

To Establish a National Health Program

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON EDUCATION AND LABOR

UNITED STATES SENATE

SEVENTY-SIXTH CONGRESS

FIRST SESSION

ON

S. 1620

A BILL TO PROVIDE FOR THE GENERAL WELFARE BY ENABLING THE SEVERAL STATES TO MAKE MORE ADEQUATE PROVISION FOR PUBLIC HEALTH, PREVENTION AND CONTROL OF DISEASE, MATERNAL AND CHILD HEALTH SERVICES, CONSTRUCTION AND MAINTENANCE OF NEEDED HOSPITALS AND HEALTH CENTERS, CARE OF THE SICK, DISABILITY INSURANCE, AND TRAINING OF PERSONNEL; TO AMEND SOCIAL SECURITY ACT; AND FOR OTHER PURPOSES

PART 1

APRIL 27, AND MAY 4, 5, 11, AND 12, 1939

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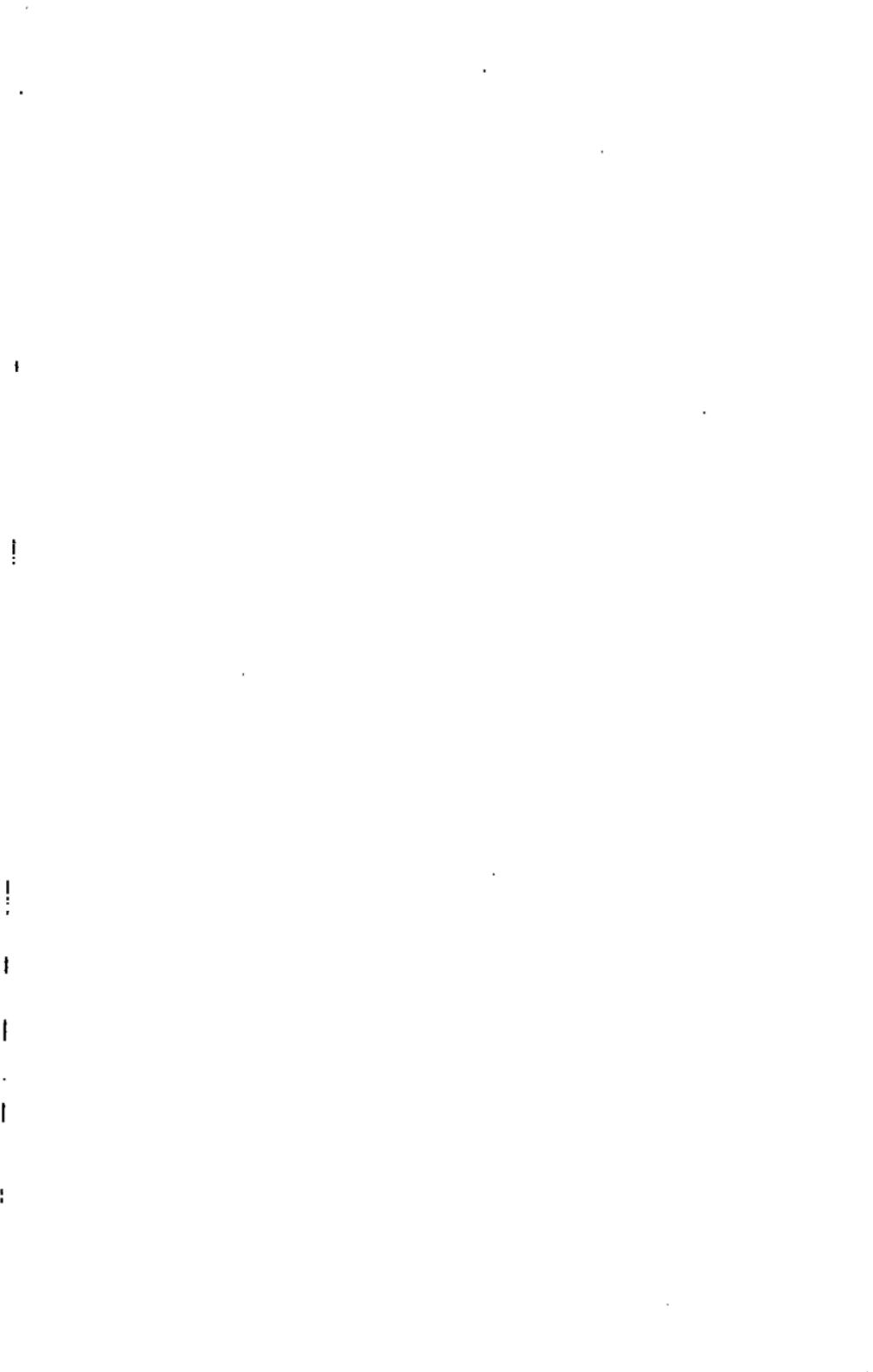
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TO ESTABLISH A NATIONAL HEALTH PROGRAM

THURSDAY, APRIL 27, 1939

UNITED STATES SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D. C.

The subcommittee met, pursuant to call, at 10 a. m., in room 347, Senate Office Building, Senator James E. Murray, presiding.

Present: Senators Murray (chairman), Ellender, Donahey, and La Follette.

Senator MURRAY. The subcommittee will come to order.

This is a subcommittee appointed by the Committee on Education and Labor to conduct hearings on the Wagner bill, known as the health bill, a bill to provide for the general welfare by enabling the several States to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability, insurance and training of personnel; to amend the Social Security Act; and for other purposes.

At this point I will introduce in the record the bill, and also the message of the President:

[S. 1620, 76th Cong., 1st sess.]

A BILL To provide for the general welfare by enabling the several States to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel; to amend the Social Security Act; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "National Health Act of 1939."

Sec. 2. Title V, parts 1, 2, and 5 of the Social Security Act are amended to read as follows:

"TITLE V--GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE

"PART 1--MATERNAL AND CHILD HEALTH SERVICES

"APPROPRIATION

"SEC. 501. For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and in areas suffering from severe economic distress, to extend and improve services, supplies, and facilities for promoting the health of mothers and children, and medical care during maternity and infancy, including medical, surgical, and other related services, and care in the home or in institutions, and facilities for diagnosis, hospitalization, and aftercare; and to develop more effective measures for carrying out the purposes of this part of this title, including the training of personnel, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum

ESTABLISH A NATIONAL HEALTH PROGRAM

of \$8,000,000; for the fiscal year ending June 30, 1941, the sum of \$20,000,000; for the fiscal year ending June 30, 1942, the sum of \$35,000,000; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this part of this title. The sums authorized under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for extending and improving such services.

"ALLOTMENTS TO STATES

"SEC. 502. (a) The Chief of the Children's Bureau shall allot to the States prior to the beginning of each fiscal year, and at such time or times thereafter as may be necessary, the sums appropriated pursuant to section 501 for such year, and the sums available for allotment under subsection (b) of this section. The amounts of the allotments to the States shall be determined in accordance with rules and regulations prescribed by the Chief of the Children's Bureau with the approval of the Secretary of Labor. In determining the allotments under this section, the following factors for the respective States shall be taken into consideration: (1) The total number of births in the last calendar year for which the Bureau of the Census has available statistics; (2) the number of mothers and children in need of the services; (3) the special problems of maternal and child health; and (4) the financial resources.

"(b) The amount of an allotment to any State under subsection (a) of this section for any fiscal year remaining unobligated and unpaid at the end of such fiscal year shall be available for allotment to States under subsection (a) for the succeeding fiscal year, in addition to the amount appropriated for such year.

"APPROVAL OF STATE PLANS

"SEC. 503. (a) A State plan to effectuate the purpose of this part of this title shall—

"(1) provide for financial participation by the State;

"(2) provide for a State-wide program or for extension of the program each year so that it shall be in effect in all political subdivisions of the State in need of the services not later than the beginning of the fiscal year ending June 30, 1945;

"(3) provide for the administration of the plan by the State health agency or for the supervision by the State health agency of any part of the plan administered by another State agency or by a political subdivision of the State;

"(4) provide such methods of administration as are found by the Chief of the Children's Bureau to be necessary for the efficient operation of the plan, including: Methods relating to the establishment and maintenance of personnel standards on a merit basis; and methods of establishing and maintaining standards of medical and institutional care and of remuneration for such care, such methods to be prescribed by the State agency after consultation with such professional advisory committees as the State agency may establish;

"(5) provide for an advisory council or councils, composed of members of the professions and agencies, public and private, that furnish services under the State plan, and other persons informed on the need for, or provision of, maternal and child health services;

"(6) provide that the State health agency will make such reports, in such form and containing such information, as the Chief of the Children's Bureau may from time to time require, and comply with such provisions as the Chief of the Children's Bureau may from time to time find necessary to assure the correctness and verification of such reports;

"(7) provide for cooperation and, when necessary, for working agreements between the State health agency and any public agency or agencies administering services related to the services furnished under the State plan, including public agencies concerned with welfare, assistance, social insurance, education, or medical care; and

"(8) provide that the State health agency (or other State agency administering services under this plan) shall have authority to make and publish such rules and regulations as are necessary for efficient operation of the services, having special regard for the quality and economy of service.

"(b) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (a).

"PAYMENT TO STATES"

"SEC. 504. (a) From the sums appropriated therefor under section 501, and the allotments made in accordance with section 502, payments shall be made to each State which has a plan approved under section 503 for each year or part thereof covered by such plan beginning with the fiscal year ending June 30, 1940, in amounts which shall be used exclusively for carrying out the purposes of section 501. These payments shall be in such proportion to the total amount of public funds expended under the State plan, during each year or part thereof covered by such plan, as is determined in accordance with subsection 1101 (e) upon the basis of the financial resources of the State, not counting so much of total expenditures as are included in any other State plan submitted for grants to the State under any other part of this title or any other title of this Act or any other Act of Congress. In no event shall the total sum paid to the State for any fiscal year or part thereof covered by its plan to be in excess of the total sum expended or obligated for amounts planned for expenditure from Federal funds.

"(b) The Chief of the Children's Bureau shall, from time to time but not less often than semiannually, determine the amounts to be paid to each State necessary for carrying out its plan, upon the basis of estimates submitted by the State and, after taking into consideration overpayments or underpayments to the State in prior periods, shall certify the amounts so determined to the Secretary of the Treasury. Upon receipt of each such certification for payment, the Secretary of the Treasury, through the Division of Disbursements of the Treasury Department and prior to audit or settlement by the General Accounting Office, shall pay to each State the amount so certified.

"OPERATION OF STATE PLANS"

"SEC. 505. Whenever the Chief of the Children's Bureau finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of a plan approved under part 1 of this title, that in the administration of such plan there is failure to comply substantially with any requirement of subsection 503 (a), he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

"FEDERAL ADVISORY COUNCILS"

"SEC. 506. The Chief of the Children's Bureau is authorized to establish an advisory council or councils, composed of members of the professions and agencies concerned with promotion of maternal and child health, maternity care and care of infants, and other persons informed on the need for, or provision of, such care, to advise the Chief of the Children's Bureau with respect to carrying out the purposes of this part of this title.

"RULES AND REGULATIONS"

"SEC. 507. The Chief of the Children's Bureau, with the approval of the Secretary of Labor, shall make and publish such rules and regulations not inconsistent with this part of this title as may be necessary to the efficient administration of this part of this title.

"PART 2—MEDICAL SERVICES FOR CHILDREN AND SERVICES FOR CRIPPLED AND OTHER PHYSICALLY HANDICAPPED CHILDREN"**"APPROPRIATION"**

"SEC. 511. For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and in areas suffering from severe economic distress, to extend and improve services, supplies, and facilities for the medical care of children, and services to cripple children and other physically handicapped children in need of special care, such services and facilities to include medical, surgical, corrective, and other related services and care in the child's home or in institutions, and facilities for diagnosis, hospitaliza-

tion, or other institutional care, and after-care; and to develop more effective measures for carrying out the purposes of this part of this title, including the training of personnel, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$18,000,000; for the fiscal year ending June 30, 1941, the sum of \$25,000,000; for the fiscal year ending June 30, 1942, the sum of \$35,000,000; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this part of the title. The sums authorized under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for extending and improving such services.

"ALLOTMENTS TO STATES

"**SEC. 512. (a)** The Chief of the Children's Bureau shall allot to the States prior to the beginning of each fiscal year, and at such time or times thereafter as may be necessary, the sums appropriated pursuant to section 511 for such year, and the sums available for allotment under subsection (b) of this section. Out of the sums appropriated pursuant to section 511 the Chief of the Children's Bureau shall allot to the States for the fiscal year ending June 30, 1940, the sum of \$9,000,000 for medical care of children and the sum of \$4,000,000 for services to crippled children and other physically handicapped children in need of special care; for the fiscal year ending June 30, 1941, the sum of \$20,000,000 for medical care of children and the sum of \$5,000,000 for services to crippled children and other physically handicapped children in need of special care; and from the sum appropriated for each year thereafter, such amounts as the Chief of the Children's Bureau deems necessary to carry out the purposes of this part of this title. The amounts of the allotments to the States shall be determined in accordance with rules and regulations prescribed by the Chief of the Children's Bureau with the approval of the Secretary of Labor. In determining the allotments under this section, the following factors for the respective States shall be taken into consideration: (1) The child population; (2) the number of children in each State in need of the services; (3) the special problems of medical care of children; and (4) the financial resources.

"**(b)** The amount of an allotment to any State under subsection (a) of this section for any fiscal year remaining unobligated and unpaid at the end of such fiscal year shall be available for allotment to States under subsection (a) for the succeeding fiscal year, in addition to the amount appropriated for such year.

"APPROVAL OF STATE PLANS

"**SEC. 513. (a)** State plans to effectuate the purposes of this part of this title shall—

"(1) provide for financial participation by the State;

"(2) provide for State-wide programs or for extension of the programs each year so that they shall be in effect in all political subdivisions of the State in need of the services not later than the beginning of the fiscal year ending June 30, 1945;

"(3) provide for the administration of the plans by the State health agency or for the supervision by the State health agency of any part of a plan administered by another State agency or by a political subdivision of the State; *Provided*, That in States where some other State agency (or agencies) is already charged by State law with administrative or supervisory responsibility for a State medical care program including medical care of children or for a program of services for crippled children as provided in section 511, and is now carrying out a substantial program of medical care of children or services for crippled children, the State health agency may, through agreement with such agency or agencies, develop and submit a plan under which the State agency or agencies designated by State law shall have the authority to administer services under the State plan for medical care of children or under the plan for services for crippled children; *Provided further*, That all plans for medical care of children or services for crippled children for the fiscal year ending June 30, 1945, and for succeeding years shall provide for administration by the State health agency;

"(4) provide such methods of administration as are found by the Chief of the Children's Bureau to be necessary for the efficient operation of the plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis; and methods of establishing and maintaining stand-

ards of medical and institutional care and of remuneration for such care, such methods to be prescribed by the State agency after consultation with such professional advisory committees as the State agency may establish;

"(5) provide for an advisory council or councils, composed of members of the professions and agencies, public and private, that furnish services under the State plans, and other persons informed on the need for, or provision of, medical services for children or services for crippled children;

"(6) provide that the State health agency or other State agencies administering the services under the plans will make such reports, in such form and containing such information, as the Chief of the Children's Bureau may from time to time require, and comply with such provisions as the Chief of the Children's Bureau may from time to time find necessary to assure the correctness and verification of such reports;

"(7) provide for cooperation and, when necessary, for working agreements between the State health agency and any public agency or agencies administering services related to the services furnished under the State plan, including public agencies concerned with welfare, assistance, vocational rehabilitation, social insurance, education, or medical care; and

"(8) provide that the State agency (or agencies) administering the plans or other State agency administering services under the plans shall have authority to make and publish such rules and regulations as are necessary for efficient operation of the services, having special regard for the quality and economy of service.

"(b) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (a).

"PAYMENT TO STATES

"SEC. 514 (a) From the sums appropriated therefor under section 511, and the allotments made in accordance with section 512, payments shall be made to each State which has a plan approved under section 513 for each year or part thereof covered by such plan beginning with the fiscal year ending June 30, 1940, in amounts which shall be used exclusively for carrying out the purposes of section 511. These payments shall be in such proportion to the total amount of public funds expended under the State plan, during each year or part thereof covered by such plan, as is determined in accordance with subsection 1101 (e) upon the basis of the financial resources of the State, not counting so much of such total expenditures by the State and its political subdivisions as are: (1) Expended for the care, in hospitals, institutions and other organized facilities, of cases of mental disease, mental defectiveness, epilepsy and tuberculosis as are not in excess of the average annual expenditures for these purposes in the three years prior to the effective date of this part of this title; or (2) included in any other State plan submitted for grants to the State under any other part of this title or any other title of this Act or any other Act of Congress. In no event shall the total sum paid to the State for any fiscal year or part thereof covered by its plan be in excess of the total sum expended or obligated for amounts planned for expenditure from Federal funds.

"(b) The Chief of the Children's Bureau shall, from time to time, but not less often than semiannually, determine the amounts to be paid to each State necessary for carrying out its plan, upon the basis of estimates submitted by the State and, after taking into consideration overpayments or underpayments to the State in prior periods, shall certify the amounts so determined to the Secretary of the Treasury. Upon receipt of each such certification for payment the Secretary of the Treasury, through the Division of Disbursements of the Treasury Department and prior to audit or settlement by the General Accounting Office, shall pay to each State the amount so certified.

"OPERATION OF STATE PLANS

"SEC. 515. Whenever the Chief of the Children's Bureau finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of a plan approved under part 2 of this title, that in the administration of such plan there is failure to comply substantially with any requirement of subsection 513 (a), he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

"FEDERAL ADVISORY COUNCILS

"SEC. 516. The Chief of the Children's Bureau is authorized to establish an advisory council or councils, composed of members of the professions and agencies concerned with medical care for children and services for crippled children or otherwise physically handicapped children in need of special care, and other persons informed on the need for, or provision of, such services for children, to advise the Chief of the Children's Bureau with respect to carrying out the purposes of this part of this title.

"RULES AND REGULATIONS

"Sec. 517. The Chief of the Children's Bureau, with the approval of the Secretary of Labor, shall make and publish such rules and regulations not inconsistent with this part of this title as may be necessary to the efficient administration of this part of this title.

"PART 5—ADMINISTRATION

"SEC. 451. (a) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$2,500,000 for all necessary expenses of the Children's Bureau in administering the provisions of this title, except section 531, and in making such studies, investigations, and demonstrations and such provision for the training of personnel as will improve the quality of the services and promote the efficient administration of this title, except section 531; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient for such purposes.

(b) The Secretary of Labor shall include in his annual report to the Congress a full account of the administration of this title, except section 531."

Sec. 3. Title VI of the Social Security Act is amended to read as follows:

"TITLE VI—PUBLIC-HEALTH WORK AND INVESTIGATIONS**"PART 1—PUBLIC-HEALTH WORK****"APPROPRIATION**

"SEC. 601. For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and in areas suffering from severe economic distress, to extend and improve public-health work, including services, supplies, and facilities for the control of tuberculosis and malaria, for the prevention of mortality from pneumonia and cancer, for mental health, and industrial hygiene activities, and to develop more effective measures for carrying out the purposes of this part of this title, including the training of personnel, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$15,000,000; for the fiscal year ending June 30, 1941, the sum of \$25,000,000; for the fiscal year ending June 30, 1942, the sum of \$60,000,000; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this part of this title. The sums authorized under this section shall be used for making payments to States which have submitted, and had approved by the Surgeon General of the Public Health Service, State plans for extending and improving such service.

"ALLOTMENTS TO STATES

"SEC. 602. (a) The Surgeon General of the Public Health Service shall allot to the States prior to the beginning of each fiscal year, and at such time or times thereafter as may be necessary, the sums appropriated pursuant to section 601 for such year, and the sums available for allotment under subsection (b) of this section. The amounts of the allotments to the States shall be determined in accordance with rules and regulations prescribed by the Surgeon General of the Public Health Service with the approval of the Secretary of the Treasury. In determining the allotments under this section, the following factors for the respective States shall be taken into consideration: (1) The population; (2) the number of individuals in need of the services; (3) the special health problems; and (4) the financial resources.

(b) The amount of an allotment to any State under subsection (a) of this section for any fiscal year remaining unobligated and unpaid at the end of such fiscal year shall be available for allotment to States under subsection (a) for the succeeding fiscal year, in addition to the amount appropriated for such year.

"APPROVAL OF STATE PLANS

"Sec. 603. (a) A State plan to effectuate the purposes of this title shall—
"(1) provide for financial participation by the State;

"(2) provide for a State-wide program or for extension of the program each year so that it shall be in effect in all political subdivisions of the State in need of the services not later than the beginning of the fiscal year ending June 30, 1945;

"(3) provide for the administration of the plan by the State health agency or for the supervision by the State health agency of any part of the plan administered by another State agency or by a political subdivision of the State;

"(4) provide such methods of administration as are found by the Surgeon General of the Public Health Service to be necessary for the efficient operation of the plan, including: Methods relating to the establishment and maintenance of personnel standards on a merit basis; and methods of establishing and maintaining standards of medical and institutional care and of remuneration for such care, such methods to be prescribed by the State agency after consultation with such professional advisory committees as the State agency may establish;

"(5) provide for an advisory council or councils, composed of members of the professions and agencies, public and private, that furnish services under the State plan, and other persons informed on the need for, or provision of, public health work;

"(6) provide that the State health agency will make such reports, in such form and containing such information, as the Surgeon General of the Public Health Service may from time to time require, and comply with such provisions as the Surgeon General of the Public Health Service may from time to time find necessary to assure the correctness and verification of such reports;

"(7) provide for cooperation and, when necessary, for working agreements between the State health agency and any public agency or agencies administering services related to the services furnished under the State plan, including public agencies concerned with welfare, assistance, social insurance, workmen's compensation, labor, industrial hygiene, education, or medical care; and

"(8) provided that the State health agency (or other State agency administering services under this plan) shall have authority to make and publish such rules and regulations as are necessary for the efficient operation of the services, having special regard for the quality and economy of service.

"(b) The Surgeon General of the Public Health Service shall approve any plan which fulfills the conditions specified in subsection (a).

"PAYMENT TO STATES

"Sec. 604. (a) From the sums appropriated therefor under section 601, and the allotments made in accordance with section 602, payments shall be made to each State which has a plan approved under section 603 for each year or part thereof covered by such plan beginning with the fiscal year ending June 30, 1940, in amounts which shall be used exclusively for carrying out the purposes of section 601. These payments shall be in such proportion to the total amount of public funds expended under the State plan, during each year or part thereof covered by such plan, as is determined in accordance with subsection 1101 (e) upon the basis of the financial resources of the State, not counting so much of such total expenditures by the State and its political subdivisions as are: (1) Expended for the care, in hospitals, institutions, and other organized facilities, of cases of mental disease, mental defectiveness, epilepsy, and tuberculosis as are not in excess of the average annual expenditures for these purposes in the three years prior to the effective date of this part of this title; or (2) included in any other State plan submitted for grants to the State under any other title of this Act or any other Act of Congress. In no event shall the total sum paid to the State for any fiscal year or part thereof covered by its plan be in excess of the total sum expended or obligated for amounts planned for expenditure from Federal funds.

"(b) The Surgeon General of the Public Health Service shall, from time to time but not less often than semiannually, determine the amounts to be paid to each State necessary for carrying out its plan, upon the basis of estimates submitted by the State and, after taking into consideration overpayments or underpayments to the State in prior periods, shall certify the amounts so determined to the Secretary of the Treasury. Upon receipt of each such certification for payment the Secretary of the Treasury, through the Division of Disbursements of the Treasury Department and prior to audit or settlement by the General Accounting Office, shall pay to each State the amounts so certified.

ESTABLISH A NATIONAL HEALTH PROGRAM**"OPERATION OF STATE PLANS**

"SEC. 605. Whenever the Surgeon General of the Public Health Service finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of a plan approved under part 1 of this title, that in the administration of such plan there is failure to comply substantially with any requirement of subsection 603 (a), he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

"FEDERAL ADVISORY COUNCILS

"SEC. 606. The Surgeon General of the Public Health Service is authorized to establish an advisory council or councils, composed of members of the professions and agencies concerned with public-health work, and other persons informed on the need for, or provision of, public-health work, to advise the Surgeon General of the Public Health Service with respect to carrying out the purposes of this part of this title.

"RULES AND REGULATIONS

"SEC. 607. The Surgeon General of the Public Health Service, with the approval of the Secretary of the Treasury, shall make and publish such rules and regulations not inconsistent with this part of this title as may be necessary to the efficient administration of this part of this title.

"ADMINISTRATION

"SEC. 608. (a) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$1,500,000 for all necessary expenses of the Public Health Service in administering the provisions of part 1 of this title, including the printing of forms and reports; in making such studies and demonstrations and such provisions for the training of personnel as will improve the quality of the services and promote the efficient administration of this part of this title; and for the pay, allowances, and travel expenses of commissioned officers (Regular and Reserve) and other personnel of the Public Health Service assigned to duty in carrying out the purposes of this part of this title in the District of Columbia and elsewhere; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient for such purposes.

"(b) Appointment is hereby authorized of commissioned officers under the provisions of section VII of the Act of April 9, 1930, without regard to the limitation as to number and research qualifications as therein provided, including not to exceed four assistants to the Surgeon General of the Public Health Service who shall have the same pay and allowances as are now or hereafter may be provided for the assistants to the Surgeon General of the Army.

"(c) The President, upon the recommendation of the Secretary of the Treasury, is authorized to change the names and reallocate the functions of the existing administrative divisions of the Public Health Service and is authorized to create such additional administrative divisions as he may deem necessary to carry out the purposes of this Act and other work of the Public Health Service. Each such division shall be under the charge of a commissioned officer of the Public Health Service detailed by the Surgeon General to be director, with the same compensation as is now received by heads of administrative divisions.

"PART 2--INVESTIGATIONS

"SEC. 611. (a) For the purpose of enabling the Public Health Service, through the National Institute of Health, to make investigations of health, disease, sanitation, and matters pertaining thereto (including the printing and binding of the findings of such investigations), for the purpose of carrying out the provisions of the Acts of August 14, 1912 (chapter 288, 37 Stat. L. 809; May 26, 1930, 46 Stat. 379), and for the pay, allowances, and travel expenses of commissioned officers (regular and reserve) and other personnel of the Public Health Service engaged on such investigations in the District of Columbia and elsewhere, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$3,000,000; for the fiscal year ending June 30, 1941, the sum of \$3,500,000; for the fiscal year ending June 30, 1942, the

sum of \$4,000,000; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient for such purposes.

"(b) Nothing in this Act shall be construed to supersede or limit any other Act of Congress prescribing the functions of the Public Health Service or authorizing the expenditure of funds therefor."

Sec. 4. The Social Security Act is amended by adding new titles XII, XIII, and XIV, as follows:

"TITLE XII—GRANTS TO STATES FOR HOSPITALS AND HEALTH CENTERS

"APPROPRIATION

"Sec. 1201. For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and in areas suffering from severe economic distress, to construct and improve needed hospitals, to assist the States for a period of three years in defraying the operating cost of added facilities, and to develop more effective measures for carrying out the purposes of this title, there is hereby authorized to be appropriated: (1) in respect to general hospitals, for the fiscal year ending June 30, 1940, the sum of \$8,000,000; for the fiscal year ending June 30, 1941, the sum of \$50,000,000; for the fiscal year ending June 30, 1942, the sum of \$100,000,000; and (2) in respect to mental and tuberculosis hospitals, for the fiscal year ending June 30, 1940, a sum sufficient to carry out, in respect to such hospitals, the purposes of this title; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this title. The sums authorized under this section shall be used for making payments to States which have submitted, and had approved by the Surgeon General of the Public Health Service, State plans for constructing and improving needed hospitals.

"ALLOTMENTS TO STATES

"Sec. 1202. (a) The Surgeon General of the Public Health Service shall allot to the States prior to the beginning of each fiscal year, and at such time or times thereafter as may be necessary, the sums appropriated pursuant to section 1201 for such year and the sums available for allotment under subsection (b) of this section. The amounts of the allotments to the States shall be determined in accordance with rules and regulations prescribed by the Surgeon General of the Public Health Service with the approval of the Secretary of the Treasury. In determining the allotments under this section, the following factors for the respective States shall be taken into consideration: (1) The needed additional hospitals; and (2) the financial resources.

"(b) The amount of an allotment to any State under subsection (a) of this section for any fiscal year remaining unobligated and unpaid at the end of such fiscal year shall be available for allotment to States under subsection (a) for the succeeding fiscal year, in addition to the amount appropriated for such year.

"APPROVAL OF STATE PLANS

"Sec. 1203. (a) A State plan to effectuate the purposes of this title, submitted in respect to either clause (1) or clause (2) of section 1201, or both, shall—

"(1) provide for financial participation by the State;

"(2) provide for the administration of the plan by the State health agency or for the supervision by the State health agency of any part of the plan administered by another State agency or by a political subdivision of the State;

"(3) provide such methods of administration as are found by the Surgeon General of the Public Health Service to be necessary for the efficient operation of the plan, including: Methods relating to the establishment and maintenance of personal standards on a merit basis; and methods of establishing and maintaining standards for institutional management and remuneration for such management, such methods to be prescribed by the State agency after consultation with such professional advisory committees as the State agency may establish;

"(4) provide that ownership of real estate, improvements, and equipment be vested in the State or its political subdivisions;

"(5) provide such safeguards as may be necessary to assure satisfactory title, location, design, construction, and equipment;

"(6) provide a system of financial support which will give reasonable assurance of continuing maintenance of added hospitals and of their potential availability to all groups of the population in the designated area subject only to the suitability of the hospitals for particular diseases and conditions and to the financial arrangement for payment for service;

"(7) provide for an advisory council or councils, composed of members of the professions and agencies, public and private, that furnish services under the State plan, and other persons informed on the need for, or provision of, hospitals;

"(8) provide that the State agency will make such reports, in such form and containing such information, as the Surgeon General of the Public Health Service may from time to time require, and comply with such provisions as the Surgeon General of the Public Health Service may from time to time find necessary to assure the correctness and verification of such reports;

"(9) provide for cooperation and, when necessary, for working agreements between the State health agency and any public agency or agencies administering services related to the services furnished under the State plan, including public agencies concerned with welfare, assistance, social insurance, workmen's compensation, labor, industrial hygiene, education, or medical care;

"(10) provide that the State agency administering the plan, or other State agencies administering part of the plan, shall have authority to make and publish such rules and regulations as are necessary for efficient administration of the plan; and

"(11) provide that the wages paid or to be paid laborers and mechanics employed in the construction of added hospitals are not less than the wages prevailing in the locality for work of a similar nature, as determined or adopted (subsequent to a determination under applicable State or local law) by the Commissioner of Labor Statistics: *Provided*, That a State plan submitted in respect to clause (2) of section 1201 during the fiscal years ending June 30, 1940, and June 30, 1941, shall provide for administration by a State agency or agencies and shall meet the requirements of clauses (1), (3), (4), (5), (6), (8), (10), and (11) of this subsection.

"(b) The Surgeon General of the Public Health Service shall approve any plan which fulfills the conditions specified in subsection (a).

"(c) The Surgeon General of the Public Health Service shall have authority to utilize the Federal Emergency Administration of Public Works, or, upon the termination thereof, another appropriate agency of the United States designated by the President, for the purpose of reviewing title, location, plans, and specifications for the construction, alteration, and repair of buildings and equipment, and of supervising the awarding and performance of contracts pursuant to plans approved under this title.

*PAYMENTS TO STATES

"SEC. 1204. (a) From the sums appropriated therefor under section 1201, and the allotments made in accordance with section 1202, payments shall be made to each State which has a plan approved under section 1203 for each year or part thereof covered by such plan beginning with the fiscal year ending June 30, 1940, in amounts which shall be used exclusively for carrying out the purposes of section 1201. These payments shall be in such proportion to the total amount of public funds expended under the State plan, during each year or part thereof covered by such plan, as is determined in accordance with subsection 1101 (e) upon the basis of the financial resources of the State, not counting so much of such total expenditures by the State and its political subdivisions as are included in any other State plan submitted for grants to the State under any other title of this Act or any other Act of Congress: *Provided*, That the funds made available for defraying the operating cost of added facilities will be paid at a rate of \$300 per added bed for general and for tuberculosis hospitals and \$150 per added bed for mental hospitals during the first year of operation, two-thirds of these amounts, respectively, for the second year of operation, and one-third of these amounts, respectively, for the third year of operation. In no event shall the total sum paid to the State for any fiscal year or part thereof covered by its plan be in excess of the total sum expended or obligated for amounts planned for expenditure from Federal funds.

"(b) The Surgeon General of the Public Health Service shall, from time to time but not less often than semiannually, determine the amounts to be paid

to each State necessary for carrying out its plan, and, after taking into consideration overpayments or underpayments to the State in prior periods, shall certify the amounts so determined to the Secretary of the Treasury. Upon receipt of each such certification for payment the Secretary of the Treasury, through the Division of Disbursements of the Treasury Department and prior to audit or settlement by the General Accounting Office, shall pay to each State the amount so certified.

"OPERATION OF STATE PLANS

"SEC. 1205. Whenever the Surgeon General of the Public Health Service finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of any State plan approved under this title, that in the effectuation or administration of such plan there is failure to comply substantially with any requirement of subsection 1203 (a), he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

"FEDERAL ADVISORY COUNCILS

"SEC. 1206. The Surgeon General of the Public Health Service is authorized to establish an advisory council or councils, composed of members of the professions and agencies concerned with the construction and operation of hospitals, and other persons informed on the need for, or provision of, such facilities to advise the Surgeon General of the Public Health Service with respect to carrying out the purposes of this title.

"RULES AND REGULATIONS

"SEC. 1207. The Surgeon General of the Public Health Service (with the approval of the Secretary of the Treasury) and the Federal Emergency Administrator of Public Works, respectively, shall make and publish such rules and regulations not inconsistent with this title as may be necessary to the efficient administration of the respective functions vested in them under this title.

"ADMINISTRATION

"SEC. 1208. (a) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$1,000,000 for all necessary expenses of the Public Health Service in administering the provisions of this title, including the printing of forms and reports; in making such studies and demonstrations as will extend and improve the quality of hospital facilities and promote the efficient administration of this title; and for the pay, allowances, and travel expenses of commissioned officers (regular and reserve) and other personnel of the Public Health Service assigned to duty in carrying out the purposes of this title in the District of Columbia and elsewhere; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient for such purposes.

"(b) There is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, and for each fiscal year thereafter, a sum sufficient to carry out such functions as are vested pursuant to section 1203 (c), in the Federal Emergency Administration of Public Works, or, upon termination thereof, in any other agency designated by the President for that purpose.

"DEFINITION

"SEC. 1209. The term 'hospital', when used in this title, includes health, diagnostic, and treatment centers, institutions, and related facilities.

"TITLE XIII—GRANTS TO STATES FOR MEDICAL CARE

"APPROPRIATION

"SEC. 1301. For the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and among indi-

viduals suffering from severe economic distress, to extend and improve medical care (including all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability), and to develop more effective measures for carrying out the purposes of this title, including the training of personnel, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$35,000,000; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this title. The sums authorized under this section shall be used for making payments to States which have submitted, and had approved by the Social Security Board (hereinafter called the 'Board'), State plans for extending and improving medical care.

"ALLOTMENTS TO STATES

"SEC. 1302. If the Board shall find that the sum appropriated for the fiscal year ending June 30, 1940, pursuant to section 1301 would be insufficient to meet payments for that year in accordance with section 1304, it shall allot to the States prior to the beginning of that year, and at such time or times thereafter as may be necessary, the sum appropriated for that year pursuant to section 1301. The allotments to the States shall be determined in accordance with rules and regulations prescribed by the Board. In determining the allotments under this section, the following factors for the respective States shall be taken into consideration: (1) The population; (2) the number of individuals in need of the services; (3) the special health problems; and (4) the financial resources.

"APPROVAL OF STATE PLANS

"SEC. 1303. (a) A State plan to effectuate the purposes of this title shall—
"(1) provide for financial participation by the State;

"(2) provide for a State-wide program or for extension of the program each year so that it shall be in effect in all political subdivisions of the State in need of the services not later than the beginning of the fiscal year ending June 30, 1945;

"(3) provide for administration of the plan by the State health agency (or by another State agency) and for supervision by such agency of any part of the plan administered by another State agency or by a political subdivision of the State, and, where a State agency other than the State health agency is charged with administration of the plan for cooperation and, when necessary, for working agreements between such agency and the State health agency;

"(4) provide such methods of administration as are found by the Board to be necessary for the efficient operation of the plan, including: Methods relating to the establishment and maintenance of personnel standards on a merit basis; and methods of establishing and maintaining standards of medical and institutional care and of remuneration for such care, such methods to be prescribed by the State agency administering the plan after consultation with such professional advisory committees as the State agency may establish;

"(5) provide for an advisory council or councils, composed of members of the professions and agencies, public and private, that furnish services under the State plan, and other persons informed on the need for, or provision of, medical care;

"(6) provide that the State agency administering the plan will make such reports, in such form and containing such information, as the Board may from time to time require, and comply with such provisions as the Board may from time to time find necessary to assure the correctness and verification of such reports;

"(7) provide for cooperation and, when necessary, for working agreements between the State agency administering the plan and any public agency or agencies administering services related to the services furnished under the State plan, including public agencies concerned with welfare, assistance, vocational rehabilitation, social insurance, workmen's compensation, labor, industrial hygiene, education, health or medical care; and

"(8) provide that the State agency administering the plan (or other State agency administering services under this plan) shall have authority to make and publish such rules and regulations as are necessary for the efficient operation of the services, having special regard for the quality and economy of service.

"(b) The Board shall approve any plan which fulfills the conditions specified in subsection (a).

"PAYMENT TO STATES

"SEC. 1304. (a) From the sums appropriated therefor under section 1301, and (with respect to the fiscal year ending June 30, 1940) the allotments made in accordance with section 1302, payments shall be made to each State which has a plan approved under section 1303 for each year or part thereof covered by such plan beginning with the fiscal year ending June 30, 1940, in amounts which shall be used exclusively for carrying out the purposes of section 1301. These payments shall be in such proportion to the total amount of public funds expended under the State plan, during each year or part thereof covered by such plan, as is determined in accordance with subsection 1101 (e) upon the basis of the financial resources of the State, not counting so much of such total expenditures by the State and its political subdivisions as are: (1) In excess of \$20 annually per individual eligible for medical care under such plan; (2) expended for the care, in hospitals, institutions and other organized facilities, of cases of mental disease, mental defectiveness, epilepsy, and tuberculosis; or (3) included in any other State plan submitted for grants to the State under any other title of this Act or any other Act of Congress. In no event shall the total sum paid to the State for any fiscal year or part thereof covered by its plan be in excess of the total sum expended or obligated for amounts planned for expenditure from Federal funds.

(b) The Board shall, from time to time but not less often than semiannually, determine the amounts to be paid to each State necessary for carrying out its plan, upon the basis of estimates submitted by the State and, after taking into consideration overpayments or underpayments to the State in prior periods, shall certify the amounts so determined to the Secretary of the Treasury. Upon receipt of each such certification for payment the Secretary of the Treasury, through the Division of Disbursements of the Treasury Department and prior to audit or settlement by the General Accounting Office, shall pay to each State the amount so certified.

"OPERATION OF STATE PLANS

"SEC. 1305. Whenever the Board finds, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of a plan approved under this title, that in the administration of such plan there is failure to comply substantially with any requirement of subsection 1303 (a), it shall notify such State agency that further payments will not be made to the State until it is satisfied that there is no longer any such failure to comply. Until it is so satisfied it shall make no further certification to the Secretary of the Treasury with respect to such State.

"FEDERAL ADVISORY COUNCILS

"SEC. 1306. The Board is authorized to establish an advisory council or councils, composed of members of the professions and agencies concerned with the furnishing of medical care, and other persons informed on the need for, or provision of, such care, to advise the Board with respect to carrying out the purposes of this title.

"RULES AND REGULATIONS

"SEC. 1307. The Board shall make and publish such rules and regulations not inconsistent with this title as may be necessary to the efficient administration of this title.

"ADMINISTRATION

"SEC. 1308. There is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$1,000,000 for all necessary expenses of the Board in administering the provisions of this title; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient for such purposes.

"TITLE XIV—GRANTS TO STATES FOR TEMPORARY DISABILITY COMPENSATION**"APPROPRIATION**

"SEC. 1401. For the purpose of assisting the States in the development, maintenance, and administration of plans for temporary disability compensation, there

is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$10,000,000; and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this title. The sums authorized under this section shall be used for making payments to States which have submitted, and had approved by the Board, State plans for temporary disability compensation.

"STATE TEMPORARY DISABILITY COMPENSATION PLANS

"SEC. 1402. (a) A State law to effectuate the purposes of this title shall—

"(1) provide for administration and payment of disability compensation through a single State agency, or through more than one State agency if the Board finds provisions therefor to be consistent with efficient administration of the State plan;

"(2) provide such methods of administration as are found by the Board to be necessary for the efficient operation of the plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis;

"(3) provide for opportunity for a fair hearing before an impartial tribunal for all individuals whose claims for disability compensation are denied;

"(4) provide for the making of such reports, in such form and containing such information, as the Board may from time to time require, and compliance with such provisions as the Board may from time to time find necessary to assure the correctness and verification of such reports;

"(5) provide authorization for cooperation and working agreements between the State agency or agencies administering temporary disability compensation and the State agencies administering any law relating to unemployment compensation, workmen's compensation, industrial hygiene, or the prevention of disease or the treatment, care, compensation, or vocational rehabilitation of sick or disabled persons; and

"(6) provide that all the rights, privileges, or immunities conferred by the State temporary disability compensation law or acts done pursuant thereto shall exist subject to the power of the legislature to amend or repeal such law at any time.

"(b) The Board shall approve any plan based upon a law which fulfills the conditions specified in subsection (a), except that it shall not approve the plan of any State which does not have a plan or plans approved under this Act under which the Board finds that reasonably adequate medical services, including preventive services, are available to minimize disability among those covered under the State plan for temporary disability compensation.

"(c) Whenever the Board, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that in the administration of the plan there is—

"(1) a denial in a substantial number of cases of disability compensation to individuals entitled thereto under such law;

"(2) a failure to establish working agreements, necessary for the efficient administration of the plan, between the State agency or agencies administering the plan and the State agencies administering any law relating to unemployment compensation, workmen's compensation, industrial hygiene, or the prevention of disease or the treatment, care, compensation, or vocational rehabilitation of sick or disabled persons; or

"(3) a failure to comply substantially with any provision specified in subsections (a) and (b),

the Board shall notify such State agency that no further payments will be made to the State with respect to any future period beginning on a date fixed by the Board in its findings (which date shall in no case be less than five days nor more than thirty days after the date of such notification) and continuing until the Board is satisfied that there is no longer any denial or failure to comply. Until it is so satisfied, it shall make no further certification to the Secretary of the Treasury with respect to such State, and it shall at no time make any certification with respect to such period.

"PAYMENTS TO STATES

"SEC. 1403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for temporary disability compensation, beginning with the fiscal year ending June 30, 1940,

(1) an amount, which shall be used exclusively as temporary disability compensation, equal to one-third of the total of the sums expended as temporary disability compensation under the State plan, during the period with respect to which the Board's certification is made pursuant to subsection (b) of this section, and (2) an amount, which shall be used exclusively for paying the costs of administering the State plan, equal to one-third of such costs of administration as are found by the Board to be necessary for the proper and efficient administration of such plan during such period.

"(b) The method of computing and paying such amounts shall be as follows: The Board shall, from time to time, but not less often than semiannually, and prior to the period with respect to which certification is made, estimate the amounts to be paid to the State for such period under the provisions of subsection (a) of this section, such estimates to be based on (A) a report filed by the State containing its estimates of the sums to be expended in such period in accordance with the provisions of such subsection, and stating the amounts appropriated or made available by the State for such expenditures in such period, and if the total of such amounts is less than two-thirds of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Board may find necessary. The Board shall then certify to the Secretary of the Treasury the amounts so estimated by the Board, reduced or increased, as the case may be, by any sum by which it finds that any estimate for any prior period was greater or less than the amount which should have been paid to the State under clauses 1 or 2 of subsection (a) for such period, and reduced further by the total of the sums, if any, paid to such State with respect to the period designated in subsection (c) of section 1402, except to the extent that such sums have been applied to make the amount certified for any prior period greater or less than the amount estimated by the Board for such prior period. The Secretary of the Treasury shall thereupon, through the Division of Disbursements of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Board, the amounts so certified.

"ADMINISTRATION

"SEC. 1404. There is hereby authorized to be appropriated for the fiscal year ending June 30, 1940, the sum of \$250,000 for all necessary expenses of the Social Security Board in administering the provisions of this title, and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient for such purpose.

"DEFINITIONS

"SEC. 1405. When used in this title—

"(a) The term 'temporary disability compensation' means cash benefits payable to individuals for not more than fifty-two weeks and with respect to their disability not arising out of or in the course of employment.

"(b) The term 'disability' means inability to work or unfitness for work by reason of injury or illness.

"(c) The term 'employment' means any services, of whatever nature, performed by an employee for his employer, except agricultural labor, domestic service in a private home, and casual labor not in the course of the employer's trade or business. The term 'employee' includes all city and traveling salesmen. The term 'employer' includes any person for whom any individual performs services as a city or traveling salesman."

SEC. 5. (a) Section 1101 (a), subdivisions (1) and (2) of the Social Security Act are amended to read as follows:

"SEC. 1101. (a) When used in this Act—

"(1) The term 'State' (except when used in titles V, VI, XII, XIII, and XIV) includes Alaska, Hawaii, and the District of Columbia. When used in titles V, VI, XII, XIII, and XIV (except when used in section 531) it includes Alaska, Hawaii, Puerto Rico, and the District of Columbia. When used in section 531 it includes Hawaii.

"(2) The term 'United States' when used in a geographical sense (except when used in titles V, VI, XII, XIII, and XIV) means the several States, Alaska, Hawaii, and the District of Columbia. When used in titles V, VI, XII, XIII, and XIV it means the several States, Alaska, Hawaii, Puerto Rico, and the District of Columbia."

(b) Section 1101 of the Social Security Act is amended by adding a new subsection (e), as follows:

"(e) The 'financial resources' of the several States shall be measured by per capita income accruing to the inhabitants thereof, as determined jointly by the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board, between January 1 and July 1 of each year on the basis of data for the most recent three-year period for which satisfactory data are available, and shall be expressed in series of matching proportions which shall fix, in a manner appropriate for effectuating the purposes of this Act, the proportion by which funds available as grants-in-aid to each State under titles V (parts 1 and 2), VI, XII, and XIII of this Act shall be related to the total amount of public funds expended under the State plan in respect to the provisions of these titles; for titles V (parts 1 and 2), VI and XII, the highest proportion (being applicable to the State with the lowest financial resources) to the 66½ per centum and the lowest proportion (being applicable to the State with the highest financial resources) 83½ per centum, with intermediate ratios; and, for title XIII, the highest proportion to be 50 per centum and the lowest proportion 16½ per centum, with intermediate ratios."

HEALTH SECURITY

MESSAGE

FROM

THE PRESIDENT OF THE UNITED STATES

TRANSMITTING

THE REPORT AND RECOMMENDATIONS ON NATIONAL HEALTH
PREPARED BY THE INTERDEPARTMENTAL COMMITTEE TO COORDI-
NATE HEALTH AND WELFARE ACTIVITIES

JANUARY 23, 1939.—Referred to the Committee on Ways and Means and ordered
to be printed with accompanying papers

To the Congress of the United States:

In my annual message to the Congress I referred to problems of health security. I take occasion now to bring this subject specifically to your attention in transmitting the report and recommendations on national health prepared by the Interdepartmental Committee to Coordinate Health and Welfare Activities.

