recount spectacular gains in lessening the prevalence and severity of many of these chronic conditions. Let me outline briefly my views of some urgent needs in an all-out attack against chronic illness.

First, we need precise knowledge of the extent of the chronic disease problem. That knowledge can be gained by local, State, and national surveys to derive estimates of the number of persons suffering from chronic illnesses and impairments. The surveys should be de-

signed to reveal information in terms of geographic areas, age groups, income levels, diagnoses, duration of the condition, and potentialities for rehabilitation and self-support.

Research efforts must also be directed toward analysis of the natural history of chronic diseases, to discover any genetic and constitutional factors that predispose people to hypertension, diabetes, rheumatism, arthritis, ulcers, allergies, and mental and nervous disorders, as well as to assess the influence of diet, housing, working conditions, and physical and emotional stresses that may play a part in the development of these conditions. Research must also extend our knowledge of the aging process to determine what constitutional and environmental factors are associated with a physically and mentally active old age, for infirmity and old age are not synonymous.

Treatment of chronic illness requires more active participation by the patient than is usually necessary in acute illness. Research in the factors that motivate people to act for their health is therefore needed to give us clearer guidance than we now have in our efforts to help the disabled and the aged to make the most of their remaining capacities for self-care and economic independence.

Research and pilot demonstrations must point the way toward more effective means of early case finding, exact diagnosis, referral for medical treatment, followup, prompt rehabilitation, and suitable employment for those who suffer from chronic illness. These measures will not only reduce human suffering and increase our manpower, but will also help to lessen the burden of public aid. Study of the recipients of public assistance, for example, reveals the striking extent to which illness has made it necessary for people to seek public aid. Prompt attention to their chronic ailments might well have forestalled the incapacity for self-support. Of those drawing relief for permanent disability, 40 percent in 30 States reported that 10 years or more had elapsed since the onset of their major impairment. The size of old-age assistance rolls is also an indictment of our failure to preserve or restore and utilize the working capacity of the aged.

A pressing problem of the future is to keep as many aged and incapacitated people as possible out of hospitals and other institutions and to treat them in their own homes. State and Territorial health officers, with their responsibilities for helping and advising States in planning for the construction of hospitals under the Hill-Burton Act, are in a strategic position to influence more appropriate planning for the aged and the chronically ill. Hospitals should be planned in such a way as to extend the availability of outpatient departments, rehabilitation services, and home care arrangements. Prolonged stays in hospitals and custodial institutions, without dynamic programs of rehabilitation, tend to increase the apathy and helplessness of the aged and those incapacitated by chronic disease.

We must, therefore, develop and apply more widely throughout the country better and cheaper methods of caring for the chronically ill and the handicapped, improving their housing conditions, their participation in community activities and their opportunities for independence and self-care. Since many different organizations are needed in this endeavor, we must have effective teamwork among all individuals and agencies in the community concerned with the care of the incapacitated. The difficulty of utilizing all available resources and the necessity for teamwork are revealed by the fact that my home community, the greater Boston area, has 400 separate health agencies. A rural county in the midwest with less than 1,000 people in its largest town had as many as 14 agencies offering some services to the chronically ill. Cooperation, coordination, and systematic referral among these agencies not only prevent duplication of effort and improve efficiency, and hence economy, but also reduce the time lag in providing the types of treatment and rehabilitative services needed by the patient in successive stages of his illness.

Encouraging Developments

This sketch of the focus of some efforts needed to combat chronic illness does not mean that beginnings have not been made in many of the directions I have outlined.

Among the many encouraging developments I might mention is the far-flung network of research being aided by grants from the Public

Health Service, as well as the new approach to integrated laboratory and clinical investigation being started at the Clinical Center in Bethesda. These approaches to solution of the mysteries of chronic illness need no amplification for this audience.

The recent report on schools of public health, published by the Public Health Service, gives heartening evidence of the trend toward greater concern with chronic illness in training public health workers. It also indicates that health departments frequently serve as training and demonstration centers for students of public health. This development provides a close link between research, education, and application of knowledge.

