Trade Barriers in the Milk Industry*

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No traveler or tourist in the United States who purchases milk can fail to be impressed with the diversity of the grade labels on milk bottles. A nation-wide survey of milk control practice made by the U.S. Public Health Service some years ago (1) indicated that slightly more than one-half of the municipalities graded their market milk supplies, and that the wide range of grade designations included certified, grade A, grade B, grade C, grade D, select, inspected, guaranteed, special, market, family, as well as no grade label. Many of these grade designations were repeated for raw milk as well as for pasteurized milk. The survey also revealed the wide differences existing from state to state and from city to city as to the legal standards for corresponding grades and the frequency of inspection and sampling.

While the last few years have witnessed much progress in the direction of unification of milk control practice, the goal is still far off. Conditions are still sufficiently chaotic to affect adversely the milk consumer, the milk control official, and the dairy industry. It may therefore prove worth while to describe the present situation, to examine its results, and to suggest possible remedies.

The great mass of dairy legislation of the last two decades has been designed primarily to accomplish one or both of the following ends: (1) To protect the health of consumers of dairy products by insuring a clean and wholesome product, and (2) to stabilize the dairy industry and to increase the purchasing power of dairy farmers. These aims are often combined in the laws and are almost indistinguishable. In the attempt to attain these objectives, legislation has been adopted which has given rise to serious interference with interstate and even intrastate commerce. These trade barriers in the milk industry were fully discussed at the Federal-State Conference on War Restrictions called by the Department of Commerce in Washington in May 1942 (2). The laws and regulations adopted by the states, districts, counties, and cities prescribe, often in minute detail, the sanitary conditions under which dairy products shall be produced, processed, and distributed. To enforce the sanitation standards prescribed, official inspection is required. Control is exercised by the granting of licenses or permits to dairy farmers, processors, and distributors to dispose of their products in a given market only after certification of satisfactory inspection by the officials of the city or state concerned, and by revoking such permit or lowering the grade of the product upon repeated violation of the standards.

Overlapping Inspections

Members of the dairy industry supplying different markets are confronted with a real problem arising from the multiplicity of laws and regulations in effect in the different states and in the various municipalities within the states. They are frequently subjected to unnecessary inconveniences and expense of multiple and overlapping re-
requirements and inspections, and even to outright inability to enter a distant market.

An excellent example of the lack of uniformity in milk control practice was described some years ago in the New York-New Jersey-Pennsylvania area (3). The State of New York, the City of New York, the State of New Jersey, and individual cities in New Jersey all require that the milk shipped to them from Pennsylvania must meet their individual requirements and must be inspected by their own staffs.

Only recently one of our District Offices reported that the new regulation of the Maryland State Board of Health governing construction and location of the milk house differs from those of both Baltimore and Washington, so that a Maryland producer complying with the State regulation may be unable to obtain a permit to ship to either of these cities.

The Federal Trade Commission cites a number of similar examples. It reports (4) that "one distributor who shipped milk to several cities and states claimed to be subjected to 57 different inspections. A Maryland receiving plant distributing in Philadelphia claimed to have been inspected by Pennsylvania State authorities 5 times in 3 months, by Maryland authorities 2 or 3 times each year, and by Philadelphia authorities once or twice each month. Although these may be extreme cases, duplication of plant and farm inspections was found in many areas visited by the Commission's representatives. . . . It is evident," the report continues, "that the additional expenses created by duplication of inspection must be borne by the producer, the consumer, or both. Also, it appears that inadequate inspection makes possible the evading of health requirements and is thus a potential health menace".

Market Restrictions

Numerous instances of tendencies toward market restriction of milk and dairy products are also given in a report by the Bureau of Agricultural Economics (5). It quotes a report of the Federal Trade Commission that "there are indications that Connecticut has used its milk-inspection laws advantageously in keeping out milk from other states, although it does not admit this use of its powers". It also lists other states, including New York, New Jersey, and Pennsylvania, whose laws require inspection by their own officials of all farms from which milk and cream are shipped into the state.