The health of the people is a public concern; ill health is a major cause of suffering, economic loss, and dependency; good health is essential to the security and progress of the Nation.

Health needs were studied by the Committee on Economic Security which I appointed in 1934 and certain basic steps were taken by the Congress in the Social Security Act. It was recognized at that time that a comprehensive health program was required as an essential link in our national defenses against individual and social insecurity. Further study, however, seemed necessary at that time to determine ways and means of providing this protection most effectively.

In August 1935, after the passage of the Social Security Act, I appointed the Interdepartmental Committee to Coordinate Health and Welfare Activities. Early in 1938, this committee forwarded to me reports prepared by their technical experts. They had reviewed unmet health needs, pointing to the desirability of a national health program, and they submitted the outlines of such a program. These reports were impressive. I therefore suggested that a conference be held to bring the findings before representatives of the general public and of the medical, public health, and allied professions.

More than 200 men and women, representing many walks of life and many parts of our country, came together in Washington last July to consider the technical committee's findings and recommendations and to offer further proposals. There was agreement on two basic points: The existence of serious unmet needs for medical service; and our failure to make full application of the growing powers of medical science to prevent or control disease and disability.

I have been concerned by the evidence of inequalities that exist among the States as to personnel and facilities for health services. There are equally serious inequalities of resources, medical facilities, and services in different sections and among different economic groups. These inequalities create handicaps for the parts of our country and the groups of our people which most sorely need the benefits of modern medical science.

The objective of a national health program is to make available in all parts of our country and for all groups of our people the scientific knowledge and skill at our command to prevent and care for sickness and disability; to safeguard mothers, infants, and children; and to offset through social insurance the loss of earnings among workers who are temporarily or permanently disabled.

The committee does not propose a great expansion of Federal health services. It recommends that plans be worked out and administered by States and localities with the assistance of Federal grants-in-aid. The aim is a flexible program. The committee points out that while the eventual costs of the proposed program would be considerable, they represent a sound investment which can be expected to wipe out, in the long run, certain costs now borne in the form of relief.

We have reason to derive great satisfaction from the increase in the average length of life in our country and from the improvement in the average levels of health and well-being. Yet these improvements in the averages are cold comfort to the millions of our people whose security in health and survival is still as limited as was that of the Nation as a whole 50 years ago.

The average level of health or the average cost of sickness has little meaning for those who now must meet personal catastrophes. To know that a stream is 4 feet deep on the average is of little help to those who drown in the places where it is 10 feet deep. The recommendations of the committee offer a program to bridge that stream by reducing the risks of needless suffering and death, and of costs and dependency, that now overwhelm millions of individual families and sap the resources of the Nation.

I recommend the report of the interdepartmental committee for careful study by the Congress. The essence of the program recommended by the Committee is Federal-State cooperation. Federal legislation necessarily precedes, for it indicates the assistance which may be made available to the States in a cooperative program for the Nation's health.

FRANKLIN D. ROOSEVELT.

THE WHITE HOUSE,
January 23, 1939.

JANUARY 12, 1939.

The PRESIDENT,*The White House, Washington, D. C.*

DEAR MR. PRESIDENT: In accordance with responsibilities assigned to the Interdepartmental Committee to Coordinate Health and Welfare Activities, I have the honor to submit the accompanying report and recommendations on national health.

This report is based on the results of an extensive review and analysis of data on health and opportunities for its improvement made during the past 2 years by our Technical Committee on Medical Care, which includes members of the staffs of the Children's Bureau, the Social Security Board, and the United States Public Health Service. The report and recommendations of the technical committee have already been transmitted to you, and at your suggestion were laid before a national health conference in Washington, July 18-20, 1938. At those meetings and subsequently the interdepartmental committee has had opportunities to confer with representatives and members of a wide range of professional groups, farm and labor groups, employers, welfare administrators, and the general public. The interdepartmental committee believes that the findings and proposals of the technical report, which is appended, are amply corroborated by professional and lay experience and opinion. Many helpful suggestions proposed by these groups have been carefully considered in the preparation of the report of the interdepartmental committee.

The interdepartmental committee has at its disposal a wealth of information arising from the activities of the Federal agencies represented in its membership and the special studies of our technical subcommittee. We will be happy to place further information at your disposal or to give any further assistance desired by you or by the Congress.

Respectfully submitted.

JOSEPHINE ROCHE, *Chairman.*

REPORT AND RECOMMENDATIONS ON NATIONAL HEALTH BY THE INDEPENDENT COMMITTEE TO COORDINATE HEALTH AND WELFARE ACTIVITIES

There can be no doubt that the general level of health in the United States is higher today than at any other time in the Nation's history. The steady gain throughout the past half century in the average length of life and in the vigor of life is specific evidence, if evidence were needed, of the knowledge and skill of our scientists, sanitary engineers, medical and allied practitioners, and of our health and welfare administrators. At the same time, the evidence is equally clear that not all of the American people have shared adequately in this progress. There are large areas of the United States where existence still is shadowed darkly by disease which could have been prevented or can be cured. In all parts of the country, moreover, in the rich States and in the poor, there are large groups of persons for whom life is still as uncertain and as brief as if the scientific progress of the past half century had not occurred.

In approaching the task assigned to it in August 1935, it has been the purpose of the Interdepartmental Committee to examine specifically the relations of sickness and insecurity. A wealth of evidence now available shows that, in good times and in bad, sickness remains the most constant cause of poverty and dependency. Except in years of widespread unemployment, sickness is the principal cause of insecurity. At all times, the direct and indirect costs of sickness weigh heavily on the national economy.

It is obviously not within the province of the committee to recommend, or even to consider, methods of treating disease. A clear distinction must be made, and has been made in our studies and deliberations, between the methods of treating sickness and the procedures to be used to ensure that in all parts of our country all those who need the protection of preventive medicine, the care of skilled practitioners, and the services of hospitals and other medical institutions have access to the best that the health and medical sciences can offer. Treatment of the sick person must always be an individual matter left to the judgment of those with the requisite professional skills. To ensure that such treatment is available to all who need it is, on the other hand, a basic public concern.

About a century ago the United States recognized that public safety and public economy, as well as the ideals of a democracy, demanded that the opportunity for an education be open to all. Today we are at the point of recognizing and making effective an equal opportunity for health and life.

In their experience as administrators in various Federal departments and agencies, the members of this committee have had an opportunity to observe the relationship of public health to the well-being of American families and its bearing on our national economy. It is the conviction of the committee, derived from this experience, that at the present time there is no greater public need, from the standpoint of individual and social security, than a comprehensive program to safeguard and improve the Nation's health. The committee believes, in brief, that it is both possible and necessary to embark on a long-range plan to put science to work so that, within the limits of present knowledge and potential resources, all of the American people will have the greatest possible opportunity to live out their lives in health and vigor, free to the maximum possible degree from the unhappiness and the economic burdens that result from sickness, disability, and premature death.

THE NEED FOR A NATIONAL HEALTH PROGRAM

As a foundation for its studies, the committee has had the benefit of a mass of factual data gathered by Federal, State, and local health organizations in the course of their administrative duties and of special studies made by these and other groups. The task of reviewing, coordinating, and summarizing this material was delegated to our Technical Committee on Medical Care, which includes members of the staffs of the Children's Bureau, the Social Security Board, and the United States Public Health Service. The findings of that technical subcommittee and its recommendations have already been incor-

porated in two special reports transmitted to you and, at your suggestion, laid before the National Health Conference in July 1938.¹

From these and other data, it is clear that the need for a national health program may be measured both in the lack of essential resources for the prevention and care of sickness and in a massive and unnecessary burden of sickness, death, and poverty. The nature and extent of that need may be broadly outlined as follows:

Public-health services for the prevention and control of sickness are largely undeveloped in many rural areas and are grossly inadequate in many smaller cities.

Hospital services for persons with low incomes are insufficient in many cities; at the same time, many hospital beds in private or semi-private rooms stand empty because patients are unable to pay the private rates. In rural areas, general hospitals and clinic services are grossly insufficient and in many places wholly lacking. Government hospitals for tuberculosis and mental disease are generally overcrowded and, in many States, inadequately supported.

Tuberculosis, pneumonia, cancer, malaria, mental and nervous disorders, industrial injuries, and occupational diseases—these and other specific ailments—are far more prevalent or more deadly than they need to be. The suffering and the premature deaths which they cause can be greatly reduced.

Maternity, infancy, and childhood are very inadequately protected, especially in rural areas. Between one-half and two-thirds of the maternal deaths, nearly one-half of the stillbirths, and between one-third and one-half of the deaths among new-born infants are preventable. Here is an opportunity to save more than 70,000 lives a year.

Preventable sickness and death among children are still much too common. Tens of thousands die unnecessarily each year. Hundreds of thousands are crippled by disease or accident. Millions are left with scars which handicap them for their future lives. Much of this is a needless waste of young life and a blight on the families of the Nation.

On an average day of the year, about 5,000,000 persons are disabled by sickness to such an extent that they cannot go about their usual work or other routine. Of these 5,000,000, about half get well, sooner or later, and resume their ordinary life; about half remain permanently disabled. Among those permanently disabled, nearly 2,000,000 are less than 65 years of age.

During the course of a year, sickness and disability cost the American people nearly 2,000,000,000 days' absence from work, school, or household duties.

Not including individuals who are already permanently disabled workers who are in the labor market lose a billion dollars or more each year in wages unearned because of sickness. Industry and the Nation as a whole suffer additional losses.

The costs of medical services exceed \$3,000,000,000 a year. About four-fifths of this amount is paid directly by families. On the aver-

¹ The Need for a National Health Program, report of the Technical Committee on Medical Care, February 14, 1938; and A National Health Program, report of the Technical Committee on Medical Care, submitted to the National Health Conference, Washington, D. C., July 18-20, 1938.

age, families spend between 4 and 5 percent of their incomes for medical care.

Average costs, however, are misleading. Sickness costs are uneven and unpredictable for the individual or for the family. Usually they cannot be postponed or controlled. What matters is not the average year, but the year that comes sooner or later to almost every family, when sickness bills are burdensome or even overwhelming—when they use up savings, require heavy sacrifices, or leave debts for the future.

Including the costs of medical and health services, the loss of wages because of sickness and the loss of potential future earning power because of premature death, the Nation's bill for sickness and postponable death amounts annually to about \$10,000,000,000.

The general picture presented by such facts as these is the more startling when the effect of sickness on specific groups of the population is examined. Sickness comes oftener and lasts longer, and death comes earlier to the homes of the poor than of the well-to-do. It is a plain fact—and a shocking fact—that the chance for health and even for survival is far less among low-income groups than among those who are in moderate or comfortable circumstances. This association of sickness and poverty bears upon the whole population in costs of dependency.

Wage earners in families whose annual incomes are less than \$1,200 suffer, on the average, more than twice as many days of disability a year as those in families with incomes of \$3,000 or more. Children in relief families lose nearly a third more time from school and play because of illness than do those who live in homes where the income is moderate or comfortable. A comprehensive study made several years ago of deaths among boys and men of working age showed that the general death rate among unskilled workers was nearly twice that of professional men or proprietors, managers, and officials. Among the poor in our large cities, death rates are as high today as were those of the Nation 50 years ago, before the beginning of the spectacular advance of public health and medical science.

In this connection it is of moment that, despite their greater and more frequent need for care, low-income families receive far less medical service than is purchased by the well-to-do. It is significant also that, in spite of the provisions of tax-supported and charitable services and the generosity of medical practitioners, families with small incomes now spend larger percentages of their incomes for medical care than do those who are in moderate or comfortable circumstances.

It is of little value to argue whether sickness and premature death are more the cause or the result of poverty. In some instances a clear connection can be traced between the circumstances in which an individual lives and his chances of ill health or loss of life. The point can be readily illustrated by inspecting the relationship between a man's occupation and his chances of living a normally healthy life. A few basic facts may be cited:

A study of sickness reports received from various industries indicates that iron and steel workers had consistently higher rates for pneumonia of all forms than occurred among employees in other industries. For the period 1922 to 1928, inclusive, the pneumonia case rate in the steel industry was nearly 70 percent above the rate in the reporting public utilities, and nearly 50 percent higher than that in all other reporting industries as a group.

It is estimated that about 1,000,000 persons are exposed to hazardous siliceous dust in the United States. It is further estimated that of this number 250,000 have silicosis in some stage. It is well known that individuals with silicosis are abnormally susceptible to tuberculosis. The prevalence of the disease in a group of silicotics is about 10 times greater than among the general population.

A large and important group of organic diseases, especially significant in adult life, shows strikingly the effects of industrial exposure. The death rates are two and three times as high as in nonindustrial groups during the active working years of life. In the hazardous industries, where workers are exposed to harmful dusts, metals, gases, vapors, or other injurious substances, excessive heat, humidity, sudden changes of temperature, defective lighting, or to noise, the effects on health and length of life are very serious. These effects may be noted in reduced efficiency, in long periods of illness and disability, and especially in cases of heart or kidney disease which strike men and women down prematurely.

At age 20, the expectation of life of men engaged in industrial pursuits is 42 years. That is, they may expect on the average to attain the age of 62. On the other hand those who are not engaged in industry may expect an additional 50 years at age 20. There is, therefore, a difference of about 8 years in the average expectation of the two groups.

Differences in the sickness or death rates among occupational groups should not be charged altogether to the specific effects of industry; other factors associated with occupation play large roles, such as economic status, race, education, and so on. It is clear, nevertheless, that if a single item were to be selected among the determining factors in the health of men and women, occupation would probably lead all others. These considerations are fundamental in our reasoning as to the place of economic factors in general plans for health services; industrial hygiene must have an important place in any list of specific health measures.

What matters fundamentally in the association of sickness and low income is that the vicious circle can be broken by well-tested methods to prevent and check illness and so to prevent the poverty it brings. There is incontrovertible evidence that the level of health has been raised for whole communities by the application of simple, accepted methods to provide public-health services and ensure facilities for medical care. Application has been made only meagerly and unevenly of the widely accepted public-health slogan: "Public health is purchasable. Within natural limitations, any community can determine its own death rate."

In summary, the committee finds after careful review of the evidence that the need for a national health program can be expressed in terms of five broad categories:

1. Services to prevent sickness are grossly insufficient for the nation as a whole.
2. Hospitals and other organized facilities are too few, too small, or wholly lacking in many communities, particularly in rural areas. The financial support of hospital services is meager and uncertain, especially the support of services for patients who cannot pay for the care they need.
3. One-third of the population, on relief or in the low-income brackets, receives no medical service or inadequate service.

4. A far larger part of the Nation suffers from the economic burdens created by illness. The largest of these burdens arise from the variable costs of medical services, costs which can be budgeted by the large group as a whole but not by the individual family.

5. Wage earners and their families need protection against loss of income during periods of temporary or permanent disability.

The needs thus briefly summarized are large and urgent. These continuing deficiencies deprive the Nation of much of its potential vigor and well-being. These needs can be met only through proper application of the resources of the Nation. Neither individuals, families, voluntary groups, localities, or States, alone and unaided, can cope with the problems. An adequate program must be national in its dimensions if it would come to grips with problems which are also national in their breadth and depth.

THE SCOPE OF A NATIONAL HEALTH PROGRAM

A program to deal with the problems which have been outlined must be no less comprehensive and no less varied than the circumstances it confronts. The interdepartmental committee recognizes that it may not be deemed wise or even possible to attempt to meet at once all of the present and urgent needs. The committee finds it vital, however, that the broad objectives of a national health program be recognized and defined and that any measures which may be adopted now or later should be such as to further those objectives and to constitute part of an interrelated whole. The committee believes, further, that there are certain elements which must be considered in evaluating any specific proposals leading toward a national health program.

Objectives.—The objective of a national health program, the committee finds, can be nothing less broad than the assurance that all areas of the country and all members of the population shall have the protection of adequate public-health services and an opportunity to avail themselves, in accordance with their medical needs, of adequate care in sickness. It is a subordinate but nevertheless essential aspect of such a program that provision should be made to compensate workers for periods of disability, temporary or permanent, during which they are unable to earn.

Available resources.—In efforts to attain these broad objectives, certain considerations are basic to any sound and economical plan. It goes without saying that a national program must build upon, and utilize fully, all present resources effective in meeting the needs of sickness. Both needs and resources vary widely in different areas of the United States. So also do present or potential expenditures from public or private funds for health services and medical care and for the alleviation of the dependency caused by sickness. Any further step, moreover, must recognize fully and must meet, insofar as is compatible with continuing progress, the differing customs and habits of communities in their health practices.

Federal aid for State programs.—As a consequence of this wide range of social organization and economic resources among the several States, the committee finds that a national health program should be built, insofar as the provision of public health and medical services is concerned, upon a partnership in which the States take the initiative

and assume the basic responsibility, and the Federal Government cooperates through grants-in-aid for State programs which meet certain basic conditions requisite for Federal approval. It is believed further that Federal grants to the States should be determined by some formula of variable-matching grants which permits recognition of the varying needs of the States and of the unequal resources actually or potentially available to meet these needs. The committee is of the opinion that the principle of Federal-State cooperation, which has proved so effective in the various health and welfare programs of the present Social Security Act, permits the flexibility essential to services as important and intimate as those for health, and that, at the same time, it offers protection to those of the American people, especially those in rural areas, whose communities have only limited means. The committee believes that the function of the Federal Government in this field is primarily to give technical and financial aid to the States. Advancement of opportunities for health among the States, through variable Federal grants-in-aid, should be supplemented by advancement of opportunities within the States through corresponding intrastate measures.

Hospitals, clinics, and other institutions.—As a consequence of the diversity of needs and resources among communities and States, there are many areas in which the basic institutional facilities for the care of the sick are inadequate or lacking. Hospitals and laboratories are the workshops of the medical profession. The committee finds that such facilities for modern medical practice must be available throughout the United States to enable our practitioners to give the level of care for which they are trained and ready.

Prevention.—In considering the services to be comprised in a national health program, it is believed that the prevention of sickness is basic. That fact is recognized in present provisions of the Social Security Act, but the means to apply preventive methods through public-health services are still far from adequate. Prevention of suffering and distress requires special attention to the needs of mothers, infants, and children. In the early years of life the foundation must be laid for future capacity to play one's part in the life of the family, the community, and the Nation. The committee therefore finds that an effective and economical program of national health must give explicit and generous recognition to the provision of adequate services for public health, including the prevention and control of disease and research in the cause and cure of disease, with special recognition of the needs of maternity, infancy, and childhood.

The history of health services in the United States shows clearly, however, that no rigid lines can be drawn between the services required for the prevention of disease and those essential for the care of the sick. Prevention of a lifetime of invalidity may hinge upon ready access to facilities for diagnosis and services for prompt and adequate care. Public provisions to isolate and care for persons sick with communicable or mental disease are older than the Nation. Progress in the control of tuberculosis, one of the most spectacular achievements of our generation in mitigating suffering and preventing orphanage and dependency, has been effected not only by the well-tried preventive methods but also by means of detecting the disease in its first insidious inroads and making medical, nursing, and hospital service available to protect the patient, his family, and his community.

Research.—An essential of any preventive program is the provision of adequate funds for research into the cause and cure of disease. Research must be recognized as an instrument of continued progress. There are large and serious groups of diseases—notable among them costly chronic diseases such as cancer, mental disease, heart and kidney diseases and arthritis—for which we must look to further scientific knowledge to save hundreds of thousands of lives and millions of dollars. These diseases most commonly strike in adult life. Their importance grows as our population ages. Any development in the extent of health and medical services must be paralleled by concomitant studies to evolve more effective and economical methods of achieving the objectives of prevention and cure. Present provisions for the investigation of disease and study of administrative methods in the field of health are wastefully inadequate.

Provision of medical care.—The committee finds that the objective of a national health program, and in particular the objective of preventing needless sickness, death, and dependency, requires that services for adequate care in sickness be made available, by one method and another, to all who are in need of care. It is incompatible with the ideals of a democracy and with the requirements of economical government and national safety that access to services required to maintain health, self-support, perhaps even life, should be seriously limited, as at present, by the inability to pay for them. The barrier of costs, which creates a wall between persons in need of care and the professions which stand able and ready to serve them, must be broken down.

Services for needy and low-income groups.—In considering the population to be served, three groups may be distinguished. There are, first, those who are now dependent upon public funds for the means of subsistence—some twenty million persons, about one-sixth of the Nation. There already is recognition in State legislation that medical service is no less essential than food and shelter. Many recipients of relief cannot hope to attain self-support until they achieve higher levels of health and vigor. As one of many examples of a situation that spells public waste and private tragedy, it may be pointed out that the prevalence of tuberculosis in a large sample of the relief population has been found to be 6 times that among families with annual incomes of \$3,000 or more; in certain regions, the incidence of tuberculosis in the relief population is 10 times that found among families in comfortable circumstances.

Just above the economic level of families on relief is another group, comprising also about 20,000,000 persons, among whom family income barely suffices for survival. In this group, as among those on relief, sickness and disability are far more prevalent than among families who are in moderate or comfortable circumstances. The means to pay for medical care, other than the simplest and most inexpensive, obviously are lacking. In such families, who maintain at best a precarious hold on self-support and independence, a single severe illness almost inevitably means economic catastrophe.

The committee is of the opinion that consideration of a national health program must include provision of public funds to meet the costs of medical care for that third of our people who are dependent or have incomes which provide for little more than bare subsistence.

Medical costs among self-supporting groups.—For the upper two-thirds of the population, the average present costs of medical care

would be within the reach of individual family incomes. If certain wasteful and nonproductive expenditures were eliminated, adequate medical services could be provided to large groups of families for about the aggregate amount that families now spend privately. This amounts to some 4 to 5 percent of aggregate family income. Yet in any given year hundreds of thousands of households run into economic disaster because of sickness even when family income is moderate or ample. Among all but the fortunate few with very large means, sickness costs are a constant specter.

Except by chance, families do not incur the average costs. Some go through a year luckily, with no medical bills and no loss of earnings from sickness and disability. Some are faced with costs or losses they can meet out of income or savings. But each year there are many—and no one can predict who those will be—for whom these costs and losses are disastrous. For the population as a whole and for large groups within the population, the costs of medical care and the income losses from disability can be predicted with a substantial degree of accuracy. For the individual family these costs and losses are almost wholly unpredictable and almost wholly uncontrollable. In this, they are unlike any other basic items that ordinarily appear in family budgets.

The committee finds that no consideration of the Nation's health will be well grounded which fails to recognize the nature of this individually, unpredictable and uneven risk of sickness, or fails to extend the present limited application of risk-sharing devices.

The consequences of the risk of sickness may be stated in economic terms; that is, in the costs and losses suffered by individual families and the consequently precarious support of medical practitioners and hospital services. The risk, however, is even more serious in that it affects both the quantity and the quality of the medical service to which most of the population has access. Too often both the patient's chances and the doctor's efforts are impeded by the fact that medical service is not called for promptly, or that the doctor is not able to bring into play all the skills of his profession because he knows that the costs will be prohibitive for his patient. As a consequence of this situation we have the anomaly of professions whose services are not fully used and whose recompense is often precarious, and of hospitals with empty beds, while at the same time many individuals in the population—many of them with incomes adequate for their other requirements—are without access to needed services which modern medical science can offer. We have patients without doctors and doctors without patients.

The committee is convinced that private and public burdens can be lightened and that greater freedom can be afforded the professions and institutions concerned with the care of the sick to give the services to which they are dedicated. The committee believes that progress on this economic front in the health field depends for the most part on a more effective and more economical use of the money now spent and of the services now available. The method of achieving that use is to apply to the costs and losses of sickness the devices that long have proved effective in meeting risks that are measurable and tolerable for a population, but unpredictable and unbearable for the individuals who compose it—that is, to spread the costs over groups of people and over periods of time.

Tax support and social insurance.—There are two ways of spreading a risk which is so extensive and so serious as to affect the well-being and safety of a people. One is by the use of general or special tax funds; the other by contributions under a system of social insurance. Both of these methods are in effective use in the provisions on which reliance now is placed for the social security of the Nation. The committee believes that present experience and present need point to the wisdom of extending that use more widely and more fully for a coordinated attack on the insecurity that arises from sickness. It believes that in such extension both of these principles can and should be used.

MAINTENANCE AND ADVANCEMENT OF QUALITY OF MEDICAL CARE

The interdepartmental committee and its Technical Committee on Medical Care have, from the beginning, been profoundly concerned with the need to maintain high quality in health and medical services which may be provided through new programs. They have been equally concerned with the need to encourage the development of new and stronger incentives for continuous improvement in the quality of service. The subject of qualitative standards has been explored at length in numerous meetings with representatives of many professional groups, and many proposals of value have been developed.

Discussions with committees of physicians, hospital representatives, public-health officials, dentists, nurses, and welfare workers have all brought out the high importance of quality of service and the essential interest of these professional bodies in the maintenance and improvement of quality. The committee recognizes that the technical quality in the performance of a professional service must be considered in association with the sufficiency of the service in amount and scope necessary to meet the needs of a population. Quality, scope, and amount of service taken together make up the inclusive concept of adequacy.

The committee's discussions with these professional bodies and its own deliberations lead to the following comments on the maintenance and improvement of quality of care.

First should be mentioned the education of physicians and other professional persons. The advance in standards of undergraduate medical education has been one of the notable contributions of American medicine, aided by generous public and private gifts during the present generation. Present standards must be maintained and improved, with due regard for the number of physicians needed in various parts of the country. While much activity is under way to promote postgraduate medical education, that field is regarded by the professional bodies as in a less satisfactory state and as presenting the greatest educational need at the present time.

Research and its encouragement through generous public and private aid underlie the advancement of medical science and the quality and flexibility of professional education.

Significant among the contributions to the maintenance and advancement of medical service has been the advancement in our hospitals and clinics in the organization of their professional staffs. Quality in service is greatly promoted by the professional association of physicians with one another in cooperative work on hospital and

clinic staffs; by the systematically organized mutual criticism in which general practitioners and specialists share as such staff members; and through the opportunities which well-organized hospitals and clinics afford physicians to utilize economically much expensive equipment and the aid of technical personnel. The professional societies of physicians and hospitals have been largely responsible for these advances. Great forward steps have been thus taken toward the organized maintenance and improvement of the quality of professional care and the opportunities of physicians who are associated with hospitals and clinics to obtain these advantages. It is to be noted, however, that a considerable proportion of physicians do not at present have access to these advantages.

Systematic supervision of the work of professional men and women is recognized as one of the essential requirements for the maintenance and improvement of quality; the staff organizations of hospitals and clinics constitute one measure through which such supervision is organized within a professional group itself, under the auspices of a governing body usually representing the general community interests, whether governmental or nongovernmental. In professional services outside hospitals, clinics, and public-health agencies, professional supervision is exercised to a certain extent through professional societies. It also appears in the organized plans of medical care which, especially in recent years, have been extending services in the homes of the sick, chiefly under local governmental auspices. Whereas in the hospital and clinic field there is a generation of growing and tested experience in methods of maintaining quality through professional organization and supervision under community auspices, in home services the experience appears to be neither ample nor satisfactory. Our conferences have brought out the increased recent attention given to this matter and the pending formulation of professionally acceptable standards.

There are also economic considerations which affect the quality of service: Adequate compensation for physicians and other professional persons who furnish medical care in institutions or elsewhere; the establishment of high standards governing the qualifications, appointment, and tenure of office of salaried physicians and others; and the assurance of adequate income to nonsalaried practitioners.

Attention has often been directed to the importance of a personal relationship between the physician and patient as a stimulus toward quality, and likewise to the right of the patient to select a physician in whom he has confidence. Our studies and conferences have impressed upon us that the personal relation required between physician and patient is much more varied today than formerly, owing to the greater specialization of medicine and the varying requirements of different specialities. Urban life and greater mobility of population have combined with specialization to render the maintenance of personal relationship much more difficult than formerly, and also to render the choice by the patient among physicians and other medical resources much more complex and difficult than was the case when medical services were fewer in variety and simpler.

The committee wishes to emphasize that all its studies and deliberations indicate clearly that its recommendations can be carried out not only without sacrifice in quality, but—more particularly—with the concurrent development of new opportunities and methods to

strengthen existing safeguards and to advance the quality of medical care. The committee has already received assurances of utmost cooperation from the professional groups toward the attainment of these goals.

THE NATIONAL HEALTH CONFERENCE

We have already referred to the fact that the studies and recommendations of our technical subcommittee were submitted, at the suggestion of the President, to the National Health Conference, held in Washington, D. C., July 18-20, 1938. That conference included members of the professions concerned with public health and medical care, representatives of farm and labor groups and of employers, administrators of public welfare, educators, and members of the general public. The conference considered carefully the technical reports laid before its members. There was no significant disagreement as to the facts or as to their demonstration of broad and urgent unmet needs.

The members of the conference were not asked to take action on our subcommittee's recommendations, which were put forward only for discussion.

Since that conference, and largely growing out of the intense public interest displayed in the work of the conference, the interdepartmental committee has received a large volume of formal communications and informal correspondence concerning these proposals. All these expressions of opinion have been weighed carefully in the formulation of the recommendations submitted in this report. The committee finds that its view of the need for a national health program and its statements of the objectives to be attained by such a program are substantiated by the direct experience of a very wide representation of the American people, including those to be benefited as patients, those concerned as employers or public servants, and those whose daily work is the prevention of sickness or the care of the sick.

RECOMMENDATIONS

In line with its review of the facts and with the considerations outlined in the preceding paragraphs, the committee submits four specific recommendations. These recommendations envisage a program developed over a period of time. It is believed that the method of Federal-State cooperation, in which the program is grounded, will be surer and more effective, though necessarily less rapid, than any effort to provide a less flexible approach to the problem. These recommendations envisage also the eventual provision of considerable sums of money. It should be pointed out that, in large part, such amounts represent a redirection of existing expenditures for more effective, humane, and equitable use; it may be anticipated further, that additional costs will be offset to a considerable extent by prevention of present burdens of dependency.

The committee wishes to emphasize its intent, in formulating these recommendations, to present a plan which provides the protection and support of a national approach but leaves wide latitude for State initiative and freedom for State choice of the appropriate methods of meeting a common objective. While it is believed that such methods should vary, and that there should be variance in the dates at which

they are made effective, the committee is of the opinion that no objective less wide than that which has been stated will serve to marshal the resources now available or in need of development to promote the health of the Nation.

The committee's specific recommendations may be stated briefly as follows:

A. *The committee recommends the expansion and strengthening of existing Federal-State cooperative health programs under the Social Security Act through more nearly adequate grants-in-aid to the States and, through the States, to the localities.*

1. *General public-health services.*—Fundamental to an expanding program of preventive services is the strengthening and extension of organized public-health services in the States and in local communities. In addition to the strengthening of public-health administrative services and organizations generally, the expanded program should be directed specifically toward the eradication of tuberculosis, venereal diseases, and malaria; the control of mortality from pneumonia and from cancer; the development of more effective programs for mental hygiene and industrial hygiene, and related purposes. In addition, the program should include special provisions for the training of skilled personnel and for studies and investigations designed to advance knowledge and skill useful in carrying out the purpose of the program.

2. *Maternal and child-health services.*—Included in this part of the recommended program are provisions for medical and nursing care of mothers and their newborn infants; medical care of children; services for crippled children; consultation services of specialists; more adequate provisions for the postgraduate training of professional personnel; and for studies and investigations of conditions affecting the health of mothers and children. The objective sought in this phase of the committee's recommendation is to make available to mothers and children of all income groups and in all parts of the United States the services essential for the reduction of our needlessly high maternal mortality rates and death rates among newborn infants, and for the prevention in childhood of diseases and conditions leading to serious disabilities in later years.

B. *The committee recommends grants-in-aid to the States for the construction, enlargement, and modernization of hospitals and related facilities where these are nonexistent or inadequate but are needed, including the construction of health and diagnostic centers in areas, especially rural or sparsely populated, inaccessible to hospitals. The committee also recommends grants toward operating costs during the first years of such newly developed institutions to assist the States and localities in taking over responsibilities.*

Our technical subcommittee finds hospital accommodations and hospital and clinic services throughout the country not altogether well adapted to the varying needs of people living under different social, economic, and geographical circumstances. A long-range program is urgently needed to meet accumulated deficiencies, with special reference to the needs of rural areas and of low-income groups and to bring about such expansion of facilities as is necessary if preventive and curative services are to approach adequacy for the Nation.

We need scarcely emphasize that hospital and related facilities should be built only after careful examination has shown the need in particular communities or areas, taking account of all available facilities useful for the service of the localities.

C. The committee recommends that the Federal Government provide grants-in-aid to the States to assist them in developing programs of medical care.

A State program of medical care should take account of the needs of all persons for whom medical services are now inadequate. Attention has often been focused on those for whom local, State, or Federal Governments, jointly or singly, have already accepted some degree of responsibility through the public-assistance provisions of the Social Security Act and through work relief or general relief, and upon those who, though able to purchase food, shelter, and clothing, are unable to pay for necessary medical care. The committee's studies show, however, that attention should more properly be focused on the needs of the entire population or, at least, on the needs of all low-income groups. Medical services are now inadequate among self-supporting people with small incomes as well as among needy and medically needy persons.

The committee believes that choice of the groups to be served, the scope of the services furnished, and the methods used to finance the program should be made by the States, subject to conformity of State plans with standards necessary to insure effective use of the Federal grants-in-aid.

To finance the program, two sources of funds could be drawn upon by the States: (a) General taxation or special tax assessments, and (b) specific insurance contributions from the potential beneficiaries of an insurance system. The committee recommends grants-in-aid to States which develop programs using either method, or a combination of the two, to implement programs of medical care.

The committee believes it is of fundamental importance that a medical-care program developed by a State should be a unified program applicable to all groups to be served. It would be unsound to have one system of medical care for a relief population and another for self-supporting groups. A unified program might be developed through tax support for public medical services for all included groups; or through an insurance system financed by contributions, including contributions from public funds on behalf of persons in need; or through other arrangements.

D. The committee recommends the development of social insurance to insure partial replacement of wages during temporary or permanent disability.

The committee believes that insurance against temporary disability should be established through Federal-State cooperative arrangements. Advantage may be taken, in the design of a specific program, of experience already accumulated in the operation of unemployment compensation. An insurance system against temporary disability could furnish substantial benefits at a cost very considerably less than that involved in unemployment compensation. Some specific characteristics of temporary disability insurance and alternative methods of financing it have been studied by the Social Security Board.

The committee believes that insurance against permanent disability should be established through liberalization of the Federal old-age insurance system, so that benefits become payable at any time prior to age 65 to qualified workers who become permanently and totally disabled. The costs could be met for many years to come from taxes

now levied for old-age insurance. Additional costs of modest size would have to be met 10, 20, or more years later.

The committee believes it essential that in measures to effect any of these recommendations provision be made for concurrent study and evaluation, to insure the progressive development of health and medical services and the prompt application of new knowledge and skill for the benefit of all our people.

A NATIONAL HEALTH PROGRAM: REPORT OF THE TECHNICAL COMMITTEE ON MEDICAL CARE¹

A SUMMARY

The study of health and medical services in the United States made by the Technical Committee on Medical Care indicates that deficiencies in the present health services fall into four broad categories.

1. Preventive health services for the Nation as a whole are grossly insufficient.

2. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas, and financial support for hospital care and for professional services in hospitals is both insufficient and precarious, especially for services to people who cannot pay the costs of the care they need.

3. One-third of the population, including persons with or without income is receiving inadequate or no medical service.

4. An even larger fraction of the population suffers from economic burdens created by illness.

The Committee submits a program of five recommendations for meeting with reasonable adequacy existing deficiencies in the Nation's health services. Estimates of the total additional annual costs to Federal, State, and local governments of Recommendations I, II, and III are also submitted. The Committee does not suggest that it is practicable to put into effect immediately the maximum recommendations. It contemplates a gradual expansion along well-planned lines with a view to achieving operation on a full scale within 10 years. Except insofar as they overlap and include portions of the first three recommendations, Recommendations IV and V involve chiefly a revision of present methods of making certain expenditures, rather than an increase in these expenditures.

RECOMMENDATION I: EXPANSION OF PUBLIC HEALTH AND MATERNAL AND CHILD HEALTH SERVICES

The Committee recommends the expansion of existing cooperative programs under title VI (Public Health Work) and title V (Maternal and Child Welfare) of the Social Security Act.

A. EXPANSION OF GENERAL PUBLIC-HEALTH SERVICES (TITLE VI)

Fundamental to an expanding program of preventive health services is the strengthening and extension of organized public-health services in the States and in local communities. It is recommended that

¹ Accepted and endorsed by the Interdepartmental Committee to Coordinate Health and Welfare Activities. Presented to the President, February 14, 1938. See Explanatory Statement, p. 87.

Federal participation in the existing cooperative program should be increased with a view toward equalizing the provision of general public-health services throughout the Nation. The Committee further recommends that increasing Federal participation be utilized to promote a frontal attack on certain important causes of sickness and death for the control of which public health possesses effective weapons.

The Committee tentatively estimates that, at its peak, an adequate program of expanded public-health service would require additional annual expenditures by Federal, State, and local governments of \$200,000,000 for these purposes: strengthening of public-health organization; the eradication of tuberculosis, venereal diseases, and malaria; the control of mortality from pneumonia and from cancer; mental hygiene; and industrial hygiene. The Committee recommends that approximately one-half of these increased funds be provided by the Federal Government.

B. EXPANSION OF MATERNAL AND CHILD-HEALTH SERVICES (TITLE V)

Included in this part of the recommended program are provisions for medical and nursing care of mothers and their newborn infants; medical care of children; services for crippled children; consultation services of specialists; and more adequate provisions for the post-graduate training of professional personnel. The objective sought in this phase of the Committee's proposed program is to make available to mothers and children of all income groups and in all parts of the United States minimum medical services essential for the reduction of our needlessly high maternal mortality rates and death rates among newborn infants, and for the prevention in childhood of diseases and conditions leading to serious disabilities in later years.

The Committee recommends a gradually expanding program reaching at least by the tenth year a total additional expenditure of \$165,000,000, distributed as follows:

| | |
|---|--------------|
| Maternity care and care of newborn infants..... | \$95,000,000 |
| Medical care of children..... | 60,000,000 |
| Services for crippled children..... | 10,000,000 |

The Committee recommends that approximately one-half of the cost of the expended program should be met by the Federal Government.

RECOMMENDATIONS II, III, AND IV: EXPANSION OF MEDICAL SERVICES AND FACILITIES

The Committee has also explored the adequacy of services for the sick, the sickness experience of, and the receipts of, professional and hospital services by broad groups of the population. The Committee finds that the needs for diagnostic and therapeutic services to individuals are greatly in excess of such accomplishments as might be effected by a strengthened program of preventive services—important as such services may be as a first step. Indeed, it has been recognized in Recommendation I that certain important causes of sickness and death require for their eradication or control, the application of diagnostic and therapeutic procedures through services to individuals in need of such care.

The Committee finds that current practices in the provision of medical services and facilities fall far short of meeting these needs.

It has taken account of personnel and facilities, financial support of services required by persons who are themselves unable to pay for the care they need, the sickness burdens of self-supporting persons, methods of paying for medical care and of assuring income for workers who are disabled by sickness. It finds that these needs warrant an expansion of medical services and facilities on a broader front than that contemplated in Recommendation I alone.

RECOMMENDATION II. EXPANSION OF HOSPITAL FACILITIES

The Technical Committee has made a special study of deficiencies in existing hospital and other institutional facilities. It is impressed with the increasing part which hospitals play, year after year, in the health and sickness services. Without adequate hospitals and clinics, it is impossible to provide many of the important services which modern medicine can furnish.

The Committee finds hospital accommodations and hospital organization throughout the country ill-adapted to the varying needs of people living under different social, economic, and geographical circumstances. In hospitals offering general care, the percentage of beds supported by patients' fees is out of proportion to the ability of the population served to pay, hence many general hospital beds are empty a large part of the time. Conversely, there are too few low-cost or free beds to satisfy the needs. By far the greater majority of these are found in our large metropolitan centers. There are wide areas—some 1,300 counties—having no registered general hospitals; others are served only by one or two small proprietary institutions. Only through hospitals located in the larger cities have out-patient clinics been developed to any considerable extent. Governmental tuberculosis sanatoria and mental institutions tend to be overcrowded, or are otherwise restricted in funds or personnel for rendering the community service which they should be equipped to give.

The Committee recommends a 10-year program providing for the expansion of the Nation's hospital facilities by the provision of 360,000 beds—in general, tuberculosis, and mental hospitals, in rural and in urban areas—and by the construction of 500 health and diagnostic centers in areas inaccessible to hospitals. These new hospitals or units would require financial assistance during the first 3 years of operation. Special Federal aid for this purpose is suggested.

Averaged over a 10-year period, the total annual cost of such a program, including special 3-year grants for maintenance of new institutions, is estimated at \$147,400,000, divided as follows:

| | 5-year construction | 5-year maintenance |
|--------------------------------|------------------------|-----------------------|
| General and special..... | \$63,000,000 | \$21,600,000 |
| Tuberculosis..... | 15,000,000 | 5,000,000 |
| Mental..... | 32,500,000 | 7,800,000 |
| Diagnostic centers..... | 1,500,000 | — |
| Total average annual cost..... | 112,000,000 | 35,400,000 |

The Committee recommends that approximately one-half of this total annual cost be met by the Federal Government. It points out that a hospital construction program should not be undertaken unless there is a concurrent program to give continuing aid toward the cost of free services such as is included in Recommendation III.

RECOMMENDATION III. MEDICAL CARE FOR THE MEDICALLY NEEDY

The Committee is impressed with the evidence now available that one-third of the population which is in the lower income levels is receiving inadequate general medical services. This applies to persons without income and supported by general relief, and to those being supported through old-age assistance, aid for dependent children, or work relief, and also to families with small incomes. These people are doubly handicapped. They have higher rates of sickness and disablement than prevail among groups with larger incomes, and they have lesser capacities to buy and pay for the services they need. Current provisions to assist these people—though generously made by many State and local governments, by voluntary organizations, and by professional practitioners—are not equal to meet the need.

The Committee recommends that the Federal Government, through grants-in-aid to the States, implement the provisions of public medical care to two broad groups of the population: (1) To those for whom local, State, or Federal Governments, jointly or singly, have already accepted some responsibility through the public assistance provisions of the Social Security Act, through the work relief programs, or through provisions of general relief; (2) to those who, though able to obtain food, shelter, and clothing from their own resources, are unable to procure necessary medical care. It is estimated that, on the average, \$10 per person annually would be required to meet the minimum needs of these two groups for essential medical services, hospitalization, and emergency dentistry. This part of the program might be begun with the expenditure of \$50,000,000 the first year and gradually expanded until it reaches the estimated level of \$400,000,000 which would be needed to provide minimum care to the medically needy groups. The Committee recommends that one-half of the total annual costs be met by the Federal Government.

RECOMMENDATION IV. A GENERAL PROGRAM OF MEDICAL CARE

The Committee directs attention to the economic burdens created by sickness for self-supporting persons. There is need for measures which will enable people to anticipate and to meet sickness costs on a budget basis.

No conclusion has emerged more regularly from studies on sickness costs than this: The costs of sickness are burdensome more because they fall unexpectedly and unevenly than because they are large in the aggregate for the Nation, or, on the average, for the individual family. Except in those years when unemployment is widely prevalent, sickness is commonly the leading cause of social and economic insecurity. Without great increase in total national expenditure, the burdens of sickness costs can be greatly reduced through appropriate devices to distribute these costs among groups of people and over periods of time.

The Committee recommends consideration of a comprehensive program designed to increase and improve medical services for the entire population. Such a program would be directed toward closing the gaps in a health program of national scope left in the provisions of Recommendations I and III. To finance the program, two sources of funds could be drawn upon: (a) General taxation or special tax

assessments, and (b) specific insurance contributions from the potential beneficiaries of an insurance system. The Committee recommends consideration of both methods, recognizing that they may be used separately or in combination.

Such a program should preserve a high degree of flexibility, in order to allow for individual initiative, and for geographical variations in economic conditions, medical facilities, and governmental organization. It should provide continuing and increased incentives to the development and maintenance of high standards of professional preparation and professional service; it should apportion costs and timing of payments so as to reduce the burdens of medical costs and to remove the economic barriers which now militate against the receipt of adequate care.

Planning for a program of medical care of a magnitude to serve the entire population essentially must be approached as an objective to be fully attained only after some years of development. The role of the Federal Government should be principally that of giving financial and technical aid to the States in their development of sound programs through procedures largely of their own choice.

RECOMMENDATION V: INSURANCE AGAINST LOSS OF WAGES DURING SICKNESS

The Committee recognizes the importance of assuring wage earners continuity of income through periods of disability. A disability compensation program is not necessarily part of a medical care program, but the cost of compensating for disability would be needlessly high if wage earners generally did not receive the medical care necessary to return them to work as soon as possible.

Temporary disability insurance can perhaps be established along lines analogous to unemployment compensation; permanent disability (invalidity) insurance may be developed through the system of old-age insurance.

COSTS OF THE PROPOSED PROGRAM

The maximum annual cost to Federal, State and local governments of Recommendations I, II, and III (with duplications eliminated) is estimated at about \$850,000,000. This figure is the estimated total annual cost *at the full level of operation within a 10-year period*, and is presented primarily as a gage of need.

The estimated total includes (1) \$705,000,000—the additional annual expenditures for certain general health services to the entire population and for medical services to limited groups of the population—the public assistance and otherwise medically needy groups—which should be reached within a 10-year period, and (2) \$147,400,000—the approximate average annual cost of hospital construction and special grants-in-aid in the 10-year program proposed under Recommendation II. It is suggested that the Federal share of this amount would be approximately one-half.

Recommendation IV is presented primarily as a more economical and effective method of making current expenditures for medical care, though it also makes provision for the medical care of persons who are not now receiving even essential services. An adequate general program of medical care is proposed in the form of alternative

arrangements which may cost up to a maximum of \$20 per person a year, i. e., no more than is already being spent through private purchase of medical care. Annual aid from Government funds would be necessary to provide services for the care of the medically needy as proposed in Recommendation III and for the parts of Recommendation I which are included in the broad program set forth in Recommendation IV.

The Committee calls attention to the fact that, in some important respects, the five recommendations present alternative choices. However, the Committee is of the opinion that Recommendations I and II should be given special emphasis and priority in any consideration of a national health program more limited in scope than that which is outlined in the entire series of recommendations.

The Technical Committee on Medical Care is firm in its conviction that, as progress is made toward the control of various diseases and conditions, as facilities and services commensurate with the high standards of American medical practice are made more generally available, the coming decade, under a national health program, will see a major reduction in needless loss of life and suffering—an increasing prospect of longer years of productive, self-supporting life in our population.

CHAIRMAN, MARTHA M. ELIOT,
Children's Bureau.
I. S. FALK,
Social Security Board.
JOSEPH W. MOUNTIN,
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Public Health Service.

EXPANSION OF GENERAL PUBLIC HEALTH SERVICES

PART I. THE NEED FOR EXPANDING PUBLIC HEALTH SERVICES

PUBLIC HEALTH ORGANIZATION

Some recognition of the necessity for protection of the public health is to be found in the legal enactments of all States and in most of their political subdivisions. Unfortunately, the existence of a health department does not always indicate that the community has a complete or adequate health program. For example, less than a third of the counties and even a smaller proportion of the cities employ full-time, professional health officers. The village and township health officer more often than not is some local lay citizen who takes time out from his other work to inspect nuisances or tack up quarantine signs.

States expend through their health departments, on the average, 11 cents per capita, while some State appropriations fall as low as 3 cents. Many local official health organizations have budgets which figure out to be no more than a few cents per capita. Health departments are fairly high on the scale when their annual appropriations reach 50 cents per capita, while the very few organizations, mostly large city health departments, having budgets that approach \$1 per capita are fortunate indeed. With budgets of this low order, health departments are expected to provide service in vital statistics, labo-

ratory diagnosis, communicable-disease control, maternal and child hygiene, protection of food supply, environmental hygiene, and to discharge other responsibilities that may be placed on this agency. A preventive program designed to reach any reasonable degree of intensity obviously is out of the question under such limitations.

