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NATIONAL HEALTH ASSEMBLY MAY 1-4, 1948
NUTRITION SECTION

Chairman: — Dr. Frank G. Boudreau, Executive Director, Milbank Memorial Fund, 40 Wall Street, New York 5, N. Y.

Steering Committee: — Mrs. Bertha S. Burke, Department of Maternal & Child Health, Harvard University School of Public Health, 55 Shattuck Street, Boston, Mass.

Mr. Rowland Burnstan, Executive Director, State Charities Aid Association, 105 East 22nd Street, New York, 10, New York.

C. G. King, Ph.D., Scientific Director, The Nutrition Foundation, Inc., Chrysler Building, New York 17, New York.

Frederick J. Stare, M.D., Department of Nutrition, Harvard University School of Public Health, 695 Huntington Avenue, Boston, Mass.

L. A. Maynard, Ph. D., Savage Hall, School of Nutrition, Cornell University, Ithaca, New York.

Staff Assistant: Harold R. Sandstead, M.D., Chief, Nutrition Section, States Relations Division, U.S. Public Health Service.

Subcommittee Chairmen: : L. A. Maynard, Ph.D., C. G. King, Ph.D., Frederick J. Stare, M.D., Dr. H.E. Longenecker, Dean, Graduate School, University of Pittsburgh, Pittsburgh 13, Pennsylvania., Dr. Elmer L. Sevringhaus, Medical Director, Hoffman-LaRoche, Inc., Nutley 10, New Jersey., Miss Pauline Murrah, Director, Nutrition Service, American Red Cross, North Atlantic Area, 300- 4th Avenue, New York 10, N.Y.

Delegates: * Alpert, Dr. Elmer, Columbia University, N.Y, N.Y.

Amidon, Mr. Paul, General Mills, Inc. Minneapolis, Minn.

Babin, Mr. L.J., School Superintendent, Donaldsville, La.

Bishop, Mrs. Robert, Jr.,(or alternate), Pres., Nutrition Association of Greater Cleveland, Cleveland, O.

Boudreau, Mrs. Frank G., New York, N. Y.

Bowes, Mrs, Anna DePlanter, Chief, Div. Of Nutrition, Harrisburg, Pa.

Delegates (cont'd) Brewe, Dr. John H., Research Associate, Burlington, Vt.

Bryan, Dr. A. Hughes, Professor, of P.H.N., Chapel Hill, N.C.

Bryan, Dr. Mary deGarmo, New York, N. Y.

Burnstan, Mrs. Rowland, State Charities Aid Assoc., N.Y.N.Y.

* Calkins, Dr. Robert, Director, Gen. Educ. Board, N.Y., N.Y.

Campbell, Miss Louise, New York, N. Y.

* Church, Dr. Charles F., New Brunswick, N. J.

* Davidson, Dr., Chas, Thorndike Mem. Lab., Boston, Mass.

DeGraff, Dr. Harold, Dept. Of Agric'tl. Economics, Itacha, N

Dunn, Dr., Max Shaw, Prof. of Chemistry, Los Angeles, Cal.

Farnsworth, Dr. Stanford F., City Helath Officer, Oakland "

Felton, Dr. J. S., Oakridge, Tennessee.

* Fischer, Dr. Dean, Director Bureau of Health, Augusta, Me.

Fry, Mrs, Martha Smith, Wallingford, Conn.

Goldsmith, Dr. Grace A., Tulane Univ., New Orleans, La.

Griffith, Dr. Wendell H., Prof. Bio. Chem. St. Louis, Mo.

Guest Dr. George M., Childrens' Hosp., Cincinatti, Ohio

Higbee, Miss Violet B., R.I, State College, Kingston, R.I.

Hilleboe, Herman E., N.Y. State Comm. Of Health, Albany NY

Hilton, Dr. M. Eunice, Dean of Women, Syracuse, N. Y.

Hoobler, Dr. Icie Macy, Director, Research Laboratory Children's Fund of Michigan, Detroit, Mich.

Hunscher, Dr. Helen A., Head of Dept of Home Economics, Cleveland 6, Ohio.

Irmisch, Mrs. Alice M., Columbus, N. J.

* Jacocks, Dr. W.P., Director, Nutrition Bureau, Raleigh, N.C.

* Kessler, Mr. A.H., Chairman, Hennepin Co. Chapter, ARC, Minneapolis, Minn.

Delegates (cont'd)

Kittrell, Dr. Flemmie, Dean, Home Economics, Wash., D.C.

* Krauss, Dr. W. E., Dairy Industry, Wooster, Ohio

Kruse, Dr. H.D., Milbank Memorial Fund, New York, N.Y.

Leonard, Mrs. Paul H., Columbia, South Carolina

* Lipett, Dr. Ronald, Research Center for Group Dynamics, Cambridge, Mass.

* Lockwood, Miss Elizabeth, Dept. of Nutrition, Boston,Mass

* Lund, Dr. Chas., Boston, Mass.

* MacDonald, Miss May, Sr. Home Economist, Albany, N. Y.

* MacKinnon, Miss C. Frances, Dept. of Nutrition Boston Mas.

MacLeod, Dr. Florence, Asst. Director Agric'tl., Experiment Stn., and Professor of Nutrition, Knoxville, Tenn.

* Merriane, Miss Oreana, Asst. Prof. Nutrition, Amherst Mas

Murrah, Miss Pauline, Director, Nutrition Serv. NY., NY

Newton, Dr. Roy, Swift and Co, Chicago, Ill.

Osborn, Mr. Fairfield, Pres., NY Zoological Society,NY,NY

* Phillips, Dr. Velma, Dean, College of Home Economics, Pullman, Washington.

* Pinkham, Miss Arline, Kingston, Rhode Island

Pollack, Dr. Herbert, New York 21, New York.

Powell, Miss Ruth, State Supervisor, School Lunch Service, Little Rock, Arkansas.

* Radke, Dr. Marian, Research Center for Group Dynamics, Cambridge, Mass.

Rice, Dr. Guy V., Div. of Maternal and Child Health, Atlanta, Ga.

Robb, Dr. Elda, Prof. of Nutrition, Boston, Mass.

Rose, Dr. W. C., Univ. of Ill., Urbana, Ill.

Ruhland, Dr. George C., Dist. Health Officer, Wash. D.C.

Delegates Cont'd.

Salthe, Dr. Cle, Nutrition Foundation, Inc. N.Y., N.Y.

* Schultz, Dr., Theodore, Univ. of Chicago, Chicago, Ill.

* Segundo, Mr. Thomas, Papago Indian Reservation, Sells, Arizona.

Shank, Dr. Robert E., Prof. of Preventive Medicine, St. Louis, Missouri.

* Snyder, Mr. J.L.K., Merck & Co., Rahway, N. J.

* Thomas, Mr. G. Cullen, Gen. Mills Inc. Minneapolis, Minn.

Tompkins, Dr. Winslow T., Nutrition Research Clinic, Philadelphia 7, Penna.

Turner, Miss Maxine, Miller's Nat'l. Federation, Chicago 6, Illinois.

* Vaughn, Miss Margaret S., Director, Public Health Nursing, Little Rock, Arkansas

Wallace, Miss Maude, State Extension Serv,. Blacksburg, Va

Wiehl, Miss Dorothy G., Milbank Mem. Fund, New York, N.Y.

Wilder, Dr. Russell M., Mayo Clinic, Rochester, Minn.

* Wilkins, Walter, Director, Nutrition Investigations, Jacksonville, Fla.

Williams, Miss, G. Dorothy, Nutritionist, New York, NY

Wilson, Dr. James R., ~~Chairman~~ Secretary, Council on Foods and Nutritions, and Chicago, Ill.

Youmans, Dr. John B., Dean, University of Illinois, Chicago, Illinois.

Young, Dr. Charlotte, Assistant Professor, Medical Nutrition, Ithaca, N. Y.

(*) No acknowledgement as of April 29, 1948

The Washington Post

WASHINGTON: SUNDAY, MAY 9, 1948

What the National Health Assembly's 10-Year Program Will Mean to You . . .

By Agnes E. Meyer
Post Reporter

THE success of the National Health Assembly was a triumph of the democratic process over tensions that appeared to be insoluble. No less significant than the far-reaching practical program that has been outlined by the delegates, was the fact that for the first time the medical profession and numerous lay groups sat down together and worked harmoniously for the common good on a Nation-wide basis.

This conference will always be memorable because it built a permanent bridge between the medical profession and the labor unions, farm organizations, cooperative health federations and other groups that have long been fighting for better health protection. It has transformed armed and hostile camps into coalescing forces whose impact upon the national welfare will gradually make itself felt throughout the country.

Members of the A. M. A. expressed satisfaction that the labor unions had such expert people on the various committees, and the labor union representatives found out that medical practitioners are not necessarily anti-social. The success of their common endeavors brought home to professional and layman that the best interests of the medical profession are served when the layman respects the physician's role in society, and that the best interests of society are served when proper organization makes the skills of the physician available to the maximum number of people.

As a result the skepticism with which many of the delegates came to this conference was transformed by mature and patient deliberations into the certainty that foundations have been soundly laid upon which an all-embracing national health program can be constructed.

10-Year Program

THE conference was called by the Federal Security Administrator, Oscar R. Ewing, at the request of President Truman, to establish the widest possible "area of agreement" between disparate factions upon a ten-year program for the health and welfare of the Nation. An executive committee appointed by Mr. Ewing joined him and his staff in selecting leaders from all parts of the country as chairmen and members of the fourteen committees on problems of organization, facilities, personnel and finance.

These sections accepted as basic to their considerations the definition of health promulgated by the World Health Organization. "Health is defined as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity."

Two other trends ran through all the discussions: that a health program is everybody's business, and that its development depends upon local initiative and a knowledge of local needs, and therefore upon the preservation of local autonomy.

What the average person will want to know about the findings of this conference is: "How do they affect me, my family and my immediate environment?" Therefore I shall give what must necessarily be an oversimplified picture of the new, healthier and happier community that will come into being when and if the major plans of the Health Assembly are carried out. I shall therefore list the committees and the names of the chairmen without attempting to give credit to individuals for the different ideas on organization, facilities, personnel and financing.

Section 1. What is the Nation's Need for Health and Medical Personnel? Chairman: Algo D. Henderson.

Section 2. What is the Nation's Need for Hospital Facilities, Health Centers and Diagnostic Clinics? Chairman: Charles F. Wilinsky.

Section 3. What is the Nation's Need for Local Health Units? Chairman: Haven Emerson.

Section 4. Chronic Disease and the Aging Process. Chairman: James R. Miller.

Section 5. A National Program for Maternal and Child Health. Chairman: Leona Baumgartner.

Section 6. A National Program for Rural Health. Chairman: Joseph W. Fichter.

Section 7. What is the Nation's Need for Research in the Service of Health? Chairman: Andrew C. Ivy.

Section 8. What is the Nation's Need for Medical Care? Chairman: Hugh R. Leavell.

Section 9. State and Community Planning for Health. Chairman: Florence R. Sabin.

Section 10. Physical Medicine and Rehabilitation. Chairman: Henry H. Kessler.

Section 11. What Can Be Done to Improve Dental Health? Chairman: Ernest G. Sloman.

Section 12. A National Program for Mental Health. Chairman: William C. Menninger.

Section 13. What Can Be Done to Improve Nutrition? Chairman: Frank G. Boudreau.

Section 14. A National Program of Environmental Sanitation. Chairman: Arthur D. Weston.

Organization

FULL-TIME local health departments in every city and county or combination of counties are essential to a strong health program. This is one of the recommendations made by the National Health Assembly, that is already implemented in a bill now before the Congress, S. 2189, which provides Federal aid to strengthen local public health units and increase their number so that there will be Nation-wide coverage.

Cooperating with these public officials, local and State health councils, made up of all agencies and individuals concerned with health, as well as business, banking and industrial groups, will help to plan the local program and keep it close to local needs. In addition, these councils must arouse the interest, aggressive support and

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HEALTH—From Page 1

participation of the entire community in a medical program that is both preventive and curative.

These councils should emphasize the primary importance of health education, the basic importance of local control of health programs, the necessity of removing inequities in medical facilities as between communities and between economic groups in the community, and the economic values to be derived from lowering high death rates, decreasing incidence of disease and accidents. Health cannot be achieved merely through a medical approach, as adequate housing, a living wage, good working conditions, education, recreation and other facilities, are all involved in physical and mental well-being.

Yet until adequate services for local health are established throughout the Nation, there will be failure in every other area of endeavor. Local health units, a retail point of distribution for complete medical care, are the basic need. Forty million people at present are not reached by such a program and many others are dissatisfied.

The lack of these retail stores for health services now creates the heavy load on medical care. The public has the right to expect that these local preventive and referral centers shall be decently housed on Main Street with a plate-glass front, not tucked away, as they often are now, in a cellar room of the courthouse or jail. Moreover, medical education and a wide variety of research must go forward to put new goods for sale on the shelves of these local retail health stores and keep them up to date.

Rural Services Few

THE various services that should be for sale in the local health centers would require:

1. Mechanism for tabulating vital statistics and interpreting their significance.
2. Control of communicable diseases.
3. Sanitation.
4. Diagnostic and laboratory procedures.
5. Hygiene of human reproduction.
6. Information on health education and laws of living.

Such a program involves the need for more factual information as to how many doctors, nurses, other medical personnel and hospital facilities are actually needed in each community. At present local health departments meeting the minimum standards are available to less than half of the Nation, and two-sevenths of the population, largely in rural areas, have no local health units whatever.

Today people clamor for security, security for the family, the community and the Nation. The most important factors in that security are good physical health and stable emotions that will produce strong, healthy and happy citizens.

The mental health specialists, whose work is essential to establishing this general sense of security, called attention to the fact that their profession is more tragically understaffed than any other. The need for increased training of psychiatrists and ancillary workers can be gauged if we realize that 62 per cent of the inmates of veterans' hospitals are psychiatric cases. The dental division is no less emphatic in demanding more dentists and technical assistants to prevent diseases by early and adequate attention to children. A special program for child care is essential, preferably in close association with the school system.