According to the same report, market restriction through inspection requirements is promoted by cities and towns as well as by states. Since 1906, New York City has maintained farm inspection of its sources of milk and cream supply, and since 1926 has definitely limited this inspection area. Several years ago Baltimore had a drastic limitation on its supplies of milk and cream. The commissioner of health of Baltimore ruled that cream for manufacturing ice cream could not be brought from a greater distance than 50 miles from the city except when "emergency" shortages were declared to exist. This ruling was contested in the Federal district court and found invalid.

Small towns as well as large cities place definite limits on the area from which they will accept shipment of dairy products. In a recent study of three Massachusetts towns, R. G. Bressler, Jr. pointed out that grade B milk for Haverhill must be produced within 40 miles of the town, for Walpole within 30 miles, and for North Attleboro within 8 miles.

A common practice for states as well as for cities is to limit the area in which inspection is conducted at public expense. Producers outside this area, or more often the distributors who buy from them, must, themselves, cover all inspection costs. Even where shippers of western cream are in a position to cover this inspection cost,
they may be confronted with difficulties in persuading eastern public authorities to provide the inspectors. In such cases the western dairymen are inclined to believe that the refusal to provide inspectors is deliberate and designed to keep western cream from the eastern market (5).

One final aspect of the restrictive effect of health and sanitary regulations on dairy products should be mentioned. The insistence of cities and states upon their own regulations and inspection by their own officials reaches rather absurd limits in areas where the production is normally carried on for more than one market. A few examples of this kind have already been given. Reports from ice-cream manufacturing plants in many parts of the country indicate that their farm sources of cream supply are often subjected to inspection by three, four, or even more state, county, or city health departments. Cities often refuse to accept the inspection reports of their own state official, and neighboring counties or townships refuse to enter into reciprocal inspection agreements. These conditions were found by the Federal Trade Commission in its investigation of the New York milkshed.

If time permitted numerous other examples could be cited of restrictive milk control laws and practices by states and cities which tend to limit the milkshed and impose price regulations. Most of you have no doubt had your own experiences with them. What are the results of this lack of uniformity in milk control legislation and of this restriction of milksheds?

Health officials are concerned primarily with the cleanliness and the safety of milk, not with its price. However, they are compelled to take cognizance of price when it begins to affect the nutritional status of the public. Any sanitary or price regulation which interferes unnecessarily with the free flow of milk and milk products tends to increase the price of milk to the consumer, and thereby tends to reduce the consumption of this nearly perfect food. The effect is particularly serious among low-income families who can afford little and frequently no milk for their children. Reduced consumption of milk and milk products may affect the nutritional status of the nation.

Most of us will agree, I believe, that the surest solution of the economic problem of the milk industry lies in increased consumption of milk and dairy products. The solution is not to be found in drastic curtailment of production, for this will not increase the farmer's total income from milk sales. In spite of all appearances, the market for milk and milk products is far from saturated. According to the survey of the Public Health Service, previously mentioned (1), the weighted mean consumption of fluid market milk, cream, and buttermilk in all municipalities of over 1,000 population in this country in 1936 was less than three-fourths of a pint per person per day. It may be slightly higher today. Nutrition experts generally recommend a quart per day for each child and a pint per day for each adult.

The maintenance of restrictions imposed against outside competition is not only contrary to the public interest but is a short-sighted policy from the viewpoint of the ultimate prosperity of the local dairy industry. Insofar as the elimination of competition from outside the local milkshed results in higher local milk prices, it tends to discourage local milk consumption and to encourage greater competition within the local milkshed. Such local competition is likely to be "stiffer" because of the shorter transportation distances involved.