A start towards remedying this situation was made with the passage of the Social Security Act, title VI, Public Health Work. The relatively small sums of Federal money thus far provided have made possible some leveling up in local health organization and some enrichment of health service generally. The impetus toward an expanding public health program created by the Federal participation is reflected in the increase in rural health services during the two and a half years of operation under title VI. At the beginning of the calendar year 1938 there had been a net gain of 623 in the number of counties under full-time health administration over the number reported at the close of 1934. There are now 8 States in which all counties are served by full-time health units or districts, as compared with the 3 so organized at the close of the calendar year 1935. However, it should not be inferred that even in the counties now under full-time health administration the service at present is adequate. Many of the counties are being served by extremely "thin" district health units. Of only a very small number may it be said that the service is even fairly adequate.

The situation in many of our smaller cities, and in some of the larger ones, is almost as bad as that existing in a large part of our rural area. There are numerous urban communities throughout the country in which health activities today are under the direction of part-time physicians engaged in private practice or lay health officers, neither possessing training in modern public health administrative practice. In some of these communities such health protection as has been afforded has been largely incidental to improvements instituted for economic and esthetic reasons, or to ready access of the population to good medical care, rather than to the activity of the health department. In many of our cities the principal health department activity still consists in the inspection of private premises for nuisances having little bearing on public health, and in an attempt to control communicable diseases by quarantine procedure—a method admitted by leading health workers to be of little avail in reducing the incidence of communicable diseases. More specifically, many of the milk supplies for urban communities are still far from being as safe as they should be, and the unsightly, open-back, insanitary privy still exists in the outlying sections of most of our small cities, with the result that typhoid fever is rapidly becoming more prevalent in towns and small cities than in the rural areas.

The need for Federal aid is not confined to rural and urban health organizations. Not more than half of the State health departments are adequately staffed or satisfactorily equipped to render the services which they alone can give, regardless of the extent to which local facilities may be developed.

The gains made in response to the stimulus afforded by Federal participation in State and local health work assume their deepest significance as evidence of the practicability and desirability of an expanding program of general public health services. Existing needs, however, far outweigh the gains and serve as a warning against the

assumption of a complacent attitude with respect to recent accomplishments. There still remain large sectors of the United States where the very foundation of a health program has not been laid—namely, a nucleus of full-time, competent, and well-trained persons having a professional point of view. Without such a minimum in staff organization, even the elementary services are not possible on an effective scale. Neither can there be an orderly enlargement of community health services without the framework expressed by a properly constituted health department.

SPECIFIC PUBLIC HEALTH PROBLEMS

In addition to strengthening health organization for general purposes, there is a need for concerted attack on specific problems of national health. The needs as well as the program of action in maternal and child health are covered in another section of the Technical Committee's report. Service of comparable intensity should be developed in tuberculosis, venereal diseases, pneumonia, cancer, malaria, mental hygiene, and industrial hygiene. With programs of proper magnitude, the eradication of tuberculosis, venereal disease, malaria, and certain occupational hazards may be envisioned; lowering of mortality from pneumonia and cancer is possible; and in the case of mental disorders, morbidity can be reduced. Each of these problems will now be considered individually.

Tuberculosis.—Students of this problem are in substantial agreement to the effect that programs now may be planned with a view to final eradication of tuberculosis, or at least to effect a reduction to a point where this disease is no longer a significant factor in morbidity and mortality. Despite the great reduction in death rate that has been accomplished, tuberculosis is still a major cause of death and disability in the United States. While for the whole population it ranks seventh as a specific cause of death, for the age group 15 to 45 years, its position is second only to that of accidents. The disease works its greatest havoc among Negroes, among workers in certain occupations, and generally among persons of low income.

On the average, 70,000 persons die of tuberculosis annually; and for each death there are estimated to be about five living cases; thus, in any year, the active disease probably is represented by 420,000 individuals. Within their families, these cases expose over a million persons to infection. By the working of this cycle alone, there is maintained a tuberculous population numbering 1,500,000.

Venereal diseases.—Legislation enacted by the last Congress may be cited as evidence of the growing appreciation which representative bodies now have for the public health importance of syphilis and gonorrhea. Funds appropriated by this act, coupled with those of State and local health agencies, will make possible improvement of laboratory service, organization of additional and better treatment facilities, and the free distribution of standard remedies for use by public clinics and private physicians. The sums of money now available, large though they may seem in comparison with previous annual appropriations, will prove sufficient only for beginning the type of attack on venereal diseases that is indicated.

To substantiate this point, no more data than the following need be adduced: It is estimated that approximately 518,000 new patients

infected with early syphilis seek treatment each year; the gonorrhea cases coming to medical attention number about 1,037,000. It is probable that even these figures, particularly the latter, grossly understate the amount of recent infection. Some 60,000 cases of congenital syphilis occur annually; syphilitic involvement of the heart and blood vessels and of the nervous system result in 50,000 deaths each year in addition to those specifically assigned to syphilis. At least 10 percent of first admissions to hospitals for mental disease are attributable to syphilis in its manifestation as general paralysis.

Early and adequate treatment of syphilis and gonorrhea is the best method, in fact it is the only feasible one known at the present time, for cutting down the incidence of these diseases and for mitigating their consequences.

Pneumonia.—Effective serums are now available for treating the more common forms of pneumonia. If serums were used generally, it is estimated that the gross pneumonia mortality could easily be reduced by more than 25 percent. The possibility it offers for saving of lives may be appreciated when one understands that 150,000 deaths each year are charged to pneumonia either as a primary or contributory cause of death.

According to the best information at hand, 5 percent would be a liberal estimate of the pneumonia cases amenable to serum therapy that now receive therapeutic serum. Perfected, or concentrated, serum is a new product which has not yet been sufficiently popularized; the cost is still high, varying from \$25 to \$75 per case. Moreover, serum therapy is not feasible except where rapid and accurate laboratory diagnostic service is available. In other words, the prevention of pneumonia mortality is an expensive job that requires certain special facilities and a scheme for coordinating the resources of public agencies with those of practicing physicians. Present activities in this field are generally inadequate. Only 8 of the 48 States have active programs for accurate diagnosis by typing and for free distribution of serum. In 15 States, no health department laboratory facilities are available for rapid typing of pneumococci, and 29 percent of American cities of 100,000 population and over have made no provision for pneumonia typing as an activity of their health department laboratories.

Cancer.—A hopeless attitude with respect to the outcome of all cases of cancer is no longer justified in view of the results obtained by modern therapy. Cancer in accessible parts of the body yields to varying combinations of surgery and radiation. Cancers at these sites account for over 40 percent of the mortality. Should success be achieved in only half of these cases, an annual saving of 30,000 lives would be effected.

Programs for prevention of mortality from cancer, like so many other public health services involving individual care of patients, have been slow in starting. At the present time, only 7 States have active, State-wide programs. Isolated tumor clinics may be found in some of the better organized out-patient departments of hospitals, but these are usually located in the larger cities. Notwithstanding the limited facilities now available, sufficient experience has accumulated to guide administrative practice.

Malaria.—The malarious area in the United States has gradually receded during the past 75 years. However, the Mississippi Delta

and certain of the Southeastern States remain endemic foci. Even in these regions, it is now largely a rural disease, but there it shows little tendency toward spontaneous decline. In theory, the disease should be eradicated easily by control of the Anopheles mosquito and other established procedures. In practice, however, economic difficulties stand in the way.

Of late, substantial progress in the application of malaria-control measures has been accomplished through work-relief projects financed by the Works Progress Administration. These programs entailed drainage operations designed to eliminate mosquito breeding places. While it is expected that additional progress may be made in this way in the future, the need for malaria-control measures of a diversified nature is of sufficient importance to justify a more permanent basis of financial support.

Mental hygiene.—Problems of mental ill health are represented only in part by the half million persons confined to institutions. At large in the general population, there is a somewhat greater number of people who are psychotic or defective in varying degrees. In addition, there is an indefinite but still larger proportion of persons below par from the standpoints of intelligence or emotional balance. Because of their personality make-ups they encounter difficulty in school, in industry, and in their relations with others. Such people, without treatment or guidance, contribute little to national progress. Aside from the economic and social problems associated with these more obvious groups, many people in all walks of life are unable to experience the happiness and fullness of life associated with mental and physical health. Because of individual emotional disturbances, family discord grows apace, antisocial behavior is bred, and industrial differences often end in unnecessary strife. Sufficient knowledge is at hand, which, if more generously applied, could resolve many of these emotional conflicts.

In the absence of specific therapy for so many of the mental disorders, the whole problem must be approached on a broad front. Persons who are seriously psychotic, those of very low mentality, and the habitually criminal, must be found and given appropriate institutional care. The benefits of modern diagnostic treatment and guidance methods must be made more generally available for the border-line groups. A program involving Federal assistance toward the expansion of both custodial and preventive facilities and services is indicated.

Industrial hygiene.—The health of more than 15 million people who constitute that important segment of our population engaged in industrial occupations, and on whom the lives and health of so many depend, should be of paramount concern to those entrusted with the welfare of this Nation. It is the object of industrial hygiene to protect and improve the health of this large group. This is best accomplished through the recognition of certain fundamental requirements of industrial hygiene.

The problem of determining the extent of illness among industrial workers remains one of the major functions of industrial hygiene. Any health program is dependent upon the standards and completeness of the health supervision provided industrial workers. At the present time, inadequate services exist, especially in plants employing 500 or less workers, representing some 62 percent of the working population. The need for industrial health education and training of professional

personnel is general throughout the country. Important work must also be done in treating and caring for workers affected by exposure to toxic substances or other detrimental environments. The development of control and preventive measures for reducing occupational diseases needs attention. Laboratory and field research are also functions which must be maintained and enlarged, since new substances and environments are constantly being developed which may affect the health of exposed workers.

PART II. RECOMMENDATION 1-A

The Technical Committee on Medical Care submits for consideration a program containing five specific recommendations. The first recommendation is concerned with the expansion of present Federal-State programs for public-health work and material and child-welfare services under the Social Security Act.

In view of the fact that a good beginning has been made in more recent years toward carrying out health activities through well-planned and directed effort, the Committee therefore proposes:

Recommendation 1-A: Expansion of the Existing Federal-State Cooperative Program Under Title VI (Public Health Work) of the Social Security Act

It is recommended that Federal participation in State and local health services under title VI be extended through increased authorization for grants-in-aid to the States. Increasing Federal participation and leadership should promote the inauguration and expansion of fundamental and accepted health services and the extension of newly developed services requiring special administrative techniques, under State and local operation and control.

PUBLIC HEALTH ORGANIZATION

The Technical Committee recommends that primary consideration be given to the development of local health organization with special reference to units for counties and large cities, and to the provision in the State and Federal agencies of consultants who are equipped to serve the local departments. Local health services will be directed by full-time health officers who will have as assistants an adequate staff of trained public-health workers. The maintenance of facilities for the training of additional public-health personnel and allied professional workers should continue.

To further the development of a basic health department structure for the Nation, the Committee recommends the addition of not less than \$23,000,000 annually to the amount now available from all sources—Federal, State, and local. This would be utilized largely for providing additional full-time health officers, epidemiologists, public health nurses, sanitary engineers, sanitarians, laboratory technicians, and other personnel.

SPECIFIC PUBLIC HEALTH PROBLEMS

The Committee further recommends that the part of the proposed national health program concerned with the expansion of public

health services under the Social Security Act be directed particularly toward reducing disability and premature mortality from certain important causes of sickness and death, with which public health is already equipped to deal in an effective manner through measures of proven value.

Tuberculosis.—A control program of the kind recommended by health authorities for the eradication of tuberculosis embraces case-finding, especially by X-ray examination of contacts to known cases; isolation and treatment (usually bed-care) of persons with active disease; and periodic observation of those whose disease is latent or quiescent. All of these procedures should be followed in an aggressive manner throughout the United States.

The Technical Committee on Medical Care recommends prevention of the spread of tuberculosis through just such a program of case-finding, directed particularly toward persons in areas of economic need and in age groups among whom the incidence of the disease is high; of providing adequate clinics under the direction of medical specialists for the examination of all cases, especially contact cases; of more extensive hospitalization of incipient cases; of the isolation of open cases; and of follow-up and rehabilitation of arrested cases.

Leadership may be expected of public health agencies, but, first, sufficient funds for defraying the costs of an active campaign must be placed at their disposal. Over and above the amounts specified in Recommendation II for tuberculosis hospital construction and temporary maintenance, the Technical Committee recommends that \$43,000,000 be made available annually from all sources for other elements of the tuberculosis program. Of this amount, \$37,500,000 would be used toward defraying the costs of hospital care for tuberculous patients; the remaining \$5,500,000 would be set aside for case-finding and other field services.

Venereal diseases.—The Technical Committee recommends a gradual increase in Federal, State, and local appropriations for the control of the venereal diseases until a level of \$50,000,000 per annum has been reached. Such a program would be developed along the well-established lines now being pursued.

Pneumonia.—For the development by States of programs for reducing pneumonia mortality, the Committee recommends annual appropriations from all sources amounting to \$22,000,000. One-half of this amount would be available for the purchase of serum; the other half would be used for the support of laboratories, nursing, and other field services. For the provision of serum, however, this estimate deals with the medically needy only.

The extension of typing facilities, the provision of free serum for every case of pneumonia requiring it, as well as adequate medical and nursing care, either in the home or in hospitals, for all persons unable to pay the cost of such services, are inherent in the effectiveness of a pneumonia control program. Such a program should also provide for training of administrative and technical personnel required in its development as an accepted public health activity, and should integrate the efforts of the private physician on whom rests the ultimate responsibility for the success of the program.

Cancer.—The prevention of mortality from cancer necessitates the setting up of diagnostic and treatment centers in sufficient numbers to be accessible for people in all parts of each State. Such facilities

may be organized as new and self-contained units, or they may operate in conjunction with preexisting general hospitals. The latter scheme can be made an important adjunct of a central State hospital. In this way, the resources of the State are made a part of general medical care and incorporated into preexisting facilities. Every cancer center, however, should have certain prerequisites. Among these may be mentioned a medical staff on which is represented the various specialties of medicine associated with the diagnosis and treatment of cancer, a pathological laboratory, X-ray equipment for deep therapy, radium, and hospital beds. Since cancer is a chronic disabling illness that entails high costs for diagnosis and care, it is essential that facilities be financed in very large measure from sources other than patients' fees.

Public clinics are at present totally inadequate to meet the need for the diagnosis of cancer. The Committee recommends the immediate extension of such diagnostic facilities, with modern equipment and operated by trained medical and technical personnel. The development of treatment centers for ambulatory cases requiring periodic application of radium or X-ray therapy is required, as well as the provision of medical and nursing care, either in the home or hospital, for persons unable to purchase such services. Such cases will require supervision after their release from treatment. In addition, a basic plan of lay education, emphasizing the importance of early diagnosis of cancer, should be a part of the general cancer program.

The Technical Committee recommends for the prevention of mortality from cancer, additional appropriations, from Federal, State, and local sources, of \$25,000,000. These funds would not be used for fundamental research, since no duplication of present Federal effort is contemplated in the Committee's program. Provision for an intensive program of cancer research, under Federal leadership, has been made in the National Cancer Act of 1937. The funds recommended by the Committee would be used by the States in the establishment of diagnostic and treatment centers and for assisting in meeting the costs of hospital care. During the early years, expenditures for facilities would be relatively large, but once these had been established, proportionately more could be devoted to the actual care of patients.

Malaria.—The Committee recommends the establishment in State and local health departments, within malarious areas, of definite units that will give particular attention to all the aspects of malaria control. In addition to extending and maintaining drainage systems already begun, a malaria program would embrace a concerted attack on the mosquito and an attempt to eliminate residual parasites in clinical cases and in "carriers" of the infection. Obviously such a program will involve considerable expense. The Committee recommends annual Federal, State, and local appropriations of \$10,000,000 to be expended by health agencies in this field.

Mental hygiene.—Another section of the Committee's report (Recommendation II) contains a program involving Federal assistance toward enlarging institutional facilities for the care of the mentally ill and defective. In addition to supplying needed beds, the funds proposed in Recommendation II should be used to improve diagnostic and treatment facilities. Thus, State institutions will be in a better position than most of them now are to exert influence in a sound program for mental hygiene. It seems only proper that these insti-

tutions should be the agencies through which the program for mental hygiene should be developed. From the viewpoints of economy, efficiency, and practicability, therefore, it is possible to visualize the initiation of a mental hygiene program in the several States with such institutions serving as centers for the provision of necessary services.

In the contemplated program of mental hygiene, provision would be made for voluntary admission of patients for intensive treatment of acute and recoverable forms of mental illness, with a view toward preventing permanent disability and restoring such patients to the community. The proposed mental hygiene centers would also provide clinics for the diagnosis, treatment, and guidance of persons suffering from maladjustments not requiring hospital care. The staff of the center would also provide consultation services to local physicians, health authorities and the courts. The resources of schools, churches, and industry for mass instruction would be used under the guidance of the center to teach the basic principles of mental health.

The development of a field service, extending to surrounding areas, and equipped to provide such diagnostic, consultant, and guidance services would require additional funds for the employment of physicians, auxiliary personnel, and for other expenses of such a service;

Over and above the sums designated in Recommendation II for structural improvements in State institutional facilities for mental disease control, the Committee therefore recommends appropriations for the provision of field programs in mental hygiene. The funds appropriated from all sources should reach the sum of \$10,000,000 as rapidly as possible and should continue annually thereafter.

Industrial hygiene.—Recent developments in organization for industrial hygiene demonstrate what may be accomplished under the leadership of the Federal Government. Prior to January 1936, only 3 States and 1 city had programs for industrial health. The very limited funds available since then through title VI of the Social Security Act have made possible the organization of units in 21 additional State health departments and 3 city health agencies. The plan of development should continue until a unit has been established in every State and in those local health jurisdictions where the problem justifies. Once the basic frame work of organization has been built up, technical personnel, laboratory facilities, and the necessary number of field consultants should be added. An appropriation of not less than \$20,000,000 is needed annually by the health agencies for essential research and for preventive work in the States.

TOTAL COSTS

The estimated maximum annual costs of the expanded programs which have been outlined would be as follows:

| | |
|------------------------------------|--------------|
| 1. Public health organization..... | \$23,000,000 |
| 2. Tuberculosis..... | 43,000,000 |
| 3. Venereal diseases..... | 47,000,000 |
| 4. Pneumonia..... | 22,000,000 |
| 5. Cancer..... | 25,000,000 |
| 6. Malaria..... | 10,000,000 |
| 7. Mental hygiene..... | 10,000,000 |
| 8. Industrial hygiene..... | 20,000,000 |

Total..... 200,000,000

¹ \$3,000,000 already appropriated by the Federal Government for the current Federal fiscal year.

The preceding table showing services needed in addition to those now provided under existing appropriations indicates in each instance the total estimated amounts required from all sources—Federal, State, and local—at the time when the recommended programs would reach their maximum intensity. The Committee wishes to make it clear, however, that the estimated maximum amounts are, to a certain extent, tentative in character. It is difficult to forecast very accurately just how much money would be needed for certain programs at their peak of operation. Much more accurate estimates undoubtedly could be made after opportunity were afforded to see how far the amounts estimated and presented here would go in meeting the specific problems. The Committee does not suggest that the maximum amounts recommended for operation at the peak should be made available during the first year. Before these programs can be organized and placed in operation successfully, the necessary technical and professional personnel must be recruited, additional physical facilities provided, and States and local communities must have time to make additional appropriations.

It should be pointed out here that certain programs with which this section of the report deals provide for some services which would be covered to a considerable extent by programs presented in other parts of the Committee's report. To the extent that costs may be duplicated by provisions in succeeding parts of the whole program, the amounts recommended in this section could be reduced if the funds were provided under the other programs.

While the operation of the programs recommended would call for considerable sums during the years of full operation, it need not be assumed that expenditures for all of the items would have to remain at the maximum level indefinitely. Indeed, should the proposed activities prove as effective as it is believed they would, the costs of maintaining services for the control of certain preventable diseases might be expected to diminish progressively and be greatly reduced in the future as the eradication of these diseases is effected.

Of the total amount recommended in this report for the expansion of preventive health services, it is considered proper that the Federal Government might be expected to contribute approximately half for the country as a whole. However, this should not be interpreted to mean that matching necessarily would be required on a 50-50 basis in each State. The basis for determination of State allotments and requirements set up for matching obviously should take into account such factors as the extent of each problem, the status of financial resources in each State, and other factors that might be given consideration.

It is suggested that in a 10-year program, the probably necessary increases in appropriations by the Federal Government for grants-in-aid to the States and for administration, demonstration, and investigation, exclusive of the expected State and local expenditures, might start at \$10,000,000 for the first year, and gradually increase until a maximum of \$100,000,000 was reached at the beginning of the seventh year.

With respect to the administration of such additional Federal appropriations as might be provided, the Committee is of the opinion that the procedure which now obtains in the administration of Federal funds available for grants to the States under title VI of the Social

Security Act might well serve as a desirable guide for the future. It is proposed that the Federal Government would continue to provide leadership and technical advisory services which it now offers in addition to financial aid to the States. Plans for the work would be initiated in the State health departments. The actual administration and control of activities carried on within the States would remain, very properly, in the hands of the State and local authorities. The chief function of the Federal Government should be that of acting as an equalizing agent among the several States in order to overcome inequality in financial resources and public health problems, to provide the leadership and guidance essential to the successful establishment and maintenance of a properly coordinated, Nation-wide attack on the important causes of disability and mortality in the country as a whole.

EXPANSION OF MATERNAL AND CHILD HEALTH SERVICES

The need for an expanded program of maternal and child health services has been pointed out by the Technical Committee on Medical Care in its report to the Interdepartmental Committee. It is the opinion of the Committee that in any plan for a national health program, primary consideration must be given to developing adequate provision for maternity care and for safeguarding the health and growth of the Nation's children.

Since the first grants to the States for maternal and child health under the Social Security Act became available in 1936, the public health agency in every State, the District of Columbia, Alaska, and Hawaii has strengthened and extended its maternal and child health program. Our two and a half years' experience with this program and with Federal grants to the States for services for crippled children has made us aware of where these activities fall short and has given us a basis of administrative experience on which we can plan for needed expansion.

The most serious deficiency in the present maternal and child health program is lack of provision for medical care for mothers and children who are so situated that they cannot obtain needed care without some form of assistance from the community.

The advances that have been made in scientific knowledge and professional skill in conserving the lives and health of mothers and children place upon us the obligation to find the ways and means whereby the whole population can benefit from this knowledge and skill.

PART I. EVIDENCES OF NEED FOR AN EXPANDED PROGRAM

SPECIAL NEEDS OF MATERNITY AND INFANCY

The health and security of children depend to a great extent on the life and health of the mother.

Each year a birth occurs in the households of 2,000,000 families in the United States, an event, the cost of which must be rated in the category of major medical expenditures. To society the outcome of these 2,000,000 births in terms of the survival and health of the mother and child is of sufficient significance to warrant the provision by government of facilities to insure the best possible care for all who are unable to provide it from their own resources.

Today there is a great and unnecessary wastage of maternal and infant life, and impairment of health is widespread among mothers and children.

Each year about 14,000 women die from causes connected with pregnancy and childbirth; about 75,000 infants are stillborn; nearly 70,000 infants die in the first month of life, four-fifths from causes associated with prenatal life or the process of birth; and at least 35,000 children are left motherless. Physicians estimate on the basis of experience that from one-half to two-thirds of the maternal deaths are preventable; that the stillbirth rate can be reduced possibly by two-fifths; and that the deaths of newborn infants can be reduced at least one-third and probably one-half. This would mean the saving each year of more than 70,000 lives.

The maternal mortality rate in the United States is high, and there has been but slight decline during the 22 years for which we have records. In 1936, the rate was 57 deaths per 10,000 live births. Rates varied widely in different States, from 40 in New Jersey and Rhode Island to 91 in Arizona and 90 in South Carolina. In individual counties, the range was even wider, from no maternal deaths at all for a 5-year period to rates of more than 200 per 10,000 live births. It is well recognized that major reductions in deaths from toxemias of pregnancy and from sepsis associated with delivery could be made at once if facilities for proper prenatal and delivery care were to be made universally available. These two causes together account for nearly two-thirds of all maternal deaths. Where proper facilities have been made available, the maternal death rate has been reduced to about one-half that of the country at large.

In the death rate of infants under one month of age, there has been but slight decline during the 22 years of record, and no decline in the death rate on the first day of life. These deaths are closely associated with the problems of maternity care and, as in the case of stillbirths, reduction in rate should result from more skillful care. Nearly one-half of all deaths in the first month of life are among prematurely born infants. With proper care of the mothers, many premature births could be prevented, and with proper care of the infants, a larger proportion could be saved.

Notwithstanding the progress that has been made in reducing infant mortality in the first year of life, there are still each year some 53,000 deaths of infants in the second to the twelfth month of life. That these deaths are closely associated with economic conditions is too well known to need discussion. In spite of great gains, there are still areas of the country and special groups in which the mortality in this age group is practically as high today as it was for the country as a whole 20 years ago. Since 1929, infant mortality in rural areas has been higher than in cities. If preventive measures so successfully applied in many places can be made available in all cities and rural areas, they should bring a further reduction in our infant mortality.

A few salient facts will indicate the inadequacy of present provisions for maternal and infant care. Recent studies have shown that many women receive no prenatal care or inadequate care. In 1936 nearly a quarter of a million women did not have the advantage of a physician's care at the time of delivery. In 1936 only 14 percent of the births in rural areas occurred in a hospital, as contrasted with 71 percent in cities. For the great majority of the 1,000,000 births

attended each year in the home by a physician, there is no qualified nurse to aid in caring for the mother and baby.

Although progress is being made under the Social Security Act in developing maternal and child health services, there are still about 1,000 counties in which no public health nurse is employed to serve rural areas. In some rural areas one nurse must serve a population of as many as 25,000 or more, whereas in cities she serves, on the average, a population of about 5,000. Such a nurse is one of the first essentials of an educational maternal and child health program. She should also be available to aid the mother at time of delivery, but funds have not been sufficient to provide nursing care at delivery or medical care, except to a limited extent on an experimental basis.

It is estimated that more than 1,100,000 births occur each year in families that are on relief or have total incomes (including home produce on farms) of less than \$1,000. Health officers report that many expectant mothers, because of lack of funds, go without proper prenatal care or hospital care and do not seek the services of a physician until too late to save them from serious illness or death.

In most communities resources are limited for providing medical, nursing, and hospital care at the time of childbirth. Certain communities, mostly urban, have provided a physician's care and hospital care through public or private effort, but there has, heretofore, been no planning on a national scale to make medical and nursing care at the time of delivery available, either in the home or in the hospital, for mothers in families that cannot provide such care unaided.

SPECIAL NEEDS OF CHILDREN

The increasing proportion of persons in the older age periods has been accompanied by a decline in the proportion of children in the population. The conservation of child life is, therefore, imperative as a measure for maintaining in the future the proportion of people in the productive ages necessary to an economically productive nation.

During childhood, exclusive of the first year, the probability of dying is less than in adult life, but the probability of being sick is greater than that for adults. Although the average duration of illness is less than in later years, such illnesses often result in protracted or permanent disability. In the recent National Health Survey in 83 cities it was found that of all children under 15 years of age having illnesses that disabled them for 7 days or more, 28 percent had had neither a physician's care nor hospital care. The proportion going without such care was largest among children in families with incomes of less than \$1,000 a year but not on relief (33 percent), larger even than among children in families on relief (29 percent).

In the period 1934-36, on the average, 14,000 children under 15 years of age died annually from whooping cough, measles, diphtheria, and scarlet fever; 35,000 from pneumonia and influenza; 19,000 from diarrhea, enteritis, and dysentery; 15,000 from accidents; 4,000 from cardiac conditions largely rheumatic; and 4,000 from tuberculosis—an average annual total of 91,000 deaths. These figures represent only a small proportion of the total number of children who are affected by these conditions and who, though they recover, may have suffered permanent injury to their health. The proportion of deaths that are preventable is not known, but there is no doubt that many

deaths and much subsequent ill health could be prevented by such measures as more adequate control of communicable disease, protection of the milk supply, and systematic health supervision, and by early diagnosis and prompt treatment of conditions and diseases that, without such treatment, tend to become serious or chronic.

In addition, there occur also in childhood many relatively minor conditions that interfere with growth and development or with the general health of the child. Prompt treatment of these is often as important in preventing future disability as is the treatment of more serious diseases.

Child health centers and clinics, to which parents, otherwise unable to obtain service, may take their children for health supervision or for diagnosis and treatment, are still lacking or are insufficient in numbers in many areas. Reports from 43 States show that in 1937 there were approximately 6,000 child health centers serving 734 counties, towns, or other local units in rural areas. About two-thirds of the rural areas of the country are not yet provided with such centers.

It is estimated that over 6 children in every 1,000 of the population under 21 years of age are crippled or seriously handicapped by disease or conditions such as poliomyelitis, tuberculosis, birth injuries, injuries due to accidents, and congenital deformities, who may be benefited or entirely cured with proper treatment. It is estimated that in the northern parts of the country at least 1 percent of school children have rheumatic heart disease, a condition largely remediable with prolonged care. Approximately 30 percent of all children under 15 years of age have defective vision due to refractive errors. Approximately 5 percent of school children have impaired hearing. Approximately two-thirds of all school children have dental defects. Wide-spread inadequacy of nutrition is responsible for many cases of the deficiency diseases in children, for increased severity of much illness, and for retardation in recovery.

Great progress has been made under the crippled children provisions of the Social Security Act in making available orthopedic and plastic surgical service, hospitalization, and after-care. There is need of further provision, however, for children crippled or handicapped from heart disease, diabetes, congenital syphilis, injury due to accident, and other conditions that require prolonged care to insure recovery or restoration leading to self-support. The need of facilities for hospital or convalescent care of children with early rheumatic heart disease is particularly urgent in the northern parts of the country. There is great need for discovering early, children with defects of vision and of hearing, and those with dental defects and for providing proper treatment to prevent and to remedy serious impairment.

When it is realized that 13,000,000 of the 35,000,000 children under 15 years of age in the United States are in families with incomes of less than \$800 a year or on relief, it becomes apparent that such families are able to pay but little toward the medical care necessary to meet their children's needs and that the problem of providing sufficient care must be the concern of government through health and welfare authorities. The provision of social services as a basic component part of a strong, well-coordinated health program is essential. Medical care is more adequate and more economical when provision is made for discovery and for assistance in overcoming the adverse social factors related to disease or disability. The relation of

measures directed toward the improvement of the economic basis for family life to those for the prevention and control of diseases and disability is obvious.

THE NEED FOR CONSULTATION SERVICE

The general practitioner gives, and will continue to give, the largest amount of medical service to mothers and children.

However, for dealing with many conditions of maternity, for diagnosing and treating many diseases of childhood, and for guiding development of effective preventive measures in a community, the general practitioner frequently needs to consult with a specialist in obstetrics or in pediatrics. There are many areas in the United States where such specialists are not available or are so inaccessible that the cost of consultation service is prohibitive. A few State agencies provide for a limited obstetric consultation service, but in most States such service is not available through public resources. Hospitals with special services for children are not well distributed geographically so as to be available for diagnosis and treatment of children in difficult cases. Well-equipped diagnostic centers strategically situated would fill a great need.

THE PROBLEM IS NATIONAL

In attempting to plan for more adequate provision of maternal and child health services, certain facts must be considered concerning the distribution of children among the several States and geographic areas, especially as it may be compared with the distribution of adults in the productive age groups who must support the children, the national income, facilities for care now available, and such indexes of adequacy of care as infant mortality.

The ratio of births or of children under 15 to the adult population which must support them and the financial resources available for their support vary to a considerable extent in the different States. For instance, 12 States in the Northeast and the District of Columbia, caring for 29 percent of the Nation's children, receive 41 percent of the national income; whereas, 11 States in the Southeast, caring for 25 percent of the children, receive only 12 percent of the national income. Adults of productive age living on farms must support nearly twice as many children proportionately as do adults of the same age groups in the largest cities. And yet it is in the rural areas and in States receiving the smallest proportion of the national income that the infant and maternal mortality rates remain high and the facilities for care are least adequate. Any plan for extending and improving maternal and child-health services must take into consideration these facts.

PART II. RECOMMENDATION I-B

With respect to expansion of the maternal and child health program, the Technical Committee made the following recommendations to the Interdepartmental Committee. In presenting its report, the Committee expressed the opinion that the recommendations relative to maternity care and medical care of children, as well as those for general public health services, should be given special emphasis and priority in any consideration of a national health program more limited in scope than that outlined in the complete series of recommendations.

Recommendation I-B: Expansion of the existing Federal-State cooperative program for maternal and child welfare services under title V, parts 1 and 2, of the Social Security Act

EXPANSION UNDER SOCIAL SECURITY ACT, TITLE V, PART I—MATERNAL AND CHILD HEALTH

It is recommended that Federal participation in maternal and child health services under title V, part 1, of the Social Security Act be extended through increased authorization for appropriation for grants-in-aid to States over and above the \$3 800,000 now available each year. Increasing Federal participation should allow for a program to provide facilities for care in two general areas: (a) Medical and nursing care of mothers throughout the period of maternity and of their newborn infants throughout the neonatal period; and (b) health supervision and medical care of children.

A plan of orderly expansion during the next few years, which is compatible with sound administration, and a reasonable program for training personnel, follows. It assumes (1) a gradual development of the program of maternity care and care of newborn infants with a view to reaching the maximum Federal contribution as soon as may be possible, but at least not later than the tenth year, and (2) a gradual approach to a general program of health supervision and medical care for children, which would not reach desirable proportions until the full medical care program contemplated in Recommendation III or IV is in effect. Administrative procedure would be designed to allow for continued expansion of the program of health supervision and medical care of children under title V, and for cooperation with other plans which may develop for medical care.

Plan of expansion.—Fundamental to the expansion of the program for maternity care and medical care of children is further increase in the basic local health services, including health supervision of pregnant women and of infants and preschool children by local physicians, public health nursing services, health supervision of school children, and the services of dentists, nutritionists, health educators, and medical social workers.

Expansion and improvement of the program should be along three lines:

1. Expansion of facilities for conservation of health of mothers and their newborn infants should provide for—

Medical care of mothers and their newborn infants throughout the period of maternity and the neonatal period, including care of the mothers at delivery in the home or in hospital, and of their newborn infants, by qualified local physicians with the aid of specialized consultants, assisted by nurses, preferably public health nurses, trained in obstetric nursing procedure.

Facilities for expert diagnosis and care in diagnostic or consultation centers and in the home.

Hospital care as necessary for medical, social, or economic reasons.

2. Expansion of facilities for the conservation of the health of children should provide for—

Health supervision, medical care, and, when necessary, hospitalization of older infants and children—the health supervision and medical care to be provided by qualified local physicians, with the aid of spe-

cialized consultants in local consultation or diagnostic centers, or elsewhere when the ill child cannot be brought to the center.

3. Increased opportunities for postgraduate training of professional personnel—medical, nursing, and medical-social—will be essential in order to provide qualified personnel to carry out the program. Additional centers for such training, especially for postgraduate instruction, would have to be established.

Estimates of cost of proposed program.—To provide for such an expanding program, authorization for increased appropriations for grants-in-aid to States under title V, part 1, of the Social Security Act, would be necessary. Estimates of cost of care and of the amounts to be authorized for appropriation by the Federal Government have been made (1) for maternity care and care of newborn infants, and (2) for health supervision and medical care of children. The estimates for (1) maternity care are based on the needs of families on relief or with incomes (including home produce on farms) of less than \$1,000 a year. There are in these families approximately 1,100,000 births annually (live births and stillbirths). The estimates for (2) care of children are based on the number of children under 16 years of age in that third of the population in need of financial assistance in obtaining basic health and medical services, approximately 13,000,000.

Estimates for maternity care and care of newborn infants: Estimates have been prepared including cost of (1) medical, nursing, and hospital care; (2) development and maintenance of 10,000 additional maternal and child health consultation centers to serve smaller cities, towns, and rural areas; (3) development of centers for postgraduate education of physicians, nurses, medical-social workers; and (4) Federal and State administration.

The total cost to Federal, State, and local governments for maternity care and care of newborn infants in families at the income levels specified, is estimated to be approximately \$95,000,000. Maximum Federal participation, including cost of administration, demonstration, and investigation, is estimated to be approximately \$47,500,000. It is recommended that for the first year of the expanding program authorization for appropriation under title V, part 1, of the Social Security Act, be increased for maternity care and care of infants by approximately \$4,500,000. Further increases would depend on the rate of expansion of the program, but it is estimated that an appropriation by the Federal Government of not less than \$25,000,000 should be reached by the fifth year and the full amount in at least 10 years.

Estimates for health supervision and medical care of children: The unit cost of providing a minimum of essential medical services for children is estimated to be, on the average, \$10 per child per year; it is recognized, of course, that in individual cases the actual expenditures would vary from much less to much more than this average figure. The average cost is intended to include increased facilities for health supervision by local physicians and public health nurses, minimum essential services of general practitioners and specialists for the care of sick children, necessary medical social services, hospitalization, and other types of special services in minimum amounts. This estimate is supplementary to the sums now being spent for medical care of children by individual families with low incomes or by communities, and represents about half the cost of reasonably adequate services such as are contemplated under Recommendation IV.

The over-all cost of providing medical care at this rate to the 13,000,000 children under 16 years of age in the third of the population in need of financial assistance in obtaining basic health and medical services would be approximately \$130,000,000 a year.

To make available at this time a portion of this amount in connection with the program of health supervision of infants and children under title V, part 1, it is recommended that sums to provide for a gradually expanding program under this title be authorized for appropriation by the Federal Government. For the first year of the program it is estimated that an authorization for appropriation of \$3,000,000 would be needed. Annual increases thereafter would depend on the rate of expansion of the program, but it is estimated that an appropriation by the Federal Government of not less than \$15,000,000 should be reached by the fifth year and not less than \$30,000,000 at least by the tenth year. It is recognized that these amounts are considerably less than the full amounts needed for a complete program. However, the difference would be reduced by the provisions of Recommendations II and III, which would supplement the recommendations submitted here.

EXPANSION UNDER SOCIAL SECURITY ACT, TITLE V, PART 2—SERVICES FOR CRIPPLED CHILDREN

It is recommended that Federal participation in services for crippled children under title V, part 2, of the Social Security Act be extended through increased authorization for appropriations for grants-in-aid to States over and above the \$2,850,000 now available each year for the purpose of meeting the needs of additional children who by reason of serious physical handicap require prolonged care of the kind already provided under existing programs. Increasing Federal participation should allow for an expansion of program as follows:

Increased facilities for orthopedic and plastic services for the care of children who are crippled or suffering from conditions that lead to crippling from diseases of bones, joints, or muscles.

Increased facilities for care of children who are suffering from heart disease, injury due to birth or accident, or other diseases or conditions that require prolonged care to insure recovery or restoration leading to self-support.

This program should be closely related to the proposed expanding program of general health and medical services to children under part 1 of title V, and should be directed toward the care of children whose physical needs or social needs arising out of their physical condition require especially intensive service. For the first year of the expanded program it is estimated that authorization for an additional appropriation of Federal funds of \$2,000,000 would be needed and that an amount of not less than \$5,000,000 would be needed by the fifth year. The amounts required after that period would be determined on the basis of experience.

FEDERAL PARTICIPATION AND PARTICIPATION BY STATES AND LOCAL COMMUNITIES

The first few years of expansion of the programs for maternity care and health conservation and medical care of children and services for crippled children may be expected to be a period of development

and equalization of services and, therefore, one in which Federal financial participation would be relatively large, supplementing present expenditures by the States or local communities. Increasing financial participation by the States would be encouraged. In determining the extent to which each State would be eligible for Federal aid, account would be taken of (1) the ability of States to provide for support of necessary services, and (2) the need for maternal and child care as shown by mortality and morbidity rates, present facilities for care of mothers and children, personnel in need of training and facilities for training, and the need for services for crippled children as shown by the number of such children in need of care and the cost of providing care.

SUMMARY

The opportunity is before us to make a major gain in our provision for the health of mothers and children. The proposed program calls for extension of our health services into all parts of the United States, for an expansion of the program to fill gaps in existing services, for more adequate facilities for training professional workers, and for cooperation of public agencies with the medical, dental, nursing, and social service professions to make sure that medical and related services are available to mothers and children of all income groups and in all parts of the United States.

The proposed program contemplates during the first year an increased expenditure by the Federal Government through grants to States as follows:

| | |
|---|-------------|
| Maternity care and care of newborn infants..... | \$4,500,000 |
| Medical care of children..... | 3,000,000 |
| Services for crippled children..... | 2,000,000 |

During succeeding years, the program would be expanded gradually, reaching at least by the tenth year a proposed Federal expenditure of \$47,500,000 for maternity care and care of newborn infants, \$30,000,-000 for medical care of children, and \$5,000,000 for services to crippled children.

HOSPITAL FACILITIES

PART I. STATUS AND NEED OF HOSPITAL FACILITIES

No scheme for promoting the Nation's health can be considered complete or wholly effective that does not give due consideration to hospitals. The growing importance of these institutions arises from a variety of causes. Chief among these is the fact that the home and the family structure are less suited to the needs of the sick than they were even a generation ago. As medicine advances scientifically, the facilities represented by a hospital become more essential for accurate diagnosis and proper care. Every indication suggests that this trend will continue and perhaps at an accelerating rate. While general statements such as these apply to all hospitals, a special set of circumstances with respect to status and need is associated with hospitals of separate categories. Sufficient definition of these points is attained by classifying hospitals according to three medical types: General, tuberculosis, and mental. Because Federal hospitals admit selected beneficiaries drawn from the Nation as a whole, they have been omitted from the estimates of needs since this report is a discussion of community facilities that may be assigned in some measure to population groups.

GENERAL HOSPITALS

The growth of general hospitals in this country has been closely related to advances in surgery. In the main, their development may be credited to charitable impulse and to private enterprise. According to returns of 1937, general hospitals which meet the registration requirements of the American Medical Association number about 4,500. Slightly more than half of these are operated by corporations not organized for profit, roughly one-third are proprietary and conducted without restriction as to the use of income, while State and local governments participate to the extent of about 15 percent as operating agents. These proportions change somewhat when facilities are computed on the basis of beds, since Government hospitals tend to be large, nonprofit of medium size, and the proprietary very small. The 410,000 beds in general hospitals are distributed by control as follows: About 27 percent are in hospitals of State and local governments, 62 percent in nonprofit hospitals, and about 11 percent are in proprietarily owned hospitals.

Source of income.—Closely allied to control of hospitals is their source of income. Governmental hospitals, as one might expect, are supported mainly through taxation; on the other hand, fees collected directly from patients furnish 70 percent of the income for nonprofit hospitals, and for the proprietary group, more than 90 percent. Endowments produce about 6 percent of the income for nonprofit hospitals and they obtain in gifts an amount of perhaps the same magnitude, but income from these sources is negligible for the proprietary group. Payments made by governments to nonprofit and proprietary hospitals for the care of public charges were larger in 1935 than the total of all private gifts. Thus, one may observe that most of the free and part-pay service of voluntary hospitals must be accomplished by passing the costs on to patients who, through payment of over-charges, create the necessary reserve. Individual hospitals, particularly in large cities, may constitute an exception to this general rule.

Distribution.—The general hospital is predominantly an institution of population centers. Among the counties of the United States, 1,338, or over 40 percent, do not contain a registered general hospital. True, most of these counties are not populous, yet nearly one-third of them have 15,000 or more inhabitants; and in the aggregate, counties without hospitals contain about 17,000,000 people. Remoteness from metropolitan centers, a very small percentage of urban population, and low tax income also characterize the counties without hospitals.

The ratio of beds per 1,000 population exceeds 5.2 in 23 of the large city-counties having more than 200,000 inhabitants and averages 4.9 for all of the counties of this type, the population of which totals 47,000,000 persons. When hospital facilities according to States are related to the combined population residing in areas designated as metropolitan in character by the United States Census Bureau, together with counties immediately adjacent thereto, it is found that hospital facilities exceed 4.7 beds per 1,000 persons in such areas for 25 percent of the States. In the areas beyond these metropolitan counties 3.1 beds or more per 1,000 are found in 25 percent of the States. Voluntary hospitals, be it recalled, are predominant among those of general medical type. Therefore it is to be expected that

economic opportunities must have had greater weight than social needs in determining the present distribution of hospitals with respect to population.

Self-evident, though often overlooked, is the fact that mere presence of a hospital in a county or one adjoining may have little meaning to underprivileged people unless funds for meeting the costs of service are assured. Previously, it was stated that proprietary hospitals subsist almost exclusively on fees collected directly from patients, and those classed as nonprofit derived more than 70 percent of their income from this source, and that governmental hospitals are as a class supported through taxation. On combining location with ownership, the data indicate very clearly that general hospital service is not available to a very large segment of the population either through faulty location of the hospital or because the potential patient is unable to purchase service. Specifically, the data at hand show that among the 1,737 counties with local general hospitals, 519 have nothing but proprietary institutions; 786 are served by nonprofit hospitals alone or in conjunction with those proprietarily owned; and only 432 counties contain local tax-supported facilities.

The counties with city-county institutions represent a total population of about 59,000,000, which is largely urban in character. Other checks such as per capita expenditures by governments for hospitalization, and days of care reported by representative samples of population emphasize over again that people of low income obtain little hospital service except in areas having a reasonable proportion of tax-supported or endowed beds. In the smaller towns and rural areas, admission of the poor to bed care usually signifies an acute emergency necessitating surgical intervention. Exceptions to this statement are found in a few counties where governmental general hospitals, and in a few States where State-supported general hospitals meet a part of the need.

The amount of chronic disease and the need and economy of adequate care has been demonstrated by the National Health Survey. Some chronic patients require diagnostic and treatment services equivalent to those of an acute hospital case; others need only skilled nursing or custodial care after their condition has been diagnosed.

Use of hospital facilities.—The average daily census of patients in general hospitals is equivalent to 70 percent of the bed capacity. Broadly speaking, the facilities of large and medium-sized capacity are utilized more fully than those of small. Average occupancy of beds is less than 50 percent of full capacity in those hospitals that depend for revenue on payments by patients, while the great majority of tax-supported beds approach full utilization. At certain seasons of the year, many tax-supported hospitals experience overcrowded conditions. In the range between these extremes, occupancy of hospital beds is inversely related to the percentage of income that is derived from patients. The proportion of hospital income that is obtained from different sources may therefore be used as a measure of their ability to serve different economic groups in the population. Obviously the economic barrier between need and service must work its greatest hardship in those areas where no provisions are made in the scheme of hospital finance for necessitous persons.

Stability of hospitals.—Another point bearing on service for a community is the assurance of uninterrupted hospital operation. In

relation to this point, the data show continuity of existence during the study period (1928-38) for 83 percent of government hospitals, 73 percent of hospitals classed as church and corporation, and 37 percent of those operated by individuals and partners. It is impossible to separate the effects of management from finance on this behavior, since the two are so intimately tied together. Sufficient is the observation that the constant needs of illness cannot be met by such ephemeral institutions as the proprietary group.

TUBERCULOSIS SANATORIA

In that section of the Technical Committee's report entitled "Expansion of General Public Health Services," recommendations are made with respect to case-finding procedures and grants-in-aid for bed care of the tuberculous. Therein it was also contemplated that the sanatorium should take a vital part in an integrated program for control of the disease. This scheme of health organization is not possible for many sections of the United States because the institutions do not exist or they lack resources in the way of personnel and funds.