But the greatest needs are for more doctors and nurses, now that public health services must be expanded. Increased population, increasing Federal, State and local programs, and increased health consciousness of the people, have accelerated the demand for expanded medical care. The estimates as to how many additional medical schools and doctors may be required are uncertain. But whatever steps are taken to extend medical training, the high quality of our present medical education must and will be maintained.

Problem of Education

THE committee on personnel recognized that more Negro physicians should be trained This problem is part of the larger problem of improving the opportunities for the education of Negroes in general, if the number of Negroes qualified to enter medical schools is to meet the acute demand. Here will be the area where follow-up work will be urgent, if this recommendation is to be quickly and effectively implemented.

The need for more hospital beds was definitely estimated at 265,000 general, 291,000 mental, 85,000 tuberculosis and 245,000 chronic diseases. This deficit, it was conceded, cannot be met within the ten years' limit set by the President. The Hospital Survey and Construction Act was praised as a sound approach to the problem, but the rural delegates insisted that it should be amended so that the poorer communities could benefit by it.

But however efficient the local health officers, health councils and health centers may be in bringing medical care to the local community, they cannot solve the whole medical problem of our people. Some form of prepayment plan or insurance, the doctors and lay representatives agreed, is essential.

Different views were expressed as to methods of effectuating the principle of prepayment or insurance. Some believe it can be achieved through voluntary plans. Others believe that a National Health Insurance Plan is necessary.

Prepayment Is Basic

BECAUSE of their importance, it is best to repeat verbatim the unanimous conclusions of the Medical Care Section in regard to health insurance:

1. Adequate medical service for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical, mental and social health should be available to all without regard to race, color, creed, residence or economic status.

2. The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services and avoid the indignities of a "means test."

3. Health insurance should be accompanied by such use of tax resources as may be necessary to provide additional: (a) services to persons or groups for whom special public responsibility is acknowledged, and (b) services not available under prepayment or insurance.

4. Voluntary prepayment group health plans, embodying group practice and providing comprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means at this time of bringing about improved distribution of medical care, particularly in rural areas. Hence such plans should be encouraged by every means.

5. The people have the right to establish voluntary insurance plans on a cooperative basis, and legal restrictions upon such right (other than those necessary to assure proper standards and qualifications), now existing in a number of States, should be removed.

Proportion Too Low

IT WAS recognized that the insurance plans, as well as those for local health organization, for the training of additional personnel, the construction of hospitals, and the expansion of research work, call for State and Federal aid of huge proportions. But relative to other expenditures in the national economy, too little is now expended in the preservation and maintenance of health.

Recognition and acceptance by the people as a whole of the values to be attained by health must precede the drive for the increase of these expenditures. The State and community planning councils will be the best means of bringing about this general recognition and acceptance. Only insofar as this is attained will public funds be forthcoming in increased volume at the Federal, State and local levels, and private funds through increased expenditure by families and individuals, by employers of labor and other sources.

Nobody dared, probably nobody could estimate, what the total bill will be if the program of this National Health Assembly is to become a reality. But Dr. Louis I. Dublin, who had been influential in urging upon Mr. Ewing and the President that this assembly should be convened, encouraged the departing delegates by asking the practical question: "What is the value of a man and how much is it worth to save him for his family and community."

He arrived at the answer by pointing out that when the family wage earner is incapacitated or prematurely killed by disease, the cost of supporting that family is statistically demonstrated to be about $35,000 if the family income was $2500 a year.

When the head of the family is incapacitated, his care represents an additional economic burden to society of varying dimensions.

We have already reduced this economic waste by conquering many diseases, but the total cost of unnecessary deaths and disabilities still represents a staggering sum. In comparison, the price of adequate health measures as outlined by the National Assembly, will be very small, to say nothing of the productivity in material, mental and spiritual areas that will be added unto us, all of which are forces basic to a free economy and a democratic social structure.

Immediately after the final session of the National Health Assembly, the executive committee met with Mr. Ewing and decided to continue the assembly and its committees but postponed the details of a permanent organization until a subsequent meeting.

June 28, 1948

FEDERAL SECURITY AGENCY
Washington 25, D. C.

FUTURE PLANS OF NATIONAL HEALTH ASSEMBLY ANNOUNCED BY
FEDERAL SECURITY ADMINISTRATOR EWING

Three proposals to implement the recommendations of the National Health Assembly, held last month, were made by its Executive Committee, meeting with Federal Security Administrator Oscar R. Ewing on June 28:

1. That the Assembly's Executive Committee maintain its own organization as a continuing advisory and coordinating group;
2. That the Federal Security Administrator appoint a small working subcommittee to recommend to the full Committee plans on public education relating to health, and on continuing organization and financing;
3. That each State be urged to hold a health assembly, patterned after the national Assembly, and giving equal representation to professional and "consumers'" groups in order to stimulate the widest possible cooperation among all concerned in health; that these State conferences endeavor, in turn, to stimulate local conferences along the same lines to emphasize and facilitate essential local planning and operation of health services.

To explore practical methods of carrying out the Health Assembly's recommendations, Mr. Ewing will ask the subcommittee to consider:

Publication of the final recommendations of the 14 Sections which constituted the National Health Assembly;

Exploring methods for follow-up and implementation of recommendations made by the Sections of the National Health Assembly--wherever possible, such follow-up should be carried on by organizations already specializing in these fields of activity;

Development of plans and guidance for State and local health assemblies.

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HEALTH FOR THE NATION

Diagnoses and Prescriptions

Early in May, over 800 representatives of medical, public health, and lay groups met in Washington on call of Federal Security Administrator Oscar E. Ewing, to discuss the nation's health needs. In the following pages Mr. Ewing and four participants in this National Health Assembly discuss its meaning and report on some of its highlights. Agnes E. Meyer is publisher of the Washington Post. Dr. Ellen C. Potter is deputy commissioner for welfare of the New Jersey Department of Institutions and Agencies. Michael M. Davis is chairman of the Committee on Research in Medical Economics. Quincy Howe is a commentator for the Columbia Broadcasting Company.

A Report by THE SURVEY midmonthly

on the

NATIONAL HEALTH ASSEMBLY

Washington, D. C. May 1—4, 1948

National Health Assembly

Washington, D. C.

May 1-4, 1948

Sections:

1. *Nation's Need for Medical and Health Personnel*
   Chairman: Dr. Algo E. Hendersen, Assistant Commissioner, New York State Department of Education, Albany
2. *Nation's Need for Hospital Facilities, Health Centers, and Diagnostic Clinics*
   Chairman: Dr. Charles F. Wilinsky, Superintendent, Beth Israel Hospital, Boston
3. *Local Health Units for the Nation*
   Chairman: Dr. Haven Emerson, Chairman, Committee on Local Health Units, American Public Health Association, New York City
4. *Chronic Disease and the Aging Process*
   Chairman: Dr. James R. Miller, President, Connecticut State Medical Society, Hartford
5. *Maternal and Child Health*
   Chairman: Dr. Leona Baumgartner, Chief, Bureau of Child Hygiene, Department of Health, New York City
6. *Rural Health*
   Chairman: Joseph Fichter, Master, Ohio State Grange, Columbus
7. *Research in the Service of Health*
   Chairman: Dr. Andrew C. Ivy, Vice-President (in charge of medical sciences), University of Illinois, Chicago
8. *Medical Care*
   Chairman: Dr. Hugh R. Leavell, Professor of Public Health Practice, Harvard University School of Public Health, Boston
9. *State and Community Planning for Health*
   Chairman: Dr. Florence R. Sabin, Governor's Planning Commission for Health, Denver
10. *Physical Medicine and Rehabilitation*
    Chairman: Dr. Henry H. Kessler, Director, New Jersey Rehabilitation Commission, Trenton
11. *Dental Health*
    Chairman: Dr. Ernest G. Sloman, Dean, University of California Dental School, San Francisco
12. *Mental Health*
    Chairman: Dr. William G. Menninger, Menninger Clinic, Topeka
13. *Nutrition in World Health*
    Chairman: Dr. Frank G. Boudreau, Director, Milbank Memorial Fund, New York City
14. *Environmental Sanitation*
    Chairman: Arthur D. Weston, Director of Sanitary Engineering, Massachusetts Department of Public Health, Boston

On May 1-4, over 800 representatives of medical, public health, and lay groups met in Washington on call of Federal Security Administrator Oscar R. Ewing, to discuss the nation's health needs. In the following twelve pages Mr. Ewing and four participants in this National Health Assembly discuss its meaning and report on some of its highlights. Agnes E. Meyer is publisher of the Washington Post. Dr. Ellen C. Potter is deputy commissioner for welfare of the New Jersey Department of Institutions and Agencies. Michael M. Davis is chairman of the Committee on Research in Medical Economics. Quincy Howe is a commentator for the Columbia Broadcasting System.

Essentials for National Health

OSCAR R. EWING

The National Health Assembly, held in Washington the first week in May, has been widely hailed in the press as "the most successful event of its kind in the history of the United States." The success of the Assembly rested on a most unusual measure of cooperation between scientists, laymen, and public officials. From the first session, all three groups were infused with the realization that health is everybody's business—it is not the monopoly of the doctors or the hospitals or the sick, but the urgent concern of us all. I think most of those who were there would agree with me that it was in a very genuine sense a thrilling occasion, because all of us—even those who came as skeptics—were caught up in the vision of a great goal: better health for all the people.

There were three major reasons for calling the Assembly:

First, I needed advice and assistance in shaping a ten-year health plan, in response to President Truman's request for such a program. This, he made clear, was to be not just a paper plan, but a working scheme for progress along many lines. "I am convinced," the President wrote, "that we have scarcely scratched the surface, and that as a nation we can make rapid progress in the immediate future." Clearly, such an undertaking called for the active cooperation of many interested and expert people, in and out of government.

Second, only such a body could map the areas of agreement and disagreement on health problems. To me, and to many others, one of the outstanding achievements of the Assembly was the narrowing of the important areas of disagreement, the discovery of how large is the common ground of the experts in the many fields of health.

Third, the Assembly was called because it is high time for a widespread, popular health movement in the communities where people live. Look back to the war years, when we had millions of volunteers working through the Red Cross, Office of Civilian Defense, and other agencies. All those ardent, self-sacrificing men and women, boys and girls, were bound together in a commonality of interest, their eyes on a single objective. Think what could be accomplished by harnessing the same drive to the solution of local health problems, to the stirring task of preventing disease and disability, of seeing to it that everyone who needs medical care receives it. We need thousands of local groups throughout the land, microcosms of the National Health Assembly, representing all groups in the community, planning and working for better health care.

Ten Year Plan

While preparing this article, I also have been engaged in the task of completing my report to the President. In outlining a ten-year health plan for the United States, it is needless to say that I am drawing heavily on the materials and the findings of the fourteen Assembly sections.

The purpose of this brief discussion with THE SURVEY readers is not to preview the report, nor summarize the conference proceedings. The major findings of the various sections are presented by other writers in this same issue. But I do want to underscore here what seem to me some of the essentials of any adequate health program for this nation, as they emerged from the reports and discussions of those four splendid days.

These essentials are really a call to action in three major fields:

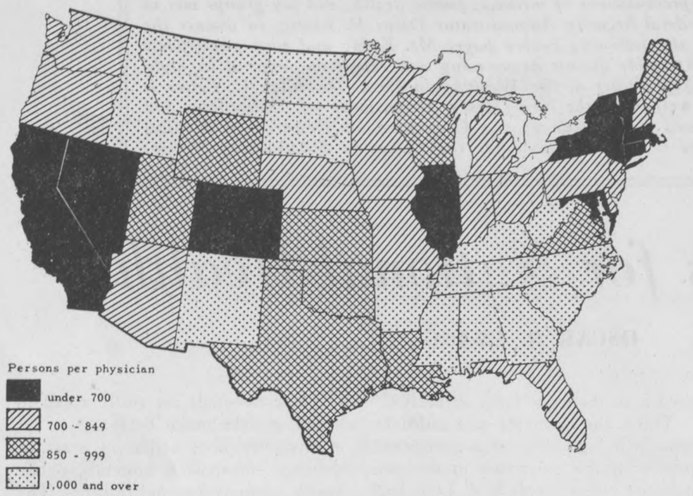
First, we need action in areas of shortage—manpower, hospitals, public health organization, and facilities. The findings of the Assembly made it all too clear that we do not have enough doctors, dentists, nurses, medical technicians, and public health workers of all kinds. We do not have enough hospital beds, particularly for mental cases and for the victims of heart disease. We are short on public health facilities. One third of the 3,070 counties of the nation do not have a full time public health officer. In those that do, only 3.4 percent of the people are served by health departments with enough staff and facilities to meet accepted minimum standards.

In addition to shortages, we have bad distribution. Shortages are more acute in some states and regions than others; more acute in rural areas than in big cities; more acute among Negro Americans than among white Americans. We need to expand our professional schools and training centers, raise the standards of many of them, make it possible for able and ambitious young people to finance their professional education. We must face the fact that many areas—most rural communities, for example—simply do not have the funds to support adequate medical care.

How are we, as a people, to provide all the training, all the equipment, all the services we need if we are to be a truly healthy nation? This was one of the most urgent questions raised by the Assembly. Some answers were offered. They call for study, decision—and *action*.

Second, we need to take definite steps to abolish discrimination in training

RATIO OF POPULATION TO PHYSICIANS, 1940



and in health service. Here education is the crux of the problem. Obviously, an ignorant nation cannot be a healthy nation. We need to revamp our scheme of things, so that the 6,000,000 children of school age who are not now in school will have their fair chance. At present, they are receiving virtually no preparation for adult life in the modern world. Then there are the inequalities which condemn some groups to inferior preparation for healthy, satisfying lives—rural children as against urban children, Negro children as against white children, Americans of Mexican descent as against young Americans of other national strains. Particularly do we need to redress the injustice which curtails the number of able young Negro Americans who can get education and training—preparatory and professional—for careers in medicine, dentistry, nursing, research.