A particularly encouraging approach is described in the report on preventive medicine in medical schools, which forms part two of the October number of the *Journal of Medical Education*. If you have not already read that report, I commend it to your attention. It indicates many ways in which medical schools are attempting to help their students acquire a clearer understanding of patients as people. Many medical schools give students an opportunity, through home care and similar courses, to observe and analyze the social and environmental factors in illness, and to collaborate with nurses, occupational and physical therapists, and medical social workers in caring for patients.

It would be my hope that the health departments would extend their interests to the educational institutions on a wider base. We have much to learn and much to gain from a closer relationship and a better understanding of health problems as they exist in the community.

In addition to their use in training medical students and visiting nurses, home care programs afford means of providing integrated services in the patient's home. Under several programs patients who remain at home receive services from physicians, visiting nurses, physical and occupational therapists, and medical social workers, in accordance with their requirements for treatment, health guidance, rehabilitation, and social services. A health department, particularly in a community that lacks teaching hospitals, can perform outstanding community service by analyzing what components are needed in a good home care program and in helping the community to decide who should administer it. The health department also can help private physicians by providing them with the services of visiting nurses and others needed in the home care of their patients.

Lastly, I call your attention to the forthcoming conference on care of the long-term patient being sponsored by the Commission on Chronic Illness, the Public Health Service, the American Hospital Association, the American Medical Association, the American Public Health Association, and the American Public Welfare Association. Study groups preparing for that conference in March 1954 are assembling facts and standards for services to patients at home and in institutions. Other study groups are concentrating on needs for integration of services and facilities, on research, and on methods of financing services. Physicians, nurses, social workers, public health specialists, medical educators, insurance groups, hospital directors, and representatives of industry and labor are pooling their knowledge and experience in this endeavor. Findings and recommendations of that conference should suggest patterns for desirable relationships among services, facilities, and programs.

Challenge to the Profession

In these developments I foresee an expanding and challenging role for health departments. They can collaborate with medical schools and other institutions training for the health professions by participating in research and in demonstrations of public health practice. They can serve as centers for the administration of medical services to the needy or for advice and help in planning those services. They can give advice and leadership in analyzing a community's needs for institutional facilities and rehabilitation departments and for special groups of personnel, such as visiting nurses, physical and occupational therapists, nutritionists, to provide more services to patients in their homes. With their new responsibilities for licensing nursing homes, they can promote higher standards of safety and care in those facilities, and can act as informational and referral centers to aid in more effective use of such homes.

They can help private physicians obtain the services of various community organizations in the care of patients in their homes so that the most appropriate type of service will be available in progressive stages of the illness.

In one field, maternal and child health, great strides have been made in developing and applying methods for health education, periodic examination, diagnostic services, and referral for treatment and rehabilitation. Given the knowledge and the will, it is within the power of the health professions to do as much for all age groups, including the aged.

The advances in the past have resulted from the application of new knowledge. Advances in the future will likewise result from new knowledge and its transmission through education and public health practice. The shift in emphasis will be to keep well people well and to rehabilitate the handicapped so that as many people as possible will be able to lead useful and productive lives. You ladies and gentlemen of the public health professions can continue to take the leadership in this important field of activity in the future as you have in the past.

Notes on the History Of the Surgeon General's Conference, 1903–53

A Working Federal-State Partnership for the Public's Health

Under the heading, "First annual conference between National and State health authorities," *Public Health Reports* published the following paragraph on page 903 of the June 12, 1903, issue:

"The first annual conference under the law of July 1, 1902, of delegates from the health authorities of the States with the Surgeon-General of the Public Health and Marine-Hospital Service, was held on June 3, 1903, at the New Willard Hotel, Washington, D. C., the conference being called to order by the Surgeon-General at 10 o'clock a. m., and final adjournment being taken at 5:30 o'clock p. m. Twenty-three States were represented by delegates, three others sending letters of regret. . . ."

Section 7 of the Public Health and Marine-Hospital Service Act of 1902 reads:

"That, when, in the opinion of the Surgeon General of the Public Health and Marine Hospital Service of the United States, the interests of the public health would be promoted by a conference of said Service with State or Territorial boards of health, quarantine authorities, or State health officers, the District of Columbia included, he may invite as many of said health and quarantine authorities as he deems necessary or proper to send delegates, not more than one from each State or Territory and the District of Columbia, to said conference: Provided, That an annual conference of the health authorities of all the States and Territories and the District of Columbia shall be called, each of said States and Territories and the District of Columbia to be entitled to one delegate; And provided further, That it shall be the duty of the said Surgeon General to call a conference upon the application of not less than five State or Territorial boards of health, quarantine authorities, or State health officers, each of said States and Territories joining in such request to be represented by one delegate."