The steady improvement of milk-shipping facilities makes possible an ever-increasing interstate shipment of milk and cream from areas of high production and low consumption to areas of low production and high con-
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Consumption. With improved transportation it should be possible for areas which can produce milk and cream cheaply to supply those where production costs are high, thus reducing the price to the consumer and increasing the consumption of milk. Any restriction which tends to overdevelop the local dairy industry in high-production-cost areas instead of in naturally low-cost areas does not seem sound from the viewpoint of the industry as a whole.

During the war, the lack of uniformity of grade standards for milk made it impossible for the Army Quartermaster to obtain the same quality of milk for all camps throughout the country. A similar difficulty is experienced by interstate common carriers in obtaining a uniform grade of milk on all dining cars, planes, and vessels throughout the country. In some sections it is impossible for these carriers to secure grade A pasteurized milk conforming to the standards of the Interstate Quarantine Regulations.

Need for Uniform Regulations

The foregoing presents a brief picture of the restraints to the free flow of milk and milk products, as well as some of the results. What is the remedy?

That there is ample justification for ordinances and regulations governing the sanitation of milk supplies, as well as for the proper enforcement of such standards, is definitely indicated by the record of milk-borne disease. The absence of effective milk control in many of the municipalities of the United States, particularly in the smaller ones, is responsible for the occurrence of from 30 to 50 outbreaks of milk-borne disease each year. For the first 18-year period during which the Public Health Service has been compiling such reports, 765 milk-borne outbreaks were reported, involving 31,735 cases and 753 deaths. In the order of their importance the diseases reported were: typhoid fever, scarlet fever and septic sore throat, food poisoning and gastroenteritis, paratyphoid fever, diphtheria; and undulant fever.

It should be noted that this compilation does not include sporadic cases of typhoid fever, scarlet fever, septic sore throat, etc., since such sporadic cases have rarely been given sufficient epidemiologic study to determine the role of milk and milk products in their causation. Nor does this compilation take any note of such diseases as bovine tuberculosis, undulant fever, or infantile diarrhea, which are largely milk-borne, but which generally occur as sporadic cases rather than in epidemic form. For undulant fever alone between 3,000 and 5,000 cases have been reported annually during recent years in the United States, and it is estimated that these reported cases represent only one-tenth of the actual cases.

The occurrence of a milk-borne epidemic of disease not only ruins the business of the dairymen whose supply is implicated, but may undermine the confidence of all consumers and adversely affect the sales of every dairymen in the community. It is obviously to the industry's self-interest, therefore, to lay aside all minor differences and to cooperate with health officials and consumers in promoting an uniform, effective program of milk control in their community and in their State. The industry is indebted to the health officer for the most effective type of advertising, namely, the official promotion of increased consumption for adequate nutrition. The industry, in turn, must be willing to produce a product which the health officer can safely recommend.

Certainly the public health must be safeguarded, but this can be accomplished by the adoption of uniform standards and uniform interpretations thereof which would make possible the mutual acceptance by one area of in-
spection reports made by another. There is as little justification for needlessly stringent and unique requirements, which in effect erect "Chinese walls" around a milk shed, as there is for inadequate public health control.

**Standard Ordinance**

Since 1923 the U.S. Public Health Service has been engaged in making field and laboratory studies in milk sanitation. As a result of these studies it has formulated a model milk ordinance which is recommended for voluntary adoption by States, counties, districts, and municipalities, in order to encourage a greater uniformity and a higher level of excellence of milk control practice in the United States. To standardize the interpretation and enforcement of the Milk Ordinance, an accompanying code was formulated which gives the public health reason for each sanitation requirement and details of satisfactory compliance. While this ordinance and code embodies the best information at present available on milk-sanitation legislation, it is subject to change as improvements are developed through experience and research. All proposals for revision are considered by the Public Health Service Sanitation Advisory Board. A new edition is issued from time to time, the latest being that of 1939, published by the Government Printing Office as Public Health Bulletin No. 220. Two amendments have since been adopted.