Our failure to train Negro medical personnel has serious consequences. Today, for every 4,400 Negroes in this country, there is only one Negro doctor, as compared with one white doctor for every 850 of the white population. I realize, of course, that physicians of one race often treat patients of the other, but these figures represent a grave disparity in opportunities for education and training. Hospital facilities and the services of medical centers are even more inadequate than the number of Negro doctors, dentists, and nurses—and this in spite of the fact that Negro Americans represent 10 percent of the total population.

Third, we must solve the problem of paying for medical care, so that the costs of sickness will not break the backs of families, and so that modern medical care to prevent illness and conserve health will not be beyond the reach of the average family budget. This was one of the great new areas of agreement staked out by the Assembly. Distinguished spokesmen for the American Medical Association joined with representatives of labor, farmers, consumers, and other groups in declaring that "the principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people."

There are various alternatives proposed for action here. I myself am on record as favoring compulsory health insurance, but I am not intransigent. National health insurance is not a goal in itself. I see it as the best method of reaching the real goal—to bring medical care to all the people. If anyone can show me a better method, I'll switch like a shot.

Watch Towers

Out of the Assembly discussion, it seemed to me that four medical-scientific problems loomed up above all others. These were mental health, geriatrics and chronic disease, child care, research. Volumes could be written about each of these. I can only point to them here as the great watch towers along the border between what we have and what we need in knowledge, and personnel, and facilities.

Looking back over the Assembly as a whole, I am impressed again by the spirit in which it worked. Seldom, it seems to me, have professionals and laymen discovered such a vast and significant range of common interest. Let me quote two telegrams that particularly heartened me. Dr. Morris Fishbein, editor of the *Journal of the American Medical Association,* wired: "Again my sincere congratulations on the best meeting of its kind I have ever attended in Washington."

And this came from the Reverend D. A. McGowan, director, Health and Hospitals, National Catholic Welfare Conference: "You have broken down barriers that have kept honest people apart. I see no reason why your objective of health care for all the American people, regardless of race, color or creed, cannot be achieved. . . . You have laid the foundations of a better understanding at every level of a problem that has plagued us for many years."

What is the next step in putting to use the material and the findings of the Assembly? I can, of course, give only my own view. My hope is that out of this meeting will come, before long, a real working formula for the community.

What does the local community require in order to organize a drive for better health? First, a measure of what it has; second, a measure of what it needs. The difference between these two totals represents the health deficit of the community. No family, no business can set to work to wipe out a deficit without knowing exactly where it stands. It is the same with a health deficit, but at present we do not have the tools to measure that. To measure a budgetary deficit, all we need are dollars-and-cents totals. Dollars and cents enter into a health deficit, too. But there are more significant criteria, and these we need to define and learn to use. They are essential for measuring the deficit, and they are essential, too, for measuring progress in climbing out of the "red."

Eventually, I believe we shall have specific blueprints by which a community can go forward. Given the size and shape of its health deficit, it will be possible for the community to get clear and accurate plans for progress. To develop these criteria and draw these blueprints seems to me the next great task of lay-professional cooperation in the health field.

Many people have asked me about the future of the National Health Assembly. Because of the spirit generated at the Washington meeting, they feel that it should go on, that there should be similar meetings at stated intervals to evaluate progress, consider needs, indicate lines of effort. This question will be answered by the executive committee which is to meet within a few weeks. If the National Health Assembly disappears from the actual scene, it will have made a permanent contribution. It furnished invaluable materials for shaping a ten-year health plan. It gave a tremendous impetus to health efforts all over the country. It provided an amazing demonstration both of interest and of readiness to act—enthusiasm not only in breadth but in depth.

But above everything else, it seems to me the achievement of the National Health Assembly was the creation of a new climate of understanding, a new, united will to lift the health standards of the people of this country.

Getting Services to People

AGNES E. MEYER

Most significant result of the National Health Assembly was the creation of a bridge between the medical profession and consumer groups. For in those three days of discussions, areas of agreement were discovered and outlined by representatives of the American Medical Association, farm groups, organized labor, the cooperative health federations and others interested in better health protection for the nation. Thus the democratic process staged a victory over dangerous group tensions that were predicted to be irremediable.

Therefore, the Assembly accomplished its purpose, for it was called by Federal Security Administrator Oscar R. Ewing, at the request of President Truman, to establish such areas of agreement as a possible foundation for a ten-year health program for the nation. Its operative machinery consisted of fourteen sections on various subjects, formed by an executive committee appointed by Mr. Ewing.

As THE SURVEY asked me to report specifically on the conference's deliberations and findings in respect to the provision of health services, I will here focus attention particularly on the sections on professional personnel, hospital facilities, local health units, rural health, and community planning.

One of the most urgent of all the recommendations came out of the section on local health units, chaired by Dr. Haven Emerson.

Full time local health departments in every city and county, or combination of counties, are essential to a strong health program, this section reported. This recommendation is already embedded in a bill now before the Congress (S. 2189) that would provide federal aid to strengthen local public health units and increase their number so that there will be a nationwide coverage.

The section also pointed out that local and state health councils, made up of all agencies and individuals concerned with health, as well as business, banking, and industrial groups, should cooperate with health department officials to plan the local program and keep it close to local needs. The consensus was that these councils must arouse the interest, aggressive support, and participation of the entire community in a medical program that is both preventive and curative. It was suggested that the councils emphasize the basic importance of local control of health programs, the primary need for health education, the necessity of removing inequities in medical facilities as between communities and between economic groups in the community, and the values to be derived from lowering high death rates and decreasing incidence of disease and accidents.

Retail Stores

Adequate housing, a living wage, education, recreation, and a good environment, as well as good working conditions, are all involved in physical and mental well-being, it was pointed out, and must be considered part of an over-all health program. However, the success of such broad areas of endeavor is likely to hinge on the provision of adequate local health services. Basic to such services are local health units—the retail points for distribution for complete medical care.

The discussions brought out some of the problems created by the present insufficiency of such units. At present, 40,000,000 people are not reached by local health programs and many others are dissastisfied. The lack of prevention and referral services puts a heavy load on medical care. Where health units do exist they are often tucked away in a cellar room of the court house or jail.

Participants in this section pointed out that the various functions of a health center should involve: a mechanism for tabulating vital statistics and interpreting their significance; control of communicable diseases; sanitation; diagnostic and laboratory procedures; hygiene of human reproduction; information on health education and laws of living.

Such retail health stores will have more and better goods for sale as medical education and research go forward. Local health programs also involve the need for more factual information as to how many doctors, nurses, other medical personnel, and hospital facilities are actually needed in each community. The discussion revealed that at present local health departments meeting the minimum standards are available to less than half of the nation, while two sevenths of the population, largely in rural areas, have no local health units whatever. People today are clamoring for security for their families, the community, and the nation. They must be helped to recognize that the most important factors in security are good physical health and stable emotions.

The section on personnel, under the chairmanship of Dr. Algo E. Henderson, pointed up the great need for more doctors and nurses. This need has been accelerated by a growth in population, increasing federal, state, and local programs, and greater health consciousness on the part of the people. The participants' estimates as to how many additional medical schools and

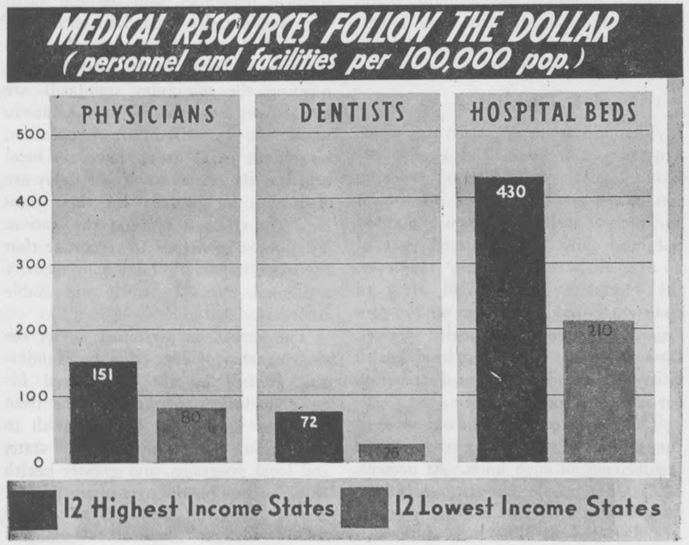
doctors may be required were uncertain. But they made it clear that whatever steps are taken to extend medical training, the high quality of our present medical education must and will be maintained.

The personnel section also recognized the importance of training more Negro physicians. This problem is part of the larger problem of improving opportunities for the education of Negroes in general if the number of Negroes qualified to enter medical schools is to meet the acute demand. Here will be the area where follow-up work will be urgent, if this recommendation is to be quickly and effectively implemented.

It was, however, recognized that better general education is also needed by other medical school applicants. Though the best medical schools can still get students of high quality, one eighth of the students in other schools are not proper material. The number of well-trained applicants has decreased as teacher training for the grammar schools has gone down. The bottleneck of talent is at the lowest level of education.

The section on hospital facilities, under the chairmanship of Dr. Charles F. Wilinsky, estimated the need for more hospital beds at 265,000 general, 291,000 mental, 85,000 tuberculosis, and 245,000 chronic disease. This deficit, it was conceded, cannot be met within the ten-year limit set by the President. The Hospital Survey and Construction Act was praised as a sound approach to the problem, but the rural delegates insisted that it should be amended to help the poorer communities benefit by its provisions.

The rural health section, with Joseph W. Fichter as chairman, advocated that every rural farm family be enrolled in a health insurance plan; that every farm have a decent water supply and a sanitary privy; that health facilities, including mobile units for isolated areas and home nursing services, be available to all rural people regardless of race; that every state have a health council and affiliated local councils. The participants of this section agreed that enabling legislation should give local governments the right of taxation for the provision of comprehensive medical care. In regard to the shortage of physicians in rural areas, it was suggested that more doctors might be willing to practice in the country if hospital facilities, more money, and cultural opportunities were available.



Everybody's Business

The section on community planning, chaired by Dr. Florence Sabin, pointed up the values of state and local planning councils for bringing about a general recognition and acceptance of health needs and the importance of public expenditures to meet them. It was suggested that only insofar as such recognition is attained will public and private funds, including individual expenditures, be forthcoming in increasing volume to meet health needs. It seemed to be the general opinion that too little is now expended in the preservation and maintenance of health in relation to other expenditures in the national economy. However, it was recognized that any drive for the increase of such expenditures must arise from acceptance by the people as a whole of the values inherent in a healthy nation.

The group also discussed the role of citizens planning projects in gathering a "body of knowledge" as a basis for stimulating action. Health education, it suggested, should encourage the conception of health as something broader than freedom from sickness—a general state of well-being based on social and economic as well as physical conditions. It emphasized the importance of sufficient personnel in carrying through health projects.

The discussions of all these sections —in fact, of the entire conference— was based on two assumptions: that a health program is everybody's business and that its development depends on local initiative and a knowledge of local needs. State and federal help would be needed, it was clear, but since health is a function of the community's total way of life, local autonomy must be preserved.

Nobody dared, probably nobody could estimate what the total bill will be if the program of this National Health Assembly is to become a reality.

But Dr. Louis I. Dublin, who had been influential in urging upon Mr. Ewing and the President that this Assembly should be convened, asked the practical question: "What is the value of a man, and how much is it worth to save him for his family and the community?" He pointed out that when the family bread winner is incapacitated or prematurely killed by disease, the cost of supporting that family is statistically demonstrated to be about $35,000 if the family income was $2,500 a year. When the head of the family is incapacitated, his care represents an additional economic burden to society. In spite of modern medical advances, the total cost of unnecessary deaths and disabilities is still enormous. In comparison, the price of adequate health measures, as outlined by the National Health Assembly, will be small. And besides physical health, it will bring on productivity in material, mental, and spiritual areas —all forces basic to a free economy and a democratic social structure.

What Our Health Needs Are

ELLEN C. POTTER, M.D.

Eight sections of the National Health Assembly were devoted to discussions of the various kinds of services that a comprehensive health programs implies—maternal and child health, chronic disease, research, rehabilitation, mental health, dental health, nutrition, and environmental sanitation. It is impossible in this short space to do more than scratch the surface of the discussions, but certain common denominators can be noted.

Every section reported progress in the last decade, and particularly in the past five years in respect to chronic diseases and rehabilitation.

Every section deplored personnel shortages and a desperate need for physicians, psychiatrists, nurses, medical social workers, nutritionists, dentists, scientists, and research personnel equipped to meet the demands of the new era in health service into which we are now entering.

Every section in some way overlapped the discussions of every other section, making it obvious that interdependence of each upon the other was essential for maximum results. For example, discussion of the prevention of chronic diseases necessarily involves consideration of maternal and child health, conception, gestation, and early childhood. Nutrition too has a role to play in prevention or amelioration of chronic illness, as well as in promoting maternal and child health, while dental health is also involved. Since the war, rehabilitation services have demonstrated their great power to conserve human resources which once were consigned to the scrap heap.

Implications of mental health were interwoven with discussions of every aspect of physical health, sickness, disability, rehabilitation—and this was natural, for without mental health, life cannot be fully lived and the individual remains an unproductive member of society. In this field the shortage of all kinds of personnel is particularly acute.

Environmental sanitarians reminded the Assembly that, while many sections were dealing with the problems of individual human beings, the sanitary engineers' broad, impersonal assignment (water supply, sewage disposal, pure food, housing) impinges on all and needs the backing of everyone interested in health and welfare services.

Research was recognized by every section as indispensable to understanding present conditions and developing integrated future plans.

So much, then, for the common denominators. What were the high points, either in accomplishment or goals for the future?

Goals Ahead

The section on chronic diseases and the agency process, under the chairmanship of Dr. James R. Miller, accepted as its chart of operations for the future the Joint Statement, "Planning for the Chronically Ill," prepared by the American Hospital Association, the American Public Health Association, the American Medical Association, and the American Public Welfare Association. This statement, based on data assembled during the past three years, has resulted in a program for action covering prevention, treatment, cure, rehabilitation, and the goal of "optimum health."