Existing facilities.—Facilities for the United States as a whole are represented by 65,000 sanatorium beds and 22,000 beds set apart for the care of the tuberculous in hospitals of other types. Of the beds in sanatoria proper, 80 percent are operated by State and local governments and 20 percent by nonprofit and proprietary agencies. The great majority of those beds not in sanatoria also are under governmental control. More than half of them are attached to institutional infirmaries and therefore are not available for a general control program.

Source of support and use of tuberculosis facilities.—As in the case of general hospitals, source of financial support is the main factor determining the extent to which available beds are used. For example, occupancy of beds rises to 92 percent of capacity where less than 10 percent of the cost is defrayed through fees collected from patients; and it falls to 67 percent when patients furnish more than 90 percent of the revenue. Bed care in tax-supported institutions, as a rule, is furnished without cost to the patient, while the opposite financial arrangement obtains in private sanatoria, except for a fairly significant proportion of persons that are maintained there at public expense. Since such a small proportion of patients meets the costs of their care, financial barriers that commonly exist between patients and medical service offer no great handicap to reasonably full use of existing facilities for bed care of the tuberculous. The immediate need, insofar as institutional care may be concerned, is for increasing the existing number of beds.

MENTAL INSTITUTIONS

For all practical purposes, institutional care of persons with mental disorders may be regarded as a monopoly of State and local governments. Together they operate 509,000 beds or about 96 percent of the total in mental hospitals. The State government being the principal operating agency, institutions are large and service is organized on a State-wide basis. While it is true that there are 52 institutions of nonprofit and 182 of proprietary classification, these

places maintain only 4 percent of the beds. Furthermore, private institutions serve in particular the well-to-do.

Data which describe the manifest demands on facilities for mental patients are found in the percentage of occupancy reported by hospitals under the various types of control. The median, or middle, nonprofit hospital reported 80 percent of all available beds in use, while 63 percent of the beds were occupied in the median proprietary hospital. Tax-supported mental hospitals reported crowded conditions. In the median hospital, under State control, 96 percent of all beds were utilized, while an occupancy of 94 percent was reported by the median city or county hospital. Governmental hospitals for persons with mental disorders may be characterized as follows: They are large and they are fully occupied. Nongovernmental hospitals on the other hand, are small and less completely filled.

FUNCTIONS OTHER THAN BED CARE

Out-patient services.—Ambulatory sick in any community exceed in number those requiring bed care. The hospital out-patient department, commonly spoken of as the free dispensary, is a device that has demonstrated many advantages for meeting the needs of the sick poor who are able to come to some fixed point. Aside from lowered service costs that accrue from volume of work, the clinic brings together specialists representing various branches of medicine at a place where they have access to laboratory services, X-ray, and similar aids to diagnosis and therapy. Since hospital out-patient departments may be utilized in carrying out Recommendation III (Medical care for the medically needy), this type of facility should be considered in any scheme of hospital organization. At the present time out-patient departments are not sufficiently numerous or widespread to afford a basis of operation.

By using organized out-patient departments of general hospitals as a measure of resources, both the deficiency and the uneven distribution of such units become even more apparent than was the case for hospital beds. According to available information, there are some 770 organized out-patient departments that operate in connection with general hospitals. About 35 percent of government hospitals and 20 percent of nonprofit hospitals afford this type of service for the destitute and very low-income groups of the population. Clearly defined departments of this type do not seem to be a feature of proprietary hospitals. Even more than hospitals, general out-patient departments are institutions peculiar to large cities. Each of the cities above 250,000 population reports one or more out-patient departments, while only 2 percent of cities below 10,000 have such resources. It is not until cities reach 50,000 that more than half of them are provided with this type of service.

As a general rule, mental and tuberculosis hospitals are not so situated that organized out-patient departments can become a regular feature of their service. Services for patients of these types are more frequently associated with general hospitals. In all, 145 out-patient departments reported psychiatric clinic divisions, and of these, 115 were associated with general hospitals. Similarly, of the 201 departments reporting tuberculosis clinic divisions, 140 had general hospital sponsorship.

Development through hospitals of service for the ambulatory sick is contemplated in the proposed program of hospital development. In some instances, the arrangement can be quite informal, involving little more than the use of regular hospital equipment. Where the problem of caring for dependent and medically needy persons is of sufficient magnitude, an out-patient department should become a definite unit in the hospital organization. For areas remote from hospitals, it will be necessary to develop centers with special equipment for diagnosis and treatment. Such facilities may be used jointly by the practicing physician and the public health agencies.

Influence on medical practice.—Over and above the bed care and the ambulatory service commonly associated with hospitals, many students of administrative medicine conceive of the hospital as having in its own right a reputation and a body of traditions—in other words, an institution with a personality. The Committee believes it is feasible, through proper equipment and staff arrangement, for hospitals to become institutions for elevating medical practice and for extending various types of care to all groups of the population.

PART II. RECOMMENDATION II

From the foregoing facts and from others that might be adduced, one should readily perceive that there are deficiencies in the present scheme of organization which serve to limit the usefulness of hospitals to patients and circumscribe their influence on medical practice. These deficiencies include insufficient number of institutions and beds, improper location, incomplete services, and inadequacy of financial support; they apply in varying combinations to hospitals of different classification. In some degree, recommendations submitted by the Technical Committee regarding public support of hospital care for necessitous persons will bring about greater use for existing facilities. Such action alone would be only a half-way measure; further construction, additions to equipment, extension of services, and broadening of the basis for financial support are indicated. To this end, the Technical Committee submits—

Recommendation II: Federal grants-in-aid for the construction of needed hospitals and similar facilities, and special grants on a diminishing basis towards defraying the operating costs of these new institutions in the first 3 years of their existence

EXPANSION OF GENERAL HOSPITALS

Since the demand for service in general hospitals is conditioned so largely by ability of patients to pay, local experience with respect to use may not always be taken as a reliable measure of need. This is particularly true of rural areas since there so large a percentage of the beds are supported by fees from patients. For urban areas, especially the populous ones, beds in more reasonable proportions are free or obtainable at less than maintenance cost; there the ratio of beds may run as high as 9.5 per 1,000 population, while for the median city-county containing more than 200,000 inhabitants, the ratio is 4.3 per 1,000 population.

Again taking for a base metropolitan areas as designated by the United States Census Bureau plus counties immediately adjacent,

the average ratio is 4.1 per 1,000 population. Despite the financial restrictions which now limit hospital utilization, 72,000,000 people residing in such trade areas have seen fit to establish average facilities approaching the standard of adequacy so frequently set by professional judgment, namely, 4.5 hospital beds per 1,000 population.

Bed accommodations also vary with States from 1.26 to 5.5 per 1,000 population, with a figure of 3.1 representing the median State. To bring all State averages up to 4.5 will require the addition of 180,000 beds. Some of these beds would be added to existing hospitals, but most of them would call for new units to be located in areas now without hospitals or having hospitals whose physical or financial deficiencies preclude their becoming true community institutions. There is need for at least 500 hospitals in areas largely rural in character. Those hospitals would be primarily small (30 to 60 bed) institutions. The large number of beds needed for chronic patients should usually be provided in association with general hospitals.

EXPANSION OF TUBERCULOSIS SANATORIUM FACILITIES

By following the generally accepted measure of institutional accommodations, namely, beds per annual death, one finds that the ratio for the United States as a whole is 1.15. Ratios for individual States vary from 2.75 down to 0.20; only 5 States have two or more beds per annual death, while in 26 States this figure is less than one. Nine States do not make legal provision for sanatoria; five of these subsidize care at local institutions, but in four States no State-wide provisions are made for hospitalizing patients. Clinical experience has demonstrated that two beds per annual tuberculosis death are required for hospitalization of the tuberculous in areas having a reasonably aggressive case-finding program. To bring facilities of the whole country up to this standard after allowing for a continuing reduction in number of deaths would require the addition of approximately 50,000 beds. Some of these beds may be incorporated into existing general hospitals and sanatoria, but in several States entirely new institutions should be established.

EXPANSION OF MENTAL INSTITUTION FACILITIES

The ratio of beds to population varies with the States from 6.88 down to 1.96. The State represented by the upper quartile has 4.8 beds per 1,000, while 3.86 beds expresses the median State. States on the upper 25 percent performance level contain about one-fourth of the total population of the United States. While no absolute figure in beds can be taken to express the needs for institutional accommodations, there is every reason to suppose that provisions already made by States in the upper 25 percent group are not in excess of actual demand as shown by occupancy in excess of rated capacity. The lower figure for this group, namely, 4.8 beds, may, therefore, be taken as a reasonable standard that is amply supported by experience.

To bring the ratios of beds to population in all States up to this standard of 4.8 would require the addition of 130,000 beds to existing accommodations. Most of these new beds would serve to augment facilities especially of those States now having insufficient accommodations. Existing institutions might be enlarged or new units could be established as local circumstances warrant.

TEMPORARY, 5-YEAR, MAINTENANCE GRANTS

Attention is here directed to the financial need of newly constructed hospital accommodations of the several classes—general, mental, and tuberculosis. Since most of these beds are to be placed in areas of low wealth, States and local communities might encounter some difficulty in taking over rapidly the added financial burden. A special program is therefore contemplated to provide Federal grants-in-aid for the maintenance of new institutions or additional beds during the first three years of their operation.

ESTIMATED COSTS FOR CONSTRUCTION

General hospitals and diagnostic centers.—When computed on the basis of \$3,500 per bed, exclusive of land value, the construction costs of general hospitals, aggregating 180,000 beds, entails an outlay of not less than \$630,000,000, of which approximately \$60,000,000 would be for rural hospitals. In remote rural areas, not readily accessible to a hospital center, provision should be made for the construction of health and diagnostic centers to serve both the practicing physicians and the public health agencies. As an initial development, not less than 500 such centers should be contemplated, entailing a gross expenditure of, roughly, \$15,000,000.

Tuberculosis hospitals.—By assuming an average cost per bed of \$3,000, the total expenditure thus incurred for construction of 50,000 beds would be in the neighborhood of \$150,000,000.

Mental institutions.—The erection of mental hospitals to accommodate 130,000 beds costing \$2,500 each would necessitate a total outlay of about \$325,000,000.

On the construction program as outlined above, the Committee recommends Federal grants-in-aid equivalent to 50 percent of the construction costs as estimated above, thus entailing a total outlay of \$552,250,000 on the part of the Federal Government.

ESTIMATED COSTS OF TEMPORARY MAINTENANCE GRANTS

Recommended Federal grants are computed on a basis of \$300 per bed per annum for general and tuberculosis hospitals and \$150 for mental institutions. The aggregate for the Nation as a whole is not to exceed 50 percent of the actual patient-day costs, with curtailment stipulated at each year so as to disappear after 3 years.

If all the hospital construction outlined above were undertaken, these special maintenance grants would involve a maximum total Federal cost of about \$177,000,000, distributed over a period of years beginning with the completion of the first hospital and ending 3 years after the completion of the last institution built under the program.

SUMMARY

The Technical Committee finds hospital accommodations and the scheme of organization ill-adapted to the varying needs of people living under different social, economic, and geographic circumstances. In hospitals offering general care, the percentage of beds that must be supported through fees from patients is out of proportion to the income distribution of the population, hence many of these full-pay beds are empty a large part of the time. Conversely, there are too

few low-cost and free beds to satisfy needs; those already provided are concentrated in centers of wealth and population. Some 1,300 counties have no hospitals, another 520 contain one or more small proprietary institutions only; and 423 counties have local tax-supported facilities. In this combination of circumstances can be found reasons why the rich and the poor of large cities secure proportionately more service than those of moderate means; why rural people generally have less hospital care than those residing in large cities; and why admission of the poor to hospital beds in rural areas and the smaller towns is confined very largely to emergency surgery.

Recommendations which the Committee offers for expanding hospital accommodations, together with making them more generally accessible, are given numerical expression in the following summary table.

In another section of the Committee's report, recommendation is made for the payment of public funds to defray the cost of hospital care of medically needy persons. This, in large measure, should promote the use of unoccupied beds in existing institutions and of the beds that are to be added through the proposed construction program.

Hospital facilities in the United States—Present status, needs, and Federal grants for new construction, in 10-year program

| Medical type of hospitals | Present status | | Beds needed | Proposed Federal grants | | |
|--|---------------------|----------------|-------------|-------------------------|---------------------|---------------|
| | Number of hospitals | Number of beds | | Construction | Maintenance 3 years | Total |
| General..... | 4,868 | 410,024 | 180,000 | \$315,000,000 | \$108,000,000 | \$423,000,000 |
| Tuberculosis..... | 1,042 | 82,591 | 50,000 | 75,000,000 | 30,000,000 | 105,000,000 |
| Mental..... | 552 | 631,445 | 130,000 | 162,500,000 | 39,000,000 | 201,500,000 |
| Total..... | 6,462 | 1,024,060 | 360,000 | 552,500,000 | 177,000,000 | 729,500,000 |
| 500 health and diagnostic centers..... | | | | | | 7,500,000 |
| Total..... | | | | | | 737,000,000 |

Much has been said and written about free clinics, but this device is not a factor of any moment in medical care for the country as a whole; only 17 percent of general hospitals operate out-patient departments and nearly half the service is rendered in the 5 largest cities having over a million inhabitants.

Tuberculosis and mental hospitals differ from general hospitals in that the preponderance of beds are supported by taxation. While existing facilities thus are available in large measure to all classes, the accommodations in most States are not sufficient for the population. Moreover, many plants are in need of modernization.

Even more than general hospitals, those of tuberculosis and mental classification have failed to develop services for ambulatory patients. Another defect of hospitals, though less tangible than physical facilities, is the failure of hospitals in so many places to become an integral part of the community program for medical service.

MEDICAL CARE FOR THE MEDICALLY NEEDY

The formulation of a national health program implies acceptance of the principle that the maintenance of the health of its citizens is a

responsibility of government. The conservation of national health requires the provision of adequate facilities and services designed to prevent disease, and, when sickness strikes, to secure its adequate treatment; but the lack of a unified public policy creates a barrier to the achievement of this objective.

Through its local and State health departments, government has assumed responsibility for the provision of preventive health services distributed on a community-wide basis. However, as previous reports of the Technical Committee on Medical Care indicate, wide variation exists throughout the country in the practical application of this policy. A more serious situation arises from the inertia of governmental bodies in the field of medical care of the needy sick. The majority of States have laid the legal framework providing for medical care of certain groups of public charges, but the practical results obtained under this essentially permissive legislation are meagre due to lack of funds necessary to implement the program. Furthermore, with the exception of a few States, no legal basis exists for the provision of medical services to the self-sustaining population above the relief level, whose financial status, precarious at best, is particularly threatened by the costs of sickness. Although there are some important exceptions, medical care remains, on the whole, "an economic commodity" which is purchased and paid for directly by the individual who needs it. The fact that this "economic commodity" is chiefly a professional service does not alter the basic fact. It, therefore, results that the ability of the individual to purchase medical care differs according to his economic status, and the individual with low income obtains the smallest amount of care.

PART I. THE EXISTING NEED

THE MEDICALLY NEEDY POPULATION

There are in the United States today probably 40 million persons—almost one-third of our population—living in families with annual incomes of less than \$800. Current studies on the cost of living indicate that this sum supports the average family of four persons only at an emergency level, and leaves a margin for the purchase of medical care at the risk of deprivation of food, clothing, shelter, and other essentials equally necessary for the maintenance of minimum standards of health and decency. Included in this group as of April 1938, is an estimated total of about 11 million persons in families on work relief rolls, 6 million in families receiving general relief, more than 1 million in families of persons enrolled in the Civilian Conservation Corps, more than half a million in families receiving Farm Security subsistence grants, over 2 million in households receiving old-age assistance, over 1 million in families receiving mother's aid or aid to dependent children, and 60,000 in families receiving aid to the blind, under Federal, State, or local provisions for these several types of assistance. This group, comprising a total of over 20 million persons, is dependent on government for food and shelter, and similarly dependent on public funds or private philanthropy for medical care. In the emergency of sickness, some 20 million persons in the marginal income class above the relief level, otherwise self-sustaining, become dependent on public aid for the provision of medical care.

THE CASE LOAD OF ILLNESS

Some indication of the magnitude of the problem of meeting the medical needs of the sick poor may be obtained from a consideration of the case load of illness in this group of 40 million medically needy persons. It is estimated that approximately 20 million cases of disabling illness will occur in this population during a year, of which a minimum of 8 million cases will cause disability of at least a week's duration. Under the conditions prevailing in 1935, about 2 million of the more seriously disabling illnesses will receive no medical care; and the 8 million medically attended cases of this category will include over 2 million patients in general hospitals.

The variety of medical services required for the care of these cases is indicated by a consideration of the incidence of illness due to certain specific causes; only the more serious illnesses (disabling for a week or longer) are included in these estimates.

Over 1 million cases of acute infectious diseases will occur in the child population; these cases will require adequate medical care to reduce their frequently serious sequelae and needless loss of life, and to prevent infection of the well. Approximately 250,000 cases of pneumonia, incident in the total population during the year, will require skilled and intensive medical and nursing care. Surgical treatment will be required by a large proportion of some 425,000 cases of tonsillitis, and 190,000 cases of appendicitis occurring in the group. Accidental injuries will account for the disability of about 700,000 cases, of which about 250,000 will require hospital care. Approximately 175,000 persons in the group will be found with severely crippling orthopedic conditions, and the majority of these persons will be totally disabled.

The major chronic diseases of later life—cancer, rheumatism, diabetes, the cardiovascular and renal diseases—will account for some million cases of illness; and the high costs of these cases, due to their long average duration and their special requirements for diagnosis and treatment, will tax severely the resources of low-income families providing independently for their medical care. Among persons of any age, long-term invalidity creates needs for treatment and rehabilitation which must be met largely by public provision. The special problems presented by care of the tuberculous and mentally diseased have been reviewed in previous sections of the report. These diseases also result in "high-cost" illnesses, which place a special burden on the poor.

THE UNEVEN DISTRIBUTION OF MEDICAL FACILITIES AND PERSONNEL

Previous reports of the Technical Committee have indicated that the uneven distribution of hospitals, outpatient departments, and medical and nursing personnel constitutes a serious defect in our national resources for the maintenance of health. In many rural areas, in which the number of physicians and nurses is low, and hospital facilities are limited, rich and poor alike encounter difficulty in obtaining adequate medical care. At the next level of adequacy, represented by small cities remote from metropolitan areas, the poor suffer the effects of limited facilities to a greater degree than the rich. With increasing urbanization, the supply of medical facilities and personnel becomes more abundant for rich and poor, and clinics,

visiting-nurse service, and tax-supported hospital care supplement the resources of low-income families. The widespread attention given to the availability of these free medical services to the poor overlooks the fact that their benefits are largely restricted to the poor in the metropolitan areas, who comprise only part of the medically needy population. A large proportion of medically needy persons is found in small cities and rural areas, in which limited hospital facilities, restricted tax support of hospitals, and insufficient medical and nursing personnel create an additional obstacle to the receipt of adequate medical care.

SICKNESS AND ECONOMIC STATUS

The restriction which inadequacy of income, coupled, in certain areas, with inadequacy of medical facilities and personnel, places on the receipt of medical care by this low-income group has serious implications, arising from the fact that its medical needs exceed those of families at higher economic levels. Death rates are an index of the end results of sickness. It is, therefore, significant that the death rate is considerably higher for the poor than for the well-to-do. This is evident from general death rates examined by occupation, from infant mortality rates, from tuberculosis rates, and from mortality statistics for other important causes of death.

Though death rates reveal the annual loss of human lives, they measure only a fraction of the toll which sickness exacts. Indeed, counting only severe disabling illnesses (i. e., those lasting for 1 week or longer), for each death there are about 16 illnesses that mean loss of work for the family breadwinner, inability of the housewife to go about her normal duties, or absence from school of the school child.

The association of sickness with low income has been demonstrated by numerous surveys which have taken account of economic status. The most recent data bearing upon this point were obtained in the National Health Survey made in 1935-36. Records of disabling illness and the receipt of medical care in a 12-month period were obtained for about two and a quarter million persons, of whom some 429,000 persons were members of families which had received relief during the survey year, and an additional group of 562,000 was in families in the marginal income class above the relief level. The canvassed population was drawn from 83 cities and 23 rural areas in 18 States, and the results thus indicate the experience of families meeting the limitations of low income under the varying environmental conditions of the Northeast, the South, the central region, the far West, and of the large and small city, and the rural area.

The findings of the survey indicated that in large and small cities in all regions of the country, and in the rural areas, the frequency and severity of illness was uniformly higher in relief and marginal income families than in any other income class. For all urban areas, the excess in the frequency rate of sickness in the relief population, in comparison with that of the highest income class, was 62 percent; for the marginal income class above the relief level, the excess was 23 percent. In the relief population, the annual days of disability per capita amounted to 16 days, in the marginal income class, to 12 days; among persons in the highest income class, the rate was only 7 days per capita.

Among children in relief families, the annual days of disability per capita was 17 percent higher than the average for children among

families in comfortable economic circumstances. The average aged person in families of the highest income class was disabled by illness for 3½ weeks in the survey year; among the aged in relief families, the rate was slightly over 8 weeks. One in every 20 family heads in the relief population was unable to work because of chronic disability, as contrasted with only 1 in 250 heads of families with incomes of \$3,000 and over.

Among all surveyed relief families, the tuberculosis case rate was more than 6 times as high as that of families above the \$3,000 income level; among southern relief families, the rate was 10 times as high as in families of the upper income group. Illness due to the major chronic diseases of later life—cancer, rheumatism, diabetes, the cardiovascular and renal diseases—was over one and one-half times as frequent among relief families as among those in comfortable circumstances.

The illustrations of the association between sickness and poverty derived from the National Health Survey have special weight because of the size and representative nature of the population canvassed, but the results are by no means isolated, nor peculiar to conditions prevailing in 1935. A similar conclusion was forecast by the results of earlier investigations of more limited groups of the population. The combined evidence of numerous studies of sickness and death rates among various economic classes of the population indicates that sickness occurs more often and with greater severity among the poor than among those in moderate or comfortable economic circumstances.

MEDICAL CARE AND INCOME

While sickness among the poor is more frequent in occurrence, and of greater severity, than among families in the upper economic groups, numerous surveys indicate that, notwithstanding their greater need, the poor obtain less medical care than the well-to-do. For example, a study made in the last prosperous years before the depression set in showed that well-to-do sick persons received nearly three times as many services from physicians, six times as many in each 100 received dental care, two and one-half times as many had health examinations as did self-sustaining families with incomes under \$1,200 a year. The proportion who went through a year of life without professional care was more than three times as high among the poorest as among the wealthiest families, despite services furnished to those in the lower income class without charge. The amount of general hospital care (per capita) received by low-income families in this survey was approximately the same as that received by families in the highest-income class. Surgical operations, however, were almost twice as frequent among persons in the well-to-do group as among the poor.

The results of the National Health Survey contribute additional evidence on the inadequacy of medical services received by the medically needy in 1935:

Hospital care in the large cities, in terms of the proportion of illnesses hospitalized, was approximately the same in amount among rich and poor, a fact explained by the relatively large supply of hospital beds supported by public funds in the metropolitan areas. In the smaller cities, in which hospital facilities are less adequate, the rich maintained the proportion of hospitalized illnesses at the level of the metropolitan centers, but among relief and marginal income families, the proportion declined progressively with city size.

Medical care in the home, clinic, or physician's office however is the type of service adaptable to the requirements of the majority of illnesses. Among relief and marginal income families, both the proportion of illnesses receiving such care, and the average number of consultations per case, were consistently lower than among families in comfortable circumstances in all parts of the country. Although the proportion of hospitalized illnesses among these low-income families in the small cities was markedly lower than in the metropolitan areas, no compensating increase was observed in the proportion of cases receiving extra-hospital medical care.

Clinic supervision provides adequate medical care for certain ambulatory cases of illness, but the concentration of out-patient facilities in the large cities, greatly restricts the benefits of these services. Clinic care was received by 15 percent of the illnesses of the canvassed relief population in the metropolitan centers, but in the small cities under 25,000 population, 2 percent, and in the rural areas, only 0.2 percent of illnesses in relief families received clinic care. While the proportion of illnesses in the relief and marginal income groups was approximately the same, 54 percent of all cases receiving clinic care were in relief families and only 19 percent in the marginal income group.

Bedside nursing care by a private duty nurse was received by only a small proportion of illnesses in relief families—less than 1 percent, compared with 7 percent among families in comfortable circumstances. Bedside nursing care provided by visiting nurses was relatively frequent in the relief group of the large cities, reaching 13 percent of the cases; in cities of less than 100,000 population, the proportion was somewhat lower, the figure being 9 percent. In the rural areas, only 3 percent of the illnesses received visiting nursing care—approximately one-fourth of the average for the large cities. As in the case of clinic care, a much larger proportion of visiting-nurse service was absorbed by the relief group than by the marginal income class.

Dental care is notably inadequate among low-income families. In one of the large cities canvassed in the National Health Survey, information was obtained on the receipt of dental care. In families of skilled, semiskilled, and unskilled workmen, the proportion of adults who had never received dental care was almost twice as high as in the families of white-collar workers. In a recent survey of families in California cities, the proportion of persons requiring, but not receiving, dental treatment was four times as high in families of the lowest income class as among the well-to-do.

The effect of the inadequacy of medical care among the poor assumes greater significance when considered in relation to certain groups of the population, or to particular diseases in which mortality is high, or disability is severe. Among children under 15 years of age, the disparity in medical attendance of illness at various income levels was found to be even greater than among adults, and, although apparent in all areas, was particularly marked in the South. In the small cities of the South, about one-sixth of the deliveries of white women, and almost one-half of the deliveries of Negro women in families with income under \$1,000 took place without the attendance of a physician. The average case of illness attended by a physician among aged persons in families in comfortable circumstances received almost twice as much care, exclusive of hospital treatment, as the average case among aged persons on relief.

Among Negro families in the relief and marginal income groups in the South, the average length of hospital-stay per patient with tuberculosis was 94 days, compared with 159 days for the average hospitalized case in white families of this class in the South, and 174 days for the Northeast. In the large cities, the proportion of cases of certain chronic diseases—cancer, rheumatism, diabetes, the cardiovascular and renal diseases—receiving hospital care was approximately the same among rich and poor, being somewhat higher for relief families, however, than for the marginal income class. In the small cities, except in the East, the inadequacy of hospital facilities resulted in a marked reduction in the proportion of these chronic cases hospitalized

in low-income families, but families in comfortable circumstances maintained about the same proportion as in the large cities.

The point should be emphasized that measurement of the amount of medical services received by the poor suffers no distortion by comparison with the services received by those in comfortable economic circumstances, since the well-to-do themselves on the average do not obtain care which is adequate in comparison with professional standards. Thus, in a recent study, it was found that families in the class with annual income between \$5,000 and \$10,000 received only two-thirds as many services from physicians, only three-fifths as many days of general hospital care, and less than one-half as much dental care as professional opinion considered necessary on the basis of their expected illness rates.

The findings of the National Health Survey and of earlier representative studies therefore provide quantitative support for the generally recognized fact that the receipt of medical care depends largely on income, and that people of small means, or none at all, though having the greatest need for care, receive, on the whole, the least service.

PRESENT FINANCIAL BASIS OF PUBLIC MEDICAL CARE

The group of some 20 million persons without income, dependent on public support for general living, is similarly dependent on public funds, or philanthropy, to meet its costs of medical care in sickness. To what extent, then, does government contribute to the support of medical services for this group? In 1935, expenditures from governmental funds for health and medical services amounted to about one-sixth of the total medical bill in that year, or approximately \$520,000,000. Of this amount, approximately \$72,000,000 was used for hospital care of patients in Federal institutions. About \$157,000,000 was absorbed by hospital care of the tuberculous and the mentally diseased. Expenditures for general hospital care (including special hospitals, except tuberculosis and mental hospitals) amounted to about \$105,000,000, representing an expenditure of approximately \$75,000,000 for care given in governmental hospitals, and \$30,000,000 for care of medically needy persons in nongovernmental hospitals. The national hospital and public welfare associations have recently agreed upon policies whereby the use of public funds for care of the medically needy in nongovernmental hospitals will be made most effective.

Included in the total of \$520,000,000 is approximately \$130,000,000 used for the support of the public health services provided by local and State health departments. The exact amount of governmental expenditures for medical care of the sick poor, exclusive of hospital care, is not known, but is estimated to be about \$25,000,000.

Excluding governmental support of hospital care in Federal institutions, and hospital care of the tuberculous and mentally diseased, total expenditures for tax-supported medical care amount to some \$130,000,000 annually. This sum, however, is drawn upon to support care not only of the medically needy population as here defined, but of other persons with income somewhat above the marginal level. There is, furthermore, uneven distribution of these governmental funds, some States and communities, in particular the large cities,

spending very much more than others in proportion to their total, or medically needy, population.

The inadequacy of this expenditure for tax-supported medical care—roughly \$130,000,000 annually—is emphasized by its comparison with the estimated cost of supplying essential medical services at an emergency level to the medically needy, which would amount to about \$400,000,000 annually. This sum would provide only a minimum amount of medical care; a volume of medical service consistent with professional standards of adequacy secured by individual purchase on a standard fee basis would entail costs of approximately five times this amount.

It is apparent, therefore, that the handicap of insufficient funds severely limits the ability of public welfare agencies to meet the medical needs of the public-assistance group. The effective distribution of public medical care is further impeded by lack of established procedures in its administration. Welfare officials have become increasingly concerned by the problems arising in connection with the provision of adequate medical care to the sick poor. A recent report of the American Public Welfare Association presents the results of an analysis of these problems based on the experience of welfare officials throughout the country. The report indicates that the present administration of public medical care is characterized by division, overlapping and duplication of authority, lack of a satisfactory policy for the determination of eligibility for care, and insufficiency and low standards of medical service.

For medical care of the group of some 20 million persons in self-sustaining families above the relief level, the present policy of public welfare agencies is casual and uneven. Expenditures for even minimum medical services constitute a serious burden for these families living at the emergency level, and a high-cost illness necessitates adjustments in the budget which endanger standards of health. If serious sickness strikes the breadwinner, the costs of medical care, combined with the loss of wages resulting from a protracted period of disability, frequently places the family in the dependent class.

PART II. RECOMMENDATION III

The foregoing evidence points clearly to the need for further public financing of medical care for the group of medically needy persons who are unable from their own resources to pay the costs of care on any basis. In many communities and some whole States, local fiscal capacity is insufficient to support adequate public medical care without the aid of Federal funds. The charity of private physicians and the resources of voluntary institutions are inadequate to meet the demands of this group for medical care. The Technical Committee therefore believes that some plan of financial cooperation between the State and Federal Governments is necessary to secure adequate medical care of the medically needy population, and submits the following recommendation:

Recommendation III: Federal Grants-in-Aid to the States Toward the Costs of a Medical Care Program for Recipients of Public Assistance and Other Medically Needy Persons

It is proposed that the Federal Government, through grants-in-aid to the States, implement the provision of public medical care to two broad groups of the population: (1) To those for whom the local, State, and Federal governments, jointly or singly, have already accepted some responsibility through the public assistance provisions of the Social Security Act, through the work relief program or through provision of general relief; (2) to those who, though able to obtain food, shelter, and clothing from their own resources, are unable to procure necessary medical care.

The program would be developed around and would be based upon the existing preventive health services. It would be in addition to the programs and costs involved in Recommendations I and II but would need to be closely related with the services provided under those recommendations. The program contemplated in the present recommendation would provide medical services on the basis of minimum essential needs. It would include medical and surgical care, with necessary diagnostic services, medicine, and appliances, hospitalization, exclusive of the period of maternity and of care of the tuberculous and mentally diseased, bedside nursing care, and emergency dental care.

The use of nongovernmental hospital beds for medically needy persons, paid for on a proper basis by public funds, is presumed as a part of this program wherever local conditions render this policy necessary or expedient. It is taken for granted that the medical and allied professions and institutions will participate in the administration of this program as has been the case in many States and communities.

SIZE OF THE POPULATION TO BE SERVED

In the previous discussion, the medically needy population has been estimated to include some 40 million persons. At the present time, this figure includes only the public assistance group, and persons in families with annual incomes under \$800 providing a standard of living at the emergency level on the basis of recent studies of costs of living. While the adoption of an annual income of \$800 or less as a basis for determining the estimated number of the medically needy is somewhat arbitrary, the size of the population to be served has been estimated on this basis, and the costs of the recommended program determined with reference to a total of 40 million persons. For future planning, it would be desirable to extend the definition of the medically needy to include families up to the \$1,000 level. Local estimates of the medically needy population will necessarily take into account regional variation in costs of living.

COSTS OF THE RECOMMENDED PROGRAM

The annual minimum cost of such essential medical services, hospitalization as specified, and emergency dentistry has been estimated at \$10 per person in the population served. Applied to the 40 million persons, including recipients of public assistance and other medically needy persons, the total annual cost would be \$400,000,000. Of this

amount, the proposed Federal contribution might amount on the average to 50 percent, or \$200,000,000, to be matched on the average by an equal contribution from the States. Total expenditures, including Federal, State, and local contributions, might amount, in the first year, to \$50,000,000, in the fifth year, to \$150,000,000. While it is estimated that the maximum annual expenditure would not be attained before the tenth year, a more rapid rate of development would bring the program to maturity at an earlier date.

It must be emphasized that the estimate of \$10 per person per year for the cost of providing medical care to the medically needy is based on a consideration of minimum medical needs. Adequate care, exclusive of dentistry, might cost more than twice this amount. Although a minimum estimate, the recommended figure probably exceeds the per capita expenditure for public medical care made by any State at the present time, and is several times higher than the present average expenditure for this group in the country. It must be recalled also that this amount is supplemental to the preventive services already supplied by organized health agencies, and that it will be augmented by the provisions of Recommendation I-A for expanded public health services including control of tuberculosis, mental disease, cancer, venereal disease, pneumonia, malaria, and the industrial hygiene program, and by the provisions of Recommendation I-B for expansion of maternal and child health services, if Recommendation III be adopted.

It should be noted that this program is exclusive of the provisions for maternity care presented in Recommendation I-B, but includes its provisions for medical care of children. If the present recommendation be adopted, it would therefore cover the costs of the special program for children presented in Recommendation I-B.

METHOD OF ALLOCATING GRANTS

Since fiscal capacity, and the availability of medical facilities and personnel vary from region to region, it is proposed that the \$200,000,000 Federal contribution be allocated to the States on a basis which takes account of two factors: (1) The number of the population in each State which is dependent or otherwise medically needy; (2) the financial status and resources of the State. It is assumed that the States themselves will take into account the wide variation in needs and resources among different areas within their own boundaries. Primary administrative and operative responsibilities would rest with the State governments. Eligibility for Federal grants-in-aid would depend upon the meeting of certain minimum conditions regarding the service to be rendered to dependent and other medically needy persons and upon provision of funds by the States for their share of the costs.

SUMMARY

In the United States today there are probably 40 million persons in families with income supporting only an emergency standard of living. Some 20 million persons in this group are in families without private income, dependent on public funds for food and shelter, and likewise dependent upon public aid or philanthropy for medical care in sickness. For the additional group of 20 million persons in self-sustaining families of the marginal income class, individual income is

insufficient to meet the costs of sickness without serious curtailment of expenditures for food, shelter, and other essentials equally necessary for the maintenance of minimum standards of health and decency. A large proportion of the needy population lives in small cities and rural areas in which limited hospital facilities and medical and nursing personnel create an additional obstacle to the receipt of adequate medical care.

While the death rate is higher and sickness more frequent and severe among the poor than among those in comfortable circumstances, the evidence of numerous studies indicates that the poor, on the whole, receive less medical care than the well-to-do. The present system of public medical care offers no satisfactory solution for the problem of providing adequate care to the medically needy. Its restricted legal basis permits care chiefly to general relief clients, providing unevenly for other recipients of public assistance, and recognizing only to a limited degree the needs of otherwise self-supporting persons whose private income is insufficient to meet the costs of medical care. The practical operation of the system is further impeded by lack of funds, overlapping of authority, and insufficiency and poor standards of medical service. The Technical Committee therefore believes that the medical needs of this large group of the population can be met only by a program of Federal-State cooperation providing the additional public funds necessary to support minimum medical services.

The success of the program will depend upon the full cooperation of physicians and others involved in giving medical services, of public and private hospitals and clinics, of health departments and welfare agencies. No one plan will meet the diverse needs of the States, and considerable latitude must be allowed in the details of State and local programs. But the problems of executing the program must not be permitted to obscure the need for Federal aid in securing to these needy citizens their rights to health.

A GENERAL PROGRAM OF MEDICAL CARE

The Technical Committee on Medical Care has called attention to the notable advances made in recent years in the prevention and cure of disease. The Committee has also called attention to the fact that there are serious inadequacies in the health services of the Nation. In the report transmitted by the Interdepartmental Committee to the President in February, the existing deficiencies were summarized in four broad categories. Of these, there have already been considered:

- (1) Expansion of public health, and maternal and child health services;
- (2) Expansion of hospital, clinic, and other institutional facilities; and
- (3) Provision for the medical services of needy and of medically needy persons.

Attention may now be directed to the fourth major problem: The financial burdens and the economic insecurity which sickness creates for self-supporting persons.

PART I. SICKNESS BURDENS OF SELF-SUPPORTING PERSONS

When outlining a national health program, the Committee placed first emphasis on prevention of disease. Recognizing the importance of private medical practice, of hospitals, clinics, sanatoria, health departments, and other institutions and agencies for the provision of modern medical service, the Committee has recommended a program to meet existing deficiencies.

Preventive services and hospital facilities are necessary, but of themselves they are not sufficient. A large proportion of illness is not yet preventable. Only a fraction of all illnesses requires hospitalization—though many more cases require or can profit from organized clinic service. But regardless of the number, distribution, technical proficiency, and quality of services available from hospitals, clinics, dispensaries, sanatoria, physicians, dentists, and nurses, these services are of no direct benefit to persons who do not use them. Society must not only have an armament against disease but must also see that it is effectively utilized. Between the individuals or institutions equipped to serve the sick and the millions of people in need of their services stand barriers, the most important of which is an economic wall which both groups are anxious to scale.

The cost of medical care—including in this phrase the costs of services furnished by physicians, dentists, nurses, hospitals, laboratories, etc.—must be brought within the means of the public. Furthermore, insecurity and dependency created by loss of earnings during periods of disability must be reduced as far as available means permit. If a national health program is to bring health security to the population, it must include provision against the burdens created by medical costs and by loss of earnings during periods of disability.

TOTAL COSTS AND PRIVATE EXPENDITURES

The purchase of medical services is still mainly a matter of private and individual action. Though government (Federal, State, and local) spends considerable sums, and though organized groups pay an important part of the Nation's bill for sickness, the individual patient still carries the principal share of the costs through private payments.

In 1929 the total expenditures in the United States for all kinds of health and sickness services were about \$3,700,000,000, of which patients paid 79 percent and government 14 percent. Philanthropy and industry accounted for the remaining 7 percent. In 1936, the total expenditures had declined to \$3,200,000,000, of which patients paid 80 percent and government 16 percent. In 1937 and in the current year, government expenditures have probably further increased, offsetting reductions in expenditures by philanthropy and industry; but private and individual expenditures still remain approximately 80 percent of the total.

INCOME AND HEALTH NEEDS

If medical services are to be effective, they must be geared to need. The need for community-wide preventive services is substantially uniform among all classes of people; but the need for individual services is not.

The association of sickness with low income has been demonstrated by numerous surveys which have taken account of economic status. By way of illustration, we may cite a survey among representative white families in many communities of the United States during the years 1928-31. It was found that in families with annual incomes of \$3,000 and more, there were 3.8 days of disability a year for each person; in families with incomes under \$1,200 a year, there were 8.9 days of disability a year per person.

A comprehensive review of the statistics on sickness and poverty would be too lengthy for inclusion here. Every substantial sickness survey, whether in urban or in rural communities, whether made by government, by philanthropy, or by business concerns, serves only to furnish additional proofs that sickness and disability are more prevalent among people of small means than those who are in better economic circumstances. This is the basis for the conclusion that the poor and those in low-income classes need more medical care than the well-to-do or the wealthy.

INCOME AND RECEIPT OF CARE

The higher sickness rates that prevail among people with small incomes might lead one to assume that they would receive more medical services than those in better circumstances. But the contrary is the fact. Either those in the lower income classes get too little care or those in the upper income classes get too much. A study of this point showed that the well-to-do were not, in general, receiving too much service as judged by professional standards. The only alternative conclusion possible is: the poor receive too little.

Studies of this kind do not show merely a special contrast between the poor at one extreme and the wealthy at the other. On the contrary, they show a more or less regular gradation from the lowest to the highest income groups. The large majority of the population which falls between the income extremes shows the same phenomenon; they receive medical care not according to their need but according to their income level. For an overwhelming majority of the entire population and for an even larger proportion of self-supporting persons, medical care must be purchased privately, and the frequency of purchase depends largely upon the purchase price.

UNEVEN BURDEN OF MEDICAL COSTS

Why do self-sustaining people with low incomes receive inadequate care? The first basic reason is found in the irregular and unpredictable occurrence of illness and of sickness costs.

Families spend, on the average, 4 to 5 percent of income for medical care, the proportion being fairly constant up to an annual family income of \$5,000, beyond which it tends to decline slightly. These average figures do not, however, give a realistic picture of the burden created by medical costs. The need for medical care by a family is uneven and unpredictable. In one year little medical service or none may be required; in another year the family may suffer one or more severe illnesses among its members and may require medical service costing large amounts. No particular family knows any month or any year whether it will be among the fortunate or among the unfortunate. When serious illness comes, it may bring large costs and may

descend with catastrophic force on the current budget, on savings, on freedom from debt, or the economic independence of the family. Every substantial study of medical costs shows that they are burdensome more because of their uncertainty and variability than because of their average amount. And this is equally true for the urban family of the industrial wage earner and for the rural family of the farmer or farm laborer.

Nor do the statistics of actual family expenditures tell the whole story. Knowing in advance that they cannot pay large medical bills, many families ask for "free" care, and many go without medical attention. Nor is it difficult to picture the distress of those families which incur large bills and undertake to pay them. In one case or another, the savings of a lifetime may be wiped out, the hopes and dreams for a home or farm thwarted, educational opportunities sacrificed, the family deprived of those things which make life pleasant and living worthwhile. Nor do the statistics leave any doubt why physicians and hospitals have difficulty in collecting their bills. Is all this necessary or inevitable? Is there no remedy? Is our system of providing, buying, or paying for medical care the best that can be devised to meet our present needs?

The burden of sickness costs is mitigated in some measure by the arrangements whereby fees are adjusted to ability to pay. But the sliding scale operates only in limited ways and is open to very serious abuses. Though free and part-pay services and facilities have been extensively developed, especially in the large cities, though physicians give generously of their services, and though governments have greatly increased tax support for services furnished to the poor, the fact remains that large costs still fall on small purses.

MEDICAL CARE AND ABILITY TO PAY FOR ADEQUATE CARE

The uneven burden of medical costs is the first cause of inadequate care. There is a second cause of great importance. A considerable proportion of the population is too poor to be able to pay, through their own resources, the full cost of adequate care. The increasing cost of good care, the more extensive public demand for it, and the strengthened determination of society to conserve the health of the people join in the creation of a new class of persons. These are people who may be self-supporting and independent for all their other basic needs but who are unable to afford the costs of necessary medical care.

The problem created by the irregular incidence of illness and of medical costs cannot be solved by an increase in average family income. If the national productivity were in some way doubled and everyone's income were correspondingly increased, the medical care problem of self-supporting people with doubled "income" would be alleviated somewhat, but would be far from eradicated.

Recent studies provide a basis for estimating the cost of adequate medical care as defined by competent professional judgment. *If purchased on an individual basis for minimum fees*, such care (exclusive of the costs of community services, dentistry, medicines, or appliances) would cost, on the average, about \$76 per person a year or about \$310 for a family of average size. Obviously, such expenditures for medical care would be possible for the great majority of all families only with extraordinary adjustments in the distribution of income, in budgets, and in standards of living.

Alternatively, the cost of adequate care may be estimated crudely on the assumption that care is purchased by groups rather than by individuals. From the experience of various organized medical service and insurance plans, about \$17.50 per person a year appears to be a reasonable minimum estimate of the cost of furnishing adequate care, exclusive of dentistry. Adequate dental care would cost at least an additional \$7.50 per person a year. This gives \$25 per person or \$100 for a family of four as an estimated minimum cost of adequate care purchased collectively by groups rather than by individuals. Expenditures of this amount would mean approximately doubling the average sum spent by families at the \$1,000 income level, adding one-third for families with \$1,500 a year and one-fifth for families with \$2,000 a year. Families with \$2,000 a year or less represent, in different years, about 60 to 80 percent of all the families of the Nation. Self-sustaining families with less than \$1,000 a year and those whose incomes must be supplemented would have to be aided even more. Families with incomes of \$3,000 and more spend more than \$100 a year for medical care.

The conclusion is inescapable that considerable proportions of the Nation's families are too poor to afford the cost of adequate medical care from their own resources. If they are to receive such care, some part of the cost must be borne by the more prosperous. This is not a new principle; it has long been practiced in the payment for medical care, and the medical profession has always insisted that people should pay for medical care in proportion to ability to pay.

Sickness has become a hazard like death or unemployment in that it entails losses which may be greater than the individual can meet unaided from his own resources. The need for food, shelter, and clothing can be budgeted by the individual family; sickness costs can be budgeted only by a large group. If medical care is to be made available to all families with small or modest incomes at costs they can afford, the costs must be spread among groups of people and over periods of time. Some arrangement must be worked out whereby individuals will make regular periodic contributions into a common fund out of which the costs of medical care will be defrayed for those who are sick. Thus, in each year, the majority who require little or no medical care will help pay the bills of the minority who happen to need much medical care. One year, some will be the fortunate ones, will have small sickness needs, and another year they may be among the unfortunate and so need the help of others.

INCOMES OF PRACTITIONERS AND INSTITUTIONS

The inadequate incomes earned by many professional practitioners deserve careful consideration. The uneven burden of medical costs upon individuals and families has its counterpart in the uneven distribution of income among the physicians, dentists, and nurses who minister to them. Even in the prosperous year 1929, for every physician who earned more than \$10,000 as an annual net income from his professional practice, there were two who earned less than \$2,500. For every dentist who earned more than \$10,000, there were four who earned less than \$2,500. This was the unhappy state of affairs in a peak year of prosperity. Since then, the economic status of doctors, dentists, and nurses has been much worse.

Inadequacies in the receipt of medical care are reflected in inadequacies in the incomes of practitioners and hospitals. While doctors are only partly occupied, while nurses suffer from substantial unemployment, and while hospital beds stand empty, millions of persons in need of service do not receive it.

It is significant to record the fact that every sound arrangement to reduce the burdens created by variable sickness costs for the public operates to stabilize and increase the incomes of those who furnish the services.

INADEQUACY OF VOLUNTARY INSURANCE

A brief reference may be made to the long and complex history of voluntary efforts to solve the problem of sickness costs which are unequal, unpredictable, and unbudgetable for individuals or families. The group payment of sickness costs is not a new concept but an old and well-established practice. Organized charity, the sliding scale of medical fees, commercial insurance, and other devices have long been practiced to reduce the burdens of sickness costs and to distribute these costs among groups of people. They have not been and they are not now adequate to deal with the problem.

Group payment through nonprofit insurance has become a more important practice. Most commonly, the group has been made up of employees of a single industry, banded in a "mutual benefit" or similar association. Usually, the employer and the insured persons share the costs. Some of these plans provide only medical benefits, many provide only cash benefits, and a few provide both.

Group payment has recently received a strong impetus through the development of nonprofit community associations for insurance against hospital costs (group hospitalization). In a number of communities, group hospitalization authorities are studying the possibility of expanding the program to include not only hospital bills but physicians' fees and other costs as well.