Voluntary adoptions of the milk ordinance recommended by the Public Health Service have steadily increased from year to year, until at the present time it is legally in effect in communities ranging in population from less than 1,000 to about 3,500,000, and located in 39 states. It has been adopted state-wide in 3 states, and by 193 counties and 1,096 municipalities in 36 other states. It has been adopted as state regulations in 25 states, but in these cases enforcement is usually left to the local communities. It is undoubtedly the most widely accepted standard in this country.

No detailed discussion of the provisions of the recommended milk ordinance can be undertaken at this time, but a brief outline may be in order. The ordinance defines the sanitation requirements for several grades of raw and pasteurized milk, states the minimum frequency of inspection and sampling for grading, requires that the grade be shown on the container label, and permits each community to decide for itself at the time of adoption which grades it will permit on the market. It provides a choice of two methods of punishing violations—either by permit revocation alone, or by degrading and permit revocation.

**Rating of Compliance**

However, it was early recognized that the mere adoption of uniform legislation throughout the country does not of itself assure uniformity of enforcement. A city which passes the recommended ordinance but permits all milk distributors to label their milk grade A, irrespective of whether or not they satisfy all grade A requirements, must not expect to retain consumer confidence in the milk supply, nor can it expect its surplus milk and cream to be accepted without question by other areas.

In order that residents, travelers, and milk-receiving communities may have available a means of judging the excellence of enforcement, the Public Health Service has developed, as a part of its recommended program, a milk-shed rating method for the periodic measurement of the control work of municipalities by the state milk control authorities (6). This rating method uses as a yardstick the grade A pasteurized and the grade A raw milk requirements of the recommended ordinance. These nationally recognized standards, rather than the local requirements, are used as a yardstick in
order that ratings of different milk sheds may be comparable with each other, both intrastate and interstate. For each community in which both raw and pasteurized milk are sold, two compliance ratings are obtained: a pasteurized milk rating and a raw milk rating. These ratings are not safety ratings, but represent the degree to which the community has enforced sanitation requirements designed to make pasteurized milk and raw milk, respectively, as safe as these grades may practically be made. A rating of 100 represents perfect compliance, but if any requirements are not satisfied the rating is reduced by an amount proportionate to the volume of milk sold by the violators and to the relative sanitation importance of the violated items.

Most of the states having communities operating under the recommended ordinance make periodic milk sanitation ratings of these communities. In order to encourage these communities to attain and maintain a high level of enforcement, the Public Health Service has, since 1934, published semi-annually in Public Health Reports a list of communities which have been awarded by their state milk sanitation authority a rating of 90 percent or more, based on the Public Health Service rating method. No community is retained on the list if its rating is more than 2 years old or if a later rating is below 90. This list was suspended for the war period, but will be resumed when normal conditions are reestablished. The Public Health Service makes available advisory assistance to the states in organizing their milk control programs and in standardizing their rating work. The district milk specialists of the Service also made occasional check ratings of communities on the 90 percent list and those which did not deserve inclusion were removed from the list.

Section 11 of the Public Health Service milk ordinance provides that milk and milk products from points beyond the limit of routine inspection may be approved by the health officer if he is satisfied that they have been produced and/or pasteurized under provisions equivalent to the requirements of this ordinance and that these provisions are properly enforced. The milk code recommends that such milk and milk products be approved by the health officer without his inspection if they have been awarded by the state milk sanitation authority a rating of 90 percent or more.

This system, developed by the Public Health Service, and employed by many states, was useful during normal times in acquainting areas experiencing a milk or cream shortage with areas from which satisfactory supplies could be obtained. The universal adoption of the recommended milk ordinance would remove all barriers created by differences in sanitary standards. The milk sanitation rating method provides the receiving community with a means of judging whether the uniform standards are uniformly interpreted and enforced, and makes possible the acceptance of reciprocal inspections. Check ratings by the Public Health Service reveal whether the rating methods of the state rating agency are acceptable. By this system a receiving community is afforded all necessary and legitimate public health protection of its distant sources of supply. It is offered as a means for overcoming existing multiple inspections and trade barriers.