A common misconception that showed up in the discussions of this section was the confusion in the public mind of chronic diseases as "diseases of the aged." Fully half of all chronically ill are less than forty-five years old and 16 percent are under twenty-five. Early diagnosis, preventive treatment, school health programs and health education, community services at home, in hospitals, in nursing homes, and rehabilitation, all must become part of the over-all pattern of service under skilled medical direction.

However, the shift in the distribution of the American population from youth to age, with a continuing trend predicted until 1980, makes the problem of chronic diseases public enemy number one, and our battle to prevent them a major obligation. Any attack on chronic diseases and the aging process must include not only prevention but also rehabilitation services.

The discussion identified diseases of the heart and arteries as the major chronic enemy. It was pointed out that the discovery of the functional chemistry of arteriosclerosis would be one of the greatest medical events of the twentieth century.

An important point that emerged in the discussions was the fact that the employment of older and disabled persons is not only of social but of economic importance for the country as a whole. Therefore, it was suggested that a revamping of industrial and governmental retirement systems, now based on chronological age, should take place. Such systems, it was urged, should include professionally qualified "retirement boards" to consider the mental and physical capacity of individuals to continue to work at advanced ages.

The section on maternal and child health, under the chairmanship of Dr. Leona Baumgartner, summed up its proposals in the following statement:

"The over-all goal toward which we are working is to assure every child the experiences in life that will result in his attaining adulthood fully mature and healthy in body and mind, emotionally secure, able to give more than is asked for, to face success and frustration with equanimity, to be self-reliant, to cooperate with his fellows, to take his place in a democratic society as a thoughtful, responsible citizen concerned with the common good, and to live harmoniously in a total changing environment."

This section's nineteen recommendations are studded with items about the rearing of children. Obviously the solution of the problems of a disorganized society can only be remedied or prevented by stable, secure, tolerant citizens. On Child Health Day, Dr. Brock Chisholm, director of the World Health Organization, told the Assembly:

"The finding of security on the part of the human being is a need of complete security in small infancy. Complete security in small infancy does not

depend even on adequate food supply or shelter. There is only one thing on which it does depend to the most important degree—unquestionable, all-embracing, obvious love, and nothing else will give a small child that degree of security on which he can build his citizenship, from which he can afford to adventure into a perilous world."

Participants in the section on research, chaired by Dr. Andrew C. Ivy, warned against the appalling shortage of scientific brains available and ready to enter the public health field. They blamed it on the meager financial returns. Pointing out that research without scientific leadership is not fruitful, they urged that federal funds be made available to foster medical research and to train medical investigators.

The section on rehabilitation, with Dr. Henry H. Kessler as chairman, presented figures from the Office of Vocational Rehabilitation, estimating that 166,000 men and women served by federal and state rehabilitation agencies increased their earnings by more than $600,000,000 and paid federal income taxes in excess of $50,000,000. With the average cost of individual rehabilitation quoted at $450, the results indicate that this is "good business." More than 1,000,000 people now need rehabilitative service, but only about 50,000 are being rehabilitated each year, while every year produces a larger "crop" of the disabled.

The years ahead require more adequate financing by federal and state governments; teaching and training of rehabilitation experts and technicians; research in prosthesis, certification of limb fitters and vendors.

The dental health section, with Dr. Ernest G. Sloman as chairman, stressed the enormous cost of dental caries to the individual and to society; the need of more widespread and understandable dental health education; the wisdom of utilizing dental hygienists under professional direction; elimination of outmoded techniques. Its participants looked to government to promote research and to provide financial support for professional education, as did those of all other sections.

The mental health section, chaired by Dr. William C. Menninger, exhibited considerable concern over the shortage of fully qualified personnel in all branches of mental health work. It considered the problem of "non-psychiatric" personnel as well as the psychiatrically trained, stressing the importance of developing more fully the competence of both groups in dealing with opportunities to promote mental health.

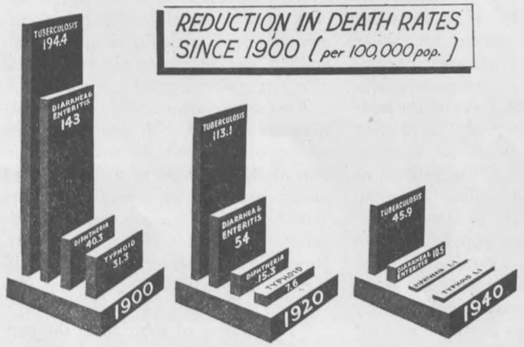
The non-psychiatric group includes public health personnel, the general physician and other medical specialists, nurses and other hospital personnel, social workers, vocational counselors, representatives of management and industry, labor leaders, lawyers, judges, law enforcement officers, recreation workers and, last but not least, teachers. The section suggested implementing the education of these groups through conferences, institutes, work shops, and "flying teams" of teaching psychiatric specialists.

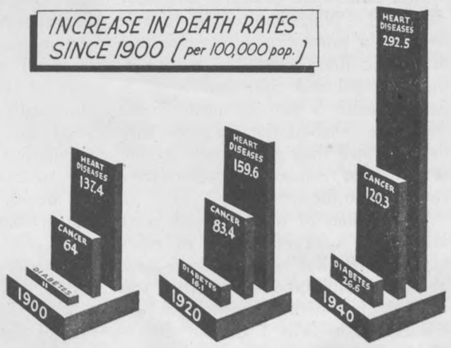
Recognition was also given to the need for improving and expanding psychiatric training facilities, especially with the view of training more "'trainers"; community planning for more mental hospital beds as well as for mental hygiene clinic service; study of the cultural environment and its role in mental hygiene; and responsibility of the school in the mental hygiene field.

The section on nutrition, under the chairmanship of Dr. Frank G. Boudreau, urged the creation of national and international nutrition councils such as were previously recommended in the Hot Springs Conference of the United Nations Food and Agricultural Organization in 1943. This section also brought out the importance of basic information on nutrition as a part of the equipment of all persons engaged in health activities.

The section on environmental sanitation, Arthur R. Weston, chairman, called for greater community participation in this field, with need for more money, more personnel, and more research.

The major accomplishment of these meetings might be summed up thus: a recognition of the interdependence of every area of our fields of service upon every other; and a frank acknowledgment of broad areas of complete agreement which can provide the base for future progress.





Who Will Pay the Costs?

MICHAEL M. DAVIS

The National Health Assembly with its many sections might be compared to a fourteen-ring circus. One issue, however, entered almost every ring—though it was often kept out of the limelight. This was the question: How shall we pay for the tasks which experts agree should be performed?

The section on personnel, for instance, considered scholarships to attract capable young men and women into medicine and to lure them toward practices in places that are now underdoctored. But what good will a medical scholarship program be to small towns unless it is possible to support young doctors who have received scholarships, so that they will be able to make a living in rural areas after they have graduated? Plans must be made for the continued financial support of doctors in many rural areas if the poorer sections of our country are to benefit from the award of medical scholarships. How this should be done is controversial.

Economic problems again hovered around the section on maternal care and child health services where specialists bore witness to their long, steady advance in formulating standards and procedures through which maternal death rates can be cut and children's health improved. But how shall these services be paid for? Should the present federal grants to the states be increased? Should an insurance plan carry more of the load? Should special grants be added, as for school health services? Should publicly supported services be open to all children, or only to those whose parents pass a means test?

Similarly, the problem was at least relevant, if unrecognized, in the section on chronic disease. The experts in this section showed great progress in defining what should be done. But how shall the care of the chronically ill be supported financially? A large proportion of chronic patients cannot finance their own medical care on the usual individual fee-for-service basis, and private charity is insufficient to cope with this problem.

The residuary legatee of the relations between health and the dollar was the section on medical care. Here was a section loaded with potential fireworks. But instead of a shambles it produced unsuspected and long overdue areas of agreement among persons generally considered to be at opposite poles of opinion. Consider the section's first three recommendations:

1. *Adequate medical service for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical and mental health should be available to all without regard to race, color, creed, residence or economic status.*

2. *The principle of contributory health insurance should be the basic method for financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services, and avoid the indignities of a "means test."*

3. *Health insurance should be accompanied by such use of tax funds as may be required to (a) furnish services which are public responsibilties; and (b) supplement health insurance as necessary to provide adequate services for the whole population.* Thus the wholly indigent would be covered. Thus dental and other special services and the needs of some rural areas could be provided for.

Harmony and Difference

Would you think that these pronouncements came from the American Federation of Labor, the Congress of Industrial Organizations, the Farmers' Union, the American Association of Social Workers, or the American Medical Association? Actually, they came from no one of these, but as an agreement of representatives of all these bodies and many others.

Affirming everybody's right to adequate medical care is nothing new to physicians or to informed laymen, though the addition of the antidiscrimination clause gives it timeliness. However, it is something new and important to agree that the "large majority" of Americans should prepay their medical costs while they are well, instead of letting the whole burden fall on their pocketbooks when they are sick or just afterwards.

A few weeks ago after a radio broadcast a listener said to me, "Why, until today I always thought that health insurance was just for low income groups." That idea has been common among lay people and doctors and has been incorporated into many of the voluntary insurance plans sponsored by medical societies. But the second recommendation of the Assembly's section on medical care recognizes that unpredictable sickness can hit any family to a degree only the wealthy can afford, and that the fear of the expense makes many persons postpone or go without needed care. It recognizes that Americans do not want charity, rebel at a means test, and wish to pay their own way.

As the discussions in the medical care section proceeded, it became apparent that, while differences of opinion did exist between organized medicine and the lay groups, the major issue was not health insurance. The issue was whether health insurance should be "voluntary" or "governmental." Then, as the talk went forward, it became clear that two sets of people were really not talking about the same thing. On the one side, physicians who insisted that joining a health insurance plan should be wholly voluntary, maintained that if payments into a health insurance plan were required by law, government would not only compel payment but would run all the rest of the show, including the doctors. They painted pictures of Washington "bureaucrats" telling doctors and people what to do.

On the other hand, the persons who advocated national health insurance displayed a wholly different conception of its functioning. They were just as insistent upon the right of the patient to choose his physician freely as were the representatives of the American Medical Association. However, they

proposed a national health insurance fund parceled out to states and localities, managed by the people and the doctors in each locality, and operated by various methods, including continuance of many of the voluntary plans that we have today.

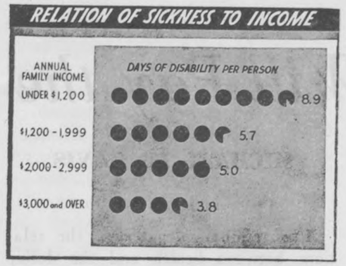
It proved impossible to get an agreement between those who saw government as an ogre and those who viewed it as an instrument.

When the invitations to the National Health Assembly arrived early this spring, many persons remembered the first National Health Conference held in July ten years ago when 200 physicians and laymen, called together at the suggestion of President Roosevelt, filled the ballroom of the Mayflower Hotel in Washington. At that conference the major issue was need—how wide are the nation's health needs and how deep?—but at this year's Health Assembly, four times bigger, the discussion turned less on needs than on what we should do about them. This may have been why the medical care section alone was as large as the whole conference of a decade ago. Physicians, administrators, and representatives of labor, farm, cooperative, women's, veterans', religious, and social work organizations expressed themselves freely.

Harmony and Variations

I came away from the meetings of the medical care section with a heightened appreciation of the American way of hammering ideas out on the anvils of open discussion. Sometimes people get hammered out too. Things moved a bit slowly at first, owing to the too general character of the first batch of assigned papers, but after the audience was given a chance, there were no dull moments. Dr. Hugh Leavell's impartial chairmanship kept the temperature down. Under the official rules that had been given him, representatives of federal government bureaus, including some of the best experts in the country on the subjects under consideration, were not allowed to speak even to answer factual questions. If it had been possible to bring a larger volume of really pertinent data before the meeting, the frontiers of agreement might have been extended still further.

There were lighter moments, too. Everyone who attended will remember how tension dropped and a spirit of medical-lay cooperation blossomed when, toward the end of one of the warmest sessions, Father Donald McGowan of the National Catholic Welfare Council told the story of the early worm who pushed his head out of the earth just after sunrise one spring morning. Close by he perceived another worm protruding. "Good morning," said the first worm, "it's a beautiful day. Let's cooperate to enjoy it." "It is a lovely day," replied the other, "and we certainly had better cooperate, for don't you know, I'm your other end!"



Representatives of seventeen national organizations, representing millions of persons, including two medical groups, drew up an eight-point statement containing the three recommendations already mentioned, plus the following:

4. *Voluntary prepayment group health plans organized on a community or collective bargaining level, embodying group practice and providing comprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means at this time of bringing about improved distribution of medical care, particularly in rural areas. Hence such plans should be encouraged by every means. It is recognized, however, that even under the most favorable circumstances such voluntary plans cannot be expected to cover the health needs of the entire nation.**

5. *The people have the right to establish voluntary insurance plans on a cooperative basis and legal restrictions upon such right (other than those necessary to assure proper standards and qualifications) now existing in a number of states, should be removed.*

6. *High standards of service, efficient administration and reasonable costs require:*

(a) *Coordination of the services of physicians, hospitals and other health agencies in all phases of prevention, diagnosis, and treatment;*

(b) *Efficient cooperation between the providers and the consumers of such services* under the general principle that the responsibility for general policies, finances, and administration should rest preponderantly upon the lay group; for professional standards and procedures, upon the professional group; for mutual consultation on all matters of joint interest, upon both groups.

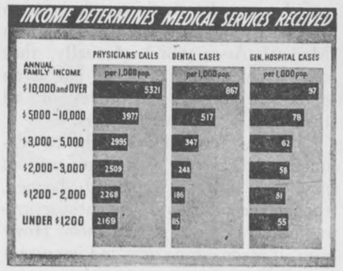
7. A national health insurance plan, assuring free choice of doctor, professional freedom for the doctor and decentralized administration through the maximum utilization of state and local bodies is necessary in order to bring the benefits of health insurance to all who need it.