The intent of this section was reiterated in

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Section 312 of the Public Health Service Act of 1944 (Public Law 410):

> "A conference of the health authorities of the several States shall be called annually by the Surgeon General. Whenever in his opinion the interests of the public health would be promoted by a conference, the Surgeon General may invite as many of such health authorities to confer as he deems necessary or proper. Upon the application of health authorities of five or more States it shall be the duty of the Surgeon General to call a conference of all State and Territorial health authorities joining in the request. Each State represented at any conference shall be entitled to a single vote."

Surgeon General Wyman presided at the first annual conference and in his opening address, published in "Transactions of the First Annual Conference of State and Territorial Health Officers with the United States Public Health and Marine-Hospital Service," said:

> "What may be the result of these annual conferences time must determine, but certainly we may consider the present, the first annual conference under the law, as a most noteworthy event. For the first time in the history of the United States there has been placed within its statutes, by the act of Congress referred to, a provision looking to harmonious and cooperative efforts in public-health matters between the National Government and the State governments.
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> "This status has long been desired, but difficult of achievement by reason of our republican form of government. It has been difficult for the National Government to extend its influence into State health matters without appearing to infringe upon the States' authority, and it has been difficult for the States, individually or collectively, to seek aid from the Government without appearing to surrender authority reserved to them by the national Constitution. In the meantime, however, the Marine-Hospital Service, now bearing the title of the Public Health and Marine-Hospital Service of the United States, has become so developed and strengthened, and the State health organization have been so perfected, that a sentiment of respect, one for the other, has been established, finding its expression in this law of 1902, and, in particular, section 7, above referred to.
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> "To my mind the outlook is bright. The great problems to be solved in sanitary affairs, the great work to be done in the suppression, and even elimination, of disease, and the cultivation of health and strength, so that physically, as well as in other respects, the United States may take a leading position among the nations, are propositions which should not be considered impossible of solution, and a proper development under the terms of this law will be an important step in this solution.
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> "One of the most important features of this assemblage is its official character. All of us are familiar with conventions of similar purpose, productive of much useful information but entirely lacking in official significance. Here, however, are assembled the legalized health authorities of the States, representing the practical administrative experience as well as the theoretical and scientific knowledge required in the consideration of public-health affairs.
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> "Many of you have devoted the best years of a long professional life to the consideration of the subjects which will come before us, having acquired, in individual instances and on special subjects, unusual knowledge and wisdom.
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> "Combined effort appears to be a distinguishing feature of this new twentieth century. This is seen in nearly all forms of civic and commercial life and even scientific and professional effort. It would seem that when the history of the twentieth century is written there will be lacking those great and single characters looming away above the average, leading, directing, or dictating; instead there will be an elevation of the average, the best individual effort will, neither in purpose nor effect, aggrandize the individual, but will be exerted in connection with other efforts of

like nature for the establishment of a parity of well-being among all. This, I take it, will be the keynote of our action, bearing constantly in mind the actual results to be attained and being determined to attain them."

The Surgeon General went on to say: "While the present is the first annual conference, it is not the first conference called under the law. Last January, upon the request of 22 States, a so-called plague conference was called to consider the situation in San Francisco. The proceedings of that conference in detail have been transmitted to each of you. The effect of it was undoubtedly very great in bringing about the present satisfactory status in San Francisco. The object of that conference was specific, but, as you will note, the law providing for the annual conference gives no details. We must assume, therefore, that the intent of the law is that we shall get together, and we are to decide ourselves as to the matters to be considered."

Dr. Wyman proposed that this first conference be organized into committees dealing with: scientific research and sanitation, prevention and spread of epidemic diseases, morbidity and mortality statistics, State legislation, education, and special committees on specific diseases such as cholera, yellow fever, plague, smallpox, tuberculosis, leprosy, and typhoid.