An outstanding example of what can be accomplished along these lines was the action taken before the war by the Midwest Regional Conference on Milk called by the Council of State Governments at Chicago. In order to remove unwarranted barriers to interstate shipment, the Conference recommended the adoption of uniform sanitation and inspection standards for the production of milk and cream for acceptance by the ten states participating. The Conference appointed a Committee of
Dairy Technicians to formulate such standards. This Committee subsequently proposed the mutual acceptance by these states of milk and cream for manufacturing purposes which the shipping state certified as complying to the extent of 90 percent or more with production standards based on the Public Health Service milk ordinance standards for market milk but with some items or parts of items omitted. This reciprocal interstate agreement was officially approved in the States of Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Ohio, Tennessee, and Wisconsin (7). Thus far the discussion has referred to normal peacetime conditions. The unprecedented demand for milk during the war period, particularly in military and war industry areas, created critical shortages of milk and milk products in many sections of the United States. As a result, many milk plants were forced to accept low-grade supplies from nearby producers or from other states—in some cases uninspected supplies that normally went into cheese, butter, milk powder, and evaporated milk. Lack of sufficient price differential between high-grade milk for the fluid market and low-grade milk for manufactured products tempted many producers away from the fluid market, and it was impossible in most places to get enough marginal producers to improve their methods so as to qualify for this market. Consequently, a definite deterioration occurred in the sanitary quality of raw milk for pasteurization throughout the country. Cities which had formerly achieved a rating of 90 percent or more found themselves losing ground, and surpluses from such areas no longer existed. Accordingly, in 1943 the 90 percent list that had been published semi-annually in Public Health Reports was suspended for the duration of the emergency.

Although milk shortages are now less severe than during the war, they still exist in many areas, particularly during seasons of low production, so that certain markets still find it necessary to import milk from other states or from other milksheds in the same state. In the absence of high-grade surpluses in cities rating 90 percent or more, standard milk ordinance areas have been compelled to draw their supplies from almost any source available. In some cases importing areas are accepting shipments on the basis of approval by health officers of shipping states. The difficulty in reaching any agreement on interstate shipments lies in the fact that shipping states have been willing to certify whether shippers are meeting their standards, whereas receiving states and cities wish to know instead whether their own standards are being complied with. In other instances, the Public Health Service has been requested to survey out-of-state sources and to report to the receiving state whether such sources comply with the latter’s standards. This clearance mechanism is satisfactory where such sources are restricted in number and are used regularly. But for a large number of sources, and particularly when these are shifted from week to week, it is obvious that the survey facilities of the P.H.S. district offices become inadequate because of their limited staffs.

**Certification Plan**

Spurred by the needs of certain states, the Conference of State and Territorial Health Authorities at its March, 1944, meeting approved the recommendation of its Committee on Interstate and Foreign Quarantine that the Public Health Service be requested to prepare a plan for the certification of interstate milk shippers by a procedure similar to that employed in the certification of shellfish shippers. Accordingly, such a plan was prepared and submitted to all State and Territorial Health Officers for their comment, in a letter from the Surgeon General dated November 24, 1944.
(8). Because the P.H.S. standards are not accepted nation-wide, as is the case with its shellfish sanitation standards, the plan suggested the publication of two, or possibly three, separate lists. List 1 would include milk shippers certified by the state of origin as having a compliance rating of 90 percent or more on the basis of the P.H.S. grade A standards (9) and the P.H.S. rating procedure (6). List 2a would include shippers with ratings of between 80 and 90 percent on the same basis. List 2b would include those rating 90 percent or more on the basis of the Northeastern States Emergency Sanitation Standards (10). The state's rating procedure would be checked by the Public Health Service.