8. Voluntary insurance plans which provide services and which meet acceptable standards should continue under a national health insurance plan.

Notice the italicized portions. In the steering committee of the medical care section, the two representatives of the American Medical Association agreed with the representatives of labor and farm cooperatives only as far as the italics go. They would not agree to any national health insurance plan, even of the kind described in point 7. They would not agree to sharing administrative responsibility with the people who receive and pay for medical services.

They did agree—and here is a great gain—that voluntary plans cannot reach everyone. (See last sentence, recommendation 4.)* And they also agreed to the people's right to start voluntary health insurance plans themselves. (See recommendation 5.)

The pinch of this fifth point is the fact that some twenty states have restrictive laws on this matter. These laws, passed during the last few years at the instance of state medical societies, limit the right of the people to establish their own insurance plans. In many states, they give control of all voluntary plans to organized medicine.



* *Editor's Note:* This sentence was omitted from the final report of the section drawn up after the Assembly.

The representatives of organized medicine in this section had been faced for two days by lay men and women from many parts of this country, who had made it courteously but firmly clear that they knew what they wanted. It does not follow that because representatives of the American Medical Association accepted these five and a half points, the official governing bodies of the state medical societies and of the AMA will approve them. Nevertheless, the fact that delegates from organized medicine publicly accepted principles like the above is encouraging to progressive physicians and will strengthen the hand of all lay groups in future national and local conferences with medical societies.

The discussion also made evident that labor and the rural cooperatives will continue their support for national health insurance, although an increasing number of unions are planning to work out health insurance plans with their employers through collective bargaining and to push rural medical cooperatives more aggressively than ever before.

Said Harry Becker, director of the Social Security Department of the United Automobile Workers, and chairman of the CIO delegation at the Assembly: "The labor and other consumer groups cannot compromise on the basic question: a public program for all of the people. As long as four out of five children live in families with incomes less than $3,000 a year, the overwhelming majority of the American people cannot pay for full and comprehensive medical care offered through voluntary plans."

Reporting a survey just made in Detroit, Mr. Becker added: "We found that 87 percent of the workers found medical costs difficult to meet. Of the workers who felt they needed some kind of medical care, 41 percent had never seen a doctor about the condition. The top worry of these workers was how to support their families if they fell sick. Then, they were worried about how they would meet medical bills. These are the areas of insecurity to which union planning must give top priority."

The medical care section achieved agreement on one more important point: that AMA representatives, labor and rural groups should meet for further discussions. Steps were taken to arrange such meetings in the near future. Much may result from these conferences.

Many persons shared the feelings of Nelson H. Cruikshank, director of the Social Security Committee, AFL, who said: "When the AMA representatives agreed with us on the principle that 'contributory health insurance should be the basic method of financing medical care' for most of the American people, that proved the success of this Assembly and made our gathering here together and the time we have spent well worth while even if we had achieved no other thing."

Where Health Needs Meet

Condensed from a Review by

QUINCY HOWE

The most human of all human interests drew us together in this National Health Assembly. It is the interest in what most of our forefathers and many of us still call "the temple of the soul." After all, nothing affects us more personally and more directly than the health of our bodies. . . .

It is the great achievement of this Assembly that so many different experts in so many different fields have reached agreement on so many subjects.

Now, there is one common denominator that struck me with special force in every one of the fourteen section reports. It is this: each section regards its own field as fundamental, basic, all important, indispensable. And in each case, the logic behind these section reports seems to me absolutely unanswerable. But it seems to me that the subjects the Assembly has covered do not conflict at all; they overlap.

Actually they complement and even duplicate each other. The need for more and better research, for instance, is a universal need. It goes through all these sections. A good local health unit is going to interest itself both in the care of the young and the care of the aged. It is going to interest itself in mental as well as dental cases; it is going to interest itself in questions of environment as well as questions of nutrition.

Several of these sections have referred to the question of discrimination against Negroes, but discrimination takes many forms, and the best cure for discrimination, after all, is education.

Perhaps the most important single common denominator in all the section reports is the need for more facts, more research, more information. For instance, how many more doctors, nurses, and medical personnel do we actually need? What do we need in the way of enlarged hospital facilities?

And these questions tie in with the question of rural health. The rural health section had a great deal more information than the section on mental health. Perhaps that is because we have had country doctors much longer than we have had psychiatrists, though the country doctor is becoming the forgotten man. To the outsider, it might seem the psychiatrist is getting all the breaks, until we read the report from the mental health section with its urgent request for much more information in a field that is perhaps more tragically understaffed than any other health field.

Without going into the whole list of section reports and the details, it seems possible to draw this conclusion: nearly all the sections called first and foremost for come information and personnel.

To most Americans "shortage" is a wartime word. To those who are fighting a never-ending war against all the ills that flesh is heir to, shortage remains just as familiar a word as ever.

First, there is the shortage of highly trained personnel, of doctors, researchers, and specialists in different fields. Then there is the shortage of assistants, especially dental assistants and nurses. Then there is the shortage of medical schools and medical teachers, the shortage of hospitals, and, it

seems above all else, a shortage of cash.

How are we going to pay for all the training, all the equipment, all the services we need? How are we going to make the career of administering to the nation's health a career that does not require superhuman effort, superhuman sacrifice, or else a superman's bank account?

Perhaps it is not so much a question of salaries as it is a question of less costly training and of greater security for those who are financially equipped to practice medicine, go in for research or engage in related fields of public health.

Taxpayers' Burden

Leaving to one side the controversial question of federal health insurance, there does seem to be a rather widespread feeling that the taxpayer is going to have to carry some, probably more, of the financial burden that better health service requires.

The rural health section, for instance, is unanimously agreed that the federal government must bear a greater share of the expense of rural medical care. The farming communities, even the farming states, just have not got the funds. On the other hand, the local health units must rely largely upon local support—perhaps through local taxation, somewhat after the fashion of our schools.

But, can local communities carry the whole load of maintaining and extending hospital service? And if the state, in addition to the federal government, comes into the picture, what part has the state medical association to play? What representation will the public have?

Dr. Ivy's section on the nation's need for research in the service of health, recommends fluid funds from federal tax sources. No less important than the need for funds is the need for personnel. Really the two go together. Get the money and you can get the men.

This Assembly cannot, under the law and under its own rules, recommend any definite legislation. I do not think this prevents me from touching on the question of the membership of the United States in the World Health Organization. I think it was clear to everyone present that all members of all sections agreed that whatever their other differences may be, they were united in wanting the United States to join the World Health Organization.

And this question of the World Health Organization is not the only matter on which this Assembly has reached agreement.

Perhaps its greatest single achievement is that all kinds of public organizations have sat down together and worked out common problems and common programs with members of the medical profession and other scientific groups.

That so many doctors not only have taken the time to work with the National Health Assembly but have shown themselves so cooperative, so understanding, so open-minded, seems to me the most promising and most important development of this whole meeting.

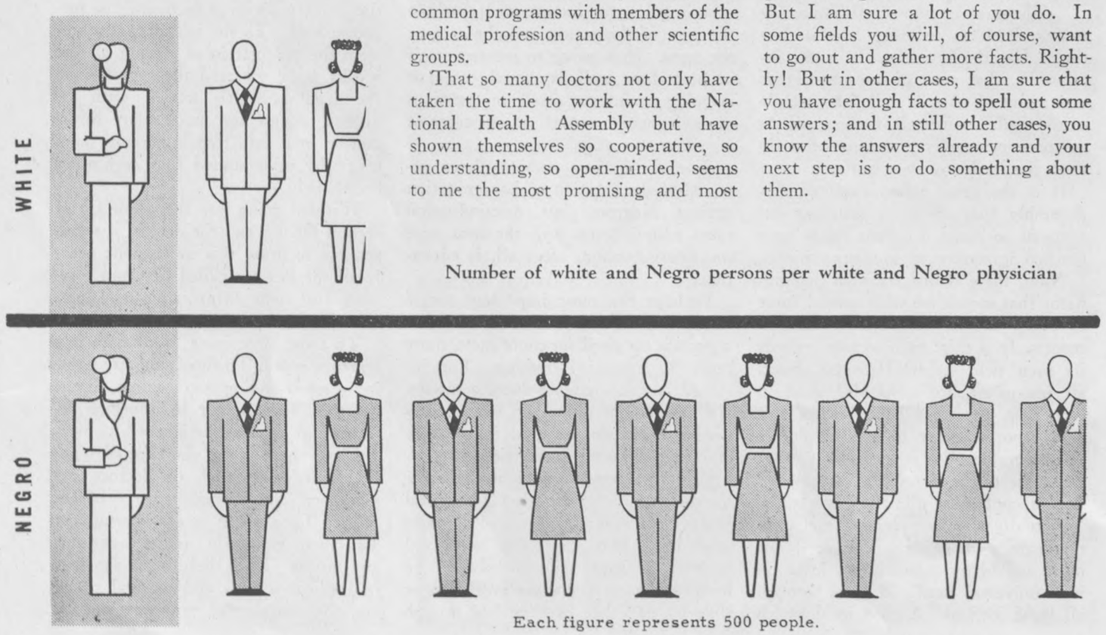
There is no question that the high spot of this Assembly is *the cooperation between men of science and the general public.*

Facts and Action

As I have already said, all the section reports call for more and more facts. Of course, none of them has yet got the complete story. That will never be told. Some of them are just beginning to pioneer. All of them need to correlate what they already know. But we Americans, as a people, seem to have a blind passion for facts as facts. We have an almost mystical faith in statistics.

Certainly, the collection of facts is a necessary and rewarding enterprise, but it is not a substitute for action. It is not a substitute for something that is even more difficult than action, and that is thought. Too many of us collect facts simply to avoid having to do anything about it. We are like the fanatic who redoubles his zeal after he has lost sight of his objective . . . the mere accumulation of facts is not an end, an aim in itself. It is what we do with the facts, it is what we make the facts mean that really matters.

I cannot tell people in the health field what the facts that they have gathered together mean. I don't know. But I am sure a lot of you do. In some fields you will, of course, want to go out and gather more facts. Rightly! But in other cases, I am sure that you have enough facts to spell out some answers; and in still other cases, you know the answers already and your next step is to do something about them.



Number of white and Negro persons per white and Negro physician

Each figure represents 500 people.

Recommendations for Health

Some steps urged in the final reports of the sectional meetings of the National Health Assembly.

Professional Personnel

Federal aid to medical, dental, and nursing schools granted in such a way as to stimulate local support from public and private sources.

Federal aid to medical, dental, and nursing students through loans, scholarships or fellowships.

Periodic analyses of the needs and demands for medical, dental, and nursing personnel.

Provision of medical education to qualified applicants without discrimination as to race, color or sex.

Hospital Facilities

Extension of the program under the Hospital Survey and Construction Act with an increase of federal appropriation.

Integration of the hospital program of the Veterans Administration with the program of the Hospital Survey and Construction Act.

Integration of functions of hospitals, health departments, and other health agencies in the interests of greater efficiency and service to the patient.

Development of diagnostic clinics, out-patient services, home medical care, and allied programs in the interests of greater efficiency and service to the patient.

The inclusion of preventive medical and dental service and public health education as a regular function of the modern hospital.

Development of standards for facilities for the care of the mentally ill and persons with chronic disease.

Development of plans for adequate hospital facilities and health programs to include well coordinated and highly integrated networks of mobile units, clinics, community hospitals, district hospitals, regional hospitals, and great medical centers.

Local Public Health Units

The establishment of full time local health units throughout the nation, financed jointly by local, state, and federal governments.

Increased personnel and facilities for training at least to double their present capacity.

Support of recruitment through good salaries, professional recognition, tenure, fellowships, and information to high school students about opportunities.

The immediate appropriation of new federal funds for training and recruitment.

The acceptance of responsibility on the part of local health units for: vital statistics, communicable diseases, environmental sanitation, laboratory service, maternal and child health, chronic diseases, and health education.

The creation by local communities of voluntary, coordinating agencies, such as a health council or committee, composed of civic-minded individuals and representatives of professional groups and official and voluntary health agencies.

Chronic Disease

Final report not available at this writing. For section discussion, see Dr. Ellen C. Potter.

Maternal and Child Health

Adoption of a national plan to put health opportunities and safeguards within reach of all mothers and children, white and Negro, urban and rural, rich and poor—backed by private enterprise, voluntary agencies, private practitioners, and local, state, and federal governmental support.

Detailed report not available at this writing. For points to be included, see Dr. Ellen C. Potter.

Rural Health

Final report not available. For high points of the discussion, see Agnes E. Meyer.

Research

Stimulation of nongovernmental support of medical and public health research from such sources as: voluntary agencies, philanthropic foundations, industrial foundations or individual industries, individual donors, and other community sources.

Fluid financial support from federal tax sources on a long term basis to foster research in medical schools and other scientific institutions to be used primarily for increase in salaries and personnel and not to exceed $100,000 annually for each institution applying.

The inclusion of basic facility costs in federal grants for research in medical and allied fields.

The provision of funds for research in fields in which progress in research is not commensurate with its importance to the health field—such as studies in accident proneness and prevention, diseases of great social importance, and Arctic health; and provision of funds for research in fields in which important discoveries seem imminent or in which conclusions need additional critical analysis.

Development of fellowship programs carefully correlated with the predicted needs of trained workers.

The establishment of an information center on research fellowships, projects, sources of support, facilities, and personnel.

A national educational program to inform the public of the accomplishments of animal experimentation, its necessity and its humaneness.

Medical Care

See Michael M. Davis, (italics) for the first six recommendations of the medical care section. An additional recommendation urged:

Coordination of a medical care program with all efforts directed toward providing people with adequate housing, a living wage, continuous productive and creative employment under safe working conditions.

State and Community Planning

Final report not available at this writing. For points tentatively recommended, see Agnes E. Meyer.