Conferences have been held annually since 1903 with the exception of the year 1946 during which two conferences were held. Early the conference became known as a "working conference" rather than a meeting in which there were presentations of many scientific papers. By 1920, some State health officers were bringing their State sanitary engineers to the meeting in order that they could enter into the discussions of the many sanitation problems which came up at the conference. This pattern of bringing staff members with them is currently followed by several State and Territorial health officers who feel that the benefits to be derived from committee discussions justify the attendance of certain members of their staff at the Surgeon General's conference.

In 1935, the State health authorities also met with officials of the Children's Bureau. In anticipation of the enactment of the Social Security Bill before the end of the calendar year, the entire time of the conference was given to discussion of the proposed program to be carried out under the provisions of the bill. Recommendations were presented by the conference to the Surgeon General with respect to the proposed allotment of funds to the States and the regulations governing submission of plans and payment of allotments.

In 1937, committee work was accomplished by joint committees of the Surgeon General's conference with the State and Provincial health officers conference.

In 1941, the need for more time for committee work was expressed. Also, it was suggested that an attempt be made to formulate ahead of time the items for discussion.

In 1942, the State and Territorial health officers organized as an association, and soon following this organization the conference committees were dispensed with and the committee work was taken over by committees of the association.

Currently items are proposed both by State and Federal constituents in the form of recommendations to be adopted by the State and Territorial health officers in conference assembled. Items proposed are referred by the executive committee of the Association of State and Territorial Health Officers to the appropriate standing committees for study and discussion at the time of the conference to determine if the recommendations should be proposed to the entire conference for adoption.

The National Mental Health Act of 1946 amended Section 312 of the Public Health Service Act of 1944 to read:

"A conference of the health authorities of the several States shall be called annually by the Surgeon General. Whenever in his opinion the interests of the public health would be promoted by a conference, the Surgeon General may invite as many of such health authorities to confer as he deems necessary or proper. Upon the application of health authorities of five or more States it shall be the duty of the Surgeon General to call a conference of all State and Territorial health authorities joining in the request. Each State repre-

sented at any conference shall be entitled to a single vote. Whenever at any such conference matters relating to mental health are to be discussed, the mental health authorities of the respective States shall be invited to attend."

The Hospital Survey and Construction Act of 1946 provided the authority for expanding further the attendance at these annual conferences by the addition of State hospital officials. Section 634 of this act is as follows:

"Whenever in his opinion the purposes of this title would be promoted by a conference, the Surgeon General may invite representatives of as many State agencies, designated in accordance with Section 612 (a) (1) or Section 623 (a) (1), to confer as he deems necessary or proper. Upon the application of five or more of such State agencies, it shall be the duty of the Surgeon General to call a conference of representatives of all State agencies joining in the request. A conference of the representatives of all such State agencies shall be called annually by the Surgeon General."

In 1947, the Association of State and Territorial Health Officers amended its constitution to include in its membership heads of or executive officers of any agencies other than the State departments of health which are legally designated as the agencies to administer plans aided by Federal funds allocated to their respective States for mental health and surveying or constructing hospitals.

A definite pattern of the annual conference has been established in order that, with as little confusion as possible, the week of the conference serve as an annual meeting of the Association of State and Territorial Health Officers, meeting of the Surgeon General with mental health authorities and representatives of State hospital survey and construction agencies, meeting of the Chief of the Children's Bureau with the above named groups and other State and Territorial health officers, as well as a conference of the Surgeon General with State and Territorial health officers. The conferences, since 1946, have been held at the end of the year in order to avoid conflict with sessions of the State and Territorial legislatures.

New Commissioner of Social Security

John William Tramburg, appointed Commissioner of Social Security, Department of Health, Education, and Welfare, by the President on November 10, 1953, was sworn in on November 24. From March 1950 Mr. Tramburg was director of the Wisconsin Department of Public Welfare. He was director of the District of Columbia Department of Public Welfare from May 1948 to February 1950.

A graduate of State Teachers College, White Water, Wis., Mr. Tramburg also attended the University of Chicago School of Social Service Administration and the Columbus University Law School. During the war he was on duty with the Navy. He was assistant superintendent of the Industrial Home School, Washington, D. C., from 1945 until appointed director of the District of Columbia Department of Public Welfare.