A report on the comments submitted by the States and Territories was prepared by the P.H.S. and considered by the Committee at the 1945 meeting. As only a minority of the states had registered their views on the plan, the Committee's report, approved by the Conference of State and Territorial Health Authorities on April 11, 1945, recommended that the plan be again brought to the attention of the members to secure a wider expression of opinion. This was done. Eventually, 40 states replied, only 8 of which were opposed to the certification plan. Publication of all 3 lists was favored by 9 states, of 2 lists by 16 states, and of only 1 list by 6 states. List 1 (P.H.S., 90 percent) was approved by 31 states, list 2a (P.H.S., 80 percent) by 20 states, and list 2b (NEES, 90 percent) by 4 states.

In view of the responses, the Committee recommended that the P.H.S. be requested to inaugurate the periodic publication of lists of shippers with surpluses certified by the State health or supervisory agency as complying with the standards of lists 1 and 2a, and that a third list (2b) be later inaugurated if the demand justifies. It also recommended that the lists be published quarterly, if necessary, in order to indicate current surpluses. The Committee's report was approved by the Conference in April, 1946.

However, the P.H.S. has not as yet inaugurated the certification procedure, although it hopes to do so by the beginning of 1947. There were several reasons for the delay. First, it was considered advisable to wait until increased appropriations were available for enlarging the field staff of the P.H.S. District Offices. For example, to date it has not been possible to obtain qualified milk specialists to fill two vacancies in the Kansas City District. Secondly, it was desired to see what action would be taken by the APHA Subcommittee on Reciprocal Sanitary Milk Control. Thirdly, possible action by the International Association of Milk Sanitarians in approving a uniform standard for raw milk for pasteurization was awaited.

In 1942, the International Association of Milk Sanitarians appointed a Committee on Milk Regulations and Ordinances for the purpose of drafting minimum essential standards that would be acceptable to the entire membership. The Committee, of which I am a member, includes representatives from both Standard Ordinance and Non-Standard Ordinance areas. It has been endeavoring for several years to arrive at a mutually satisfactory standard for the production of raw milk for pasteurization, as it is in this field, rather than in pasteurization plant requirements, that the greatest differences exist between the P.H.S. standards and those of the northeast group of states. I am happy to report that the Committee finally reached compromises on disputed points and reported the proposed production standards to the International Association of Milk Sanitarians at its recent annual meeting in Atlantic City. The proposed standards have been closely patterned after those of the P.H.S. milk ordinance, and will, I believe, be generally acceptable both to Standard
Ordinance and Non-Standard Ordinance areas. The Committee was authorized by the Association (1) to draw up standards for receiving stations, tank trucks and tank cars, and pasteurization plants, (2) to submit the complete ordinance draft to the membership by mail, (3) to make such changes as may be suggested by a majority of the members, and (4) to submit the final draft to the P.H.S. for the consideration of the Sanitation Advisory Board in connection with the preparation of a new edition of the P.I.I.S. Milk Ordinance and Code. I have high hopes that through this united effort the goal so long sought by the P.H.S. will be reached—a set of milk standards that would eventually achieve universal acceptance. As the Surgeon General pointed out in his letter of November 24, 1944, to all State Health Officers (8), the universal acceptance of one set of milk standards would greatly simplify the procedure for the certification of interstate milk shippers, and would facilitate such shipments. As it now appears unlikely that the Committee can complete its draft and have it considered by the P.H.S. Sanitation Advisory Board in less than 5 or 6 months, it does not seem advisable to postpone the inauguration of the certification system that long. However, when a revised edition of the P.I.I.S. Milk Ordinance is issued, the revised standards will be used as a basis of certification instead of the present P.H.S. standards.