Rehabilitation

Federal grants-in-aid to assist universities to develop opportunities for the professional training of rehabilitation personnel; to help states inventory their rehabilitation, physical medicine, and workshop facilities, survey the need for further facilities, and develop programs for their establishment under public and private auspices; to provide states with a broader financial basis for the establishment, expansion, and support of such facilities; to encourage universities, nonprofit research institutions, and governmental agencies to develop research in rehabilitation methods and techniques; to help each state conduct a study to determine the characteristics of its disabled population.

An educational program to encourage young persons to go into the professions involved in the fields of physical medicine and rehabilitation.

Cooperation and exchange of information among public and private, national, state, and local organizations engaged in various aspects of rehabilitation.

An educational program to inform professional personnel as well as the general public in regard to developments and needs in the field of rehabilitation.

The inclusion in all hospitals of services in physical medicine.

The inclusion of instruction in physical medicine in all medical schools.

Dental Health

The provision of federal funds to expand research in dental health and for studies and experiments in various ways of administering dental health programs for school children, the indigent, low income groups, and residents of rural areas.

The creation of a commission to define standards of dental care.

The provision of additional courses in dental health education in all institutions which train personnel for the fields of health and education.

Utilization by the dental profession to the fullest extent of known measures of prevention and control.

Financial participation in dental health programs by the federal and state governments with needs indicated and policies determined at the local level.

Federal grants to dental schools for scholarships and fellowships, for the construction and equipment of dental facilities and for assistance in maintenance, operation, and research.

The expansion of opportunities for Negroes to secure dental education.

The establishment of additional courses for the training of dental hygienists, assistants, and technicians in dental schools and other nonprofit educational institutions.

The maintenance of present high standards of dental practice in all dental health programs.

Mental Health

Final report not available at this writing. For points under consideration, see Dr. Ellen C. Potter.

Nutrition

Incorporation of instruction in nutrition in the training programs of all health personnel, particularly physicians, health officers, dentists, health educators, social workers, and teachers.

The development of a cooperative nutrition education program on national, state, and local levels.

The establishment of a National Nutrition Organization.

The expansion of the present nutrition section in the U. S. Public Health Service to division status, and increased funds for grants-in-aid for the development of state nutrition programs.

The establishment of special nutrition units in state health departments, directed by full time qualified administrators.

The creation of state nutrition councils representative of official and non-official agencies in the field of nutrition.

The establishment of local nutrition councils and the provision of nutrition services by local health departments.

The expansion of food production based on actual nutritional needs and taking into account probable future age-sex distribution of the population as well as increases in total population.

The adoption of a national conservation program involving soil, water, and related biological resources and including land use planning.

Improved educational programs to step up application of our present knowledge in regard to the conservation of the nutrient content of food.

An expanded school lunch program for the malnourished.

Amendment of the Food, Drug, and Cosmetic Act to authorize the administrator to define standards of nutritional quality for processed foods.

The extension of research in the relationship between nutrition and health, particularly in regard to the nutritional status of population groups, the fundamental human nutritional requirements, the effect of levels of nutrition upon degenerative diseases, methods of protecting groups vulnerable to malnourishment, measurements of nutrients, functions of foods, educational methods.

Environmental Sanitation

Greater community participation in environmental sanitation concerns.

Joint campaigns by federal, state, and local authorities to correct and abate surface water pollution and to develop and protect underground water resources.

Expansion of milk pasteurization and compulsory refrigeration of certain foods, the development of sanitary codes by food industries, and the authorization of health departments to reject substandard foods.

Financial participation by the federal government in housing for low income groups and participation of local health departments in promotion of programs for better community housekeeping, such as smoke control and refuse disposal.

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NATIONAL HEALTH ASSEMBLY - May 1-4, 1948
SECTION 13 - NUTRITION; SUBCOMMITTEE ON RESEARCH

DRAFT RECOMMENDATIONS

There is an urgent need for investigation in man of the relationships between nutrition and health. As defined in the constitution of the World Health Organization, "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Although health may be expressed in many ways, it will be considered here in its relation to nutrition in terms of such vital phenomena as physical and mental growth and development, pregnancy, lactation, freedom from congenital defects, immunity and resistance to disease, physical and mental performance, aging and longevity.

Many studies on animals have indicated that relationships do exist between nutrition and these aspects of health. But ultimate acceptance and application depends in part upon their demonstration in man. (New relationships of nutrition to health are being discovered continually.) For a few, convincing evidence is already available from studies on man; most, however, await this demonstration. Because these relationships are of such social significance and hold such great promise for health and economic benefit, they should be high on the agenda of investigations to improve and safeguard health.

Among specific items that merit urgent attention in planning a health program are the following:

NUTRITION RESEARCH NEEDED TO IMPLEMENT THE PUBLIC HEALTH PROGRAM OF THE FUTURE

Report of Subcommittee on Research
Nutrition Section, National Health Assembly
Washington, D. C., May 1-4, 1948

Summary of Recommendations

1. Nutritional status. Research to develop satisfactory methods of appraising nutritional status of representative population groups should be conducted vigorously. Data of this kind are essential to appraising the relationships between food practices and public health and for the continuous guidance of agencies that establish or modify food policies. ~~Government~~ OFFICIAL agencies have a primary responsibility for such investigations.

2. Human requirements. Fundamental research into human nutritional requirements is essential to public health protection. Until such information is at hand, public health officers, physicians, agricultural scientists, educators, and laymen ~~are~~ WILL BE seriously handicapped in their respective areas of responsibility.

3. Degenerative diseases. Investigations should be conducted to identify more clearly the effect of different levels of nutrition upon the degenerative diseases. There is evidence of relationships between food practices and diabetes, heart disease, arteriosclerosis, liver disease, cancer, kidney disease, and dental disease, but in all of these areas the information now available is too vague for adequate guidance of national policies and education of the public. These and other effects are evident, however, in zones of nutrition above those regarded as characteristic of deficiency diseases. Meticulous care and long periods of time are essential to gaining adequate information in this area of nutrition research.

4. Vulnerable groups. EVERY ~~Each~~ population group has within it special groups that need consideration in regard to nutrition practice. Their problems need intensive study. Examples of vulnerable groups that require special protection from a nutritional point of view are mothers during gestation and lactation, infants, adolescents, the aged, and those injured by infections or other forms of stress.

5. Measurement of Nutrients. Improved methods of measuring all of the nutrients - essential and non-essential - are of critical importance in guiding the production, processing, STORAGE, distribution, consumption, and ~~health~~ appraisal of HEALTH VALUE foods. The development of methods of analysis is dependent, however, upon identifying the nutrients in a definite chemical sense. The identification of According, there is immediate need for research to identify the many unrecognized ingredients of foods.

6. Functions of food. The functioning of ~~individual~~ nutrients such as INDIVIDUAL sugars, amino acids, vitamins, minerals, and fats in the human body must be understood more fully ~~by the medical profession and by those working in the allied sciences~~ in order to permit an intelligent use of foods, either for protection of public health or for restoration of health after illness and injury.

7. Educational methods. Research in methods of public and professional education is essential as a basis for progress toward good health through proper use of foods. In every part of the world ~~faulty~~ INADEQUATE educational measures now result in needless sacrifice of human health and wastage of economic resources.

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The development of a comprehensive research program should include improvement of graduate training facilities for professional personnel, integration of plans with ~~other government~~ OFFICIAL agencies, and effective cooperation with ~~independent~~ ALL organizations having allied responsibilities.

Assuming ~~the~~ development of the ABOVE recommended research program within a framework of efficient administration, highly qualified personnel and adequate facilities ~~for research~~, the expenditure would be justified by ~~the return of substantial contributions~~, in terms of improved health, economic gains, and social betterment.

Nutritional status

Nearly everyone accepts the principle that inadequate food intake is basic to the protection of public health, but there is much ////////// uncertainty regarding what constitutes a satisfactory state of nutrition. Methods of detecting borderline types of malnutrition are not adequately developed.

Severe forms of deficiency diseases such as rickets, scurvy and pellagra are gradually disappearing, but it is clear that large numbers of individuals do not eat sufficient quantities of essential nutrients to achieve their best health. The simplest forms of malnutrition, over-eating or eating too little, are promptly reflected by excessive gain or loss in body weight. But deficient intakes of vitamins, minerals, or proteins are much more difficult to identify. Generally a prolonged period of deficiency occurs before there is physical evidence of injury. Meanwhile, health can be impaired many ways not readily recognized or specifically associated with a deficiency. Hence it is highly important that techniques be developed to identify the earliest signs of deficiency, including the tests based on physical examination and those dependent upon chemical analysis. In both of these areas, sufficient progress has been made to justify further intensive and sustained research. Microchemical tests using only a few drops of blood, supplemented by physical examinations and dietary records, have become especially useful and promising in school health programs.

From a public health point of view, there should be no doubt of the need for carefully organized teams to survey representative segments of the population at frequent intervals. The data thus provided would be of value as a measure of trends in food practices and in gaining reliable

information relating food practices to health. Every state and large city health unit should make provision for such surveys regularly and should participate in the related fields of nutrition research and education.

A further type of specialized survey - and - research should deal systematically with dental diseases. The current high incidence of tooth decay and loss of teeth represents a major problem in public health and an enormous loss in an economic sense. Despite the recognized magnitude of the problem, provision has not been made for adequate surveys of representative population groups to provide a reliable base-line for research, education, or appraisal of corrective measures. Only from such records can the nation be sure of present conditions or the degree of progress in future years.

Human requirements

Animal nutrition research has advanced nearly twice as far as human studies. Obviously it is highly advantageous to develop exploratory and public health research on the basis of controlled animal experimentation; by following such a sequence, basic principles can be developed more rapidly, with greater confidence with less hazard to human health and with a great saving in expenditure. However, the margin between pilot tests with animals and re-checking in human experience should receive greater consideration, particularly in the educational and research programs of schools of medicine and public health. Systematic efforts should be made to establish the qualitative and quantitative human requirements of each of the essential nutrients. In addition, careful investigations should be conducted to appraise the optimal balance or contribution to the body's efficiency that can be made by non-essential nutrients such as many of the carbohydrates, fats and protein

fragments. Work of this nature is tedious and expensive but it has far-reaching value in safeguarding life and health.

The Recommended Dietary Allowances published by the Food and Nutrition Board of the National Research Council represent a valuable guide in public health planning. There is great need for extending and re-checking such information, however, because present information permits only a very limited listing of specific nutrients, and the data summarized in the publication are of necessity based upon incomplete evidence in many instances. Extension of such basic information would have great economic and educational value, in addition to its service in protecting health.

Degenerative diseases

The health records of the nation and of the parts of the world show unmistakably a broad trend of correlation between malnutrition and a higher incidence of degenerative diseases abundant evidence from animal tests show such relationships even more strikingly. Yet the evidence at many points is not well enough established for adequate guidance in medical and public health practice. Research directly in human situations and by controlled animal tests to explore new areas should be developed extensively.

Degenerative diseases associated in varying degree with faulty food practices include the cardiovascular diseases - America's number one killer, diabetes - which afflicts between one and two percent of the population, dental caries and loss of teeth - which has an incidence of ninety to ninety five percent in many areas, some forms of cancer - the most dreaded disease, fatty and cirrhotic livers, many kidney pathologies, lowered resistance to infections, toxemias of pregnancy,

premature aging of the skin, sterility, and shortened life span. The etiologies of such diseases are varied and complex, and involve many uncertainties insofar as nutrition is concerned, but the evidence is already impressive in showing that good nutrition constitutes an important measure of defense against them. Alert research groups are undertaking programs of investigation in these areas, but scarcely more than a beginning has been made.

Respectfully submitted by:

W. W. King, Chairman

point of view are mothers during gestation and lactation, infants, adolescents, the aged, and those injured by infections or other forms of stress.

MEASUREMENT OF NUTRIENTS

5. Improved methods of measuring all of the nutrients - essential and non-essential - are of critical importance in guiding the production, processing, distribution, consumption, and health appraisal of foods. The development of methods of analysis, however, is dependent upon identifying the nutrients in a definite chemical sense. Accordingly, there is immediate need for research to identify the many unrecognized ingredients of foods.

FUNCTIONS OF FOOD

6. The functioning of individual nutrients such as sugars, amino acids, vitamins, minerals, and fats in the human body must be understood more fully by the medical profession and by those working in the allied sciences in order to permit an intelligent use of foods, either for protection of public health or for restoration of health after illness and injury.

EDUCATIONAL METHODS

7. Research in methods of public and professional education is essential as a basis for progress toward good health through proper use of foods. In every part of the world, faulty education results in waste of needless sacrifice of human health and economic resources.

The development of a comprehensive research program should include consideration of improvement of graduate training facilities for professional personnel, integration of plans with other governmental agencies and effective cooperation of independent organizations having allied responsibilities.

THE NEED FOR IMPROVED METHODS OF ASSESSING NUTRITIONAL STATUS

Robert E. Shank, M.D.

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The nutritional status of a population group is an important factor in conditioning the general state of health of that group. This concept is given wide recognition among public health authorities and is predicated by many different types of evidence to be found in the medical literature. The observations of various workers in the United States and Canada have demonstrated quite conclusively that the hazards of pregnancy are increased both for the mother and the child, when the mother is provided with an inadequate diet during her period of pregnancy ( ). Likewise, the rate and extent of growth and development of children has been shown to be conditioned by the diet ( ). Morbidity data give conclusive evidence indicating increased incidence of various diseases during periods of inadequate food supply or among population groups subsisting on diets quantitatively or qualitatively poor ( ). The mortality rate for a disease such as tuberculosis may increase markedly among groups in poor states of nutrition ( ). These are but a few of the many types of evidence which may be cited to illustrate the important relationship which exists between the state of nutrition and the health of community groups.

It is of singular importance to public health officials to have information concerning the nutritional status of segments of the population. An inadequate dietary may be suspicioned in communities in which economic conditions are such

that incomes do not provide for subsistence on an adequate level or where for other reasons such as poor food supply or unusual food habits, large proportions of the population cannot be assured of diets which are adequate in quantity or quality. It is desirable under such circumstances to have means which will provide information concerning the character of the diet and the state of nutrition of individuals in these groups, as compared with others on different types of diets.