These and other efforts to solve the problems of sickness costs deserve high commendation. The proof of their value, however, is not their good intentions but their actual accomplishments in achieving coverage. Voluntary sickness insurance without subsidy or other encouragement through official action may be important as a method of experimentation with the technical and social problems of group payment, but it has nowhere shown the possibility of reaching more than a small fraction of those who need its protection. After decades of effort, about two million persons in the United States receive comprehensive or even substantial medical care through voluntary insurance arrangements, and one and a half million persons (some of them the same persons) are members of so-called approved, non-profit hospital insurance associations. In the face of needs which are vital and urgent for at least 100 million persons in the United States, the Technical Committee on Medical Care cannot find the answer to the Nation's problem in voluntary insurance efforts.

PART II. RECOMMENDATION IV

The Technical Committee on Medical Care has reached the conclusion that Government must assume larger responsibilities than it has carried in the past if it is to help self-supporting people meet the problems of medical costs.

A program to provide a rational basis for the financing of medical costs cannot start in a vacuum; it must take account of existing customs, facilities, and practices. Wide variations in existing personnel, institutions, and economic conditions require that a national program must be flexible and must be adaptable to diverse social and economic conditions in different areas of the country. The program must aim at the eradication of socially undesirable differences, but it must recognize that this can be effected only over a period of years. Such considerations lead the Committee to the conclusion that effective operating programs should preferably be designed and administered on a State-wide basis. On this basis, the role of the Federal Government should be principally to give financial and technical aid to the States in their development of sound programs. Accordingly, the Technical Committee on Medical Care submits as its fourth recommendation:

Recommendation IV: Federal Grants-in-Aid to the States Toward the Costs of a More General Medical Care Program

The implications of this recommendation may first be examined in respect to programs which may be developed at the State level. If effective medical services are to become a reality, people of small means must be able to obtain these services without facing the costs at the time the services are needed. The costs can be distributed among groups of people and over periods of time through the use of taxation, or through insurance, or through a combination of the two.

EXPANSION OF PUBLIC MEDICAL SERVICES IN THE STATES

It has been pointed out that tax-supported public medical services already involve annual expenditures of about \$500,000,000 to \$600,000,000. The use of tax funds to pay for medical services is, of course, a very old method of distributing the costs. The principle of distribution is, however, applied in an extreme fashion, because, in general, public medical services are available to needy and, more recently, to medically needy persons and not to other taxpayers who provide the funds. A more general program, which would meet the needs of a larger proportion of the population to whom medical costs are burdensome, could be developed through expansion of existing public medical services, provided such services were made more generally available to the population.

Existing public medical services are, broadly considered, of two kinds: (1) General services for the needy, and (2) limited classes or categories of service for special groups in the population. The scope of services for the needy is well known, and the deficiencies are widely recognized. The categorical services are usually highly specialized; they include services which State and local governments have developed for persons afflicted with diseases infused with an element of public danger (e. g., the acute communicable diseases) or with diseases which, being long-continued or chronic, or involving highly specialized care, create costs which are beyond the ability of individual families to meet (e. g., cancer, infantile paralysis), or which, because of lack of care, precipitate dependency and large social burdens (e. g., tuberculosis, mental diseases).

The expansion of public medical services can be effected—as some think they should—through this categorical approach. On this basis, government would make particular kinds of services available to the public, some only to the needy, some to the medically needy, and some to wholly self-supporting persons or to the entire community. Some of the possibilities in these directions have already been discussed; only their expansion to all or most income groups is involved here.

It is fitting to note two objections against the expansion of public medical services through this categorical approach. First, each limited development brings additional administrative and organizational complications because of the diversity of the separate services that are made available, and because of the gaps that remain between them and also between them and privately purchased services. In many of our cities today, the complexity of these categorical services already defies the understanding of even the expert, and much evidence shows the confusion in the public mind concerning what is and what is not available, who is and who is not eligible. Second, the limitation of particular services to particular groups in the population piles up further complexities because of the necessity of investigating the financial status of the person who needs the care. People who are self-sustaining for the other necessities of life have profound objections against a means test for medical services, whether this means test is administered by a government agency, a social worker, or by a private medical practitioner.

If functional arrangements are to be simplified rather than be made more complex, if medical care is to become available without a means test for those who need service, if the public is to have ready access to these services, it seems essential to contemplate expansion of public medical services as a general program and not through a categorical approach. Such a program would produce a close similarity between public medical care and public education.

Medical care in the United States now costs approximately three and a quarter billion dollars a year. Subtracting the amount already being spent by governments (Federal, State, and local), a general program of public medical care for the Nation would require about two and three-quarter billions a year. A limited program of public medical services could be designed to cost considerably less; the services could be of less than complete scope; or—despite obvious objections—they could be restricted to people in the lower income levels; or, as has been done in Recommendation III previously discussed (medical care for needy and medically needy persons), they could be limited in both respects. In any case, a program of sufficient size and scope to come to real grips with the national needs must involve new tax expenditures involving between one and three billion dollars a year. These sums include the expenditures that would be involved in carrying out Recommendation III, which calls for an outlay of about 400 million dollars. The possibilities in this direction deserve careful exploration, with special regard for the forms of taxation which may be feasible to raise the necessary funds.

It should be emphasized that the new tax funds for public medical services would not represent a new kind of expenditure by the population; most of these sums are already being spent from private funds.

The essential change would be to effect a wider distribution of medical costs by changing the method of payment.

DEVELOPMENT OF HEALTH INSURANCE BY THE STATES

The raising of the funds required to finance a program of public medical services through general revenue taxation may be expected to present some difficulties. A general program of medical care can also be financed through insurance contributions. Health insurance designed to provide adequate care could be financed principally by direct, earmarked contributions. Like public medical care, health insurance is a method of budgeting expenditure so that each family carries a budgeted, rather than, as at present, a variable and uncertain risk. As is shown by large experience, the insurance procedure is entirely compatible with freedom of all practitioners to participate in the plan, with free choice of physician by the patient, and with wide latitude left to physicians as to the method of their remuneration.

Health insurance by itself is limited in its capacities to reach all who need its protection in much the same way as are other social insurance schemes. National coverage of all persons, or of all with earnings below a specified income level, may be difficult to effect; self-employed persons, domestic servants, and farm laborers cannot be easily brought within the plan, because of the anticipated difficulty of collecting regular contributions from them. However, experience with compulsory systems abroad, and with voluntary systems in the United States as well as in other countries, indicates that these difficulties are not insuperable, especially if insurance contributions are combined with general taxation or special assessments.

A health insurance system might properly be limited to individuals under a specified income level (e. g., \$3,000 a year), or might cover all persons in specified employment groups through contributions levied on income up to, say, \$3,000 a year. In order that the establishment of an insurance system should not lead to one program for the purchase of medical care for insured gainfully employed persons and another for noninsured dependent groups, the system should make provision for the inclusion of persons without income through contributions on their behalf from public funds. Thus, tax payments would be used jointly with insurance contributions to support a unified scheme for self-supporting and needy persons. The insurance benefits of this system should be distinguished from insurance against wage loss, which will be discussed separately. Under such a general system to meet medical costs, medical need might disappear if contributions were related to income.

A comprehensive system of health insurance nationally developed would call for total funds equal to 4 or 4½ percent of income of the covered population. The major portion of these funds should be obtained from the direct contributions of insured persons, with assistance from employers and from government.

The costs of health insurance do not represent new expenditures. Inasmuch as the over-all cost is estimated to be substantially what is already being spent by individuals, health insurance would be primarily a method of substituting average for variable costs. Only to the extent that part of the cost is placed on employers or is shifted to government and is not in turn shifted back to the insured persons, is the impact of medical costs changed from its present pattern.

STATE CHOICE OF PROGRAM

A choice between public medical service and health insurance involves many alternative considerations. Public medical service is potentially applicable to whole areas and to entire populations; it can be used wherever the taxing power of government reaches. Health insurance is somewhat more easily applicable to industrial than to agricultural areas, though this limitation is by no means an absolute one.

The two procedures are not mutually exclusive alternatives. On the contrary, each may have substantial advantages for particular areas or for particular portions of the population to be served. Experience in many countries suggests health insurance for urban and industrial areas and public medical services for rural and agricultural areas. In countries where health insurance is widely practiced, it is always supplemented by public medical provisions, even in urban areas. For example, it is common to find hospital service largely financed through tax funds and serving nearly all the population in countries with extensive systems of health insurance. The relative usefulness of either method by any State would depend upon the characteristics and the composition of the State. One State, more highly industrialized and urbanized than another, may find the insurance technique generally or extensively applicable. Another State, more generally agricultural and rural, may find the method of payment through taxation or special assessment more widely useful. The choice of method or combination of methods should, in the opinion of the Technical Committee on Medical Care, be made by the States rather than by the Federal Government.

When making decision as to the program to be developed, many States would need to give careful consideration to the unequal financial resources of areas within the State. The same kind of public policy that is the basis for Federal aid to the States dictates State aid for underprivileged areas within the State.

Federal aid to assist the States in the development of sound programs should be equally available to the States for the development of public medical services, health insurance, or a combination of the two. Recommendation IV should, therefore, be understood to mean that Federal grants-in-aid to the States should be available within reasonably wide limitations as to the procedure, categories of services, or population groups which a State may decide to assist. Federal grants-in-aid should be geared to approved classes of expenditures under a State program rather than to the administrative or financial techniques used by the State.

It is scarcely necessary to emphasize that the development of a sound State program for medical care need not wait, in States where financial resources are adequate, on the availability of Federal aid.

AN ESTIMATE OF FEDERAL COSTS

The cost to the Federal Government of a program developed under Recommendation IV cannot be estimated closely until the essential features of the plan are determined. Furthermore, a complete program could be attained only after some years of development. Account must be taken of: (a) The rate at which States would be prepared to develop programs; (b) their ability to cover the populations

which should be protected by health insurance or by public medical services; and (c) their ability to develop effective distribution of professional personnel, hospitals, and other facilities in areas where these are now deficient.

A rough estimate of the Federal cost might be made only to indicate its order of magnitude. The over-all cost of services to be furnished through health insurance or analogous public medical services, or both, may be estimated to be about \$2,600,000,000 a year, assuming a theoretical population coverage of 130,000,000 persons¹ and provision of such services as could, on the average, be furnished for \$20 per person.² This would be the eventual cost for complete national coverage. If one-tenth of the total might be made effective in the first year and the Federal share of the cost were assumed to be something between a minimum of one-fifth and a maximum of one-third of the total involved in furnishing services, the Federal cost at the outset might fall between \$52,000,000 and \$87,000,000 a year. The growth of the State systems would occur through expansion of the population covered and through increasing completeness in the variety of services furnished. If the grants-in-aid continue to be necessary, the annual Federal cost would presumably increase tenfold in perhaps 10 years, reaching an eventual maximum falling between one-fifth and one-third of the two and six-tenths billion dollars over-all cost.

These estimates of Federal cost include (and duplicate) several items arising out of preceding recommendations. They include considerable portions of Recommendations I-A and I-B for the expansion of public health, maternal and child health services, and all the cost involved in Recommendation III dealing with grants-in-aid toward medical care for needy and medically needy persons. Recommendation IV proposes a more general program which embraces the more limited programs, submitted in Recommendations II and III.

Development of public medical services and health insurance through Federal aid such as is suggested above might not be as rapid as may be desired. If this is a meritorious objection to the grants-in-aid plan, more rapid development can be effected through a uniform payroll tax (with a tax-offset arrangement) as in unemployment compensation.

INSURANCE AGAINST LOSS OF WAGES DURING SICKNESS

We have already pointed out that sickness brings economic burdens not only because medical services involve costs but also because disability of the wage earner leads to wage loss. Loss of income in turn makes the purchase of medical services all the more difficult.

PART I. THE INCIDENCE OF DISABILITY

TOTAL AND AVERAGE INCIDENCE OF DISABILITY

On the average day of the year, there are probably at least five to six million persons who are temporarily or permanently disabled by illness. These persons are unable to work, to attend school, or to pursue their other customary activities.

¹ Including persons with and without income.

² This figure excludes services already provided through tax funds, takes account of reasonable economies which can be made, and excludes certain current wasteful, valueless, or even harmful expenditures.

Among gainful workers, the rate of disability varies considerably, depending on age, sex, economic level, occupation, and other factors. Taken by and large there are probably between 7 and 10 days of disability per person a year among the gainfully employed, but the figures range from as little as 3 or 4 days up to 15 or more days a year per person for different groups in the population. These figures underestimate the incidence of disability because they do not fully take account of those who have fallen out of gainful employment by reason of long-continued disability.

If all our gainful workers were employed and earning an average wage of \$4 or \$5 a day, a disability rate of 9 working days per year would mean that disability wage loss would amount to \$36 or \$45 per person a year. A more conservative estimate may be based on the assumption that those who are gainfully employed suffer an average disability of about 7 working days a year. For a period like the year 1929, the wage loss due to disability was nearly two billion dollars; for a period like the present, when there is widespread unemployment, it would be at least one or one and a half billion dollars. These figures take no account of the larger losses to industry and to society generally.

UNEVEN INCIDENCE OF DISABILITY

Stating the wage loss from disability in terms of averages or of total costs is significant but also somewhat misleading—just as average or total costs for medical care may be misleading. If each worker had the average annual disability and the average annual loss of earnings we should not have a problem worthy of extended discussion. Unfortunately, a wage earner does not suffer average illness or average loss, except by chance. Disabling illnesses are not all of 7, 8, or 9 days' duration. On the contrary, disabling illness ranges from less than a day to the entire year, and in some cases the disability is permanent. Whether an illness will be mild and nondisabling, or severe and disabling, whether disability will last a day, a week, a month, a year, or the remainder of the individual's lifetime depends upon many factors which in general cannot be foreseen or predicted by or for the individual. Though we can forecast with substantial accuracy what will happen in a large group of workers, the individual cannot know in advance what will happen to him. This is the essential reason why the averages are misleading and why disabling sickness is a constant threat to the security of the individual and the family of small or modest means.

The effects of *temporary* disability are in all important respects like the effects of temporary unemployment; each deprives the worker and his family of income for a shorter or longer period. The effects of chronic, long-continued, or *permanent* disability are like the effects of old age, except that unlike old age, disabling disease is not confined to the last and relatively nonproductive periods of life. Disability affects persons at all ages. When the worker has dependents to support, its consequences are most severe.

AN ESTIMATE OF THE PERMANENTLY DISABLED

Of the 5 or 6 million disabled persons on an average day of the year, perhaps one-half, more or less, are suffering from temporary disabilities from which they will recover sooner or later. The other

half are permanently and totally disabled from disease and other disabling conditions. Four-fifths of these persons, or nearly 2,000,000, are in the ages under 65. Many of these persons have families and dependents; in many instances, these disabled persons have been the sole support of their families. A rough estimate which takes account of the immediate families of these disabled persons suggests that between 8 and 10 million persons are probably quite directly affected by their permanent disablement and loss of earning capacity.

PART II. RECOMMENDATION V

Under the present social security program, workers are assured some continuance of partial income, in lieu of their regular wages, when they become unemployed and are able to work. Under the workmen's compensation laws, most of them are protected against wage loss resulting from accident or injury arising out of employment. But generally they have no protection against wage loss resulting from nonindustrial sickness or accident. A limited number of workers do have some such protection through voluntary insurance schemes, commercial or nonprofit; but they are a small minority in the total. If the wage earner becomes unemployed for lack of a job, he is insured for some continuity of income between jobs (if he is in employment covered by unemployment compensation); but if he becomes unemployed because he is unable to work, he is thrown back upon such private and individual resources as he can command. Experience has shown the need for more substantial protection.

The Technical Committee on Medical Care therefore submits as its fifth recommendation:

Recommendation V: Federal action toward the development of programs for disability compensation

DIFFERENT INSURANCE PROVISION FOR TEMPORARY AND PERMANENT DISABILITY

There is good reason to believe that the insurance against disability can best be treated not by a single insurance system but by two systems closely coordinated. There is, first, the problem of the temporarily disabled worker—the workers who has an acute illness and for whom there is every reason to expect that, after a few weeks or a few months, he will recover and return to work. There is, second, the problem of the permanently disabled worker—the worker who, by reason of crippling or chronic illness, will probably never again be able to enter gainful employment. The administrative problems to be met in paying benefits to the first worker are quite different from those which arise in the case of the second worker, and there are important reasons for believing that the rate of benefits provided through insurance should not be identical. An arbitrary line may be drawn between temporary and permanent disability, defining the first, for example, as disability lasting less than 26 weeks and the second as disability lasting more than 26 weeks.

Temporary disablement is much like temporary unemployment. Insurance against temporary disablement may be patterned after unemployment compensation, with repetitive certification of disability by a physician as a procedure analogous to repetitive registration at an employment office.

Permanent disablement is more like old-age retirement. The permanently disabled worker leaves the labor market in the same sense as does the aged person; both of these classes of persons permanently cease to have earnings. The disabled worker is generally younger than the retired worker and therefore more often has a dependent spouse and dependent children. Hence, assurance of some income is at least as urgent, socially, for the disabled as for the aged. Not involving the need for repetitive certification (except for those cases in which recovery or rehabilitation is possible), permanent disability (invalidity) insurance is similar to old-age insurance where certification of retirement age establishes the basis for the award of a retirement annuity. Permanent disability insurance may, therefore, be conveniently patterned after old-age insurance and may actually be established by introducing invalidity benefits into the present old-age insurance system.

Temporary disability compensation, patterned after unemployment compensation, would involve a cost of approximately 1 percent of wages. With a substantial but not unreasonable waiting period—7, 10, or 14 days—this would probably support benefits calculated at 50 percent of wages for a maximum of at least 26 weeks. The allocation of the cost may have to be different from that which is customary in unemployment compensation.

Permanent-disability insurance with benefits geared to old-age benefits, would probably cost 0.1 to 0.2 percent of wages at the outset and the cost may be expected to rise in the course of years, attaining between 1 and 2 percent of wages in 20 years and perhaps 1.5 and 3 percent a generation or two later, the exact cost depending upon the benefits provided and upon numerous other factors.

A disability compensation program is not primarily part of a medical-care program. Nevertheless there are important interrelations between the two. The cost of compensation for disability would be needlessly high if wage earners generally did not receive essential medical care. Hospitalization and other institutional care, and vocational rehabilitation for workers who are disabled, are essential if those who can be restored to working capacity are to receive the necessary care. Without such facilities and services, the cost of invalidity annuities would be unnecessarily burdened. These and similar considerations indicate some of the interrelations between disability insurance and a general health program.

CONCLUSION

This discussion of Recommendations IV and V submitted by the Technical Committee on Medical Care has probably raised more questions than it has answered. The Committee's purpose has been to present the needs which exist and to outline, only in broad terms, the general pattern of programs to meet these needs.

It is obvious that Recommendations IV and V deal with somewhat different procedures, but both bear on common problems. The fundamental objectives involved here are: First, conservation of health and vitality; and, second, reduction of the role of sickness as a cause of poverty and dependency.

This report from the Committee began by dealing with the needs of self-supporting persons. It has inevitably come to deal both with

them and with the more unfortunate. A general program of medical care therefore makes provision simultaneously for both. No one wants two systems of medical care—one for the self-supporting and another for the needy—any more than two systems of education.

Though not explicitly stated, it has been assumed throughout the Committee's report that any general program would provide for effective coordination between preventive and other services. It has also been assumed throughout that such a program, by furnishing a strengthened economic base, provides new opportunity for improvement in the quality of medical services through the concerted activities of official agencies, educators, and practitioners.

In good times and in bad times, sickness is a major cause of poverty, destitution, and a large part of all dependency. Through periods of prosperity and of depression, sickness still remains the most constant factor in dependency. It occurs more frequently and for longer periods among the unemployed than among the employed, among the poor than among the rich. It is associated with various other manifestations of social disorganization, such as unemployment, low income, poor housing, and inadequate food. If we are to lessen destitution and poverty, if we are to penetrate to the causes of dependency, we must strike simultaneously at this whole plexus of social evils within our society. It is of little avail to employ modern techniques in solving the problems of unemployment, housing, and low wages if we leave to the forces of laissez faire the problem of sickness which pervades and contributes to these other factors in dependency, because so frequently it strikes down otherwise self-supporting persons.

During the last quarter of the nineteenth century, public health authorities and medical practitioners made a brilliant and successful record through a mass attack on unhealthful environments and on communicable disease. But we cannot be satisfied with the great achievements of the past. A similar attack is needed now on the ailments and disabilities of individuals. Our primary concern at present is not with catastrophic plagues, but with ever-present diseases responsible for the disabling illness of 5 or 6 million persons.

We have been derelict in failing to work more actively to prevent dependency. Many widows and orphans are now being supported at public expense who have been deprived of their natural support by preventable accidents and equally preventable diseases. Many persons are now among the unfortunate whom we label as the "unemployables" solely because they could not afford the medical care that would have kept them employable and independent. So long as we fail to provide adequate programs for medical care and for protection against loss of earnings, just so long are we permitting the creation of a permanent class of disability dependents. The sick do not gather in crowds on the streets of our cities, but their needs are not less urgent.

The Committee submits this report with the hope that the recommendations may serve as a basis of discussion on which to crystallize a program to meet the basic essentials of a Nation's health.



EXPLANATORY STATEMENT

In the fall of 1937 the President's Interdepartmental Committee to Coordinate Health and Welfare Activities charged the Technical Committee on Medical Care to survey the health and medical care work of the United States Government.

As the study progressed, two facts became increasingly clear to the Technical Committee: First, that existing services for the conservation of national health are inadequate to secure to the citizens of the United States such health of body and mind as they should have; second, that nothing less than a national, comprehensive health program can lay the basis for action adequate to the Nation's need.

These facts were impressed upon the Committee from a general review of current health and medical services, from the substantial bodies of information available to various branches of the Government, and from recent surveys conducted by governmental and non-governmental agencies. The Committee records its indebtedness to the numerous groups which have generously supplied information.

In spite of the gains made in the preservation of life during recent years, the utilization of health and medical services has been irregular and uneven. There are serious inadequacies everywhere in the health services of the United States, and the deficiencies are acute in many areas and among large groups of the population. Unaided, States and local communities cannot deal with their existing problems. The Technical Committee, therefore, has submitted recommendations on Federal participation in a national health program, giving special consideration as to how best, and to what extent, the Federal Government may discharge its responsibilities in the field of health conservation, while leaving due and ample place for the work of State and local governments, and for voluntary action.

The Technical Committee presented a program containing a series of specific recommendations, five in number (see pp. 1-4). Some of the recommendations are broader than others; one may include all or part of what is proposed in another. Each recommendation deals with a certain phase of the problem. In some important respects the five present some alternative choices, especially in respect to the scope of a program to be undertaken. They complement one another and lead, all together, to an inclusive program of health and medical services to all the people. Action is needed on all the fronts represented in the five recommendations, and as rapidly as resources, personnel, and public opinion make possible.

The report of the Technical Committee on Medical Care was considered in detail by the Interdepartmental Committee to Coordinate Health and Welfare Activities, and after discussion, it was accepted as a report of the Interdepartmental Committee. It was submitted to the President on February 14, 1938. The section of the report dealing with the Need for a National Health Program was made available for distribution in order that it might be fully discussed.

On March 8, 1938, the President wrote to the Chairman of the Interdepartmental Committee:

I suggest that your Committee give consideration to the desirability of inviting at some appropriate time representatives of the interested public and of the medical and other professions, to examine the health problems in all their major aspects and to discuss ways and means of dealing with these problems.

Following this suggestion, the Interdepartmental Committee to Coordinate Health and Welfare Activities called the National Health Conference to meet in Washington, July 18 to 20, 1938, to present and discuss the needs of the people of this country for preventive and curative service in illness and for the reduction of the economic burdens caused by illness, as revealed by governmental and other studies; and to discuss steps which may be taken to meet these needs, as proposed by representatives of the Government and by members of the Conference.

Invitations were sent to approximately 275 men and women from the medical professions, from agencies actively interested in health and medical services, and from labor, agriculture, and other groups of citizens. A total of 176 of those invited attended the Conference and participated in its discussions.

As stated by the Chairman of the Interdepartmental Committee to Coordinate Health and Welfare Activities, those in attendance at the National Health Conference were not asked to endorse any of the specific recommendations of the Technical Committee on Medical Care. The recommendations were laid before the Conference and the country for attention and constructive criticism.

Senator MURRAY. The hearing this morning was called for the purpose of having Senator Wagner introduce some witnesses who are anxious to be heard before the regular meetings of the committee will commence. These witnesses are in town, and it will save them the trouble and inconvenience of having to come back again.

Senator Wagner will now present the witnesses to be heard at this time.

Senator WAGNER. Mr. Chairman and members of the committee. I want to thank you very much for granting these witnesses an opportunity to be heard out of the order of the regular meetings. I prefer to defer my own statement outlining the provisions of the bill until the formal hearings begin.

Those here represent very important farm organizations and farm groups, personally well informed, and also holding positions so that they may speak with authority for these different organizations. As the chairman said, they are here on another mission and they are very grateful to you for affording them the opportunity to present their views now so that they may not have to come back for the regular hearings.

The bill was just outlined by the chairman. The rural areas are particularly interested. Each title specifies that grants authorized are to be made available "especially in rural areas and in areas suffering from severe economic distress." The matching formula for grants-in-aid vary according to the relative per capita incomes of the States. Predominantly rural States have low per capita income, and consequently would receive a higher proportion of the Federal funds.

I think we are all agreed that that is a very worthy objective and activity of the Federal Government.

Without taking further time, I would like to introduce Mr. Edward A. O'Neal, the president of the American Farm Bureau Federation of Chicago, Ill.; and who is known to all of us, of course. I would like to ask him to be the first witness, and if he may, to present the other witnesses to be heard by the committee.

STATEMENT OF EDWARD A. O'NEAL, PRESIDENT, AMERICAN FARM BUREAU FEDERATION, CHICAGO, ILL.

Mr. O'NEAL. I appreciate very much this opportunity, and with your permission I will read a brief statement showing the position of the American Farm Bureau on this subject.

My name is Edward A. O'Neal, president of the American Farm Bureau Federation, headquarters in Chicago, Ill., speaking for 40 organized States.

The American Farm Bureau Federation for several years has been concerned with the inadequacy of the health and medical facilities, especially in rural areas. A little over 2 years ago I appointed a national committee on medical care with representatives of all regions of the United States to study this problem and make definite recommendations to our board of directors. The committee studied this problem over a period of 2 years, conferring with representatives of the medical profession and others from whom information could be obtained. In cooperation with the American Medical Association a

survey was made of the health and medical facilities available to farm people.

The studies of our committee further confirm other studies showing the inadequacy of the health and medical facilities available to farm people. Great numbers of farm people are unable to obtain adequate medical and hospital care for their families. The costs of medical care are all too often out of line with the ability of farm people to pay.

Our committee made definite recommendations to the American Farm Bureau Federation which are embodied in resolutions which were given approval by the Associated Women and the American Farm Bureau Federation at our annual meeting last December.

Following the action of our annual meeting, our executive committee, meeting here in Washington in January, adopted a legislative program to carry out the resolutions of our annual meeting. Included in this program of matters requiring major attention was the following objective:

Since it is further apparent that preventable disease and lack of proper medical care and hospitalization in some areas cause great economic loss and human suffering, the Federal Government should reasonably extend its public-health program with respect to maternal and child health, rural hospitals, public-health services, and medical care for those unable to provide such care for themselves.

Last summer several representatives of the Farm Bureau Federation attended and participated in the National Health Conference called by the Interdepartmental Committee on Health, at which time the recommendations of our organization were presented.

So far as national legislation is concerned, the American Farm Bureau Federation favors Federal grants-in-aid to the States for the following purposes: The extension of maternal and child health services, the improvement and extension of public health facilities, the development of more adequate facilities for rural hospitals and health centers, the extension of aid to the States in providing health and medical care to persons unable to obtain these services.

We favor the objectives of the Wagner bill (S. 1620) which provides for grants-in-aid for these purposes. I am glad to note that throughout the bill in the provisions relating to the apportionment of funds to the States special attention is directed to the need in rural areas. We would like to see the bill further strengthened in this respect, so as to provide more specifically for the apportionment of funds to the States on a basis which will assure that the States which need the money the most will receive the largest share of Federal funds, and so that the Federal funds may be utilized primarily to equalize health and medical facilities.

Due to the enormous concentration of taxable wealth in urban and industrial areas which has taken place in this country over the years, we face a condition of great inequality as between the States with respect to their ability to provide for public education, public health, and the other necessary services for the welfare of our modern society and the well-being of our people. In order to conserve the health of all of our people and bring about a greater degree of equality in health facilities throughout our Nation, the assistance of the Federal Government through grants-in-aid to the States is necessary in order to enable all the States to deal with these problems effectively. Such

legislation should safeguard the rights of the States to develop their own programs to meet their own local needs. The Federal Government is not justified in assuming the burden of supporting the health and medical facilities that the States can and should bear. The assistance of the Federal Government is justifiable only to the extent necessary to bring about equalization of health and medical facilities in rural areas. This is a problem of national as well as local concern. The rural areas are rearing, educating, and training millions of youth to go to the cities to live. On the average throughout the United States about 40 percent of the young people living on farms move to the cities and towns, and during the 10-year period ending in 1930, 60 percent of all the people leaving the farm came from farms south of the Mason and Dixon line.

It has been estimated by Dr. O. E. Baker, of the United States Department of Agriculture, that:

the cost to the farming people of feeding, clothing, and educating the more than 6,000,000 farm people, mostly youth, who left the farms during the decade before the depression and did not return, at least during that decade, may be estimated at approximately \$14,000,000,000.

Because of migration of such large numbers of rural youth to the cities, it is a matter of practical concern to the future welfare of the urban areas that they be concerned with the health of the youth who come from the rural areas, so that they may be better prepared to assume the responsibilities of citizenship and earning a livelihood.

The fundamental philosophy upon which our Nation was founded is equal opportunity to all. Equality of opportunity is the foundation-stone of democratic government. Without it we cannot hope to maintain the democratic ideal which America holds dear.

We, therefore, favor the objectives of the Wagner bill which are directed toward the end of equalizing health and medical facilities.

Unless there are some questions, I would like to introduce the next witness.

Senator MURRAY. You mentioned the inadequacy of the States to take care of this problem. I suppose you are familiar with the conditions that developed in the "dust bowl" areas of the country, which rendered thousands of families destitute?

Mr. O'NEAL. Yes, sir.

Senator MURRAY. Is it not a fact that in many of those areas, the medical profession withdrew and left them stranded entirely?

Mr. O'NEAL. Yes, sir. That is true to a lesser degree in many areas of the United States. The country doctor is a thing of the past.

Senator MURRAY. And, in many instances, the Red Cross had to be called upon to render emergency help in communities of that kind?

Mr. O'NEAL. Yes, sir.

Senator MURRAY. That is all; thank you.

Mr. O'NEAL. Now, if I may, I would like to introduce Mrs. H. W. Ahart, who is president of the Associated Women of the American Farm Bureau Federation. She is from California, and I might say that the Associated Women is the affiliated organization, the woman's branch of the American Farm Bureau Federation. She will tell you all about it.

STATEMENT OF MRS. H. W. AHART, PRESIDENT, ASSOCIATED WOMEN OF THE AMERICAN FARM BUREAU FEDERATION

Mrs. AHART. Senator Wagner, Mr. Chairman, and members of the committee, I am Mrs. H. W. Ahart, the president of the Associated Women of the American Farm Bureau Federation. We are organized in 40 States and have a membership of nearly half a million farm women.

In this country there are 55,000,000 people living in rural communities, so it seems rather important to discuss the problems of providing medical care to this vast segment of our population.

All of the objectives of the American Farm Bureau Federation and of its affiliate, the Associated Women, are specifically identified with improvement of national welfare. It is common knowledge that our program goes far beyond the field of mere agricultural improvement; it extends into every phase of national well-being which American rural life touches daily.

Our organizations have definitely expressed themselves on the problem of obtaining adequate medical care for our rural people.

We desire to obtain this medical care at terms commensurate with the ability of our farmers and their families to pay for its costs.

Rural people are traditionally proud and desire to pay their way insofar as it is humanly and practically possible.

We recognize the fact that our health services are inadequate, not because of the capacity to produce but of the capacity to distribute, and that the greater use of preventive and curative services which modern medicine has made available waits on the purchasing power rather than on the need of community or individual.

What do we mean by adequate medical care. In answer to this question, I should like to present a compilation of answers given by representative farm women throughout rural America. These women said they should include the following:

First, regular health examination of all individuals, adults and children, the emphasis to be not on the cure of the disease but on preventive measures.

Second, prompt care of anyone who is ill, such persons to have the privilege of a complete examination to determine the nature of the illness, including adequate consultation with specialists where needed, adequate hospitalization, nursing, operative procedure when necessary, and adequate convalescent care to be provided.

Third, prenatal and postnatal care for the pregnant woman.

Fourth, medical provision for children until they begin to go to school, babies, of course, included.

Fifth, adequate medical attention for all school children, not only with reference to disease but also to the child's physical development.

Sixth, the organization of knowledge to attack successfully tuberculosis, cancer, syphilis, allergic diseases, cardiac disease, disease of the nervous system, and so forth.

This list includes the composite thought of several thousand farm women. It thus comprises the recommendation that we should make. This is the service we wish for our farm families.

Evidence from all directions points to a startling decline in population growth. There is a grave possibility of a stationary America within a very few years and likelihood of declining numbers within a few decades.

Statistical evidence indicates that there will be about 1,000,000 fewer children between the ages of 9 and 16 in 1940 than in 1930.

Agricultural States hold up well in contrast to the great eastern centers where the decline in birth rates is staggering. In other words, our large urban centers must depend on human replacement from the farms of America. The farm people of the Nation are providing the foundation of human resources upon which this country is building its future. Yet, how recklessly human life in rural America is being wasted. Some 12,000 women die annually from causes connected with childbirth, 75,000 babies are still-born each year, and 70,000 die during the first month of life. It has been estimated that two-thirds to three-fourths of these deaths are avoidable or preventable. Many of our rural communities today are in dire need of suitable medical attention and hospitalization. Throughout the land, many a rural community has poorer medical facilities at its disposal today than it had a generation ago. Even at the peak of agricultural and national prosperity four-fifths of the rural areas of the United States lacked any organized health service. As to hospitals, nearly 1,300 (42 percent) of the counties in the United States have no registered general hospitals. A total of 31,000,000 people now live in areas with less than two general hospital beds per 1,000 persons.

We have presented our brief on High Cost of Medical Care versus Rural People. We have appealed our case to the supreme court of public opinion and the decision has been rendered in our favor.

The house of delegates of both the Associated Women and the American Farm Bureau Federation at their last annual meeting in New Orleans pledged themselves to work for the enactment of legislation as provided in the following resolution adopted by the Associated Women and approved by the American Farm Bureau Federation.

III. RURAL HEALTH

Since representatives of the American Farm Bureau Federation and Associated Women of the American Farm Bureau Federation attended the National Health Conference, called by the President in Washington, we endorse the principles of the resolutions presented by them at that time.

1. EXTENSION OF PUBLIC HEALTH SERVICE

Much of the costs entailed by sickness can be averted or reduced by preventive measures. The curtailment of disease is to the betterment of our society, but the costs are beyond the economic resources of many of the people: Therefore be it

Resolved, That the Associated Women of American Farm Bureau Federation hereby approves and urges the extension of all forms of preventive medicine throughout the country, particularly in the rural areas, and that the Associated Women further recommends a greater appropriation of funds under the Social Security Act for this purpose.

2. RURAL HOSPITALS

The protection, conservation, and restoration of the health of the people is a matter in which the Government must be interested for its own welfare. Since adequate hospital facilities are indispensable in the proper care of the sick, and since hospitals are inaccessible to many rural people living in sparsely settled sections of the country: Therefore, be it

Resolved, That the Associated Women of American Farm Bureau Federation urges the establishment of hospitalization facilities and provision for adequate medical care, accessible to all of the people at a price within their ability to pay.

3. MEDICAL CARE IN RURAL AREAS

It is impossible for the individual to predict the cost of adequate medical care. Attempts to meet this situation are being met by numerous plans providing for prepayment of medical services and hospitalization on an insurance basis. It becomes apparent there is need not only to protect the members of the medical profession from burdensome regulation but to also protect the insured from exploitation; Therefore be it

Resolved, That the Associated Women of American Farm Bureau Federation recognizes this problem and recommends that the several State federations of the American Farm Bureau Federation take action looking forward to the enactment of necessary regulation embodying these principles.

4. CHILDREN'S BUREAU

We recommend strengthening of the Children's Bureau so that these agencies in the United States and her possessions may provide further extension of maternal and child health work in all of its aspects of Federal and State cooperation.

The bill introduced by Senator Wagner (S. 1620) carries out many of these objectives of our resolution. It provides for Federal grants-in-aid to the States, for the extension of maternal and child-health services, for the expansion of public-health work, for assistance to the States in the construction and improvement of hospitals and health centers, and grants assistance to the States in providing medical care to persons unable to obtain it. We know no definite resolution with respect to the proposal in title XIV of the bill providing grants to the States for temporary disability compensation.

We feel very strongly that the funds which are to be allocated to the States under this bill should be apportioned on the basis of the health needs of the respective States and the inability of the States to provide adequate health facilities in such a way that the States and areas within the States which need the money the most will receive the largest share of the funds.

Studies which have been made show that the greatest deficiencies in health facilities, hospital facilities, and medical care exist generally in the rural areas. Furthermore, these areas generally have the smallest financial resources with which to provide and maintain health facilities. Farm families and rural areas oftentimes are making the greatest sacrifices in order to provide these services, even though the facilities are much less adequate than those available in urban areas.

The Wagner bill recognizes this need of the rural areas by specifying in each case in connection with the grants to the States that these funds are to be utilized for the purposes specified "especially in rural areas and in areas suffering from severe economic distress." This recognizes where the principal need exists, but in addition we feel it would safeguard and improve the effectiveness and usefulness of this program if a more definite formula and mandate were written into the bill with respect to the apportionment of funds to the States so as to require the distribution of funds on the basis of need and the inability of the States to supply these services.

As a member of the National Health Conference called by the Inter-departmental Committee last summer, I was deeply impressed with the unanimity of sentiment among the delegates representing a vast cross section of the American people in almost every occupation and profession, as to the inadequacy of our health and medical facilities and the imperative need for national action to meet these needs.

We strongly endorse and support the objectives and purposes of this legislation which carry out the objectives of our resolutions, and hope that favorable action by Congress can be had along these lines.

I thank you.

Senator MURRAY. You mentioned in your testimony the necessity for fixing a formula for the distribution of the funds to the various States. Have you any suggestions to make as to the form of such a plan?

Mrs. AHART. Well, according to the bill S. 1620, the States have to prepare the program and submit it to the various agencies for their approval, and I would suggest that the various people in the States could get together on this program and submit it.

Senator MURRAY. Where the distribution is to be made on the basis of need, it is a very difficult thing to figure out a formula that would cover the entire country, it seems to me.

Mrs. AHART. I think every State has to make its survey and determine just where the need is to be, and submit this to the various State legislatures or to the various State agencies, rather, and then it be turned into the National agencies for their approval and suggestions.

Senator ELLENDER. Mrs. Ahart, I notice on page 3 of the bill there are four conditions to be taken into consideration in distributing the funds to the States. It states on line 12:

(1) The total number of births in the last calendar year for which the Bureau of the Census has available statistics.

That will certainly take care of the country or rural areas' needs more so than that of the city, because I think the figures show that the birth rate in the country is a great deal higher than that in the city. Is that true?

Mrs. AHART. Yes.

Senator ELLENDER. Then "(2) The number of mothers and children in need of the services". I think that is another condition where again the rural needs would prevail over the city. And No. 3. "The special problems of maternal and child health" and "Fourth, the financial resources".

Could you suggest any other condition that would necessitate more of the funds be given to the needs of rural areas?

Mrs. AHART. Well, as we said in our testimony, both Mr. O'Neal and I, that we are facing in the rural areas a great economic crisis, and consequently I presume—I did not perhaps just get what you are referring to—but if the States—they would probably have to make a larger appropriation, or the community would, in those districts where the financial resources are inadequate. Is that what you mean?

Senator ELLENDER. I say, those four conditions stated there, that I just named to you would, in my mind, lead us—

Mrs. AHART (interposing). To the rural areas.

Senator ELLENDER. To the conclusion that a formula has been prepared to help the rural areas?

Mrs. AHART. Yes, sir.

Senator ELLENDER. Where you find more necessity for the services?

Mrs. AHART. Yes, sir. Of course, we realize that in certain portions of our cities, there is a large birth rate also, and also the cities need help too, but I am just appealing now for our rural people to.

strengthen further the formula for distribution of funds to the States, so as to assure that the funds will be distributed on the basis of need.

Senator ELLENDER. But I think the statistics show that the birth rate in the country is a great deal more than it is in the cities?

Mrs. AHART. Yes, and I think those four things will help the rural districts greatly.

Senator ELLENDER. To get them more money than they would otherwise have?

Mrs. AHART. Yes, sir; I think so.

Mr. O'NEAL. I should now like to present Mrs. Charles W. Sewell, of the Associated Women. Mrs. Sewell is from Indiana.

STATEMENT OF MRS. CHARLES W. SEWELL, ADMINISTRATIVE DIRECTOR OF THE ASSOCIATED WOMEN

Mrs. SEWELL. Senator Murray, and gentlemen, I am Mrs. Charles W. Sewell, representing also the Associated Women, with the position of administrative director. Before the Associated—the association of the present name was set up, I served as the home and community director of the American Farm Bureau for the past 10 years, so that I have been fairly familiar with the situation nationally, but I should particularly like to call attention to the need in my own Midwest, because that is supposed to be the section of the country which is well provided for.

I might say that I have no prepared statement—I just want to speak to you about it.

I think that for the period of years which the American Farm Bureau has been organized, we have perhaps been usually thought only to be an economic organization, but in the constitution of the American Farm Bureau, the aims are set out as being for the purpose of advancing, promoting, and protecting the business, the economic, the legislative, the social, and the educational needs of the farm family. Very early in the history of the organizations, we took a definite stand on proposals and provisions of the old Shepard-Towner bill providing for more help and money for maternal and child-welfare care, particularly in the rural areas.

We are rapidly approaching Mother's Day, which comes early in May. I think perhaps it might be well to remember that many of the white carnations which will be worn on that day in honor of a departed mother, and many of the deaths were from causes due to childbirth which we believe can be preventable.

In the Middle West, we have not quite the same economic propositions which confront the people of some other areas of the country, and yet there are vast portions of the Middle West which due to crop failures, the "dust bowl," or many of these things that have come to us in the last few years, have been very, very hard to bear. I should like particularly to call attention to those farm people, who are trying to pay their way and who are very much in need of some provision that will enable them to take care of medical needs in a little better way.

We feel, too, in regard to the maternal and child-welfare needs, that there is a great deal of need for better training of obstetricians. We usually have in the rural areas, as president O'Neal has brought out—we have the vanishing country doctor—but those who are left

are many times the very busy and overworked practitioner who has not been able to go back to school or into the city hospital for some of the new and up-to-date methods since his graduation. He has not had the opportunity, perhaps, to read and study as he might with a number of colleagues in a city clinic, and so he consequently is not prepared to take care of the emergencies which are coming up at the present time and constituting very many tragedies. So we should like to read into this record that we believe this to be one of the great needs.

I live in a naturally rich agricultural county of Indiana, the farthest boundaries of which lie 40 miles from the nearest hospital, and that many times constitutes a loss of time which is very, very much regretted. So there are needs in all of these fields, we believe, and we feel that this bill which is under consideration offers a great deal to carry out some of the principles which have already been brought before you as being the program of the American Farm Bureau, and the Associated Women of that organization.

We have tried very honestly to study all proposals suggesting a remedy for these needs. We find we cannot meet them by individual effort. The concentration in the cities makes it so very necessary, increasingly necessary and apparent as the years go on, that we must call upon all of the people to help equalize and iron out these affairs.

I should like to say to you that I have been told by many agencies that at the present time, one-tenth of the Nation's income is being received relatively by the Nation's rural population. Two-tenths of the child-bearing mothers reside in the rural areas, and two-tenths bear three-tenths of the Nation's children, so that we believe that we have a case here, as has already been stated.

Thank you.

Senator ELLENDER. You are from the rich State of Indiana. Would you be able to tell the committee how many charitable hospitals there are in the State of Indiana, and where the State maintains them?

Mrs. SEWELL. No; I could not, but I think there must be someone in the room who can. May I call Dr. Elliott?

Senator ELLENDER. She will probably testify.

Mrs. SEWELL. Yes; I think that she will testify later. I am not prepared, Senator Ellender, to tell you that. The hospitals of which I know, they are private, but there is a provision for some charitable work, but it is very, very inadequate and does not take care of the people as we need to at the present time.

Senator ELLENDER. But you do not know of any charitable hospital in your neighborhood in Indiana?

Mrs. SEWELL. I certainly do not; no, I do not.

Senator MURRAY. Thank you for your statement.

Mr. O'NEAL. Our Associated Farmers seem to be a little late. The Farmers Union people are coming. I understand that they will be here in a few minutes. I have no other witnesses here.

Senator MURRAY. Then we will recess until 11 o'clock.

(Whereupon a short recess was taken, after which the hearing was resumed.)

Mrs. SEWELL. I should like to present Mrs. Saidie Orr Dunbar, president of the General Federation of Women's Clubs.

**STATEMENT OF MRS. SAIDIE ORR DUNBAR, PRESIDENT,
GENERAL FEDERATION OF WOMEN'S CLUBS**

Mrs. DUNBAR. Mr. Chairman and members of the committee, I regret to say that I have no prepared statement. I have just come from the Conference on Children in a Democracy and I have not had the opportunity to prepare a statement relative to the bill.

May I speak to you from two standpoints? I served for 25 years in the State of Oregon as one of the voluntary health workers. I was voluntary secretary of the Tuberculosis Association in a strictly agricultural State. We have a State of magnificent distances in Oregon, and we have, as you know, a very largely rural population. I began as one of the pioneer public health workers in that State, and I am thoroughly familiar with every problem of the rural areas as well as the urban communities of our State.

I began at a time when there was practically no health machinery. There was no satisfactory State health program in that the State board of health was not adequately financed. It had a very inadequate staff, it had no money for transportation, it had no way of developing local units, and so there began in my State, as in many other States, a program of joint participation.

Wherever volunteer agencies could finance their work they would do it through the cooperation of the medical society, the county board of health, if there was one; the county health officer; and the State health department. We developed a very fine cooperative program. We moved along in a very small way. We occasionally got a full-time health officer. We moved very slowly. We placed many more public-health nurses. Oregon has gigantic counties—one county, for instance, is as large as the State of Connecticut—and we had very sparse population in some of those counties, so that even with a full-time worker the program was still inadequate. We had to face the fact of high maternal and child death rates; we had to face the fact that whenever a given investigation was made or medical examination was made of our children, the children in the rural communities showed a high percentage of physical defects, even higher than the adults. We had to face the fact that we had many mothers and children beyond the reach of medical attention, or if they received any attention it was just occasionally.

I had in my State when I first began to work one town that was 110 miles from the nearest doctor. You can understand that that constituted a problem in itself.

So the emphasis was first to place the services that would enter as many homes as possible, that would reach as many persons as possible, particularly the mothers and children, and particularly school children, and to confine our activities as volunteer agencies to cooperation with the additional agencies in that field. Then when other legislation would be passed by the State, or by the Federal Government, with State participation, we would offer better health if we possibly could, either through the control of communicable diseases or other methods for which the State might put on additional workers.