Another development that should be mentioned is the interest shown in this subject by the American Public Health Association. During the annual meeting of the Association in October, 1944, an informal conference was arranged to discuss reciprocal sanitary milk control among the states, with Dr. Haven Emerson presiding. The discussion emphasized that reciprocal acceptance of inspection data among the states would remove the expense and inconvenience of overlapping and conflicting inspections, and that no reciprocal action is possible without a generally accepted basis of dairy farm standards and a system of checking state certification procedure. The conference adopted a resolution calling on the Governing Council to study this matter further.

For nearly two years nothing more was done by APHA; but a few months ago their Committee on Administrative Practice created a Subcommittee on Reciprocal Sanitary Milk Control. At its meeting on September 6 of this year the Subcommittee, of which I am a member, discussed the subject, and agreed that each state should establish an inspection system to determine the adequacy of local control within the state, and that the Public Health Service should inaugurate a system of certification for interstate shippers with periodic spot checks to determine the acceptability of state inspections and laboratory supervision. It was suggested that instead of publishing lists of shippers who achieved minimum ratings of 90 percent and 80 percent, one list should be published containing all interstate shippers, together with their actual ratings. It was felt that this system would be of greatest service to receiving states as it would insure a larger list of shippers than would be possible in these days of shortages with a 90 percent or even an 80 percent list, and each community would be in position to obtain milk of the highest quality available at the time; nor is there any reason to believe that shippers would have less incentive for improvement under this system than under a two-list or three-list procedure.

And so we come down to the present day. In planning the certification procedure the Public Health Service is confronted with a number of problems. For example: (1) Shall certifications be accepted from State Agricultural Departments or only from State Health
Departments? (2) Shall lists be published semi-annually or quarterly, and should supplemental lists be issued monthly or whenever notices of additions or deletions from the list are received from the States? (3) Shall state certifications be based on only state inspection and laboratory results, or shall results of local official inspection and sampling be accepted if periodically checked and approved by the state? (4) On what minimum number of inspections and samples per year shall certification be based? (5) How often should the state’s rating procedure be checked by the Public Health Service? (6) Should the rating procedure be checked for each state sanitarian inspecting sources for certification? (7) Should bacterial counts be given a greater weight than the present 15 points in computing the rating of producers? (8) Should the Public Health Service start with lists of raw milk shippers only, or include separate lists of pasteurized milk shippers and cream sources? Your comments and discussion of these questions would be welcomed.

In closing, may I point out that the certification procedure should not be too burdensome to the shipping state, yet it must be protected by adequate controls which will offer the receiving community a reasonable guarantee of the accuracy of the ratings.

References

NOTE: Since the presentation of this paper, the Surgeon General has circularized all state milk control authorities for the purpose of inaugurating the publication of lists of interstate milk shippers. The letter follows this article—Editor.

TO ALL STATE MILK CONTROL AUTHORITIES

Subject: Publication of lists of sanitary ratings of interstate milk shippers.

Upon the recommendation of the Conference of State and Territorial Health Officers, the U. S. Public Health Service is undertaking to issue periodically a list of interstate milk shippers and of supplies available for interstate shipment. These lists are intended to acquaint areas experiencing milk shortages with available sources and their sanitary ratings. Health officers of cities actually experiencing shortages will be in position to authorize the receipt by local milk plants of supplies from listed sources with the highest sanitary ratings. Application by shippers for listing as well as acceptance of listed supplies by any city will be entirely optional. Lists will be published quarterly, or oftener if necessary, beginning March 1, 1947, and will show sources of raw milk for pasteurization, pasteurized milk, and later cream and possibly other fluid milk products.

In order that health authorities of receiving areas may feel justified in accepting shipments from beyond their milk sheds without sending their own inspectors to the producing areas, the plan provides for the rating by the State of origin of sources which apply for listing, and for spot checks by the Public Health Service of the State’s inspection, laboratory, and rating procedures to insure uniformity and to protect receiving areas against laxity. Ratings will be made and computed in accordance with the Public Health Service rating procedure which has been employed for years by many of the States. The