In attempting to appraise the diet and state of nutrition of an individual it must be recognized that several grades or zones of nutrition probably exist. There is an ideal or optimal zone in which individuals are provided with the energy giving foods and essential nutrients in quantities which allow for all of the body needs. To either side of the ideal state in nutrition are the extremes. First, there is the state of malnutrition or dietary deficiency accompanied by the appearance of clinical syndromes and marked metabolic dysfunction in which there may be real risk to life itself. On the other extreme is the state of hypernutrition, exemplified by obesity, which is associated with higher incidence of diabetes and other diseases and shorter life expectancy. The area between the states of ideal nutrition and extreme malnutrition is of great importance in the study of human nutrition and a zone in which assessment of states of nutrition should be of greatest significance from the standpoint of individual health and

of public health. It is to be presumed that levels of intake of the essential nutrients which provide less than the amount actually required for optimal function give rise to limitations and abnormalities of function. Although such a concept is widely accepted among workers in the field of nutrition, little definitive information is as yet available concerning the limitations accompanying sub-optimal levels of intake.

Various methods have been utilized in attempting to assess the nutritional status of humans. By accumulating a record of the quantity of all foods eaten by a given individual over a period of a number of days it is possible to estimate the level of intake of each of the energy providing food substances ~~and~~ of vitamins, and essential minerals during the period in which the record was made. Such a record should represent the usual diet of the individual and should cover a sufficient period of time so that it can be considered an average intake. Interpretation of data derived in this manner is dependent on comparison with standard tables of intake.

In the United States the table of reference usually adopted for this purpose is that of the Recommended Dietary Allowances of the National Research Council ( ). The daily levels of intake recommended for each of the essential food substances in this table were carefully selected to be well in excess of apparent minimal requirements. Therefore, a diet demonstrated to contain less of the essential

dietary components than recommended might still be a wholly adequate diet. Using this ~~means of appriasal~~ STANDARD OF REFERENCE it has been claimed that relatively large proportions of our population have an inadequate diet ( ). However, before such a conclusion can be ~~validly reached~~ CONSIDERED VALID, it is necessary that comparison be made of data derived in this manner with minimal requirements as established in human subjects. The present lack of standards representing minimal required levels of intake constitutes a major deterrent to further progress in the appraisal of states of nutrition in humans.

Physical examination represents a second means of appraisal of the nutritional state. These observations are exceedingly important in designating gross evidences of poor general nutrition or syndromes of marked deficiency of essential food materials. Claims have been made for the appearance of physical or morphological changes specifically related to low levels of intake of certain of the vitamins. Many of these signs no longer can be accepted as evidences of a specific deficiency, unless they can be shown to occur in an individual on a diet poor in the particular vitamin and ~~in addition~~ ALSO TO disappear with the single addition of that vitamin or essential nutrient to the diet.

Laboratory procedures are used as a third means of assessing states of nutrition. Methods are available by which it is possible to determine the

concentration in blood or in tissues of many of the essential nutrients or their metabolically active components using chemical or microbiological assays. It is also possible to determine the quantity of certain of the vitamins or their excretion products in fasting urine specimens. Interpretation of this type of data is based on the assumption that the concentration in blood or the rate of excretion in urine while fasting is in some measure proportional to the recent level of intake of these substances. ~~It is possible~~ By this means ONE MAY to demonstrate marked differences ~~in concentration among~~ BETWEEN population groups on diets rich AND poor in the nutritional essential for which analysis is made. However, it is often difficult to draw conclusions from concentrations demonstrated in a single individual. More information is required concerning the concentrations in blood and urine to be found in human subjects CTS maintained on varied levels of intake for prolonged periods of time. Laboratory procedures as a means of appraisal have the distinct advantage of being objective measures which are relatively easily obtained.

It must be recognized that there are serious limitations to each of the means of nutritional appraisal now available. Much has been gained, however, in nutritional surveys by a combined effort utilizing the dietary record, physical examination and laboratory determinations. Such a procedure permits a comparative analysis of all of the data and tends to decrease the apparent disadvantages of

each method of assessment.

To the investigator in the field of nutrition and to workers in this field of endeavor in public health a real need is apparent for information which will permit more exact interpretation of data derived by methods of appraisal already available and in wide use. Perhaps the greatest need is ~~for~~ for data of the type referred to above, which would designate the minimal levels of intake of the vitamins, minerals, and other food substances necessary to maintain the human subject in a state of health. Again, it is important to have ~~further~~ ADDITIONAL fundamental information concerning the roles of each of the dietary essentials in roles of body metabolism and the pathways which they follow. When this type of information is available it is conceivable that new and objective measures of the state of nutrition ~~might~~ MAY be achieved by the development and use of tests of chemical or physiologic function intimately and directly related to the metabolic function of ~~the~~ A particular nutrient.

The Nutrition Foundation, Inc.

CHRYSLER BUILDING
NEW YORK 17, N. Y.

C. G. King
SCIENTIFIC DIRECTOR

TELEPHONE
MURRAY HILL 5-6127

Statler Hotel
744
or Cosmos Club

April 26, 1948

Special Delivery

Dr. R. E. Shank
Public Health Research Institute
Foot of East 15th Street
New York 9, New York

Dear Dr. Shank:

Developing from the weekend meeting of the Steering Committee, National Health Assembly, could you prepare and bring to Washington a draft copy of a manuscript for the final record, under the title "The need for improved methods of assessing nutritional status"?

The length of this manuscript is left to your discretion. Something in the range of five to ten pages might be suggested as a general standard.

If the preparation of this manuscript would be too much of a burden for your schedule, notes and a brief outline of ideas would be useful. Secretarial help will be provided in Washington.

Formal plans will probably call for three types of copy: (1) brief recommendations to go before conference, (2) a summary manuscript covering the needs for nutrition research, particularly as related to public health in a long-time view, and (3) more detailed manuscripts in separate sections, as submitted by individual authors.

Sincerely yours,

C. G. King
Chairman, Research Section

CGK:DSO

Rainbow Room — 10:00 AM (after 9:15)
3:00 PM

National

Health

Assembly

MAY 1, 2, 3, AND 4, 1948

HEADQUARTERS: *Hotel Statler*

WASHINGTON, D. C.

Executive Committee

of the

NATIONAL HEALTH ASSEMBLY

Oscar R. Ewing, *Chairman*

Rev. John W. Barrett
Rev. Beverley M. Boyd
Edward L. Bortz
Mrs. J. L. Blair Buck
Earl Bunting
Elisabeth Christman
John W. Dargavel
Graham L. Davis
Katherine Densford
Louis I. Dublin
Robert P. Fischelis
Jerome N. Frank
Vlado A. Getting
Albert S. Goss
William Green
The Most Rev. Francis J. Haas
Paul R. Hawley
Frieda Hennock
Harold Hillenbrand
Mrs. L. W. Hughes
William Harding Jackson
Eric Johnston
Mrs. Albert D. Lasker
Mrs. David M. Levy
George F. Lull
Mrs. Eugene Meyer
James L. Morrill
Philip Murray
James G. Patton
Mrs. Anna M. Rosenberg
R. L. Sensenich
Earl O. Shreve
Frank Stanton
M. W. Thatcher
Jerry Voorhis
Walter White
Charles F. Wilinsky
Abel Wolman

Howard M. Kline, *Executive Secretary*

CONFERENCE ARRANGEMENTS

The Assembly headquarters will be at the Hotel Statler.

Registration will take place on the Mezzanine Floor. An information desk will be located nearby. Messages for persons registered at the Assembly will also be handled at this desk.

Tickets for the several official eating functions will be available at the Registration center. Tickets will be issued only to the extent of seating capacity. No tables will be reserved. Dress will be informal. Tickets for Saturday's Dinner will not be available for purchase later than Saturday noon. Owing to Secret Service regulations, guests will not be admitted to the Dinner later than 7:30, and must present their tickets at the door.

Press Information. Information concerning press credentials, press releases, and other press matters of the Assembly may be secured in the Potomac Room, Mezzanine Floor, Hotel Statler.

The Assembly Staff will be located in the Town Room, Mezzanine Floor.

Daylight Saving time will commence in the District of Columbia Sunday morning. To avoid confusion, set watches ahead one hour before retiring Saturday night.

Program

SATURDAY, MAY 1

9:00 a.m. REGISTRATION. Mezzanine Floor, Hotel Statler.

10:00 a.m. MEETING OF SECTION CHAIRMEN. Council Room, Hotel Statler.

11:00 a.m. GENERAL SESSION Congressional Room, Hotel Statler.

Welcome to Delegates, Hon. Oscar R. Ewing,
Federal Security Administrator

Plan of the Assembly, Howard M. Kline,
Executive Secretary, National Health Assembly

12:00 m. LUNCHEON in Observance of Child Health Day
Presidential Room, Hotel Statler

Presiding: Lee Forrest Hill, Past President,
American Academy of Pediatrics

The President's Proclamation of Child Health Day
Mrs. Mary McLeod Bethune, Founder-President,
National Council of Negro Women

A Doctor's Look at Child Health
Lee Forrest Hill

Child Health Is the People's Business
Mrs. Oswald Bates Lord, Chairman, United States Committee, International Children's Emergency Fund

An Experiment in Teamwork
Mrs. David M. Levy, President, Citizens' Committee on Children of New York City

A New Look at Child Health
Brock Chisholm, Executive Secretary, Interim Commission, World Health Organization

2:30 p.m. FIRST SECTION MEETINGS

Section 1. What is the Nation's Need for Health and Medical Personnel?
Chairman: Algo D. Henderson
Room: District Room, Hotel Statler

Section 2. What is the Nation's Need for Hospital Facilities, Health Centers and Diagnostic Clinics?
Chairman: Charles F. Wilinsky
Room: French Room, Hotel Raleigh

Section 3. What is the Nation's Need for Local Health Units?
Chairman: Haven Emerson
Room: Victory Room, Hotel Ambassador

Section 4. Chronic Disease and the Aging Process.
Chairman: James R. Miller
Room: South American Room, Hotel Statler

Section 5. A National Program for Maternal and Child Health.
Chairman: Leona Baumgartner
Room: Empire Room, Hotel Ambassador

Section 6. A National Program for Rural Health.
Chairman: Joseph W. Fichter
Room: Capitol Room, Hotel Statler

Section 7. What is the Nation's Need for Research in the Service of Health?
Chairman: Andrew C. Ivy
Room: Continental Room, Hotel Statler

Section 8. What is the Nation's Need for Medical Care?
Chairman: Hugh R. Leavell
Room: Congressional Room, Hotel Statler

Section 9. State and Community Planning for Health.
Chairman: Florence R. Sabin
Room: Federal Room, Hotel Statler

Section 10. Physical Medicine and Rehabilitation.
Chairman: Henry H. Kessler
Room: Foyer 3, Hotel Statler

Section 11. What Can Be Done to Improve Dental Health?
Chairman: Ernest G. Sloman
Room: Fourth Assembly Room, YWCA

Section 12. A National Program for Mental Health.
Chairman: William C. Menninger
Room: Jefferson Room, Hotel Mayflower

Section 13. What Can Be Done to Improve Nutrition?
Chairman: Frank G. Boudreau
Room: Gold Room, Hotel Hamilton

Section 14. A National Program of Environmental Sanitation.
Chairman: Arthur D. Weston
Room: Council Room, Hotel Statler

7:30 p.m. DINNER — Presidential Room, Hotel Statler
Presiding: Hon. Oscar R. Ewing,
Federal Security Administrator
Vocal selections: The Singing Squires
Music by The United States Marine Band Orchestra
Citations for Awakening Interest in National Health Needs:
Hon. Oscar R. Ewing.
Address: The President of the United States

SUNDAY, MAY 2

10:00 a.m. SECOND SECTION MEETINGS

1:00 p.m. LUNCHEON — Presidential Room, Hotel Statler
Presiding: Louis I. Dublin, Vice President,
Metropolitan Life Insurance Company

The Aged Will Be Tomorrow's Children
Theodore G. Klumpp, President, Winthrop-Stearns, Inc.

3:30 p.m. Tour of National Institute of Health, Bethesda
(Open to wives and delegates not engaged in afternoon Section meetings. Reservations to the extent of capacity of buses may be made at Registration Desk.)

Afternoon THIRD SECTION MEETINGS
Evening Time to be set by each section

MONDAY, MAY 3

9:30 a.m. GENERAL SESSION — Presidential Room, Hotel Statler

Presiding: J. Donald Kingsley, Assistant Administrator, Federal Security Agency

Presentation by Section Chairmen of problems which impinge upon other Sections

Discussion

2:30 p.m. FINAL SECTION MEETINGS

Formulation of Reports and Recommendations

8:00 p.m. GENERAL SESSION — Presidential Room, Hotel Statler

Presiding: Mrs. Eugene Meyer,

Medicine as a World Problem

Morris Fishbein, Editor, Journal of the American Medical Association

Cooperation in Health in the Western Hemisphere

Fred Soper, Director, Pan American Sanitary Bureau

Problems in International Cooperation in Health

Henri Laugier, Assistant Secretary General for Social Affairs, United Nations

TUESDAY, MAY 4

9:30 a.m. GENERAL SESSION — Congressional Room, Hotel Statler

Presiding: Hon. Oscar R. Ewing, Federal Security Administrator

Report to Assembly: Quincy Howe, Columbia Broadcasting System

Discussion

1:00 p.m. LUNCHEON in Observance of 150th Anniversary of the United States Public Health Service — Presidential Room, Hotel Statler

Presiding: C. E. A. Winslow, Editor, American Journal of Public Health

In Retrospect, Warren F. Draper, Deputy Surgeon General, Retired, U. S. Public Health Service

Response: Jack Lawrenson, Vice President, National Maritime Union

Response: Hon. Eliot Wadsworth, former Assistant Secretary of Treasury

Response: Vlado A. Getting, President, Association of State and Territorial Health Officers

The Health Officer Meets the Physician, Edward L. Bortz, President, American Medical Association

The Future of the Public Health Service, Leonard A. Scheele, Surgeon General, United States Public Health Service

Music by The United States Marine Band Orchestra

SECTION PLANNING COMMITTEES

Section 1. What is the Nation's Need for Health and Medical Personnel?