We moved along in that way until we came to the depression. I think it was a fine, conservative, and steady growth. We would never have had any reason in the world to apologize for the progress that we made under our own initiative, our own steam and finances. But

it was not fine enough and was not reaching enough people and was not solving the problem. Then the depression, as I said, came along, and we found that more and more people could not take care of their problems. Fewer and fewer people were having medical care, fewer and fewer mothers were being taken care of properly, and more and more children were showing up at the schools inadequately prepared physically for this great transition in their life, and so we began to hold a series of conferences; and when I say "we," I mean that the process was repeated in over 40 States. We began to hold conferences as to what to do. We began to seriously look into all of the sources of revenue and finances.

I think the saddest chapter of the depression is written on the pages of county history. Counties very soon found that they could not carry the burden of the relief problem, let alone adequate health services, or a program of prevention. And yet there were those of us who were working as teachers and volunteers who saw that this problem was going to increase and expand and extend, and unless we did work in the preventive field, that the load was going to get greater and greater.

And so we did what everyone else did—we turned to our State board of health. The State boards of health did not have the money; they could not take over services which the voluntary agencies had started. And finally our State did just like what all the other States did—turned to the Federal Government. And when the appropriations were made through the United States Health Service, it was to our State board of health.

In my State we all agreed to pool all of our strength there so that we would have united strength. I represented a voluntary agency that gave the State board of health one worker after another, by giving them money to have addition work done. If there was a proven need and they did not have the money, we gave them money. I suppose you would not be interested in the figures, but that is the way we started out in the development of a steady program.

It would be absolutely impossible for these rural communities under the present condition of the average State finances to assume the responsibility that we owe to our citizenship, particularly our women and children and the homes of our States, unless we are going to have a combination service, unless there is money coming in to help the State board of health to maintain its high standards, and unless there is a possibility of the extension of those services. So I think you will find amongst the volunteer workers a united appeal that there be no lessening—on the other hand, that there be an expansion of this public-health service. We think that those services are vital; we think that they are absolutely essential to the well-being of America. We think that they are absolutely essential to the well-being of the homes of America. We think that the children are all-essential.

Off the record, if you would like to have a quotation, Homer Folkes made a very strong statement at our conference, in which he said:

If we knew today which one of our children would be president in 1980, how carefully we would wish to prepare him for leadership. We have no way of finding this child and singling him out. He may come from any home. Since we do not know who he is, we must provide the minimum facilities for all children. Not only for our future President, but for everyone who will determine the future of our democracy.

And that is the way the mothers feel, and that is the way social workers and the public-health workers feel. We owe this thing to our children, and in this time of stress and strain, which we as social workers recognize, the demands of the aged for pensions, and so on, still we recognize that these things should not be done at the sacrifice of our children and our homes and our health and our well-being.

Then may I come to you now as the president of the General Federation of Women's Clubs? That is an organization with representatives and representative clubs in every section of the United States. There are 14,558 clubs affiliated with us, and we have a membership of 2,000,000. We are very proud of that. Their direct members are affiliated members with their State and county federations. But we do not boast a power or strength unless we are willing to assume a sense of responsibility.

The Federation of Women's Clubs has from the very beginning supported certain things that we are now asking for and asking you to give your most serious consideration to—maternity and infancy programs, for instance. It is a matter of concern to us far more than it is to those who are considering it for the first time, that we have not been able to pull down the death rate in maternity and infancy more rapidly and more surely than we have. That is partly due to a lack of services. Some of the figures that were given to us in the last 2 days were very startling, of the mothers who are confined without any help at all—just neighborly help—the women who are not having adequate medical services, the children who are not having adequate medical services.

When a child enters school, he is fortunate if he goes to a school that gives a medical examination to its children. It is an indictment of the services of the home, if we cannot give this care to children before they reach this school age of 6 years, they are inadequately prepared to face this time of stress and strain in their lives. So our Federation has always supported programs for infancy and maternity. We have always supported the public-health agencies. I think that almost every health officer in the United States would stand and say that the Federation of Women's Clubs has been a very fine ally and a supporter and a friendly helper in the extension and development of his program, but we know that we cannot do it alone back there in those counties. The money is not there. We cannot build adequate machinery for it unless it is going to be a joint effort, and so we come to you with a petition that you consider the needs not only of the urban, but the rural people.

We are essentially a rural nation, and back in those counties they are, after all, the people in those further homes that are paying the taxes that are keeping the counties going. It is not a wide stretch of the imagination when we say that the time has come when the mothers and the organized women of America are asking for consideration of those things that make vital the homes in America in which children have to grow and live and develop. As these children go out of our homes with the stamp of those homes upon them, they must start out physically fit. We have come to the place where we are giving serious consideration to those three fields in which children have a vested interest, health, education, and the well being and welfare of children, and we earnestly petition that those of you

who represent us here at this great Capital will think of the children and put their interests forward and give them primary consideration, knowing that it is a permanent investment, and a subject of timely interest, and knowing that there are more people interested in this question of health and welfare today than at any other time.

It is my privilege as the president of the Federation to travel around about the entire United States. I am visiting each State in convention assembled, and so I am literally meeting hundreds of thousands of women in these 3 years that I shall serve. I have attended 16 State conventions this year, and I find that there is not any question that is receiving the same amount of consideration now as this question of health, education, and welfare, particularly of the children.

And so I will raise my voice both as the president of the organization I now represent, and as a woman who has given 25 years of her life in the field of health education in behalf of women and children and the home, of the health of the Nation, the home, the school, and the community in behalf of the future citizens of this country. I hope that this statement of mine has some value, and I hope that it has a degree of representation of the viewpoint of our Federation. I am leaving Monday for our national convention. We are going to have a resolution out there. It has been passed by the board of directors. It has three points. One is that we urge this Congress to give favorable consideration to every necessary legislation for the expansion of public health and the maternal and child health services, for the expansion of hospital, clinic, and other institutional facilities and for medical services for medically needy persons.

(The resolution mentioned above was passed by the national convention on May 10, 1939.)

The general provisions of medical care should be developed, we think, by the individual States in collaboration with their medical men and the medical leadership of that State, but we certainly are impressing upon our women the importance of needs of community health and medical services and of meeting them more adequately.

I thank you very much for according me the opportunity of making this statement.

Senator ELLENDER. Mrs. Dunbar, you are from the State of Oregon?

Mrs. DUNBAR. Yes, sir.

Senator ELLENDER. How much is the State contributing now for health services that you speak of?

Mrs. DUNBAR. I could not answer that to give you the figure exactly now, because the legislature has just adjourned, and I left a year ago.

Senator ELLENDER. How much has it been?

Mrs. DUNBAR. Those appropriations for the State board of health have been running into—I would say \$200,000 or \$300,000, all told. If you add what the counties are putting in, it is more, because many of our counties, through the joint program of the Federal and State and county, are installing a full-time county health unit, and then the figure goes up.

Senator ELLENDER. Do you know how many hospitals there are in your State that are State maintained or county maintained or city maintained?

Mrs. DUNBAR. The State has hospitals for the insane; we have two of those. We have two in operation and one in the course of construction for tuberculosis. Then we have the usual feeble minded, and the cost of those. That is all the State maintains. There are few of the county hospital hospitals—there are not very many. In the majority of these rural counties, the county does not establish a hospital. It may make a sort of hospital service or medical service at the Poor Farm or at an institution which they are running, but very seldom. I can name them all if you let me count my 30 counties.

Senator ELLENDER. But you do not really have any State hospital in the State of Oregon that is devoted entirely to the taking care of the poor?

Mrs. DUNBAR. No; we have not. That is a plan that is being worked out more or less in conjunction with the State relief committee. As a rule, it works this way, when we have a county relief committee which applies for help, the only hospital in that county may be a privately owned hospital. It may be owned by one or two doctors in that community. I have counties that only have one or two doctors in them; there may be six or eight or ten in others. Then sometimes they are on the contract basis, and sometimes it is on a daily fee basis that has been agreed upon by the hospital and the county court, if the county court sends the patients there.

Senator ELLENDER. Thank you.

Senator MURRAY. Are there any other questions?

(No response.)

Senator MURRAY. Thank you for your courtesy in appearing.

Mrs. SEWELL. I should like to present President John Vesecky, of the National Farmers Union.

STATEMENT OF JOHN VESECKY, PRESIDENT OF THE NATIONAL FARMERS UNION

Mr. VESECKY. My name is John Vesecky, and my home is in Salina, Kans. I am the president of the National Farmers Union. Our organization has been for a long time interested in public health. We have now in Elk City, Okla., a cooperative hospital that has been growing larger every year. The clinic there furnishes medical services for the farm folks at \$24 per annum for a family of five, with very low charges for hospitalization, operations, and other things, compared to the regular charges, but we find that that cannot be done everywhere. There are many of our communities that cannot even get that \$24 per family, because you have to have a good many families before you get enough of those \$24's to get not only the hospital but the right kind of medical staff for the hospital, because you have to have a good medical staff, and for that reason our organization last year at its national convention passed a resolution—shall I read it?

Senator MURRAY. You may read it.

Mr. VESECKY. The resolution is as follows:

Whereas the National Health Conference called by the President found that 31,000,000 people in the United States live in areas lacking in adequate hospital facilities and that thousands of people are dying each year from ailments that could be cured or prevented if adequate medical aid were provided; and

Whereas the Farmers' Union, recognizing the lack of medical care available to our farm families, blazed the trail in setting up the first cooperative hospital in the United States; and

Whereas the program developed at the National Health Conference is in complete accord with the resolutions previously adopted by the Farmers' Union, and is vitally needed if we are to close the gap between what is being done and what can be done to protect the health of our people; and

Whereas the national-health program which aims to bring medical care within the reach of all families by establishing clinics, cooperative hospitals, and health programs, is now being supported by all of the major farm, labor, and other organizations, and is being actively opposed only by a small clique of bureaucrats who are seeking to dominate the medical profession; and

Whereas the activities of the Farm Security Administration in bringing medical aid to rural families in a few areas, has shown the need for extending medical facilities and the tremendous value of such work; and therefore be it

Resolved, That this convention instruct the National Board to cooperate with other organizations in securing the passage of national-health legislation necessary to safeguard the health of our families.

Our farm people, especially during the last few years, are woefully deficient in the means to get the right amount of medical attention. Preventative medicine is almost entirely out of the question. They will wait until they are so sick that they can hardly move before they will call a doctor, and then they won't call him often enough because they do not have the money to pay, and they still are too proud, most of them, to take charity, to ask the doctor to come and attend to them when they cannot afford to pay him. For that reason, many of our children, and also the adults, contract diseases that could be cured easily in the early stages, but after awhile they just cannot be taken care of.

I have in mind a man that permitted a cancer to get such a start before he would go to the doctor's to find out what was the matter; we thought for awhile that he could not be cured. It happened that a few of us got together and dug up the money out of our pockets and sent him to a clinic, and he is cured now from the cancer, having gotten medical attention in time. Such things as that, if they could be handled with the aid of this Government subsidy or whatever you want to call it, would save thousands and hundreds of thousands of people from either having to die or go through life unfit to make their own living and to enjoy living as they should.

I believe that with the help the Government can give to equalize the opportunity of these people to get preventive medicine rather than only curative, will increase the health of this Nation so much that it will many times repay to the Nation what the cost would be as provided in this bill. We are very strong in favor of legislation of this type, but we do ask in passing the legislation that care be taken not to interfere with the work of people that are trying to build up cooperative hospitals and cooperative clinics.

We have had some experience with that. I don't know whether I should testify to that or not, but I believe that a bill drawn up like this bill is should safeguard the interests of the people who want to build up a cooperative health institution like ours at Elk City, and provision be made that nobody interferes and nobody sabotages the doctors that want to serve in such cooperative health institutions.

I believe that this bill provides that all doctors employed should be good doctors, and that we should insist that the medical people who have to do with these hospitals and with any of these clinics, should

be good doctors, but I do not believe that any doctor should be persecuted because he happens to connect himself with an organization built by the people themselves putting together their money and trying to get health insurance for themselves through a health clinic in a cooperative hospital. We are in favor of this measure and we hope that it will pass.

Thank you.

Mrs. SEWELL. I should like to present the next witness, Mr. James G. Patton, president of the Farmers' Union of Colorado, who has done a very fine piece of work in health matters.

STATEMENT OF JAMES G. PATTON, PRESIDENT OF THE FARMERS' UNION OF COLORADO AND MEMBER OF THE NATIONAL FARMERS' UNION BOARD

Mr. PATTON. Through our various agricultural programs which the Federal Government has instituted, we have been attempting at least to provide an economic-security program for farmers. It seems to me that one of the most important factors in a security program for farm people has to do largely with the health of our rural people. A family, particularly a rural family, cannot feel much security even though they may have a bit of economic security when the health of their children and their family is in danger or is impaired, because lack of medical attention and particularly some regularity as to medical attention is a vital factor.

I was discussing this problem of health with a group of Farm Security Administration in Denver recently, and was pointing out two or three services which they had made in contemplation of agreements with medical societies, county medical societies, and the question had been raised as to what compensation the County Medical Society members might receive for bringing the health of the people in the community up, and the people involved in the project, up to a standard where they could figure their costs on somewhat of an average basis. They took the position that the health of the people involved, who were low-income farmers, was in such condition, there were so many people with poor teeth and having diseases arising out of poor dental conditions, and other factors, that it would probably take a year or two or additional services or expert services in order to bring the health of these people up to a minimum standard.

I recently visited a project in Montana and had quite a discussion with a young chap who was a doctor on the project, and where some 150 families were involved, and I asked him if he had bumped into this same problem, and he said that he had done almost twice as much work as the preliminary survey which had been made had indicated that there would be, that every family had to have a lot of dental work, that there were bad tonsils, and many other conditions which contributed to rheumatism and arthritis, and other diseases of long standing.

We need definitely to move the mountain to Mohammet and not Mohammet to the mountain. In Colorado, for example, we have only one institution, the Colorado General Hospital, and the county commissioners have to okay it; and if you happen to have a way to the county commissioners, you can get to the hospital in time on emergency matters. If you do not happen to have a way to the county

commissioners, then you have to first find a way to the county commissioners politically, and then you get to the Colorado General Hospital.

Senator ELLENDER. Is that a State-maintained hospital?

Mr. PATTON. It is a State-maintained hospital.

Senator ELLENDER. Why must you go to the county commissioners?

Mr. PATTON. The clearance has to come through the county commissioners because they contribute. The State maintains the institution, but they contribute a per diem hospital fee to the State for their county patients, and indigents or people who are the same as relief clients are the only ones who can get that free of charge. Others have to pay a hospital-bed fee. In western Colorado we have no hospital facilities which are recognized by the American Hospital Association. In many of the Mountain States the same condition exists.

It therefore seems to me that it is time for the Federal Government to bring itself up to date in comparison with many European countries and to take into consideration the most valuable asset which we have, namely, the health of our people, particularly our low-income people. We can develop cooperative hospitals and cooperative medicine on a prepayment plan, but a farm family with \$275 to \$375 annual income cannot make much of a prepayment on their health bill. If this splendid bill, which is the result of years of study, is made a law, it seems to me that we shall have taken a very definite step in the way of progress to make America a better Nation. We are unqualified behind this measure and for it and urge the support of the Congress to it.

Senator MURRAY. Thank you.

Mrs. SEWELL. We feel that we have been able to bring to you these people representing widely diversified sections of the country, and we hope that we have proved that there is a need for this kind of provision and a place for it.

Unless the committee desires to ask some questions, we will rest the hearing at this time.

Senator MURRAY. We have listened to your statements with a great deal of interest, and I am sure that they will be of great help to us in studying the bill. If you have any other witnesses whom you would like to have had appear here today and could not, they will be able to present a written statement if they desire.

Mrs. SEWELL. That will be fine; we would like to have that privilege. Thank you very much.

Senator MURRAY. We will now recess until May 4.

(Whereupon, at 11:30 a. m., the hearing was recessed until May 4, 1939.)

TO ESTABLISH A NATIONAL HEALTH PROGRAM

THURSDAY, MAY 4, 1939

UNITED STATES SENATE,

SUBCOMMITTEE OF THE COMMITTEE ON EDUCATION AND LABOR,

Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in room 357, Senate Office Building, Senator James E. Murray presiding.

Present: Senators Murray (chairman), Ellender, La Follette, and Taft.

Senator MURRAY. Senator Wagner, who is the author of this bill, is present. Senator, we would like to have you make a statement in support of the measure.

STATEMENT OF HON. ROBERT F. WAGNER, UNITED STATES SENATOR FROM NEW YORK

Senator WAGNER. If I may be permitted, I will present a statement, after which, I understand Miss Roche, who has really been at the head of this movement, will make an additional statement, more in detail, on the specific facts demonstrating the need for national action.

Senator MURRAY. Yes; you may proceed.

Senator WAGNER. Mr. Chairman and members of the committee, the national health bill is the logical next step in the expanding role of the Federal Government in safeguarding the people's health. This role has evolved steadily with the impact of economic circumstances and the march of medical knowledge ever since the dawn of the Republic.

Spurred by the recurring menace of yellow fever, President John Adams, back in the eighteenth century, recommended "suitable regulations in aid of the health laws of the respective States." Congress responded with legislation authorizing Federal cooperation in the enforcement of State quarantine and health laws. About the same time, Congress established a system of compulsory health insurance for seamen in the merchant marine, a system which is the foundation of what we now know as the Marine Hospital Service. The scope of Federal action expanded with the development of bacteriology and the shifting emphasis of medical science from quarantine to disease prevention and positive health control. We have come a long way since Theodore Roosevelt put the full weight of his influence behind intelligent national action in the field of health. "This Nation," he urged in a message to Congress, "cannot afford to lag behind in the world-wide battle now being waged by

all civilized people with the microscopic foes of mankind, nor ought we longer to ignore the reproach that this Government takes more pains to protect the lives of hogs and of cattle than of human beings." Under his dynamic leadership and that of his successor, President Taft, the Federal Government first undertook the collection of vital statistics; provided protection against impure food and drugs; established the Children's Bureau, the first of its kind in the world, to safeguard the health and welfare of children; and extended the research functions of the Public Health Service into all the diseases of man.

Since 1917 Congress has made some appropriations, however slight, for cooperative health work between Federal and State agencies, notably in the fields of maternity and infancy under the Sheppard-Towner Act. The Social Security Act, with its appropriations for maternal and child care and public health work, marked another important milestone, and very recently we enacted special legislation establishing the National Cancer Institute and meeting frankly and squarely the problem of venereal-disease control. Work relief funds have made possible still further development of public health activities, and have given substantial aid to the States in the construction of needed hospitals.

Today, no responsible person challenges the proposition that the health of the people is a direct and vital concern of Government, Federal as well as State. The increasing realization of that fact impels us in all good sense to take stock of our own unmet medical needs, to coordinate more effectively what has already been done, and to lay down a rounded program for future development. Careful studies to that end, first undertaken by the Committee on Economic Security in 1934, have been carried to completion by a staff of Government experts, and presented for the consideration of Congress in a special message by the President.

As our resources of medical skill, facilities, and personnel have advanced, so have the costs of medical care increased, to a point far beyond the means of a large proportion of our citizens. As the general health level has been improved, so have the inequalities in the distribution of medical care been widened, especially as between rural and urban centers. These facts have been documented by a mass of data, gathered in survey after survey over the last 10 years, covering periods of prosperity as well as periods of depression.

The American people are already meeting a staggering bill for health services exceeding \$3,000,000,000 a year. Their plea is that the blessings of modern medical science be brought within the reach of all. They ask, as eloquently expressed at the recent national health conference, that "our Government take health from the list of luxuries to be bought only by money, and add it to the list containing the inalienable rights of every citizen."

The national health bill was drafted in response to that plea. There is urgent need for its enactment now, if the lessons of the facts we have marshaled and the sound diagnoses we have developed are not to be dulled by passage of time and eventually "lose the name of action."

There is no intention to put the Federal Government into the business of furnishing medical care, or to interfere with States in the

licensing of medical and other practitioners. On all phases of the bill, the initiative will rest with the States, which will develop and administer plans suited to their local problems, formulated only after careful surveys of their local requirements. Federal encouragement and cooperation will be effected through the traditional method of grants-in-aid, allotted and distributed in a manner to bring the greatest measure of Federal aid to the States which are in the greatest need of the services, and which are least able to meet those needs by their own financial resources.

The bill itself consists of a series of amendments to the Social Security Act. To carry out the prime objective of prevention, it reenacts in revised and expanded form the present titles V and VI of that act, to authorize grants-in-aid to the States for health services during maternity, infancy, and childhood, for the medical care of children and especially for crippled and other handicapped children, and for public health work and investigation, with particular regard to industrial hygiene, pneumonia, cancer, mental diseases, tuberculosis, and malaria. These programs, under the respective jurisdictions of the Children's Bureau of the Department of Labor and the United States Public Health Service, have already brought forth enthusiastic response from every State in the Union. Their expansion under this bill, with more careful elaboration of conditions of approval of State plans, will enable the Federal and State Governments to meet more adequately those public-health problems which are part of the responsibility of every civilized community.

Going hand in hand with preventive measures is a new program, under title XIII, to enable the States to extend and improve existing provisions for the care of the sick and the treatment of disease. The Social Security Board, which is charged with the administration of this title, is not authorized to give or withhold grants at pleasure, or to require State plans to develop along any predetermined lines. I have said again and again that nothing in the bill requires the States to establish compulsory health insurance.

Within the limits of certain necessary standards, the States are free to provide programs of medical care compatible with the needs and desires of their own people, and made effective through methods of their own choice. The State plan may apply merely to people on relief or to extend to others higher in the economic scale. It may be financed by general taxation, by the contributions of the beneficiaries of the medical services, or by combinations of these methods. The scope of medical services and the manner of their provision will be for the individual State to decide, so long as the program is State-wide or becomes such within 5 years; involves financial participation by the State; and complies with other standards prescribed by the bill.

I want to emphasize that the State plans under titles V, VI, and XIII may provide health and medical services either through public agencies or hospitals or by compensating private practitioners, or nongovernmental hospitals or clinics for performing such services. The voluntary and charitable hospitals have an established place in our social system. Since the onslaught of the depression, that place has been jeopardized by the diminishing support of philanthropy. I am confident that the financial aid made available through this bill would enable them to carry on more effectively the work which they

have so long pursued with high accomplishments and unswerving devotion to the finest concepts of public service. The private and professional and other agencies which furnish services under State plans will, of course, have a voice in guiding their administration. If any possible question arises as to the intent of the bill in these respects, I shall be happy, of course, to see it amended to accomplish the desired result.

These programs to bring about better and wider distribution of preventive and curative services are further implemented by title XII, which authorizes grants to States for the construction and improvement of needed hospitals, health, diagnostic, and treatment centers, institutions and related facilities, and for 3-year maintenance of such added facilities. The allotments are made and the grants administered, through the United States Public Health Service, which will have the cooperation of the appropriate Federal public works agency in handling technical construction problems.

The bill does not propose to flood the country with hospitals and health centers, regardless of need and regardless of the ability of localities to maintain these facilities once they are erected. No grants would be made for hospitals and health centers in any State until after the submission of a careful State plan in conformity with the bill, based upon detailed surveys of State needs by the duly constituted State agencies. Not a dollar would be advanced to match State expenditures pursuant to such plans unless the added facilities are needed in the area where constructed, and unless the State can provide a system of financial support giving reasonable assurance of continuing maintenance. As I have already said, existing hospitals, governmental and nongovernmental, may be utilized to the fullest by the State in its program under the legislation. No new hospital construction or expansion would be financed or aided by the Federal Government except upon a clear showing that existing facilities, private as well as public, are inadequate to satisfy the community's needs.

Throughout these various titles, particular emphasis is laid on the economy and quality of the service. In connection with the framing and administration of various State plans, the bill requires the establishment of, and consultation with, advisory councils on which the professions will be fully represented. Included in the purposes of the various grants-in-aid is the training of administrative and technical personnel for the efficient operation of the services. To qualify for grants under any title of the bill, the States are required to establish and maintain administrative personnel standards on a merit basis. Finally, to bring about the efficient coordination of the various parts of the program at the operating—or State—level, the State plans must provide for working agreements between the State agency administering the plan and other public agencies administering parts of the plan or services related thereto, including social insurance, workmen's compensation, industrial hygiene, education, and public assistance.

My object, through these and other provisions, was to insure the highest possible administrative and technical efficiency in the administration of a program that so vitally affects the health and happiness of us all.

Federal administration of the respective titles has been vested in three existing Government agencies—the Children's Bureau, the Public Health Service, and the Social Security Board. I have recognized from the outset the importance of coordination at the Federal as well as the State level, as regards both the Federal bureaus and the Federal advisory councils. It seems to me desirable, however, as a beginning, to place before Congress and the public a bill embodying the essential principles of a national health program. The highly complex problems of Federal administration have not been neglected or overlooked, but have rather been reserved for further consideration in the course of committee deliberation, in the light of such action as might be taken by the President under the Reorganization Act.

The plan of reorganization recently submitted by the President properly conceives of health protection as an integral part of our efforts toward human security. By placing both the Social Security Board and the Public Health Service in the new Federal Security Agency, the reorganization plan establishes a sound nucleus for the coordination of Federal health functions which is so essential to the efficient operation of a national health program.

A comprehensive approach to health needs cannot overlook the protection of wage earners against loss of income during periods of temporary or permanent disability. For the American worker, this income loss reaches the total of \$1,000,000,000 a year. Certainly our State or Federal Governments, which provide insurance protection against loss of earning power through industrial accidents, unemployment, and old age should extend like protection where nonindustrial sickness or accident deprive wage earners of their incomes and subjects their meager economic resources to the added drain of the doctor's bill.

Permanent disability compensation is already under consideration by the Ways and Means Committee of the House in connection with amendments of the old-age insurance provisions of the Social Security Act. Temporary disability compensation is established under title XIV of the bill now before you. This title authorizes Federal grants, through the Social Security Board, to assist the States in the development and administration of approved plans for cash benefits to workers, over a period not exceeding 52 weeks, with respect to disability not arising out of or in the course of employment. Such Federal grants are conditioned, however, on the maintenance by the State of approved plans, under other titles of the bill, extending reasonably adequate medical services to minimize disability among those covered by the temporary disability-compensation plan. This condition is a guaranty of sound and economical administration of the insurance funds; even more important, it underscores the preventive purpose of social insurance.

For the financing of the program, the bill authorizes no new Federal pay-roll taxes; the Federal costs would be met out of general revenues. The new appropriations authorized in the first year total about \$80,000,000, apart from sums which Congress may appropriate, in its discretion, toward the construction of tuberculosis and mental disease hospitals. Gradually increasing over an extended period, these sums are available for matching those appropriated by the States under approved plans. Federal grants under titles V, VI, and

XII range from 33½ to 66½ percent of total public funds expended under State plans, and under title XIII, from 16½ to 50 percent of total public expenditures, the grants varying inversely with the relative financial resources of the several States measured by per capita incomes. Under title XIV, however, Federal grants are made on the fixed matching ratio of 33½ percent of total State expenditures. These expenditures will help lift up the general health level for the people as a whole, and tend to iron out the serious inequalities which now exist among different groups of the population and between different areas of the country.

The enactment of this program would result in the practice of economy in the highest sense of the term. The total capitalized cost of illness and premature death, in terms of medical bills and loss of earnings and earning power, amounts to about \$10,000,000,000 a year. Sickness is responsible for fully one-third of all dependency on public relief or private charity. Federal and State Governments are already expending over one-half billion dollars a year for health services, expended almost entirely for care and cure, rather than disease prevention.

The essential problem is not so much to increase substantially the total now expended from all sources, but to redirect our expenditures more wisely and more economically. Increased expenditures for preventive measures now will yield rich returns in reducing the costs of medical care and diminishing the economic losses of illness and dependency—costs and losses which will have to be met later on out of the pockets of our people, either as private citizens or as taxpayers. By the application of known techniques of prevention and cure, we could save the lives of 70,000 mothers and infants who die each year in connection with childbirth, as well as a large proportion of the people doomed by venereal disease, malaria, cancer, pneumonia, diphtheria, and tuberculosis.

How this works out in dollars and cents is illustrated by the experience of the city of Detroit, which in 1936 launched at modest cost a comprehensive program to detect and control tuberculosis in its early stages. The city was then spending \$3,500,000 a year merely for the hospital care of tuberculosis patients. By 1938 the tuberculosis death rate, which had gone up in Michigan outside the city, registered an actual decline of 17.5 percent in Detroit itself. The program is bringing substantial savings, now, and increasingly for the future, in the cost of caring for the helpless victims of this scourge of mankind.

I hope, may I say, to have as a witness, if the committee will indulge him, the gentleman who proposed this program for the city of Detroit, which is now in actual operation. I think he succeeded in proving to the large taxpayers that his inauguration of this program would ultimately result in a decrease of tuberculosis, and ultimately reduce public expenditures in this field. So far it has been a great success. He told me he predicted that within 30 years, if that program were pursued, tuberculosis would be wiped out.

There can be no question that a national health program is a sound and economical investment in the human resources of America.

In closing, I want to pay deserving tribute to the unselfish spirit, enterprise, and generosity of the members of the medical profession,

for their splendid and self-sacrificing labors in alleviating sickness and promoting the people's health. A major purpose of this legislation is to help them to carry more effectively a burden which they have long carried alone. Both in the consideration of the bill and in its administration upon enactment, we bespeak, and we know we will have, the support and cooperation of the members of the noble profession which "has for its prime object the service it can render to humanity."

Senator ELLENDER. Senator Wagner, have you figured out how much appropriation it would require of the Congress for the first, second, and third year of this program?

Senator WAGNER. About \$80,000,000 in new appropriations, exclusive of appropriations for mental and tuberculosis hospitals.

Senator ELLENDER. I have it roughly figured out here for the first year, 1940, it would require \$92,000,000; for the second year, \$123,500,000, and for the third year, \$234,000,000.

Senator WAGNER. Yes.

Senator ELLENDER. Now you stated that this bill provided for no new taxes to be put into effect but you expected to get the needed amount out of the general fund.

Senator WAGNER. Yes.

Senator ELLENDER. Well, of course, you know the condition of the general fund now. It is muchly overdrawn.

Senator WAGNER. Of course, I am looking at this from the long-range point of view. This ultimately will be a great economy not only for the States but for the Federal Government. By this expenditure now we are in the future going to reduce expenditures, by inaugurating this preventive-medicine activity rather than waiting for the patient to become ill and then attempt to cure him.

The reason I pointed to the Detroit incident is because, on a small scale, it represents exactly the philosophy of this legislation.

Senator ELLENDER. I am not arguing that phase of the bill at all. I am in thorough sympathy with you on that point. There is no question that something ought to be done to alleviate suffering.

Senator WAGNER. Yes.

Senator ELLENDER. But the Congress is called upon frequently, and I might say particularly during this period, to appropriate a lot of money for various worthy causes. You have in one corner of the room a lot of people who say "Down with taxes," and on the other side you have the people who say "we want this," and "we want that." I am wondering how to reconcile those two positions.

Senator WAGNER. I think, on the question of taxes, the majority of American people want service. Of course, as some advocate, we could do away with all of our governmental activities. We could reduce the health department down to where its appropriation would be so small that its activities would be crippled. That actually happened, may I say, in New York State. We had an interesting experience over a period of years, from 1911 to 1920, we expanded the governmental activities. We enacted workmen's compensation laws, and about 50 other laws which made New York State a leader in social legislation. Of course it required a large expenditure of money to carry on these activities, but the people of that State recognized that in the end to be economy, in the better sense.

So we expanded our industrial department from a two-room proposition to the largest function of our State government. In 1920 there was a change in the governorship. The Governor was out of sympathy with all of these activities, but he was not sure that he could advocate the repeal of these laws. So what was done was to cripple the departments by cutting their appropriations in half, and some of them even less than one-half of what they needed to carry out the mandates of the legislation. Of course there was a protest throughout the State, and 2 years afterward that same Governor submitted himself for reelection and he was defeated. I think that policy was one of the main grounds for his defeat.

The question is whether the service is needed and whether in the end it will be a benefit to the country both from the standpoint of humanity and from the standpoint of economy. Miss Roche will give you more detailed figures on disabling illness and health needs.

Senator ELLENDER. I am not questioning that at all, I am not questioning that figures can be produced to show that in the long run it will be at the head of the procession.

Senator WAGNER. Yes.

Senator ELLENDER. What I am thinking about is the present condition of our Treasury, and the tendency to keep on adding demands to make our deficit greater, I am just wondering what backing you would get from the same people when it comes time to raise the taxes to get money to carry on the various worthy causes.

Senator WAGNER. I am sure that the American people are in favor of a program of this kind and would be willing to expend the amount necessary for that purpose much more than some other expenditures.

I do not want to appear to question appropriations for defense. But from the standpoint of national defense this is an important measure—to have healthy citizens. If you remember the experience in the draft in the World War, I think something like one out of every three were physically unfit to undertake service. I am not one of those that are bringing up our boys to be soldiers; I am one of those that hates war and am going to do everything possible to keep out of war. From every standpoint I think this is a very meager sum to expend for this noble purpose, not only from the standpoint of economy but from every standpoint. It is of great benefit to the Nation. If I may say so, I think we have delayed this too long. I think this should have been undertaken even before we dealt with the question of unemployment insurance and even workmen's compensation.

Senator TAFT. There is some national assistance given to States now for health. Do you know how much it amounts to, Senator? Not very much, I imagine.

Senator WAGNER. I do not offhand, but it is a substantial sum. It is not as much as this. It is about \$17,000,000.

Senator TAFT. \$17,000,000 a year?

Senator WAGNER. \$17,000,000 a year. That, of course, only began, in large part, with the Social Security law.

Senator TAFT. And your maternal health law, yes.

Senator WAGNER. Maternal and child care, public health, and some investigatory activities. I really think that this is a very modest beginning. It is an insignificant sum compared to some of our other expenditures. I do not know of anything that has greater public support than the national health program.

You heard the testimony from the representatives of the farm organizations here on last Thursday. That made a great impression on me. While I read these reports, I was very much impressed with their testimony as to the lack of medical care in the rural sections of our country. They have been neglected. As they said, the country doctor is gone, and of the mothers who die in childbirth, the preponderance are in the rural sections of the country. There the need is greatest.

Senator ELLENDER. To what extent will the States have to furnish money in order to obtain health aid from the Government?

Senator WAGNER. Of course it is a grant-in-aid. It is a sort of a variable grant-in-aid whereby the poorer sections will get the most, which they should.

Senator ELLENDER. As a matter of fact you find less money in the poorer sections than anywhere else and probably more need for care.

Senator WAGNER. Yes.

Senator ELLENDER. How would the bill help out in that respect?

Senator WAGNER. They get a larger percentage. For instance, the matching proportions go as high as two-thirds by the Federal Government to one-third by the State, all depending upon their per capita income.

Senator ELLENDER. Does that apply to each subdivision under this bill?

Senator WAGNER. Yes; under titles V, VI, and XII.

Senator ELLENDER. About one-third to two-thirds?

Senator WAGNER. Yes; one-third to two-thirds. The wealthier communities would get less, because their per capita income is greater.

Senator ELLENDER. About the same yardstick is used?

Senator WAGNER. Yes.

Senator MURRAY. Are there any further questions?

Thank you very much, Senator, for your very excellent and illuminating statement on the objects of the bill.

Miss Roche is the next witness.

STATEMENT OF JOSEPHINE ROCHE, INTERDEPARTMENTAL COMMITTEE TO COORDINATE HEALTH AND WELFARE ACTIVITIES

Senator MURRAY. Miss Roche, you have a prepared statement. Do you wish to follow your statement?

Miss Roche. Yes. I will possibly divert slightly from it, Senator.

Mr. Chairman, and members of the committee, and Senator Wagner, the Interdepartmental Committee to Coordinate Health and Welfare Activities was appointed by the President in August 1935, following the passage of the Social Security Act for the purposes which are implied in its name. I have here, Mr. Chairman, copies of the Executive orders creating the committee and later enlarging it. I would like to file them for your information.

Senator MURRAY. They may be filed with the record.

(The papers referred to were filed with the committee.)

Miss Roche. In February 1938 this Interdepartmental Committee forwarded to the President a report on "The Need for a National Health Program," including a recommended plan for correcting the existing grave deficiencies in services for the prevention of disease and treatment of the sick. The report represented the conclusions reached after more than a year of study by the technical committee

on medical care—a subcommittee consisting of medical and economic experts from the staffs of the Children's Bureau, the Public Health Service, and the Social Security Board.

The President suggested that representatives of the general public and of the professions concerned with health and welfare be invited to consider the plan proposed by these technical experts. The National Health Conference, held in Washington on July 18, 19, and 20, 1938, was the outcome of the President's suggestion.

A group of men and women, 176 to be exact, attended the conference and participated in its discussions. The conference membership represented in about equal proportion persons actively engaged in the provision of health and medical services and representatives of the potential recipients of these services. There were 55 doctors of medicine, including general practitioners, surgeons, specialists, public health officers, and faculty members of medical schools. Included in the nonmedical professional group were 25 experts in public health and social welfare, hospital administrators, medical economists, dentists, nurses, and pharmacists. Among the 96 participants representing the public were members of organized labor and farm groups, civic organizations, local voluntary and official public welfare agencies, educators, representatives of industry, of radio, and the press. The conference was a representative cross-section not only of the professions and agencies that provide the Nation's health and medical services, but also of the public for whose benefit these services are maintained.

The report of the technical committee on the national health problem and a proposed national program for its solution was presented to the conference for discussion. This report has been presented to the Congress in a special message by the President, dated January 23, 1939, and published as House Document No. 120, and therefore I will review it, I think, only very briefly here, Mr. Chairman, presenting, if I may for the record, a copy of House Document No. 120, which is very inclusive.

SENATOR MURRAY. It may be filed with the record.

(The document was filed with the committee.)

MISS ROCHE. When our technical committee began the study of health needs and services, it drew on reports of the committee on the costs of medical care, the committee on economic security, the Bureau of the Census, and other Federal agencies, and data available from many studies conducted by local governmental and private agencies. There were also the reports from over 2,000 physicians received by the American Foundation Studies in Government, published in two volumes entitled "American Medicine: Expert Testimony out of Court" which recorded what doctors knew about the conditions in their communities. Also available were the results of the Consumer Purchases studies conducted by the Departments of Labor and Agriculture. In addition, the results of the National Health Survey, which was then nearing completion, provided a body of evidence on national health needs surpassing in extent and detail that of any previous study, and revealing conditions which can no longer be ignored.

This survey included a canvass of some two and three-quarter million persons living in 83 small, medium-sized, and large cities in 18 States, giving a fair and comprehensive sample of the American people who live in cities, and, in addition, a sample drawn from rural

communities in three States. Records of illness and the receipt of medical and nursing care during a year were obtained for each family, together with information on annual income. The results thus permitted a comparison of medical care received in families of high and low income, and of care received in communities adequately and inadequately supplied with physicians, dentists, nurses, hospitals, and clinics.

The important fact emerging from the results of the National Health Survey was the deficiency in medical care among the poor and people with small incomes. In families on relief, and in the self-sustaining group at what is called the marginal income level (with family income less than \$1,000), both the proportion of patients receiving home or office care from a physician, and the number of consultations the patient received, were lower than in families in comfortable circumstances. In the large cities having relatively adequate hospital facilities, the sick poor requiring hospital care received approximately as frequent hospitalization as the upper-income families. But low-income families living in small cities of 2,500 to 25,000 population did not fare as well in this respect as those in the metropolitan centers. In small cities, the limited supply of hospital beds and the restricted support of hospital care of the needy from public funds resulted in less adequate hospital care of the poor. In the large cities, the sick in low-income families also received medical care in clinics, but clinic care was negligible in the small cities and rural areas in which not many clinics are found.

It is interesting, Mr. Chairman, also, I think, to note that the evidence as to inadequate health services revealed by the national health survey in 1935 by no means reflected conditions in a single year. In the prosperous years before the depression a survey of representative families in 130 communities had shown that well-to-do sick persons received nearly three times as many services from physicians, and six times as many in each 100 received dental care, as did self-sustaining families with incomes under \$1,200 a year. In fact, Mr. Chairman, survey after survey has shown that the amount of illness varies inversely with income, that the poor are sick more often and that their sicknesses last longer. The results of the national health survey showed that low income families have greater medical needs than the well-to-do. Among surveyed relief families, the time lost from work, school, or home activities as a result of sickness and accident was 16 days per capita in a year; in families not on relief, with incomes less than \$1,000, 12 days per capita; but in the class with incomes above \$3,000, the figure was only 7 days per capita.

Death rates, too, go up as income goes down. The death rate from all causes in 10 States in a recent year was more than twice as high for unskilled workers as for the professional class. The death rate from tuberculosis was seven times higher among unskilled workers than among professional workers; and the pneumonia death rate, three and one-half times higher among unskilled workers than in the professional class.

The effects of the hazards of industrial life are seen in the high incidence of certain diseases among workers. Studies by the Public Health Service showed that over a 7-year period the pneumonia case rate in the steel industry was approximately 50 percent higher than

in all other reporting industries as a group, and the death rate from pneumonia in 27 iron and steel manufacturing towns was 66 percent greater than in the United States as a whole.

A million workers are exposed in their daily jobs to the hazards of silicosis. About one-fourth of them already have silicosis in some stage, and with it an unusual susceptibility to tuberculosis. The prevalence of tuberculosis in a group of silicotics was found to be 10 times greater than among the general population.

The committee's report brought out such facts as the following: The lives of more than 70,000 mothers and infants might be saved each year if those deaths were to be prevented which physicians estimate are preventable, yet in 1936 nearly a quarter of a million women did not have the advantage of a physician's care at the time of delivery. Among the counties of the United States, 1,338, or over 40 percent, do not contain a registered general hospital. Hospital facilities for care of the tuberculous meet accepted standards of adequacy in only five States. In many States, institutions for the mentally diseased are badly overcrowded. Less than a third of the counties and even a smaller proportion of the cities employ full-time, professional health officers.

At the National Health Conference the mass statistics of our people's health needs, of which these just mentioned are but a few examples, were amply verified and reverified for every section of the population by the first-hand experience of representatives of the great labor and farm organizations, women's organizations, organized parents and teachers, social workers, welfare administrators, and other civic and public organizations seeking to advance health and welfare. At the end of the first day's session one of the participants asked the question, "Are there any members of this conference who seriously challenge the statements with reference to need which were made this morning?" This question was stated to the conference by the presiding officer. There were no challenges then and there have been none since.

The technical committee concluded that only a coordinated plan of services providing for the prevention of disease and treatment of the sick could solve the needs revealed by its studies (and subsequently confirmed by the testimony of participants in the conference). The services provided by well-organized local health departments such as health consultations for mothers and children, the control of acute communicable disease, of tuberculosis, the venereal diseases, sanitary supervision of water and milk supplies, and sewage disposal—are of fundamental importance in a national health program. It is evident, however, that these preventive services, however valuable, are not sufficient if there are not also other health and medical services available. For example, the supervision of the health of the mothers in the prenatal period is of little avail in protecting mother and child if a competent physician is not in attendance at childbirth, or if a hospital is not accessible for care of emergency cases which cannot be treated adequately in the home.

Many diseases, as we know, spread by contact of the sick with the well cannot be controlled effectively unless the sick receive adequate medical care. Furthermore, much serious disability and premature death is caused by diseases for which medical science has not yet

developed specific methods of prevention; control of these diseases—shortening of the period of disability and promotion of recovery—require adequate medical care with access to all the modern facilities for diagnosis and treatment.

In its recommendations for a national health program the technical committee therefore proposed a plan which would reduce sickness and death through a coordination of the methods of preventive and curative medicine, and of the services of local health departments and voluntary health agencies with those of private practitioners, hospitals, and clinics.

The committee's specific recommendations contained in our report to the President and transmitted to the Congress may be stated, briefly, under four headings. I might say, Mr. Chairman, that under each of these four headings I have endeavored to summarize very briefly the provisions, but I think probably here it would be more convenient for you if I would simply give the four headings.

I should like to state also, Mr. Chairman, that there is present today the full membership of our technical committee that is responsible for the long research and work that went into the preparing of these recommendations and the various modifications they went through, and they are available for any detailed technical questioning which your committee desires to submit to them.

The recommendations are as follows:

A. The expansion and strengthening of existing Federal-State co-operative health programs under the Social Security Act through more nearly adequate grants-in-aid to the States and, through the States, to the localities.

This recommendation would provide for:

1. Development and expansion of the public health services operated locally by health departments, including specific effort toward the control of tuberculosis, the venereal diseases, malaria, cancer, pneumonia, and activities in mental hygiene and industrial hygiene, with research and training of personnel required for these services;

2. Expansion of maternal and child health services to make available to mothers and children in all income groups and in all parts of the United States the services essential for the reduction of our needlessly high maternal mortality rates and death rates among newborn infants, and for the prevention in childhood of diseases and conditions leading to serious disabilities in later years.

B. Grants-in-aid to the States to assist them in developing adequate hospitals and health centers.

This recommendation applies to the construction, enlargement, and modernization of hospitals and related facilities, including the construction of health and diagnostic centers in areas, especially rural or sparsely populated, inaccessible to hospitals. The committee recommended that Federal grants-in-aid should assist the States in developing general, mental disease, and tuberculosis hospitals, health and diagnostic centers, clinics, and related facilities in those communities in which careful surveys show the needed facilities are lacking or inadequate. Also recommended were grants toward operating costs during the first years of such newly developed institutions to assist the States and localities in taking over responsibilities. Financial aid to enable people to make more extensive use of existing hos-

pital facilities, in qualified governmental and non-governmental hospitals, is a parallel need covered in the committee's third recommendation.

C. Grants-in-aid to the States to assist them in developing programs of medical care.

Under this recommendation. Federal financial aid would promote development by the States of programs of medical care for dependent and medically needy persons in self-sustaining low-income families, or more general programs designed to meet, in addition, the needs of families in the middle-income range. To finance the program, two sources of funds could be drawn upon by the States: (1) General taxation or special tax assessments, and (2) specific insurance contributions from the potential beneficiaries of an insurance system. The committee recommends grants-in-aid to States which develop programs using either method, or a combination of the two, to implement programs of medical care.

D. The development of social insurance to insure partial replacement of wages during temporary or permanent disability.

The committee believes that insurance against temporary disability should be established through Federal-State cooperative arrangements. Advantage may be taken, in the design of a specific program, of experience already accumulated in the operation of unemployment compensation. It is believed that insurance against permanent disability should be established through liberalization of the Federal old-age insurance system, so that benefits become payable at any time prior to age 65 to qualified workers who become permanently and totally disabled.

There has been some misunderstanding of these recommendations in certain quarters; that there may be no misunderstanding here, let me first summarize what the committee did not recommend. It did not recommend "State medicine" or a federally administered system of compulsory health insurance. It did not recommend the construction of hospitals where adequate public or voluntary facilities were already available—hospitals should be built only after the need has been demonstrated by careful State surveys assisted by expert professional advisory councils. It did not recommend regimentation of doctors or of patients—none of its recommendations is incompatible with personal relationship between physician and patient, free choice of physician by patient, and freedom of all qualified practitioners to participate in the provision of medical services.

Senator ELLENDER. At this point, were all of your "did-nots" carried out in this bill?

Miss ROCHE. So far as I have been able to see, sir; yes.

Senator TAFT. Is there any of this social insurance in the bill?

Miss ROCHE. No, sir.

Senator TAFT. That was not put in the bill?

Miss ROCHE. I am sorry. I thought the Senator referred to the "did-nots."

Senator TAFT. He did, but I was asking about the "dids."

Miss ROCHE. The committee did recommend, Mr. Chairman and members of the committee, an expanded program of Federal grants-in-aid to the States similar to that which has operated successfully under titles V and VI of the Social Security Act, a program which

would make possible substantial health and medical services even in the poorer States and rural areas. It believes that health and medical services should be strengthened by making fullest possible use of qualified existing personnel, hospitals, and other facilities. The committee believes that a national health program should be built on a partnership in which the States take the initiative and assume basic responsibility and the Federal Government cooperates through grants-in-aid for State programs which meet certain basic conditions requisite for Federal approval. It was believed further that Federal grants to the States should be determined by some formula of variable-matching grants which permits recognition of the varying health needs of the States and of the unequal resources actually or potentially available to meet these needs. Senator Wagner stressed that point in speaking. It was felt that the function of the Federal Government was primarily to give professional, technical, and financial aid to the States. Corresponding measures to level up opportunities for receipt of health and medical services should be taken by the States for the benefit of various localities within their boundaries.