Algo D. Henderson, *Chairman*

Walter A. Bloedorn
Joseph Hinsey
Joseph Johnson
Ruth Kuehn
John T. O'Rourke
David Rutstein
Donal Sheehan
Ruth Sleeper
Herman Weiskotten

Section 2. What is the Nation's Need for Hospital Facilities, Health Centers and Diagnostic Clinics?

Charles F. Wilinsky, *Chairman*

Arthur C. Bachmeyer
George Bugbee
Msgr. Maurice F. Griffin
Katherine Hardwick
Malcolm T. MacEachern
Rev. John G. Martin

Section 3. What is the Nation's Need for Local Health Units?

Haven Emerson, *Chairman*

Reginald M. Atwater
Carl E. Buck
John W. Ferree
Robert H. Riley

Section 4. Chronic Disease and the Aging Process.

James R. Miller, *Chairman*

Damon Kerby
Karl Meister
Edna Nicholson
Howard A. Rusk

Section 5. A National Program for Maternal and Child Health.

Leona Baumgartner, *Chairman*

Herschel Alt
Hazel Corbin
John Hubbard
Herbert R. Kobes
Duncan E. Reid

Section 6. A National Program for Rural Health.

Joseph Fichter, *Chairman*

Ransom Aldrich
Franklin S. Crockett
Gladys T. Edwards
Harry G. Gould
C. Horace Hamilton
Frank Peck

Section 7. What is the Nation's Need for Research in the Service of Health?

Andrew C. Ivy, *Chairman*

H. G. Baity
Ward Darley
C. A. Elvehjem
T. Duckett Jones
Josiah J. Moore
John Stokes
S. Bernard Wortis

Section 8. What is the Nation's Need for Medical Care?

Hugh R. Leavell, *Chairman*

Ernst P. Boas
Nelson Cruikshank
Horace Hansen
Thomas A. McGoldrick
James R. McVay
Harry Read
C. Rufus Rorem
Louis Wright

Section 9. State and Community Planning for Health.

Florence R. Sabin, *Chairman*

Rose Cologne
John Conlin
Ruth Freeman
Charles Johnson
H. W. Nisonger
Jean Ogden

Section 10. Physical Medicine and Rehabilitation.

Henry H. Kessler, *Chairman*

William H. Bayne, Jr.
Dudley Britton
Josephine Buchanon
Charles Carll
Kermit Eby
Mildred Elson
N. W. Faxon
Bell Greve
Margaret Pope Hovey

Section 11. What Can Be Done to Improve Dental Health?

Ernest G. Sloman, *Chairman*

P. E. Blackerby, Jr.
Mrs. Charles D. Center
Allen O. Gruebbel
Harry Lyons

Section 12. A National Program for Mental Health.

William C. Menninger, *Chairman*

Thomas Rennie, *Co-Chairman*
Paul Lemkau
Helen Ross

Section 13. What Can Be Done to Improve Nutrition?

Frank G. Boudreau, *Chairman*

Bertha S. Burke
Rowland Burnstan
C. G. King
L. A. Maynard
Frederick J. Stare

Section 14. A National Program of Environmental Sanitation.

Arthur D. Weston, *Chairman*

Earnest Boyce
Mrs. S. J. Francisco
W. L. Mallmann
Sol Pincus
B. A. Poole

NOTES

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NATIONAL HEALTH ASSEMBLY

Tentative Statement of Scope of Sections

1. Professional Personnel

This section will consider the present supply and distribution of personnel. It will review the cost of professional education to institutions and to individuals, the effect of present financing on training facilities and the output of professional personnel, and professional and financial opportunities in the health professions.

2. Hospital Facilities

The purpose of this section will be to outline the nation's needs for hospital beds, hospital services, health centers and diagnostic clinics; to determine the practical approach to meeting those needs; and to show the relative role of the Hospital Survey and Construction Program as it affects or will affect such needs.

3. Local Health Units

This section will consider the deficiencies in local health services, the needs for local health services, and attempt to determine a "calendar of accomplishment" in the light of available resources.

4. Chronic Disease and the Aging Process

This section will consider the problems of chronic disease and the aging process in terms of their medical, social, and economic significance for the Nation. Within this broad framework, attention will be devoted to the analysis of the findings of recent community studies of chronic disease; provision of care for the chronically ill in terms of the Nation's available resources in health facilities and personnel, funds, etc.; various methods both institutional and extra-institutional, of providing such care; the relationship of the medical specialty groups to chronic disease care; the implications of an increasingly aging population in the United States; and possible administrative and financial techniques for dealing with the problems of disability (whether it results from illness or aging) during the next ten years.

5. Maternal and Child Health

This section will review the present status of child health and the facilities and services available to meet the need. It will consider what must be done to give all children the opportunity to grow up to be healthy, well-adjusted individuals, and more particularly, what steps can and should be taken now toward that end.

6. Rural Health

This section will consider the special factors involved in bringing the benefits of modern medical science to all rural people. This will include an analysis, in the light of the social and economic characteristics of our rural areas, of the supply and distribution of doctors and other health workers; and of related factors that will assure the provision of health and medical care services of the highest quality to rural people.

7. Research

This section considers those broad areas of research in medical and related sciences which need stimulation and implementation, the establishment of effective liaison between research groups, the relative proportion of basic and applied research, the means for augmenting the number of qualified research workers and the potential sources of support for expanded research activities.

8. Medical Care

This section will discuss the organization and financing of personal health services. It will consider the present needs of the public for improved health services; the adequacy and potentialities of various plans and arrangements, such as existing voluntary prepayment plans and group practice for meeting current needs, and steps to be taken toward making better health care available to the population.

9. State and Community Planning for Health

This section will discuss the ways of stimulating through lay and professional teamwork local awareness of unmet health needs and the methods for bringing about action to bear upon these needs. Members of the section will speak from experience and give successful (and unsuccessful) case histories showing "how it was done back home." From these experiences the section will attempt to develop a set of essential principles and guides to planning and action.

10. Physical Medicine and Rehabilitation

This section will discuss the size and needs of the nation's handicapped population, including the availability of existing facilities for restoring disabled persons to their fullest physical, mental, social, vocational and economic usefulness, the extent to which the need is now being met, and appropriate means for providing services which are not at present available from public or private sources.

11. Dental Health

This section will consider the need for dental health services and methods of closing the known gap between needs and dental care; the number of dental and auxiliary personnel required, the existing provisions for recruitment and training of such personnel, how they may be augmented, and how better geographic distribution may be effected; and what measures are necessary to bring about an expansion in dental research and in the facilities for conducting such research.

12. Mental Health

This section will consider the adequacy of personnel in the field of mental health, the improvement in facilities for the prevention, care, and treatment of mental illness and research into the causes, prevention and treatment of mental illness.

13. Accidents and Public Health (Tentative)

14. Nutrition in World Health

This section will discuss its extension of nutrition services in health departments, the training of personnel, and the formulation of a national nutrition program.

15. Industrial Health and Safety

This section will consider the special factors involved in protecting and improving the health and safety of workers. It will discuss the availability of the varied types of services which help protect workers from occupational health and safety hazards, and the next steps which should be taken by management, labor, professional technical personnel, and government to extend these services to all workers.

16. Environmental Sanitation

This section will be concerned with the development of a healthful environment for the people of the nation. It will review the present state of environmental sanitation, will consider the essential needs for continued progress in such fields as water, milk, food, air, wastes and vectors of disease for the protection of the public health, and will also review the personnel and administrative functions required to develop a healthful environment.

April 14, 1948

Mr. Oscar R. Ewing
Chairman, Executive Committee
National Health Assembly
Washington 25, D. C.

Dear Mr. Ewing:

I am pleased to have received your invitation to take part in the discussions of the Nutrition Section of the National Health Assembly. It is my plan to attend these sessions.

Most sincerely,

Robert E. Shank, M. D.

RES:rc

Nutrition

xxxxxxxxxxxxxxxx

1. Means of appraisal of nutritive status.
2. Encouragement of research programs attempting more adequately to define optimal levels of intake of essential nutrients.
3. Plans for an equitable distribution of important food materials.
4. Education programs to inform the public concerning a proper choice of dietary and the most economical and effecient means of preparation of foods for consumption.

Robert E. Shank, M.D.

STATISTICS IN NUTRITION RESEARCH

The need for statistical advice in planning and conducting research projects should be emphasized. Before any investigation or experiment is begun, plans for the study should be reviewed by a qualified statistician or person with training and experience in statistical methods as applied to research. Unless sound statistical principles are followed at each stage of an investigation, the study may fail in its objectives. Thus, the objectives or questions for which an answer is sought must be clearly defined; the variables or factors related to the problem which are to be studied or controlled must be identified and methods for collecting and recording the data must be carefully planned to assure uniform and objective measures of the variables; and, finally, there should be a general plan for analysis and interpretation of the findings. Too often, the statistician is not consulted until after the data are collected and assistance is sought for analysis of the data and intrepretation of the results. At this stage, faults in the plan for the study or in the data usually can not be corrected and the findings may fail to provide an answer to the questions which were the initial objectives. To avoid such a situation, any group or organization undertaking research should have a statistician on the project from the very first, if the scope of the study warrants it, and if this is not practicable, it should seek competent statistical advice from some source.

Surveys of populations to determine the prevalence of malnutrition and to describe the nature and extent of specific nutritional deficiencies are an important part of the public health nutrition program.

In such an investigation, it is usually desired to obtain from a sample of the total population (city, county, or state) rates which are valid for the total community, since it is not possible to examine clinically or to obtain diet records from all persons in the community. The selection of sample populations from which reliable estimates for the total may be obtained is a highly technical procedure, and plans for selecting sample populations to be surveyed and methods for estimating population rates should be entrusted only to specially qualified persons.

Data collected in surveys frequently will be improved if a statistician is consulted on methods for standardizing the procedures used. Interviewers need training in the collection of information. Laboratory methods should be evaluated for their accuracy and a uniform procedure should be adopted and maintained throughout a study and by different persons cooperating in the study. Clinical findings, for the most part, are subjective evaluations by a physician, and comparability of clinical ratings by different physicians requires agreement on carefully defined descriptions of specific conditions.

Vulnerable groups

Within each community, there are special groups for whom the problem of good nutrition is differentiated somewhat from that visualized for a typical child or adult. They need to be aware of the fact that their nutritive requirements are not "average" for the population, about them.

Convincing evidence has come from several studies in the United States, Canada and Western Europe, showing that the health of mothers during the reproductive cycle, including lactation, and the health of their offspring can be benefited markedly by food practices that are better than commonly followed. In England, for example, a striking demonstration was provided by their experiences in regard to maternal and child health, as a result of special nutritional provision for these vulnerable groups. All-time low maternal and infant death rates were achieved in successive years, from 1942 to-date, largely as a result of the improved food practices. Gradually, the incidence of tuberculosis and dental diseases also declined, as one would expect from careful nutrition studies with experimental animals. It should be borne in mind that these many gains in health in several sections of the world, have been achieved in the zones of ~~xxtix~~ nutrient intake well above the levels of intake that result in the classical signs of nutritional deficiency.

In recent investi ations of nutritional problems of the aged, it is clear that this group, too, requires special consideration, and that conventional food practices have not provided for their best health. The special problems in this area require extensive study through long periods.

Still more constructive, in some respects, would be research to guide improved nutritional practices in infancy and early childhood, to ward off

this area require extensive study through long periods.

Still more constructive, in some respects, would be research to guide improved nutritional practices in infancy and early childhood to ward off early injuries that lead to impairment of health throughout the lifespan. It is clear that early injuries to the skeletal and glandular tissues, caused by marginal degrees of malnutrition, cannot be fully offset by later improvements in food intake. There is great need, however, to explore more fully the long-time effects of faulty food practices in both human research and in studies of experimental animals. Research with primates should be particularly significant in this area of investigation.

Measurement of Nutrients

Empirical feeding tests with foods of unknown composition have served to guide early explorations in the science of nutrition, but with increased knowledge of the chemical nature of individual nutrients such as sugars, amino acids, vitamins, and mineral elements, progress was more certain and useful results were obtained with increasing rapidity.

Identification of all of the nutrients in foods therefore represents a basic groundwork that is both helpful in research and immediately useful in industry and the practical arts. Among the immediate gains from identifying food constituents, more precise and more rapid methods of analysis are of major importance. The resultant economies, by which expensive and non-specific animal tests can be replaced by rapid chemico-physical tests are of great practical advantage. In addition, new analytical techniques permit extension of the of measuring nutrients in biological, medical and industrial research where biological tests often cannot be applied.

Provision of Food

In the provision of nutrition and as a guide to optimal resources, much basic research is underwriting the functions of individual nutrients is of great significance. A broad approach to such studies, in terms of the integrated economy, is [illegible] by such experiments. The recognized role of nutrients in a successful well may well lay the groundwork for a solid increase in [illegible] animal and human physiology. And in many such new guiding principles in normal physiology and biochemistry almost inevitably leads to more efficient nutrient processing and conserving human [illegible] health. Of all the areas of research directed toward public health, this basic field of exploring the causes of normal living processes will probably pay the highest dividends in the long run.

Educational Methods

In a democratic society, there is very excellent to develop standards of education so that the public will realize a variety of [illegible] nutritional practices that promote [illegible] health. Many agencies are endeavoring to educate the public and the responsible professional groups that are responsible for food and nutrition practices. To date, it is clear that advances in educational outcomes have been woefully inadequate. Highly specialized approach to solid fact, to find some of educating children and adults, at their respective levels of susceptibility so that their making habits will accord more fully all these principles in operation.

Research in this practical realm of [illegible] should be developed in parallel with improved education in professional groups. The training of medical and public health personnel in regard to the science and practical aspects of nutrition also calls for intensive study. The various national organizations and many public and private agencies are working to the problem, but there is no question regarding the fact that a tremendous goal of achievement is still far in the distance.