Maintaining and improving the quality of health and medical services was considered of first importance and all the studies of the committee indicated that its recommendations would promote progressive improvement in the equality of medical services. Methods of appraising the qualifications of the necessary administrative personnel, the general practitioners and medical specialists, required in the operation of the program, and provision of opportunities for post-graduate education and research to maintain a high level of medical practice received special consideration. Considered also were the special problems arising in connection with the recommendation for the expansion of hospital facilities, clinics, and diagnostic centers, including the formulation of standards for the appraisal of the physical plant and personnel.

Following the National Health Conference, many professional organizations requested conferences with the interdepartmental committee and the technical committee on medical care to discuss the details of a practical program of action. Of course we announced at the conference that we desired to have conferences with all professional and technical groups who could take the time to come and confer with us. I submit, if I may, Mr. Chairman, a list of the 19 groups that met with our committees, following the conference last summer and this fall.

(The list referred to is as follows:)

MEETINGS WITH COMMITTEES APPOINTED BY INTERESTED ASSOCIATIONS AND GROUPS TO CONSULT WITH THE INTERDEPARTMENTAL COMMITTEE AND THE TECHNICAL COMMITTEE ON MEDICAL CARE FOLLOWING THE NATIONAL HEALTH CONFERENCE

American Medical Association, October 31, 1938, and January 15, 1939.

American Public Health Association, November 19, 1938.

Committee of Physicians for the Improvement of Medical Care, Inc., November 20, 1938.

American Hospital Association, November 21, 1938.

Catholic Hospital Association, November 21, 1938.

American Protestant Hospital Association, November 21, 1938.

National Tuberculosis Association, November 22, 1938.

National Medical Association, November 22, 1938.
National Chiropractic Association, December 7, 1938.
American Osteopathic Association, December 7, 1938.
Committee on Rural Hospitalization, December 8, 1938.
National Committee for Mental Hygiene, December 15, 1938.
American Dental Association, December 15, 1938.
National Organization for Public Health Nursing, December 16, 1938.
American Public Welfare Association, December 16, 1938.
American Association of Social Workers, December 16, 1938.
American Association of Medical Social Workers, December 16, 1938.
Birth Control Clinical Research Bureau, January 18, 1939.
American Optometric Association, January 18, 1939.

Miss ROCHE. Discussion with these groups brought out again the high importance of quality of service and the great interest of these professional bodies in the maintenance and improvement of quality. These groups were in essential agreement as to the need for action and, so far as there were any differences of opinion among some of these groups, they differed only as to how far and how fast such action should proceed.

The program has been widely discussed by professional and public organizations—State medical associations, labor organizations, and farm groups, and civic bodies. Many of these have given specific or broad endorsement of the recommendations of the National Health Program and all agree as to the need for action. As a result of the intense public interest, the interdepartmental committee has received a large volume of formal communications and informal correspondence concerning these proposals. These expressions of opinion, together with the deliberations of the conferences with professional groups, were weighed carefully in preparing the final report of the interdepartmental committee, which, as I have stated, was transmitted by the President to Congress on January 28, 1939, in a special message. It has been filed with your committee.

In conclusion, may I emphasize that the committee's recommendations are not aimed merely at conditions as they exist today but, in the words of the President of the United States to the National Health Conference, "we have before us a comprehensive, long-range program, providing for the most efficient cooperation of Federal, State, and local Governments, voluntary agencies, professional groups, mediums of public information, and individual citizens." The committee does not visualize that it is practicable to put into effect immediately the maximum recommendations. It contemplates expansion along well-planned lines with a view to achieving operation on a full scale within possibly some 10 years.

Senator ELLENDER. To what extent will that expansion take place?

Miss ROCHE. It is outlined in the technical reports step by step, so much in the first year, so much in the next, and so much in the next, and so forth.

Senator ELLENDER. How much would the Congress have to appropriate in those 10 years?

Miss ROCHE. It is varying amounts. In the first year, second year, and third year, it would approximately coordinate with Senator Wagner's recommendations.

Senator ELLENDER. How about future years?

Miss ROCHE. Well, it would go on until at the end of the tenth year when it would probably be about \$800,000,000 all told.

Senator TAFT. Does the \$800,000,000 include Federal and State? We are interested in the Federal appropriation. It is \$800,000,000 Federal?

Miss ROCHE. \$850,000,000 total.

Senator ELLENDER. How much of that would be Federal?

Miss ROCHE. It would depend slightly on your matching. Approximately an over-all average of 50 percent.

Senator TAFT. That does not include, however, sickness insurance?

Miss ROCHE. No, sir.

Senator TAFT. I am referring to your recommendation No. 4.

Miss ROCHE. It includes Federal and State funds required for care of dependent and other medically needy persons. However great the difficulties, it must be realized that we shall learn only by doing. The committee therefore feels very strongly that the time has come to make a decision on a national health policy and a beginning on a national health program.

The bill introduced by Senator Wagner, S. 1620, now under consideration by the Senate Committee on Education and Labor, would translate into reality the recommendations of the interdepartmental committee. In view of the importance of the Nation's human resources, I trust that this legislation may be given serious and prompt consideration.

Senator ELLENDER. Are you familiar with the details of the bill, as to how it would work for each State?

Miss ROCHE. No, sir; I am not sufficiently familiar with them. I would rather one of our technical people, who is fairly familiar with it, be of assistance to you on it.

Senator ELLENDER. Will there be any witnesses to give us a detailed explanation of how this bill is going to work?

Miss ROCHE. Yes, sir.

Senator WAGNER. We have got the basis of it now.

Senator ELLENDER. I mean, how much money will be apportioned; whether or not it is safeguarded so as not to let some States get more than others. In other words, except in proportion of need, your amount is limited here.

Senator TAFT. There is a formula.

Senator WAGNER. There is a formula followed by the Federal Government now, under the Social Security Act, which sets up certain standards, and similar standards are provided in this act.

Senator ELLENDER. Assuming all of the States would reach the standards, would be able to comply with the yardstick?

Senator WAGNER. Then there would have to be an apportionment, of course.

Senator ELLENDER. Until that is done, what is there in the bill to prevent one from getting more than the other? In other words, this is a small amount for such a proposition.

Senator WAGNER. As to the exact mechanics, probably some of the technical people could give you that.

Miss ROCHE. It is very charitable of you, Senator, to mention that it is a small amount of money.

Senator ELLENDER. I wish you could appropriate a billion dollars to put us in fine shape.

Senator WAGNER. If you appropriate a billion you would save two or three billion in a short time.

Senator ELLENDER. There is no doubt about it.

Miss ROCHE. Mr. Chairman, I have substantially concluded my remarks. I thank you for your courtesy in permitting me to address you.

Senator TAFT. I would like to ask you a question, Miss Roche.

Miss ROCHE. Yes.

Senator TAFT. I have had some correspondence from private hospitals in Ohio and some, I think, from the national association. They say that in the original conference there was a good deal of discussion on including in the hospital assistance the private hospitals and they doubt whether, under this bill, any such assistance would be possible. What were the facts about that, do you know?

Miss ROCHE. I would question their reaction on that, sir, very much. I should be very happy to have the technical committee member who is in charge of all of the discussions on the hospitals answer you in detail.

Senator TAFT. If the State plan includes any hospital assistance to private hospitals it could be included under the bill?

Miss ROCHE. Yes, it could; I am quite sure, Senator.

Senator WAGNER. There is no question about that in my mind, although there has been apprehension on the part of some of the charity hospitals.

Miss ROCHE. We would be very anxious to utilize to the full extent any existing agency that qualified, of course.

Senator TAFT. As I glanced over the bill it seemed to me there was a good deal of doubt about it.

Senator WAGNER. I might say, Senator, in my brief statement I did state if there is any question about it—because the question has been raised—if it is not definite enough in the bill—it should be made definite, because the desire is to aid them just like others. They receive aid now from municipalities. The municipality, for instance, will make a contribution to them—“compensate them for taking care of ‘city’ cases.”

Senator TAFT. This bill mentions “public agencies.” Now, I do not suppose a charitable hospital would be a public agency the way we define “public agency” in Ohio.

Senator WAGNER. That means the officials of the community in charge, officials dealing with the private institution.

Senator TAFT. In any event if there is any doubt about it you would be glad to include it?

Miss ROCHE. Yes, indeed, sir. There would be no question about it at all.

Senator TAFT. I have also been called a good deal by the optometrists of Ohio, where we have a higher standard of optometry than any other State, I think, who are concerned in the question as to whether they are excluded from any State money.

Senator WAGNER. Not unless the State excludes them.

Senator TAFT. Our State recognizes them.

Miss ROCHE. It all goes back to State determination, Senator.

Senator ELLENDER. In your statement you mentioned that five States had certain plans that you referred to there, I noticed a while ago. I am just anxious to find out this point, if I can: To what

extent have you found that the various States of the Nation are carrying out the health program along the lines that you are suggesting?

Miss ROCHE. Well, insofar as the appropriations under the Social Security Act are concerned, titles V and VI, of course they have been a very great stimulus, but as against the unmet needs, they are just a drop in the bucket. They have helped, they have pulled standards up, and they have done a marvelous job in public education, in arousing public interest on those things, but the adequacy is not there.

Senator ELLENDER. Are there any States that do not maintain public hospitals and institutions?

Miss ROCHE. I do not know, Senator. I do not think so.

Senator MURRAY. I think a great many of them do not.

Miss ROCHE. I think there are a great many that do not. You see there are these counties that have no registered general hospital at all.

Senator TAFT. I imagine large States do, but there are large areas in States that do not.

Miss ROCHE. I could not answer that question satisfactorily, but I will be glad to have it answered for you.

Senator ELLENDER. I had asked Senator Wagner to furnish me with a statement on that, but the statement you did furnish, Senator, is not in detail. I wonder if we could get it by States.

Senator WAGNER. I suppose the subheadings would show it more in detail.

Senator ELLENDER. There are a number of hospitals of all kinds that are maintained by the States or by the county or municipality in each State.

Senator WAGNER. Charitable, not public.

Senator ELLENDER. Yes; that is what I mean.

Senator WAGNER. There is a difference. The charitable hospital usually is a nonprofit, privately operated hospital with a grant-in-aid usually in the form of compensation for patients that they take in.

Senator ELLENDER. Out in our State we refer to charity hospitals as those maintained by the State.

Miss ROCHE. I am sorry, I misunderstood.

Senator ELLENDER. We have several of them. That is why I was using that term.

Senator MURRAY. In some States they have the old-fashioned poor farms which have recently had their names changed to county hospitals, but they have not changed the situation at all. Is that not true?

Miss ROCHE. That is quite true.

Senator MURRAY. I am quite sure in my State, Montana, we have no public charitable hospitals, except insane asylums. We have one tuberculosis institution which, of course, is entirely inadequate to take care of the situation. We have a waiting list of hundreds of men affected by silicosis from the mines waiting to get in, and we are trying now to increase the capacity of the institution.

Senator TAFT. Miss Roche, why was the recommendation for health insurance omitted from the bill?

Miss ROCHE. There was never any recommendation in any of our reports on any compulsory health insurance, but we have it right in

the bill that grants-in-aid be made to States, leaving it to the States to determine the method of financing their program, whether health insurance or public medical care.

Senator TAFT. This No. 4 you said was omitted from the bill in regard to temporary or permanent disability.

Senator WAGNER. Temporary disability is quite another thing from a general health insurance program. We leave the question of health insurance entirely to the State. There is no effort to organize a Federal health insurance program, but the State may develop one and then they may receive some grants-in-aid, but temporary disability is quite a different thing. That simply applies to the wage earner who may lose some time because of illness, though it is not in the course of his employment, so that he is without aid from any unemployment insurance and he is left helpless.

Senator TAFT. But you are not preparing compulsory Federal aid?

Senator WAGNER. No.

Senator TAFT. It is nothing like the unemployment-compensation law?

Senator WAGNER. No; nothing like the unemployment-compensation law.

Senator TAFT. Did the Interdepartmental Conference discuss questions of raising money from taxes to provide for this tax burden?

Miss ROCHE. To some extent, Senator—I would be very glad to have Mr. Falk clear that up—in a general way, not in great detail.

Senator ELLENDER. To what extent will States be helped that are already providing, to a certain extent, for the unfortunates in hospitals that are operated by the State?

Senator WAGNER. I do not know just what you mean.

Senator ELLENDER. Let us take my State. We have, in Louisiana, seven charity hospitals maintained by the State, to take care of the people—when I say "hospitals" I mean general hospitals, and that excludes hospitals for the insane, for the epileptics, and even tuberculosis hospitals—and suppose that we are already providing for that purpose \$2,500,000. To what extent will this bill help Louisiana?

Senator WAGNER. As I understand it—the experts will perhaps give you more accurate information on that—so far as the services that you are rendering are concerned, you are already paying from the State, so you do not need aid from the Federal Government. The difficulty may be you are not able because of financial difficulties to increase your program, which is desirable, and as to that increased aid the Government will help.

Senator ELLENDER. In other words, all States who have gone forward and who have taxed themselves for many years to come, maybe not an adequate service but as much as they could, would be precluded from this appropriation?

Senator WAGNER. No; I did not say that. I mean the survey shows to what extent there is inadequate medical care, and in order that the State may be stimulated to provide increased medical care the encouragement is given by the Federal Government.

Senator ELLENDER. That would mean, necessarily, then, more appropriations from the States?

Senator WAGNER. Perhaps, not necessarily; but there again the poorer States are better treated. It is just a little different from the

ordinary matching basis. We are trying to help the States which, because of their lack of wealth, are not able to give as much aid, medical aid, as the wealthier States. Their aid is higher than the wealthier States; the apportionment is from one-third to two-thirds, depending upon the per capita income.

Senator ELLENDER. You know good and well that many States in the Union today are well able to do as much as Louisiana has done, but they have not done it. Now, would this bill put Louisiana in the same category as a State that is wealthier than Louisiana which should have done it but did not do it?

Senator WAGNER. I do not see how it will do that.

Senator TAFT. As I understand it, a State would not suffer because they have done more hospital work. They may get less money because they happen to be a wealthier State, which is perhaps why they did more hospital work, but they would not be discriminated against, as I see it, by reason of the fact that they have gone faster than another State in the same wealth position. Is that correct?

Senator WAGNER. That is correct, of course.

Senator ELLENDER. Not as I read the bill. I might misunderstand it, but I do not believe the bill provides that way, Senator Wagner.

Senator WAGNER. What matching basis can you make except on the basis of need, and then you have got to have a formula as to that. The formula provided, as I understand, is the per capita income, which is about the best test that you can have to determine the ability of the State itself.

Senator TAFT. If you can find what it is. It is a little difficult to determine just what it is.

Senator WAGNER. I do not know of any other formula that can be used.

Senator ELLENDER. Of course, if that need has been met to a large extent, and to the limit of that State's ability, in order for it to get help under this bill you will have to get more funds from some place, would you not?

Senator WAGNER. On the matching basis you may need to secure some funds to match, yes, under certain provisions, but not under others.

Senator ELLENDER. And that is in addition to what they are already getting, to improve the service they are already rendering, is that not true?

Senator WAGNER. To improve the service they are already rendering?

Senator ELLENDER. Yes.

Senator WAGNER. Yes.

Miss Roche's committee's survey showed the inadequacy of medical care throughout the country. There is a lack of medical care in most of our States. That is one of the problems that we have neglected to some extent. This is like other efforts—through a cooperative system between the State and Federal Government—to bring about a better condition. We did that in the case of unemployment insurance, Senator. There was not a State in the Union except Wisconsin that, at the time we proposed the enactment of the social-security law, had any unemployment-insurance law. Today every State in the Union has one. Many of the States were unable to help

the aged to any appreciable extent, and the Federal Government came in under the social-security law and matched the State for old-age assistance.

Senator ELLENDER. I did not want to go into that in detail, but where you find old-age assistance more necessary is really in the poor States, and they are the ones who are less able to raise the money.

Senator WAGNER. There is a proposition now pending to make that matching variable, and I am in favor of that. I think the poorer States ought to be able to get somewhat more than an even matching basis. Number at the time we were proposing this legislation the road was not as easy as it is today. There were many concessions that had to be made before you could get the legislation through. I believe, so far as old-age assistance is concerned, that need ought to play a part, as in this particular situation. Even there you ought to have some sort of maximum and minimum. Here it is one-third up to two-thirds. You have got to have some sort of formula. I am speaking as a legislator, but these experts that deal with it from the practical side perhaps can enlighten you better than I can on it.

Senator MURRAY. Miss Roche, does the medical profession claim that the bill affects the status of the profession in any way?

Miss ROCHE. I have not talked with any of them on the bill, sir. I have talked with them many times in great detail on the recommendations, which are, of course, in substance the same.

Senator MURRAY. It is not intended by the bill in any manner to change the situation or status of the medical profession.

Miss ROCHE. It certainly was not in our recommendation. It certainly was not in the bill, as I read it, sir.

Senator WAGNER. May I say there definitely that everything in the bill depends upon the program that the States provide, and they determine whether they want health insurance, or what type of public-health service they want to render, subject to certain standards that we set. It is up to the States entirely. So that those in the medical profession who are fearful of "socialized medicine" as they call it, must address themselves to their States. We are not proposing it in any sense.

Miss ROCHE. I think it is fair to say that my little "did not" paragraph applies equally to the bill; is that not right, Senator Wagner?

Senator WAGNER. Exactly.

Miss ROCHE. We are entirely at one on that.

Senator MURRAY. Thank you.

Miss ROCHE. Thank you, Senator, very much.

Senator MURRAY. The next witness is Abel Wolman, president of the American Public Health Association.

STATEMENT OF ABEL WOLMAN, PRESIDENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Senator MURRAY. State your name and position, Mr. Wolman?

Mr. WOLMAN. I represent, Mr. Chairman, a national professional body known as the American Public Health Association. It is an agency composed of about 50 percent physicians and 50 percent seat-

tered membership covering sanitary engineers, nurses, laboratory workers, epidemiologists and other groups interested in the public health of our people. It is an agency that has today existed approximately somewhat less than three-quarters of a century. It has participated in the development of the public-health movement in this country during that entire period, and we believe has had considerable to do with at least part of the advances which have taken place in the prolongation of life and in the prevention of disease. Its membership today is approximately 6,500.

The association has been concerned, as I say, for a period of almost three-quarters of a century with the matters which the bill proposed by Senator Wagner covers.

It has of necessity reviewed and explored the deficiency in service and in characters of disease which affect this country.

Within the last 2 or 3 years it has participated, of course, in many of the discussions to which Senator Wagner and Miss Roche have referred. It has created a small committee composed largely of physicians representing medical officers of health in the States, in the municipalities, and in the counties of this country, to discuss with the members of the Interdepartmental Committee the findings as to fact, the recommendations as to principle, and the recommendations as to administration.

With that history in mind, and with the fact that that association has, during the last 12 months, gone officially and publicly on record with reference to the principles which concern it regarding the national health program, I have attempted to subject the act proposed to the test of those principles, and if you will permit me I should like to run through that rapidly.

Senator MURRAY. How is your association maintained?

Mr. WOLMAN. The association is maintained exclusively by the membership fees of its membership. Its restriction as to type of membership is based largely on the questions of professional attainment, experience, academic training, equipment in the field of general public health. There are no subsidies. There are special grants from time to time on the part of special agencies for particular studies, such as in administrative practice, but the current operating budget of the association is exclusively made up of membership fees. Its membership, as I say, is about 6,500.

During the previous year we have struggled, to a considerable extent, in attempting to formulate certain guiding principles on an advanced national health program. In Kansas City, at our national meeting in the fall of 1938, we agreed upon certain of those principles.

Following that period we put into our official publication a restatement of the principles in the light of the facts and the findings of the Interdepartmental Committee. Our principal summary, to which I should like to refer in perhaps minor detail, is of this nature, and I shall file with the committee a restatement of those principles, with a comment on each one as to where the proposed Wagner Act coincides or differs with the principles which this professional body has reviewed and set forth.

The American Public Health Association has and does approve the features that affect the interests of the Federal Government in

the health of the Nation as embodied in the proposed national health program. That, of course, is a very wide, a very general statement as to its position.

It feels, secondly, that there are large areas, economic and geographic areas, which do not have today the benefits of adequate health service. The State health departments and local health agencies we believe are necessary to provide a continuing and expanding service indispensable to the people of this country.

The recommendations of the technical committee to which Miss Roche refers, covering the expansion of public-health service in the field of maternity and infancy, the expansion of hospital facilities, general and special, the provision of essential medical, hospital, and nursing care as required to persons unable to support such care from their own resources, and compensation against wage loss through sickness are all embodied in the Wagner Act. The association stands for those particular principles and those particular findings.

We believe that wide latitude should be allowed to the States in the definition of the population to be served, and in the method of providing these public-health, medical, and hospital services. The Wagner Act agrees with that major essential principle.

Perhaps I ought to stop a moment to emphasize that fact, that the act, regardless of whatever other disabilities it may have, certainly makes careful provision on what we believe to be a democratic basis for that evolution of the program in its essential features and that in all of its parts it should rest upon the local people and should not be handed down from above by the Federal Government. We are happy to say that in most of the essentials the Wagner bill provides for that kind of a development, without which we believe there would be considerable risk in future performance.

We believe that the benefits of a national health program should be provided for the entire population.

The Wagner Act is, frankly, an equalization proposal, and because it is frankly that it leads to a number of difficulties in the arrival at the formula for dispensation of funds, in arrival at some general scheme of standardization, kept, we hope, at a minimum, but it is, frankly, a standardization plan and has perhaps some of the difficulties which are involved in any effort of the Federal Government to superimpose upon the States an extension of service without running the risk of perhaps distributing funds without care and without adequate raising and maintenance of standards of practice. We believe, however, that the Wagner bill has developed a plan of action for the next 6 years which would provide, for a Nation-wide coverage on the State basis, and which we hope will, incidentally, provide the experimental evidence on which an extension on a broader base, particularly in the field of medical care, can be evaluated by the Congress at that time.

The primary Federal function, we believe, is to give financial aid and technical aid for the approved programs. We do not believe that the Federal Government should administer in detail the various aspects of the program. We are aware, and I believe every member of the association and its committees is aware that there are difficulties attached, particularly at this time, in the appropriations requested, and we believe, necessarily, that whether the rate at which

they are requested in the Wagner bill is the most desirable one depends upon the competitive position which the national health program and its function should take in the national scheme.

We do feel that when subjected to a competitive evaluation with reference to all of its Federal and State functions health ought to take a major and higher place. We are fairly reasonable in our feeling that that is not solely because we have devoted the bulk of our existence to public health endeavor, but because we feel that the maintenance and preservation of life, the extension of life, the making more comfortable of the average circumstances of our people at all economic levels is an important and essential governmental function. We do not attempt to suggest that it should outstrip or take priority over every other governmental function, but we believe its position should be high in the competition for funds during even acute periods such as we are now in.

We should stress the position that a single State agency, for the purpose of administration, and certainly for the purposes of coordination, should be designated in the Wagner Act. The Wagner Act so does. It selects State agencies, it makes provision, as we believe it should, for the State agency negotiating for services through other existing State agencies, for implementing this bill. That is a wise provision, from our standpoint, because a great many of the States have developed auxiliary and parallel agencies to the State health departments which maintain and operate hospitals, which carry out activities in the field of providing health service for children, which certainly run in parallel with health departments for health service, disease control, tuberculosis, or otherwise. Where the States are maintaining these adequate services, or adequate offices the bill provides, and we agree it is a sound practice, that the State agency should be the single coordinating or sieving agency through which your Federal funds ought to flow.

Senator ELLENDER. In that connection, how about such States as have a board whose function it is to attend to hospitalization?

Mr. WOLMAN. In that instance, the board will continue to spend and operate, will continue to spend the money which results from your Federal contribution, but it will do so in consultation with your State health department, so that whatever plan of action it develops will be reasonably coordinated with the other activities of your State in the health and hospital field.

Senator ELLENDER. Would it not be feasible to have an alternative in the bill that where States do have boards that maintain hospitals that are not in the State—

Mr. WOLMAN (interposing). The bill provides for part of that distance but not all of it. I am inclined to believe that the reason it provides only part is that there is a fear, and I think a legitimate fear, that if the bill should provide negotiation with innumerable State agencies for the disposal of their funds it will become unwieldy. My own feeling is, as a State agent during my entire life, that it becomes difficult for the Federal Government to negotiate with multiple State agencies for a single purpose. I rather suppose, Senator Wagner, that that is the reason you recognized a single health department, and recognized equally the existence of such boards as you suggest, and as, of course, exist in many States,

which would be the standing agency to which they go. I think this is sound administrative practice and should be correlated with the general health program in the State. I cannot see that it would work any particular hardship. It will require negotiation on the State and local level, which negotiation, I feel, ought to result anyhow regardless of the passage or failure to pass of this act. There is need for coordination of the State and local level of all the health services. I feel that that would be to the advantage of the individual taxpayer and to the advantage of the individual States.

Senator WAGNER. Don't you find, as a matter of experience, that these different agencies within a State who deal with health problems do coordinate now?

Mr. WOLMAN. I might take as an example your own State, with which I am reasonably familiar, a very large and complicated State with very active and highly complicated agencies in various fields, which this bill covers. They are coordinated agencies. They have an equal political status of responsibility within your State. I feel any bill which would wipe out that coordinated status would be foolish, but a bill which proposes to perpetuate and continue the kind of relationship which now exists in New York State would do the job. I do think it might be difficult to have a Federal agency distribute funds to a multiple series of units in New York State, New York City, Albany, and so on. It might become pretty chaotic.

Senator ELLENDER. I did not mean to extend it that far, but what I had in mind was States such as I know, in Louisiana, for example, which has a board created for no other purposes than to supervise its various hospitals.

Mr. WOLMAN. You see that same situation in at least half of the States of the country. You find in addition boards for the operation and control of mental diseases; you have separate boards in many of your States for tuberculosis hospitals as distinct from general hospitals. The problem is the same everywhere. I think there is plenty of room for debate as to whether you should have the single track of conduct, relying on State officials to maintain the multiple negotiations within their State, or whether you want to extend the Federal arm down into your individual State agencies. My own personal preference, as the result of study and experience, is you would get a more unified evolution of your program by earmarking a single State agency for active cooperation with the Federal Government. It is difficult enough as it is now with even the present grant-in-aid relationship between the State and Federal Government, but it will multiply it in many, many other directions.

Senator TAFT. And if it does not fit the State the legislature can always pass a law changing the set-up?

Mr. WOLMAN. The legislature, of course, since 1933, has developed many, many ways in which to handle it because of the complications that have arisen in such grants in aid as the W. P. A., the P. W. A., and so forth. There has been an effort to place the statehouse in order to have unified participation in Federal relationship.

Senator LA FOLLETTE. In regard to that program of yours, it seems to me, Mr. Wolman, you could not hope to have a coordinated program unless you set up some special State agency under which that coordination can take place. If all of them come to the Federal

Government to support separate programs you will have confusion and you will have a program which is not coordinated.

Mr. WOLMAN. You do already have confusion in the past, even with the smaller part of participating services, the Children's Bureau, public health services, and other groups, and they would, I think, tell you that it would be far better for the Federal agencies to operate through responsible single State units, that is, a State unit set up through your legislature or otherwise, and give the State unit the responsibility of doing a decent job in the State.

Senator ELLENDER. As I understand the bill, each State will have to pass some law to come within the purview of this law, will it not, Senator Wagner?

Senator WAGNER. I am sure it will. Senator La Follette took the words out of my mouth. One of our experiences has been in having legislation. In order to cooperate under the United States low-rent housing and slum-clearance program, many States found it necessary to eliminate conflicting agencies by creating housing authorities.

Senator ELLENDER. The reason I ask that, why not have the agency named by the State when the act is proposed, in order to come within the act?

Mr. WOLMAN. Our reaction to that proposition is of this nature: You have in this country developed, through a long term of years, as much as a half century in some instances, strong, competent, and, in many instances, nonpolitical health departments.

Senator ELLENDER. And you have the reverse in other States.

Mr. WOLMAN. You have the reverse in other States.

Senator ELLENDER. That is why I was mentioning it.

Mr. WOLMAN. I do not feel, and I imagine the association would bear me out, that you can correct, through a Federal act, the disabilities inherent in your State organizations which may be, politically or otherwise, inefficient. I feel, and I think most of our observers would agree, that the place to correct that agency is down home. Now, whether the Wagner Act, or the like, could suddenly revolutionize the other half of the States in the United States toward a competent unit, or toward competent administrative units, I doubt.

It is a slow process and one in which I feel the States would probably make the longer gains more probably, given the time and financial stimulus and the raising of the levels of standards through your Federal agencies, on which I put considerable emphasis, as we have experienced in other fields.

The Federal Government can, by judicious and competent professional advice, gradually lift, as it has done, the general level of State performance and of State organization. It has done it in the public-health field through a period of almost half a century, and I feel quite confident it can do it in this field, given time and given a set of Federal regulations that are not too rigidly controlling. The qualified advice which we believe is essential to developing this field, particularly where you are going into the more or less unexplored areas, is an additional requisite in the national health program. We believe the Wagner bill provides for that requisite qualified advice. We should point out, however, that we think it provides it in an unduly cumbersome fashion.

I hope Senator Wagner will forgive me if we point out that a search should be made for professional advisory bodies which would not result in the great numbers which we estimate would result from your process. We estimate that there would be somewhat over 225 advisory boards created on the Federal and State levels throughout the country to implement the professional advice in this bill. We think that that could be tremendously improved in a reduction in numbers, without losing anything in quality or in strength.

One of the best ways of improving it, to our minds, and I merely suggest it here because the association has also gone on record on this principle, a principle which the act does not correct and which, at the moment, we believe is one of the major deficiencies of the Federal performance in this field—the association has gone on record very strongly for a number of years for reorganization of the Federal public health services in the direction of simplified coordination. At this time, even with the President's reorganization plan, which improves that situation materially, we still feel that there is room for unifying the administration of the public-health services of the Federal Government to a greater degree than has already been accomplished.

We see no reason, for example, for continuing the partition of activities in the various health fields on the Federal level. We have commented rather strongly on the deficiencies of the State level. I think the record should show that we are commenting equally strongly on the deficiencies of the Federal level. We see no reason, for example, for dividing the public health activities of the Federal Government according to age, according to sex, according to area, according to geography, and that is what the Federal Government has done because of various important historical reasons during this past period.

Senator TAFT. Will you specifically refer to those bureaus?

Mr. WOLMAN. I refer to the United States Public Health Service, the Children's Bureau, the health functions of the Indian Service, and a few minor ones.

The reorganization plan, as suggested at the moment, does improve the situation by putting the Public Health Service in a secure group where there will be an opportunity for relating its activities to others, but it does not include the Children's Bureau, it does not include the functions in the health direction of the Indian Service and quite a few minor agencies of the Federal Government.

Senator WAGNER. It still might happen, Mr. Wolman.

Mr. WOLMAN. I merely point it out because I feel the association would feel I have given only half of the story by recommending strictly a coordination at the State level without maintaining the position which we have taken for many years for an equal coordination at the Federal level.

The Wagner Act provides for a coordination at the Federal level, which the association feels is an essential part of any extension of our national health program. We will need additional numbers of people in various branches of public health, and money should be provided for both the Federal and State levels to do that as promptly and as rapidly as the program should require.

The Wagner Act provides, and the association agrees, that the program in general should be developed around and based upon exist-

ing health services. That seems to be the nucleus which gives it the greatest promises of ultimate success.

The act emphasizes the desirability of the wide latitude to be given to the States in defining the population to be served in the selection of a method for providing for public health, medical and hospital services, and of equal importance in the method of raising funds in the individual States.

There has been considerable comment, prior to the introduction of the act, as to whether or not the program includes or does not include compulsory health insurance. The association has rather avoided a commitment on the plan of raising money throughout the United States in a program as comprehensive in numbers of people affected and in area affected, but does take the position that if individual States from time to time feel that they are anxious and willing, after thorough review, to develop a compulsory health insurance program, they should certainly be permitted to do so, and should certainly be eligible, if they do so, to participation in this particular allotment or grant-in-aid. Any scheme, either general taxation, voluntary insurance, or compulsory health insurance which will result in an efficient spreading of health service to the people of the United States we feel ought to be recognized, if the individual States and their constituents so decide, and ought not to be disbarred because of theoretical or other reasons unless they demonstrate failure in the performance of their duty under your Federal regulations.

We agree that the Wagner Act provides for practically all of the principles which the association has enumerated. I will file those with the committee. Our association repeats them and reaffirms its belief that they should be as promptly as possible, consistent with funds, put into effect on a nationally coordinated basis.

We are not positive as to the financial details in the proposed act. We understand that Senator Wagner proposes that the exact amount for the first, second, third, fourth, and fifth years should be hammered out in further discussion with the technical experts. The amounts, I should say, for the most part, in many of the categories which the bill covers, are modest. It does not appear to us for a national program of this character and of this significance to our permanent welfare, that the expenditures of figures which run as high as a half to 1 cent per capita per day ought to appall the various professional groups who might oppose the program. We do feel, however, that the program ought to be established on a sound fiscal basis, and on a sound professional basis. The association maintains that if those provisions and restrictions are kept carefully provided and safeguarded the amount of money ultimately to be provided seems to be a small drop in the bucket to provide what we still consider to be the basis of our national existence.

I feel, gentlemen, that that covers in a general way what the association stands for. I think that it can be more specifically stated in the record, which I am presenting to your clerk. I shall be pleased to answer any further questions on our attitude, if I can.

(The paper referred to is as follows:)

The American Public Health Association has approved in principle the major aspects of the national health program and has directed a committee to lend the assistance of this professional society of public health workers in order that these principles may be translated into effective action.

The national health bill of 1930 has been studiously compared in detail with the principles declared by the association as desirable or requisite for such a document. We conclude that, with but one major exception, this effort to implement the national health program meets the conditions published by the association.

The association approves the evidences of effective interest of the Federal Government in the health of the Nation.

We accept the proofs presented again and again that large areas of our country do not have the benefits of adequate health service.

We believe that State health departments and local health agencies are necessary to provide indispensable services.

We specifically endorse the recommendations of the technical committee on medical care as they provide for (1) expansion of public health services including maternity and infancy, (2) expansion of hospital facilities, both general and special, (3) provision of essential medical, hospital, and nursing care as required to persons unable to support such care from their own resources, (4) compensation against wage loss through sickness.

We are gratified to find these four recommendations all embodied in the Wagner bill.

We believe that wide latitude should be allowed the States in the definition of the population to be served and the method of providing medical services. Here again we note that the Wagner bill agrees.

We believe that these benefits should be provided for the whole population, and are pleased to note that the National Health Act of 1939 specifies that a plan to provide a State-wide coverage at once or in not more than 6 years must be submitted in order for a State to qualify for Federal aid.

We believe that the primary Federal function in this field is to give financial and technical aid to States for approved programs. We note that the Wagner bill does not depart from this primary function.

We believe that it is desirable that a single State agency, the health department, should be administratively responsible for all the provisions of the national health program. We note that the Wagner bill agrees in general except on the administrative responsibility of the disability compensation provisions.

We believe that the State health department can provide better personnel and maintain higher standards for these services than any other State agency. We find no apparent disagreement with this position in the bill.

We believe that qualified advice will be requisite from several professional groups concerned. We note that it is provided for in the bill, although in a somewhat cumbersome fashion.

We believe that increased funds for training purposes will be essential, and we note that these are provided in the bill.

We believe that the program should be developed around and based upon existing preventive health services, and we find provisions to this effect in the act.

We believe that wide latitude must be given to the States in defining not only the population to be served and in the selection of the method of providing medical service but also in the method of raising funds in the States. We believe this latitude is embodied in the Wagner Act.

We believe that the fundamental objectives of this program are, first, the conservation of health and vitality and, second, the reduction of the rule of sickness as a cause of poverty and dependency. We find no disagreement with these objectives in the Wagner Act.

We believe that the expansion of public health and maternal and child-health services, the expansion of hospital, clinic, and other institutional facilities, and the provision of medical care for the medically needy should have priority in initiation. We assume that under the bill as proposed the States are left with discretion sufficient to choose the items to be developed and the order in which they will be begun.

We believe that the existing provisions for State aid under the Social Security Act constitute a good framework for expansion, and we note that the Wagner Act is an amendment and an expansion of the Social Security Act.

We believe that State programs in order to be approved must provide for the maintenance of high personnel standards, and we believe that Federal aid should be withheld on substandard services. The concurrence of the national health bill is noted with approval.

We believe that Federal authorities should have power to establish minimum standards after consultation with competent advisory bodies. Again we note agreement of the Wagner Act.

We believe that Federal aid should be conditioned on the inclusion in the State plans of adequate safeguards for standards in general, and this we find included in the Wagner Act.

We believe that the extension and improvement of public-health services require the integration of health services at the Federal level under one Cabinet officer, preferably a Secretary of Health.

We note here a major divergence in the draft of the National Health Act of 1930 which makes the Children's Bureau responsible for maternal, infant, child hygiene, and crippled children's services, whereas the United States Public Health Service is to be responsible for general public-health work, for investigation, and for hospitals and health centers, and the Social Security Board is to be responsible for the medical care features and for disability compensation.

In this connection we have noted with interest that the recent reorganization order transfers the United States Public Health Service and the Social Security Board to a new independent agency without Cabinet representation. No clear provisions for coordination are made. This may therefore be consolidation without coordination, particularly since the Children's Bureau is left in the Department of Labor and various other Federal agencies, such as the Medical Service of the Indian Service are left where they are.

It is therefore apparent that the Wagner Act meets the recommendations of the American Public Health Association in practically all respects excepting the failure to make a single Federal agency responsible for all features of the act. In this respect the National Health Act of 1939 even further complicates the Federal administration of health services by imposing upon the Social Security Board a new responsibility for which it now has neither staff nor experience.

It is further noted that although advisory councils are requisite both at the Federal and State level, the provisions as made by sections 503, 513, 603, 1203, 1206, and 1303 will require a total of 292 separate councils. We believe that these are too numerous and unwieldy. It would perhaps suffice to provide for one council to each Federal agency responsible under this act and for one council to each State agency chosen for State responsibilities. This would reduce the number probably to less than 100. Nevertheless, the membership, the duties, and the responsibilities of these councils are still vague. We believe that these details of advisory councils, their number, and their duties and responsibilities are matters that can well be cleared in conference.

With the above exceptions, we believe that the National Health Act of 1939 can be approved as a device to implement the National Health Program.

Senator MURRAY. The next witness is Fred K. Hoehler, director of American Public Welfare Association.

Will you give your name and the organization you represent?

STATEMENT OF FRED K. HOEHLER, DIRECTOR OF AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. HOEHLER. My name is Fred K. Hoehler. I am director of the American Public Welfare Association.

Senator ELLENDER. What is your membership?

Mr. HOEHLER. We have about 3,000 members.

Senator ELLENDER. How are you maintained?

Mr. HOEHLER. Maintained by both the membership's subscriptions and subsidy from a foundation. The subsidy goes to special studies.

Senator ELLENDER. From what foundation is that?

Mr. HOEHLER. The Spelman fund.

Senator ELLENDER. Oh, yes.

Mr. HOEHLER. The American Public Welfare Association has not passed resolutions on the national health program. We have been busy trying to do something about the very serious medical needs among 6 million families who are receiving public aid through 51 State and Territorial welfare agencies.

Several years ago the American Public Welfare Association, which exists to help administrators and workers in public welfare agencies

do a more effective job, began studies in the gaps which exist in welfare services. One of the most glaring lacks was in the health and medical care service provided for persons on relief, or those who were a part of the low-wage group. Several monographs and pamphlets were published by the association urging the use of private and public hospitals and medical facilities by public relief and welfare agencies. One of these monographs which has been revised several times stresses the use of voluntary or private hospitals by public authorities on a payment for service basis. This monograph is the result of intensive study of the need for hospital care and of the desire to assist in working out plans for properly coordinating services in the local community. Our committee and staff discovered that there were many areas where there are insufficient hospital bed space and facilities. The more serious lack was in the diagnostic and clinic service for people, particularly in the rural and highly industrialized centers. The people who came within the low-wage or dependent groups were unable to pay for services and were therefore dependent either on the charity of the individual doctor or hospital or the assistance of private or public welfare agencies.

While it is true that many doctors do provide service free or at low cost and sometimes through welfare agencies, a great many more cases than were treated went entirely unattended. This was true for several reasons. First and most important was, and still is, the unequal distribution of medical practitioners. Many rural districts and industrial areas are singularly lacking in good doctors. We have seen many conditions and read many letters from the field concerning the substitutes which are used for good medical practice. These range from voodoo and witch doctors through the list of worthless patent medicines and unsanitary midwifery in attendance at childbirth.

A study of medical care through relief and health agencies revealed for the most part poor organization, lack of financial support, and woefully inadequate coverage. Unattended illness has created greater dependency, causing additional unemployment, and in a large percentage of cases it has destroyed productive capacity among those fortunate enough to have held a job. Local and State governments have not met this problem either with appropriations or staff. The task of restoring work capacity to men who have been ill and of rehabilitating those on relief can make no progress as long as health and medical care needs go unmet.

The national health survey reports which were published in 1938 by the W. P. A. and the Public Health Service gave substance and figures to the facts which most welfare officials had already known. Those studies confirmed their opinion that the area of greatest danger from sickness and destruction of national productive capacity is among the low wage and dependent families. There is evidence of serious neglect in the medical care of children and families. This is true because of the great emphasis which States have placed on appropriating funds for old-age assistance to the neglect of child care and because the local communities are unable to carry adequate case loads of those who are unemployed. Immediate necessities are cared for in some cases but medical care like rent is one of the things that relief agencies put off, hoping that some other provision

will be made to meet it through resources of families and friends. This hope has not been realized in most cases.

Study of causes of dependency in private and public social agencies before 1929 revealed sickness as ranking well above all other factors causing dependency. This condition has been aggravated ever since then and where the original cause of dependency might have been unemployment due to business depression, we find continued dependency too frequently due to sickness either mental or physical. There are, relatively, no increased facilities or public appropriations provided for meeting this growing problem.

Your committee will have an abundance of statistics and figures, but we feel it is our obligation to call attention to the inability of existing agencies and funds to meet these important problems.

I have here a report of the American Public Welfare Association, the committee on medical care, which discusses, on page 10, the unmet needs, giving specific examples that have come in from the answers to questionnaires in the field visits to 37 States of the country. The questionnaires reveal that in practically every instance there are inadequate provisions for medical care, and in a great many cases totally inadequate hospital care.

I am also leaving with the committee a copy of some principles on the administration of tax-supported medical care which were drafted by the committee of the association.

I am also leaving with you some studies which were made in the field of hospital care for the needy, developing relationships between public-welfare agencies and private hospitals, the matter brought out earlier in the discussion this morning.

We have urged the use of all community facilities that were available, using resources, private or public, to meet this problem, because we felt it needed meeting as early as possible, without waiting until public facilities could be provided to meet it.

Senator MURRAY. All these records will be filed with the record.

(The papers referred to were filed with the committee.)

Senator MURRAY. Thank you. The committee will meet tomorrow morning at 10 o'clock.

(Whereupon, at 12 noon a recess was taken until the following day, Friday, May 5, 1939, at 10 a. m.)



TO ESTABLISH A NATIONAL HEALTH PROGRAM

FRIDAY, MAY 5, 1939

UNITED STATES SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in room 357, Senate Office Building, Senator James E. Murray presiding.

Present: Senators Murray (chairman), Ellender, La Follette, and Taft.

Senator Wagner also present.

Senator ELLENDER. Senator Wagner, you desire to be heard again?

Senator WAGNER. Just briefly. Some questions arose yesterday as to the mechanics of the proposed legislation, and I would just like to make a brief statement with reference to those things. The simplest way, Mr. Chairman, to tell how the bill would operate is to take as an illustration the very first program at page 2 of the bill, title V, part 1, authorizing Federal grants for maternal- and child-health services in the States. The sum of \$8,000,000 is authorized in the first year.

This is not a new program, but represents an increase of about \$4,000,000 next year for substantially similar activities now functioning under title V of the Social Security Act.

Now precisely how does this \$8,000,000 appropriation get out to the States, and in what proportion? Quite obviously, this sum could not possibly meet the whole need for maternal- and child-health services throughout the country, or any substantial part of it. The money must therefore be allotted to the States, in some fair proportion, taking account of the size of the job to be done in each State and the need for Federal help in doing that job. The bill provides, on page 3, that such allotments shall be made by the Chief of the Children's Bureau, prior to the beginning of the next fiscal year, in accordance with rules and regulations which are to take into consideration first, the total number of births; second, the number of mothers and children in need of the services; third, the special problems of maternal and child health; and fourth, the financial resources of the State. These conditions of allotment are similar to those embodied in the present title V, part 1, of the Social Security Act and have been shown to be sound and workable.

Senator TAFT. What title does that deal with?

Senator WAGNER. Mothers, infants, and children.

Senator TAFT. Dependent mothers?

Senator WAGNER. Yes.

Senator TAFT. Mothers with dependent children?

Senator WAGNER. Yes. Also general maternity and infancy problems, of course.

Dr. Martha Eliot, a distinguished physician, who has been in charge of this program for years and who is also chairman of our technical committee, is present and ready to place at your disposal any information you may desire regarding the departmental procedure now followed, or projected under the new bill.

Senator ELLENDER. Senator, is that the only amendment to the act, that is, an increase of \$8,000,000, or have you added anything to it?

Senator WAGNER. We have not added anything to that portion of it, have we Doctor?

Dr. ELIOT. An increase of \$4,000,000.

Senator WAGNER. Yes.

Senator ELLENDER. In other words, if you have added nothing to the act except to increase the appropriation, why rewrite the whole act or the whole section?

Senator WAGNER. There is another provision here; one dealing with mothers and children, general medical care. That is part 2 of the same title. I was going to refer to it in a moment. May I finish this statement?

Senator ELLENDER. All right.

Senator WAGNER. Or not—I don't care.

Senator TAFT. I wondered if the method of allotment is really so indefinite that it gives complete discretion, I would say, to the person allotting it. Wouldn't you say so?

Senator WAGNER. Well, the only way I can answer that—I don't know how to make it more definite than it is made. These are similar to the provisions that we used in the Social Security law.

Senator TAFT. There was a question raised yesterday. If one State already was taking care of all of the mothers and children, then there would be no mothers and children in need in that State, consequently the allotter would be justified in allotting no money to that State, simply because the State is already spending its own money. That certainly is not a very desirable result. I do not know whether any more definite system could be worked out, but this, it seems to me, is as good as nothing. It seems to me that you might as well say that the chief may allot it as he pleases. I do not see that this is really any restriction on allotment.

Senator WAGNER. This title does not provide that limitation. Here there are no requirements that they must spend money in addition to what is already spent in order to secure an allotment.

Dr. ELIOT. No.

Senator WAGNER. That has to do with another provision of the act, as I understand it.

Senator TAFT. The allotments in the other titles are more definite than this one?

Senator WAGNER. I will tell you what I would rather do, since you want the mechanics of it. Suppose we have Dr. Eliot tell you how under these limitations, how she worked out the program so as to have the allotments fair and according to needs?

Senator ELLENDER. Is Dr. Eliot at the head of the Maternal Child Health Service?

Dr. ELIOT. Assistant Chief of the Bureau.

Senator WAGNER. In charge.

Senator ELLENDER. So she could tell us, I suppose, all about that particular phase?

Senator WAGNER. How it actually operates at present.

Senator ELLENDER. And how this amendment differs from the present law?

Senator WAGNER. Yes.

Senator TAFT. I suggest that Senator Wagner finish his statement first, don't you? Because we may wish to question him further.

Senator ELLENDER. Yes.

Senator WAGNER. After the appropriated sums have been allotted, the next step is the examination of plans submitted by the States which want to cooperate under the program. The conditions for the approval of such plans are laid down in some detail in section 503, at pages 3 to 5 of the bill. These specifications are based on the best judgment available as to the conditions which should be met by a State plan in order to assure that the Federal funds will be expended to effectuate the purposes of the bill, leaving to the State, however, a large measure of discretion in framing the nature and scope of its plan. If a State plan meets these requirements, it must be approved by the Chief of the Children's Bureau.

The next step is the actual payment over of Federal funds. Such payments are made from the allotments made as I have described, on a matching basis varying from 33½ to 66⅔ percent of the total amount of public funds expended under the plan, but in no event to exceed, of course, the total amount allotted to the State. The matching ratio for each State depends upon its relative financial resources, measured by per capita income, as determined jointly by the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board (p. 47, line 18, and following). The State of Louisiana, for example, which has relatively low financial resources, being about the thirty-eighth in the list of States in per capita income, would have the relatively high Federal matching ratio of about 60 percent—that is, \$6 of Federal money for every \$4 of State money expended under the plan.

There was a question raised yesterday as to whether the expenditures required of the State must consist wholly of new expenditures, or whether the Federal Government would match sums now expended by the States and localities under approved State plans for the particular purpose. The answer varies somewhat under the different titles of the bill. Under title V, all existing State expenditures may be counted, with certain exceptions I will note, so that Federal grants may be made to extend and improve what was already being done in the State. Of course, if a State is not now expending for maternal and child services enough to use up its entire allotment under the matching requirement, it would have to appropriate additional funds if it wants to take full advantage of the Federal program; in other words, if the State is expending only \$100,000, and its allotment under the Federal regulation would be \$200,000—of course I need not say that if it wants the full \$200,000, it has got to add \$100,000 to its own appropriation. It may not be that same ratio. I am assuming a 50-50 matching.

Under part 1 of title V the only limitation laid down—this appears in section 504, page 6, lines 8-12—is that in determining the

Federal grant-in-aid, no account shall be taken of any expenditures which are included in any other State plan submitted under any other part of this title or any title of this bill. This provision excludes the possibility of matching the same State and local money more than once.

Under part 2 of this title V, dealing with medical care of children, including handicapped and crippled children, there is an additional provision, on page 13, line 23, to page 14, line 7. This provides that the Federal grant may not match any expenditures for hospital and institutional care of mental or tuberculosis cases except as expenditures for such cases exceed the average annual expenditures in the 3 years prior to the effective date of this act. This is done in order not to have the relatively meager Federal sums appropriated, used up by matching certain existing health expenditures which are already widely made by practically all States. The effect is to encourage new State expenditures in these directions or else to apply the allotments to existing health functions where Federal aid is more desperately needed. There is a similar provision with regard to tuberculosis and mental hospital care under title VI, page 21, lines 8-13; and under title XIII, page 38, lines 24-25, page 39, line 1, such expenditures for institutional care of mental or tuberculosis patients are excluded altogether for matching purposes. These provisions, I want to make clear, apply to *medical care* in hospitals for the patients with these particular diseases. They do not preclude, and there is nothing in the act which precludes, the making of grants for the construction of needed hospitals by the States for these purposes under title XII, with added maintenance grants for 3 years only. This is made perfectly clear by the provision of title XII, at page 26, lines 11-13.

I may interpolate there that Louisiana has a very fine record in the construction of hospitals. I understand they are one of the few States that are pretty high up, under Governor Long.

Senator ELLENDER. The movement started under Governor Long, yes; and Governor Allen. We have spent in the last 3 or 4 years, I think over \$15,000,000 just to build hospitals.

Senator WAGNER. I believe that these provisions are reasonable and will lend themselves to practical handling by both the Federal and the State authorities. The Federal agency will undoubtedly establish the necessary rules, regulations, and forms that will enable the States to submit plans that are within the intent of the legislation. The States, in turn, will have reasonably clear knowledge, in advance, of the expenditures which they intend to make and which may be included for matching purposes in the plans which they submit to the Federal agency for approval. The accounting procedures which will be involved will, I am sure, be as completely practical as are the similar accounting procedures now in operation.

Let me say that we have had extensive experience with similar programs. In a number of agencies, there are set-ups for determining the allotments to States, so that, as you know, this is not a novel undertaking at all.

Finally, let me illustrate with title V, how the services of non-governmental hospitals may be utilized for the purposes approved in the bill—and this is important, because there has been some apprehension about this provision.

Payments to States, under this or any other title, will be made, of course, only to State agencies administering State plans. Once paid, these are as much State funds as if they had been appropriated by the State legislature itself. The State agency administering the plan may determine to give the service through the State salaried officials or public hospitals, or else compensate private practitioners and non-governmental hospitals for performing these services. Any such groups or agencies will have a voice in guiding the administration of the State plan.

All this is made perfectly clear by section 503 (a) (5), on page 4, lines 21-25, which requires the State plan to provide for—

an advisory council composed of members of the professions and agencies, public and private, that furnish services under the State plan, and other persons informed on the need for, or provision of, maternal and child-health services.

There is a similar provision in every one of the medical care titles, sections 513 (a) (5), 603 (a) (5), 1203 (a) (7), and 1303 (a) (5).

Under title V, parts 1 and 2, of the present Social Security Act, the services of private agencies are now being used by many of the States under their approved plans. For instance, in connection with the crippled children's program, the States are purchasing care for crippled children from a total of 601 hospitals. Senator Ellender asked some questions, or I think it was Senator Taft, about the private hospitals, whether they would get any benefits through this legislation, or whether they were excluded, so this becomes interesting. The States are purchasing care for crippled children, from a total of 601 hospitals, of which 512 are private, nongovernmental institutions. So you see they are now dealing with these hospitals, and the State compensates them for the patients which they take.

Senator ELLENDER. That is in one phase of the work?

Senator WAGNER. Yes; I am referring now to one phase of the work, but the same idea is carried throughout the bill.

Under part 1, services of private visiting-nurse agencies are also being utilized. Nothing in the bill is intended to change that situation, and I am entirely willing, as I have said, to accept appropriate amendments to eliminate any doubt on this score.

In substance, this is the basic procedure which would apply to each of the titles which involves the allotment of funds among the States. There is no one that can so advise and enlighten as a particular individual who has had experience and expert knowledge on the matters of an enterprise of this kind, and for that reason I hope that you will hear Dr. Eliot, who will enlighten you very much more than I can.

Senator ELLENDER. We will now hear from Dr. Eliot. And Dr. Eliot, will you give your name in full, and your present occupation for the record.

STATEMENT OF DR. MARTHA M. ELIOT, ASSISTANT CHIEF OF THE CHILDREN'S BUREAU, DEPARTMENT OF LABOR

Dr. ELIOT. My name is Martha M. Eliot, and I am Assistant Chief of the Children's Bureau of the Department of Labor, and chairman of the technical committee on medical care of the interdepartmental committee.

I may say that I am here this morning at your request as chairman of the technical committee. The other members of the technical com-

mittee are here, and I shall ask them to answer certain of the questions that relate specifically to the fields in which they are particularly interested and informed. Would you like me to proceed with the question of the allotments first?

SENATOR ELLENDER. Yes. For your particular department, if you don't mind.

DR. ELIOT. I think, to clarify the differences between the method proposed in this bill which is before you and the procedure now used, that it would be well if I made a brief statement with regard to what the Social Security Act now includes for the allotments of grants under maternal and child-health services. Section 502 of the present act specifies that out of the sums appropriated pursuant to section 501, for each fiscal year, the Secretary of Labor shall allot to each State \$20,000, and such part of the \$1,800,000 as he finds that the number of live births in such State bore to the total number of live births in the United States in the latest calendar year for which the Bureau of Census has available statistics. Secondly, out of the sums appropriated pursuant to section 501 for each fiscal year, the Secretary of Labor shall allot to the States \$980,000 in addition to the allotments made under said section (a), according to the financial need of each State for assistance in carrying out its State plan as determined by him after taking into consideration the number of live births in such State.

A later section indicates that from the sums appropriated under section 502 (a), the Secretary of the Treasury shall pay to each State which has an approved plan, for each quarter beginning with July 1, 1935, an amount which shall be used exclusively for carrying out the State plan equal to one-half of the total sum expended during such quarter. I quote that because it indicates that for a certain portion of the money appropriated for maternal and child-health purposes, there is a matching plan in which the State must put up an equal amount to that which it is granted by the Federal Government.

There is, however, this sum of \$980,000 which is granted to the States on the basis of the need of each State for assistance in carrying out its plan. This latter sum does not need to be matched by the State, but is what we might call a free grant to the State.

The allotment for the first type is, as you see, clearly defined in the act and is not left to the discretion of the Secretary of Labor or the Chief of the Children's Bureau. However, the allotment of the \$980,000 is left to the discretion of the Secretary of Labor as to how that sum shall be allotted to the States within the limits in the act, that is, for assistance in carrying out the State plans.

During the last 3½ years, a plan of allotment of that sum of money, \$980,000, has been used which has proved to be satisfactory. The \$980,000 has been allotted to the States on the basis of need for assistance as described by the States themselves.

This fund, called the B fund, has been divided into two main categories: \$255,000 to be allotted uniformly to the States, \$5,000 to each State; \$725,000 has been allotted on the basis of special need, as shown by statistical indexes of need. The allotments under the first category are in recognition of the need of extending and improving services for promoting the health of mothers and children in every

State. The allotments under the second category are in recognition of the special need for extension and improvement of services in the rural areas and in areas suffering from economic distress and the special financial needs of such States for assistance in carrying out State plans for extension and improvement of services in such areas.

The statistical indexes which have been selected after much research as the basis for this second category are as follows: First, the sparsity of population; second, maternal mortality; and third, infant mortality. These indexes are found to be generally high in the areas in which the per capita income and total taxable income were low, that is, the areas of the greatest financial need. The use of these indexes has served to make the funds largely available to States with relatively sparse population—States with high maternal- and infant-mortality rates—States with especially great need for financial aid in the extension and development of their services.

In planning the allotments of the three indexes, the three indexes were given approximately equal weight. Of the \$725,000 assigned to this category, \$245,000 was assigned for distribution by the sparsity index, \$240,000 by the mortality of maternal indexes, and \$230,000 by the infant-mortality indexes.

I give you the detail of this to indicate the way that the Secretary of Labor has proceeded to distribute funds where discretion has been given to the Department for such distribution.

Now, under the bill as you have it before you, the method is somewhat changed, although the general principles are the same. Because of the introduction of the variable matching ratio, it is no longer necessary to have part of the funds distributed on a flat 50-50 matching basis and part distributed with no matching requirements, but the plan would require that all of the funds be distributed to the States on the variable matching basis. As a matter of fact, under the present act, the introduction of the funds for free distribution without matching actually brings into the plan a variable grant feature, and it has been our feeling, as we have reviewed the provisions of this bill, that a reasonable distribution of funds to the States could be brought about under the scheme as proposed in the amendment.

Senator ELLENDER. I noticed you added one more index here on page 3 of the act. You said that you had three under the old bill.

Dr. ELIOT. Three under the old bill, I think that you refer to—

Senator ELLENDER (interposing). That you referred to.

Dr. ELIOT. That I referred to, I mean, the uniform grant, the grant on the basis of population, and then the free fund to be given on need for assistance.

Senator ELLENDER. You have changed that method?

Dr. ELIOT. Yes; the method has been changed in this bill.

Senator ELLENDER. Of course, it is your opinion that this present method, that is the method presented today, is better than the one that was presented in 1935?

Dr. ELIOT. It seems to me that this method will work satisfactorily.

Senator ELLENDER. Have you made a table of the amount of money that might be allotted to each State should we appropriate what is called for in this bill?

Dr. ELIOT. We have begun to work on that problem, Senator Ellender, and our statistical division is now proceeding to provide for us

such distributions of the money. We have been trying several different methods using different indexes of need as we see them for the different elements in the program that you have before you. The Department of Labor when it appears before you, if you as a committee request representatives of the Department, will be ready to submit a little later such proposals.

Senator ELLENDER. This committee will no doubt be sitting for probably 3 or 4 weeks, and I am wondering if you could not work out for the record a table showing how the \$8,000,000 would be distributed under the old method among the various States, and how each State would fare under the present method, so that we can have a comparison, and then if some need more than others, and others less, you might state why that occurs.

Dr. ELIOT. Yes; I would be glad to report that and see whether we cannot submit such a statement to you.

Senator ELLENDER. It does not have to be accurate—just approximate. So that we can make the comparison for the rest of the Senators if and when the bill is presented to the Senate.

Dr. ELIOT. The method of arriving at such a distribution would be different from the method of arriving at the present one, but we might be able to reach a similarly satisfactory result.

Senator ELLENDER. And it ought to be better. It ought to be an improvement on what you had before.

Dr. ELIOT. I should hope so.

Senator ELLENDER. That is your hope?

Dr. ELIOT. Yes. Now, does that clear up some of the problems with reference to the allocation of funds?

Senator ELLENDER. Yes; very much.

Dr. ELIOT. Are there any other questions that you would like to raise at this time?

Senator ELLENDER. That refers to part 1, does it not? Only to maternal and child-health service?

Dr. ELIOT. Yes. Part 2, which is the medical services for children and crippled children—

Senator ELLENDER (interposing). Before we go to that—can you point out to the committee any other amendments that were made as to part 1, maternal and child health service, I mean other than what you have already mentioned?

Dr. ELIOT. Actually the bill that you have before you is essentially a nearly complete revision of title V. I may say in connection with this particular title, the revision has been made, as have revisions in title VI, in order to bring the two titles more into alignment one with the other, to permit uniformity of procedure in relationship to the State agencies responsible, to improve administrative and accounting procedures in a number of respects.

We feel that many of the changes that have been made will be to that end. There are many differences in making a comparison between the old and the new. Would you want me to go through and point them out in detail now?

Senator ELLENDER. Senator La Follette calls my attention to the fact that there are out-of-town witnesses here, and it may be better that we defer that phase of it.

Senator LA FOLLETTE. My suggestion would be that at some time in the consideration of this bill that we go through it with the help of the technical committee and the various Department representatives and thus have a consecutive analysis and comparison of this measure with what has been done under the various departments and agencies of the Government, and an explanation of the extent and the ways in which this bill proposes to expand and enter new fields, but it would seem to me that it would be more logical to do that at some particular time and we could have it consecutively in the record.

Dr. ELIOT. We would be glad to return and give you in detail any help that you would like.

Senator WAGNER. Can I make a further suggestion to the committee, that perhaps in the meantime some of those who helped work on the bill might prepare an analysis of the old law and the new law and the changes that have been made, for the use of the committee?

Senator LA FOLLETTE. That would be very helpful, but it occurs to me also that some members of the subcommittee may desire to ask questions which would not be covered in such an analysis.

Senator WAGNER. I do not mean to substitute that for testimony, but preparatory to listening to the witnesses, we could have that analysis.

Senator LA FOLLETTE. That would be very helpful.

Senator ELLENDER. If you do not mind then, Dr. Eliot, we would like to call these out-of-town witnesses.

STATEMENT OF DR. ARTHUR W. BOOTH, OF ELMIRA, N. Y., CHAIRMAN OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. Booth. My name is Arthur W. Booth.

I am a practitioner of medicine and surgery at Elmira, N. Y.

For 8 years I was a member of the house of delegates of the American Medical Association, serving as one of the elected representatives of the medical society of the State of New York.

Since 1932, I have been, by election by the house of delegates, a member of the board of trustees of the American Medical Association and am now chairman of the board.

Senator LA FOLLETTE. May I ask, Doctor, do you appear in a representative capacity for the American Medical Association?

Dr. Booth. That is the only capacity. My own personal feelings in the matter are entirely submerged.

Senator LA FOLLETTE. I just wanted the record to show.

Dr. Booth. I thank the committee for this opportunity to state the position of the American Medical Association with respect to some of the proposals set forth in the pending bill, S. 1620, and for the opportunity to be given later to introduce evidence in support of the association's position. In order that the committee may better appraise what I say and the evidence to be presented hereafter by the association, I submit for the record a memorandum showing briefly what the American Medical Association is and what its objectives are.

Such information is particularly needed just now because of attacks on the association, some made in good faith and some made apparently because of selfish interests.

It is sufficient at the present moment to say that the American Medical Association is a federation of State medical associations. It is governed by a house of delegates, made up of 154 delegates elected by the State medical associations of which the American Medical Association is composed; 15 elected by the several sections into which the scientific assembly of the association is divided, each devoted to a particular branch of medicine, such as surgery, obstetrics, and internal medicine; and three appointed, one each by the Surgeon General of the Army, of the Navy, and of the Public Health Service from the commissioned medical corps of those services. Of the 173,879 physicians lawfully authorized to practice medicine in the United States, 113,113 were on May 1 of this year members of the association.

The house of delegates of the American Medical Association fixes the policies of the organization. The house has not met, however, since the bill now under consideration was introduced. It will assemble on May 15, in St. Louis, and will consider the bill, and representatives of the association will report to your committee as promptly as practicable whatever action the house takes. They will lay before you, too, some of the many data that the association has assembled during recent years, relative to the economics of medical service from the standpoint of the physician, of the hospital, and of the people.

Although the house of delegates has not had an opportunity of considering the pending bill, it did consider, at a special session in September last, the so-called national health program formulated by what is sometimes referred to as the Technical Committee on Medical Care. This technical committee, it should be understood, was created by a committee appointed by the President and known as the Interdepartmental Committee to Coordinate Health and Welfare Activities. The report of the Interdepartmental Committee to the President, including the report of its technical committee, was submitted to the Congress by the President (see H. Doc. 120, 76th Cong., 1st sess.), and S. 1020 proposes to make the recommendations of the Interdepartmental Committee, or some of them, effective. The conclusions of the house of delegates of the American Medical Association, at its special session in September last, based on the report of the technical committee, are therefore relevant to the pending bill and to the deliberations of your committee, insofar as the bill is founded on that report.

Judged by the principles laid down in the resolutions of the house of delegates in September last, S. 1020, as a whole and in many of its details, is unsound, and its enactment would not be in the public interest. Its enactment, it is believed, would prove a costly mistake, jeopardizing the welfare of the people and seriously compromising the future development of the science and art of medicine in the United States. If the Federal and State taxes that will have to be imposed to carry this bill into effect must be imposed, then at least a substantial part of the proceeds had better be devoted to providing for the needy adequate food, clothing, and shelter. So far as this

bill is concerned, hunger, nakedness, cold, and storm are to be left to wreak their damage, the bill proposing only to provide medical, hospital, and nursing service to cure the damage for a while after it has been done.

If the principles laid down by the house of delegates are unsound, the association will welcome enlightenment. Fortunately, the proponents of this legislation have the opportunity of presenting their evidence in support of it before the house of delegates of the association meets in St. Louis, May 15-19. That will make it possible for the house to have such evidence before it in the course of its deliberations. If the house that is about to convene finds that modifications of the conclusions of the house that met in September last are called for, it will make such modifications.

Coming now directly to a discussion of the pending bill, I call attention to the fact that it proposes to authorize the imposition on the people of annual Federal appropriations of variable amounts, ranging from \$98,250,000 upward to an indefinite skyward limit and to require the States that cooperate with the Federal Government under the act to impose on their people proportionate State appropriations. It may seem paradoxical to speak of "imposing" appropriations on the people, but since every appropriation has implicit in it the taxes that have been or must be levied to provide the money appropriated, every appropriation that is made is "imposed" on the people just as truly as are the taxes themselves. The fact that an appropriation is primarily for the benefit of one class of the population while the taxes necessary to cover the appropriation fall directly on another class, possibly even on future generations, does not alter the situation.

So far as I am informed, no evidence has ever been offered to show that any of the project embodied in S. 1820 was devised by any of the people of the several States or that the enactment of this legislation is being promoted by them. On the contrary, it is understood that every project embodied in this bill was devised by appointive Federal officials and employees, to be handed down to the people on a "take it or leave it" basis. If the bill is enacted the Federal Government will levy on the people the taxes necessary to provide for the payment of the cost of all activities authorized under the act and will then say to the people, "Unless you come in on this venture we keep every cent we have taken from you."

Propaganda has been and is being organized to advance the plans of the Federal proponents of this legislation, but the Federal origin and driving force back of all these projects must not be lost sight of. The origin of these projects need not damn them, but it certainly lays on their Federal organizers and proponents an even heavier burden of justification than they would have if the projects had originated in the several States. In meeting that burden, inasmuch as the taxes that the bill requires will fall on the people of all the States, its proponents are called on to justify it for each and every State; not for Alabama or Mississippi or Nevada alone, but for New York, Pennsylvania, Massachusetts, Illinois, and every other State. The prime necessity for such a State-by-State justification of this bill lies in the fact that if there are States whose people are destitute and in distress beyond the power of the respective States to aid them,

the Congress may appropriate for their relief on such terms as it sees fit, but without using such destitution and suffering in one State as an excuse or justification for imposing tax burdens and Federal guidance and control on States whose people are not destitute or suffering and that are able to manage their own affairs.

It has been claimed in support of universality for legislation of this type that the Federal taxation and the Federal guidance and control that go with it are necessary—

1. To stimulate the States.

2. To equalize the health opportunities in all the States; and

3. To procure uniformity in health activities throughout the United States.

To lay the heavy hand of Federal guidance and control on a State may serve quite as well to destroy its initiative as to stimulate it, and to subject every State to Federal control and thus to establish uniformity may deprive the Federal Government of stimuli from the States; and stimuli from the States and a critical attitude on their part are as necessary to Federal efficiency as are Federal stimuli and criticism needed to insure State efficiency.

The phrase "to equalize the health opportunities in all the States" is a seductive phrase, but what assurance have we that the increase in taxation and the establishment of Federal supervision and control to bring health opportunities to a common level, while raising the opportunities in some States, will not degrade the opportunities that exist in others, and thus procure equality, certainly, but an equality of doubtful advantage?

To bring about uniformity of health activities among all the States would certainly tend to delay and possibly to diminish and to destroy opportunities in health endeavors for variation and experimentation that is possible under State control alone, which, under our normal constitutional form of government, furnish advantages that are too little appreciated and taken advantage of. The house of delegates of the American Medical Association, at its special session in September last, emphasized particularly the need for the promotion of local initiative, supported by State aid and guidance if necessary, and by Federal aid, guidance, and control only when rendered necessary by the destitution or incapacity of the State.

The fact that the authority granted certain Federal officers and the money placed at their command, by the Social Security Act, have not already reduced illness and disability to the extent apparently anticipated by some of the proponents of that act seems to have led to the demand in this bill for enlarged authority and more money, as if authority and money were together all-sufficient to work miracles in the field of health. If this bill be enacted, in all probability within a year or two we shall have a repetition of our present experience, a demand for more authority and more money, in the vain hope of hastening a millennium in the field of health. But there is no royal road to health, either of the people as a whole or of individuals. Time and effort are required over long periods of years, and even after such long periods, time and effort will be found to have produced smaller returns in some communities than in others; for conditions over which we have but limited control, such as race, heredity,

and meteorological conditions, may be the chief determining factors in causing disease and death.

If the Federal Government can, in the brief 10 years that have elapsed since the Sheppard-Towner Maternity and Infancy Act was expressly repealed by the Congress, June 30, 1929 (Public, No. 566, 60th Cong., 44 Stat. L., p. 1024), go as far as is proposed in this bill in spreading itself over intrastate activities in the field of health and medical service, there would seem to be no limit on its right to expand. A Federal subsidy for police service might well give the Federal Government supervision and control of all police service throughout the country. A Federal subsidy for the operation of State systems of assessment and tax collection might be devised to give the Federal Government supervision over State activities now regarded strictly as State functions. Possibly a line might be drawn against Federal encroachment on the legislative activities of a State, but one can readily envisage a Federal subsidy for the aid of State legislatures that would lead to the Federal direction and control of their functions.

Concerning the action of the house of delegates of the American Medical Association in special session in September last, there has been some misunderstanding and some misrepresentation. To make clear what the house did it is necessary to go at some length into its proceedings. In doing so it is necessary to emphasize again the fact that the action of the house of delegates at that time had reference not to S. 1620, but to the recommendations of the Technical Committee on Medical Care, an agency of the Interdepartmental Committee to Coordinate Health and Welfare Activities created by the President on which that bill seems to rest. It is, therefore, only as S. 1620 undertakes to translate into organization and action the recommendations of the technical committee that the action of the house of delegates in September 1938 is pertinent.

(1) The house of delegates in September 1938 recommended the establishment of a Federal Department of Health with a Secretary at its head, who should be a doctor of medicine and a member of the President's Cabinet. S. 1620 provides for no such officer. In fact, it proposes to leave the preventive and curative medical services of the Federal Government scattered as widely as ever through the Federal organization.

(2) The house of delegates proposed that expenditures for the expansion of public health and maternal and child-health services should not include the treatment of disease except so far as it could not be successfully accomplished through the private practitioner. The pending legislation proposes to provide for the treatment of disease under various conditions, without in any way safeguarding the existence of the private practitioner.

(3) The house of delegates favored the expansion of general hospital facilities where need exists and emphasized its approval of the recommendation of the technical committee stressing the importance of the use of existing hospital facilities. The house of delegates did not endorse the committee's recommendation for an increase in special hospitals and for what the technical committee calls "health and diagnostic centers." S. 1620 includes no provision for the increased

use of existing hospital facilities. It does not limit the expansion of general hospital facilities to situations in which need exists. It does propose an extensive program in the field of special hospitals and health, diagnostic, and treatment centers.

(4) The house of delegates advocated recognition of the principle that the complete medical care of the indigent is a responsibility of the community, medical, and allied professions, and that such care should be organized by local units and supported by tax funds. It recognized the necessity for State aid for medical care in poorer communities. It proposed the limitation of Federal aid to cases in which the State was unable to provide assistance for local communities. S. 1620 proposes to make Federal aid for medical care the rule rather than the exception. Nothing has been found in it to limit to persons in need the medical care provided by Federal funds.

(5) The house of delegates urged the importance of well-coordinated programs for the improvement of food, housing, and other environmental conditions, for the prevention of disease and the promotion of health. It urged the establishment of a definite and far-reaching public health program for the education and information of all the people, to enable them to take advantage of the medical service now available. For these basic needs for the prevention of disease and the promotion of health S. 1620 makes no provision.

(6) The house of delegates refused to foster any system of compulsory health insurance. S. 1620 proposes to pave the way for compulsory health insurance by leaving to the Social Security Board the determination of what constitutes "methods of administration" necessary for the efficient operation of State plans for medical service. The provisions of the bill for grants to States for temporary disability compensation squint in the same direction. The house of delegates approved the provision of compensation for loss of wages during sickness, but S. 1620 proposes to provide not merely for loss of wages but to provide medical services also.

(7) The provisions of S. 1620, authorizing the Chief of the Children's Bureau and the Surgeon General of the Public Health Service to set up what are termed "demonstrations," the provisions for the training of personnel, the provisions for an indefinite number of ill-defined "advisory councils," and the provisions for the promulgation by various agencies, Federal and State, of rules and regulations are matters that have never come before the house of delegates of the American Medical Association. Obviously, they are all of serious import and will require careful consideration.

The House of delegates authorized the appointment of 10 physicians, under the chairmanship of Dr. Irwin Abell, president of the American Medical Association, to confer and consult with the proper Federal representatives relative to the proposed national health program. This committee was not consulted in the framing of the pending bill. Had it been consulted, it is possible that through joint studies and investigations and mutual endeavor a bill would have been produced containing an irreducible minimum of issues between the medical profession of the country on the one hand, insofar as it is represented by the American Medical Association, and, on the other hand, the proponents of this legislation, a consummation for which your committee might well most devoutly wish,

I append here an outline of the organization and activities of the American Medical Association.

Senator MURRAY. That may be placed in the record.
(The matter referred to is as follows:)

OUTLINE OF THE ORGANIZATION AND ACTIVITIES OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association was organized in 1847. Of its early history and troubles, it is not necessary to speak further than to say that until 1902 membership was not contingent on membership in any State and county medical association but was the direct, primary membership of the individual physicians who composed the association.

In 1902 the association was reorganized. It was then incorporated under the laws of the State of Illinois as a corporation not for profit and, with several amendments to its articles of incorporation since that date, it still remains a corporation not for profit. The sole object of the association, as stated in its articles of incorporation, is "to promote the science and art of medicine." To that objective all activities are contributory. In the course of reorganization of the association, it became a federation of State medical associations. Membership, except honorary fellowship granted to medical officers of the Army, Navy, and Public Health Service, is limited to physicians licensed to practice medicine and is conditioned on membership in the medical association of the State in which the physician practices.

The State medical association, each within its own State, have organized county or district medical societies covering the entire State, and membership in the State organization is dependent on election by the county or district medical society within whose jurisdiction the physician has his office. If disciplinary measures are contemplated, they must be initiated, except in the extraordinary cases, by the county or district society to which the member belongs, and suspension or expulsion from membership rests with that organization. So long as a physician is a member of his county or district society, he is also a member of his State association and of the American Medical Association.

State associations are governed each by a house of delegates, made up of delegates elected by the several county or district medical societies. The number of delegates that each county or district society may elect bears a certain stated relation to the size of the membership of the county or district society in relation to the total membership of the State association.

Similarly, the American Medical Association is governed by a house of delegates. The total membership of the house of delegates of the American Medical Association is 172. Of these, 3 are delegates from the medical services of the Army, Navy, and Public Health Service, appointed by the surgeon generals of those services, respectively. Of the remaining delegates, 15 are elected by the members of the several scientific sections into which the scientific assembly of the Association is divided, each such section representing one of the commonly recognized branches of medical practice, such as surgery, obstetrics, internal medicine, diseases of the eye, etc. The remaining 154 delegates are elected by the State medical associations, each association being entitled to elect delegates in proportion to the number of its members.

Membership in the American Medical Association involves no financial obligation to that association. All dues paid by a member of the American Medical Association as such, go into the treasures of his county or district society and his State medical association. A member, if he so desires, may become a fellow of the American Medical Association, and if and when he so qualifies, he must pay to the association \$1 as annual dues and must subscribe for the Journal of the association at a cost of \$7 annually. Persons who are not fellows of the association and who subscribe to the Journal pay \$8 a year.

Of 173,879 physicians licensed to practice medicine in the United States, a considerable number of whom are not engaged in practice, 113,113 were, on May 1, 1939, members of the American Medical Association.

It is from money derived from fellowship dues, from subscriptions to the periodicals published by the association and advertising in them, and from invested reserves, that the association pays its expenses. Much of its income

is devoted to activities that are exclusively in the public benefit. How extensive the activities of the American Medical Association are in various fields from which it derives no income and which are operated primarily for the benefit of the public may be understood by reference to the number and character of the agencies so maintained, namely, the council on pharmacy and chemistry, the council on medical education and hospitals, the council on foods, the council on physical therapy, the bureau of legal medicine and legislation, the bureau of health education, the bureau of investigation, and the council on industrial health.

Senator WAGNER. Doctor, do you mind if I ask you one or two questions?

Dr. BOOTH. Certainly not, Senator.

Senator WAGNER. You do know that the State health officers have an association, have they not?

Dr. BOOTH. Yes, sir.

Senator WAGNER. And that they have endorsed this particular legislation?

Dr. BOOTH. True.

Senator WAGNER. Is there anything in this bill as you see it—because I got the impression from what you say that the bill contains an imposition upon the State—is there anything in this bill that imposes anything upon the State against its own will?

Dr. BOOTH. The point we tried to make there, Senator Wagner, was that we assumed that the total cost will be prorated against every State whether they avail themselves of the cooperative money or not. Is that true? For instance, I am a member of New York State, which you represent. I am taxed for the entire medical bill that this S. 1620 calls for, am I not?

Senator WAGNER. Yes.

Dr. BOOTH. I am going to pay taxes to take care of Mississippi and Nevada, and so forth.

Senator WAGNER. Perhaps I misunderstood you, then. I thought you said something about how the enactment of this law would impose upon the States additional expenditures, and the inference I got was that that was against their own will.

Dr. BOOTH. It is, according to our interpretation.

Senator WAGNER. Is there anything in this bill which requires the State to set up any particular public health service?

Dr. BOOTH. Not that I am aware of.

Senator WAGNER. Or which requires them to match Federal aid as a matter of compulsion?

Dr. BOOTH. Not as a matter of compulsion, Senator, but what we tried to imply here was, if you take New York State, for example, suppose the prorated amount of taxes to swing this whole bill were \$18,000,000. Suppose we did not care to go into the scheme at all; aren't we imposed \$18,000,000?

Senator WAGNER. Do you mean the contribution into the Federal Treasury?

Dr. BOOTH. Yes.

Senator WAGNER. That may very well be; yes.

Dr. BOOTH. That was what we tried to imply here, I believe.

Senator WAGNER. Then you are opposed to any kind of Federal aid?

Dr. BOOTH. Not necessarily.

Senator WAGNER. Well, you must be, because you are assuming now that any amount which would be extended in aid to States—

Dr. BOOTH (interposing). We are not, no; I beg your pardon. I should have explained myself. We definitely state in my thesis here that we think that States that actually need it should have it.

Senator WAGNER. Exactly.

Dr. BOOTH. We do not think that all of the States ought to have it.

Senator WAGNER. You do not think what?

Dr. BOOTH. We do not think all of the States ought to have relief. We think some States can take care of themselves.

Senator WAGNER. How are you going to work that out? How are you going to provide for that?

Dr. BOOTH. Our provision is that a secretary of health ought to know where the trouble is in this country.

Senator WAGNER. Well, suppose we find a dozen States—there are many States which need aid, don't you think there are?

Dr. BOOTH. Most certainly there are. We have known it, too, long before it was found out here in Washington.

Senator WAGNER. We are always late. [Laughter.]

Dr. BOOTH. No.

Senator WAGNER. Say that there are a dozen or more States that are in need of Federal aid because of the lack of medical care, would you object to granting aid to those States simply because New York, which may not need it, will have to pay a portion of that money for the needy State?

Dr. BOOTH. Not if it is a need. If it is a real need, I believe we should do it. We are very sympathetic with that part of it, but this bill, Senator, if I may be allowed to explain my last statement, rather encourages every State to take a portion of that money and we do not think that that is necessary.

Senator WAGNER. Do you think they will whether they need it or not?

Dr. BOOTH. Yes, sir.

Senator WAGNER. You mean they will increase their own appropriations so as to take advantage of this aid?

Dr. BOOTH. Yes. They will say, "Here is some easy money."

Senator WAGNER. Are there States that are up to 100 percent in medical care?

Dr. BOOTH. Well, 100 percent, of course, is an ideal that is never going to occur, but our own State, Senator, I believe is self-sufficient and is taking care of its sick adequately. I honestly believe so—our own State of New York. I think there are many other of the richer States that are doing it. We do object, you understand, to the centralizing of power in a central bureau in the National Government. We think this is a matter of each locality to decide for itself what should be done.

Senator WAGNER. I think that this bill does leave it entirely to the locality, outside of some standards. If you are going to spend Federal money in aid, you have got to fix some kind of standard, and every law that I know of which has been enacted giving aid to the States provides for some standards to be applied, and I am sure that you would favor this prescribing of these standards.

Dr. BOOTH. I really believe a secretary of health, a broad-minded physician, with proper and adequate help could produce the effect much better than the way you have done, Senator. This is our idea. You must understand that we are not coming here in opposition to you; we appreciate and are in sympathy with the idea of giving help to the people who cannot get help.

Senator WAGNER. I know that. We are differing as to how it should be done.

Dr. BOOTH. The technique.

Senator WAGNER. That is the only reason I am questioning you. I do not for a moment question your motive or your sincerity, but I am just trying to reach some common ground with you, if I can.

Dr. BOOTH. That is just exactly what we would like to do, Senator, and I would suggest if I may, that we have technical gentlemen in our office who are much better informed on the statistical data concerning the needs, and so forth, than I am. They will be here some time, I believe later this month, the 24th or the 25th, and in the meantime, our house of delegates will have had an opportunity to express itself, and I may come with an entirely different story.

Senator WAGNER. Of course, those on this committee who have studied it much more intensively than I have may be somewhat more familiar with some of the phases than I am at the moment, but I have conferred with a number of doctors. It is just unfortunate that I did not confer with you, getting the different points of view, but they are not all in accord with your views on this question. Do you happen to know Dr. Baker of Montgomery, Ala.?

Dr. BOOTH. Yes; very well.

Senator WAGNER. Is he not a distinguished physician?

Dr. BOOTH. Very much so.

Senator WAGNER. And I happen to have an analysis of the national health bill made by Dr. Baker in which he favors the legislation.

Dr. BOOTH. I know; I read it. We published it in our Journal.

Senator WAGNER. Yes, you did, and I am going to take the liberty of putting that article into the record, and also your editorial which answers the article.

Dr. BOOTH. I have read it.

Senator MURRAY. Do you wish it incorporated in the record at this point?

Senator WAGNER. Yes; I should like to, Mr. Chairman.

Senator MURRAY. Yes; it may be inserted at this point.

(The article referred to follows:)

ORGANIZATION SECTION, THE WAGNER BILL—AN ANALYSIS OF THE WAGNER NATIONAL HEALTH BILL OF 1939

(By J. N. Baker, M. D., Member, House of Delegates, American Medical Association, and Alabama State health officer, Montgomery, Ala.)

Just a few weeks ago—on February 28, to be exact—the senior Senator from New York, Hon. Robert F. Wagner, introduced in Congress a measure of far-reaching importance to the people of the United States and particularly to the people of the South. This measure, known as the National Health Act of 1939, has been referred to the Senate Committee on Education and Labor and is now awaiting action by that committee and later by the two Houses of Congress.

The chief purpose of this measure, as described in its preamble, is "to provide for the general welfare by enabling the several States to make more adequate

provision for public health, prevention and control of disease, maternal and child-health service, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance," and so on.

More specifically, the measure makes use of the sound procedure of grants-in-aid to the various States, which provides a wide latitude to the individual States in the development of their own health plans, conditioned by the particular health problems of greatest importance to their own people. Such grants-in-aid are provided for the purpose of establishing, expanding, and improving State programs in the fields of child and maternal health, general public health services and investigations, construction of hospitals and health centers in communities where they are most needed, general medical care, and insurance against loss of wages and salaries during periods of temporary disability. Administration of the act, if it is passed in its present form, will become the responsibility of three already established Federal agencies—the Children's Bureau, the United Public Health Service, and the Social Security Board. In discussing the bill at the time of its introduction, its sponsor declared that "the fullest development of this program would bring the benefits of modern medical science, both preventive and curative, within the reach of all groups of the population, especially in rural areas suffering from economic distress." In view of the fact that such a large percentage of the people of the South are residents of rural sections and the even more significant fact that they rank extremely low in per capita wealth, the National Health Act of 1939 promises to make available to the people of this State a degree of medical, nursing, and hospital care never known in the past.

It has been pointed out that under no circumstances will the Federal Government undertake to furnish medical care. Administration in all cases, except, of course, in the matter of the necessary Federal allocation of funds and insistence on States complying with the proper standards of performance, will be through the States, which will formulate their plans on the basis of local needs, conditions, and problems. No attempt will be made to displace existing activities with new ones, although naturally these activities will be able, with additional funds, to expand and to operate much more effectively.

No system of health insurance is contemplated in the bill as a function of the Federal Government, nor is any participating State required to institute such a system. In that section of the measure dealing with a general program of medical care (title XIII) the States will be at complete liberty to develop, under the inspiration of local needs, conditions, and problems, the types of medical care programs they peculiarly need, subject of course to the proviso that the programs devised must square with certain basic standards to be set by the three Federal agencies that have been mentioned. The general program of medical care which a particular State may formulate as best for its own people may be limited at the discretion of its officials, to persons on relief or, again at their discretion, it may be broadened to include those of nonrelief status. It may be financed entirely by insurance contributions, from tax funds or from both. The method and scope of medical services to be provided likewise are to be determined by the proper officials of the State concerned and, of course, these services may be provided by private agencies and institutions already in operation, if that is desired. Provision is wisely made for the training of personnel employed to provide these services, and such personnel must be selected on a merit basis.

An important aspect of the bill which should not be lost sight of is the absence of specific detail for operation incorporated into the basic law. Such specifications would have destroyed the autonomy of States in the effort of each to work out its own salvation in a yet uncharted field.

The act carries appropriations totaling approximately \$80,000,000 for the first year, exclusive of such sums as Congress as its discretion may appropriate for aiding the States in the construction of needed tuberculosis sanatoriums and mental hospitals, with increases from year to year over a 10-year period. Under its terms Federal appropriations would be available for the matching of sums appropriated by the individual States as their share of the cost of their own health programs. The measure carries no authorization of new Federal payroll taxes.

In order to accomplish one of the main purposes of the measure, namely the aiding of economically impoverished communities in their efforts to provide needed hospital, medical and nursing care, the measure stipulates that the Federal funds appropriated to put it into effect are to be allocated to the

several States on a variable matching basis, the amount to be received by a particular State depending on that State's relative financial resources, as determined by the per capita income of its population. Thus the bill is intended by its sponsor and supporters to "raise the general level of health protection throughout the country, while reducing the existing wide variations among the States, and especially as between rural and urban areas."

In addition to the health services in the preventive and curative fields, already mentioned, the bill provides grants-in-aid to the States to be used in setting up insurance plans by means of which cash benefits may be made available during periods of temporary disability. Such systems would be so devised as to provide the greatest possible protection to the American wage earner against wage loss resulting from such disability, which loss is estimated at more than \$1,000,000,000 a year. Thus systematic insurance payments would insure the continuance of workers' incomes through those periods when they are most needed.

The National Health Act of 1930 is not intended to transform the United States into a utopia in health matters overnight. However, it was framed and introduced in the hope and belief that it would bring the blessings of health protection to multiplied millions of our people whose need for such protection is no less great because as a result of their financial status they have not been able or at best have been only partially able, to finance it in the past.

BUREAU OF MEDICAL ECONOMICS

The article by Dr. J. N. Baker was submitted to the Bureau of Medical Economics of the American Medical Association, which submits the following comment:

"The basic questions raised in connection with the Wagner bill are probably the following two: First, whether the proposed appropriations for the various purposes are suitable to the needs; second, whether the bill, by extending Federal help or subsidies is intended to encourage the establishment of sickness-insurance systems by States.

"This discussion appears to assume that the Federal allocation of funds will actually be made through the States, which will formulate their plans on the basis of local needs, conditions, and problems."

It also states that "no system of health insurance is contemplated in the bill as a function of the Federal Government," which is probably a correct statement. But if Federal subsidies are to be used to encourage States to adopt such plans, then it is to that extent a sickness-insurance bill providing for partial support by the Federal Government.

Is "the absence of specific detail for operation" in the basic law wholly desirable if the effect of the law is to subsidize plans the "specific detail" of which would be determined largely by the Federal authorities?

BUREAU OF LEGAL MEDICINE AND LEGISLATION

Dr. Baker's statement was submitted also to the Bureau of Legal Medicine and Medical Legislation, which submits the following comment:

"Dr. Baker's analysis is entitled to careful consideration not only because of his professional and official standing but also because it presents a view of Senator Wagner's proposed amendments to the Social Security Act that seems to be based largely on local considerations and on economic conditions that everyone hopes are only temporary.

"The bill introduced by Senator Wagner, S. 1620, is described in its title as 'A bill to provide for the general welfare by enabling the several States to make more adequate provision for public health, prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel; to amend the Social Security Act; and for other purposes.' Of this bill Dr. Baker says:

"In view of the fact that such a large percentage of the people of the South are residents of rural sections and the even more significant fact that they rank extremely low in per-capita wealth, the National Health Act of 1939 promises to make available to the people of this State (Alabama) a degree of medical, nursing, and hospital care never known in the past."

"To accomplish this result—

"* * * the measure makes use of the sound procedure of grants-in-aid to the various States, which provides a wide latitude to the individual States in the development of their own health plans, conditioned by the particular health problems of greatest importance to their own people."

"The arguments advanced by Dr. Baker in support of the amendments to the Social Security Act, proposed by Senator Wagner, have a certain degree of validity. They must be weighed, however, in the light of his status as the health officer of great State, but a State whose people happen just now to be in financial distress and in need of help. Speaking for the country over, one might reply to Dr. Baker's arguments along the following lines:

"The term "grants-in-aid" implies that the Federal Government will pay to the several States, or to some of them, money to aid in carrying on certain intrastate activities. Such a grant, however, is generally made only on condition that the State appropriate State funds to help defray the cost of such activities and always on condition that it submit to certain conditions imposed by the Federal Government, including the supervision and control of the work by Federal officers. Leaving all question as to the essential soundness of such Federal grants, in a country such as ours, organized under a Constitution carefully designed to preserve the rights of the several States from infringement by the Federal Government, a brief examination of the operation of such grants seems to show not only that the underlying principle is essentially unsound but also that, instead of enabling the several States to make more adequate provision for public-health and such other activities described in the caption of the Wagner bill, they tend to limit the ability of many States to do so.

"In the first place, we must ask where the Federal Government is to obtain the money wherewith to pay such grants-in-aid as are proposed in this bill. The Federal Government cannot create money, and it must get it somewhere. It can get it only by taxation, and the ultimate consumer pays the price in the cost of living. Conceivably it might abandon governmental activities already under way and apply to the new projects proposed by Senator Wagner the money thus saved. On the other hand, it might and presumably will levy additional taxes if the bill should be enacted.

"No proponent of the Wagner bill has even as much as suggested that any Federal activity now under way be curtailed or abandoned to provide the funds necessary to pay the Federal share of the expenses of the activities proposed by Senator Wagner. The abandonment of any such activity, however, would still leave the cost to be paid out of the taxes thereby rendered unnecessary and which might be discontinued but for the enactment of this bill. It is generally assumed, however, that the money for the Federal share of the expenses of the proposed activities will be provided by additional taxes. If the bill is enacted. As the bill now stands, it does not propose to levy additional taxes in the form of Federal pay-roll taxes or specific taxes of any kind, having direct reference to the expenses of this legislation; for any proposal to levy taxes for that specific purpose would bring to the attention of the taxpayers of the country the cost of the pending bill and probably insure its defeat. The needed money, therefore, must presumably be raised by increasing the rates at which some of our existing taxes are levied or by imposing new general taxes of some kind, and the taxpayer, even though he may complain of the increase in taxation, will not be able to associate the increase with the cost of this bill. And the primary taxpayer—that is, the taxpayer who pays the money directly into the Federal Treasury—will, whenever he can, pass the tax along, and sooner or later it will rest on the back of the ultimate consumer, whose ability to maintain himself and his dependents will be decreased in proportion to the increase in taxation.

"But that is not all. Grants-in-aid given by the Federal Government will generally have to be matched wholly or in part by money provided by the several States to which such grants are made. The State accepting a grant-in-aid will find itself, therefore, in the same position as that of the Federal Government; it will have to curtail or discontinue present activities and public benefits in order to obtain the money wherewith to meet the Federal grant or else will have to increase State taxes. If the State activities curtailed or discontinued are essential to the public welfare, the public will suffer. If new taxes are imposed or the rates of taxation with respect to old taxes increased, the increase in the tax burden will reach the ultimate consumer, with corresponding further increase in his cost of living and with further diminution in his ability to provide support for himself and his dependents.

"There is another aspect of the grant-in-aid system such as Senator Wagner's bill proposes that is seldom recognized. Even though it may enable some States

to make more adequate provision for projects covered by the act, it lessens the ability of other States to do so. With respect to States in the latter class, so-called grants-in-aid are not "in aid" but are only the return by the Federal Government to the State of money taken from its people through Federal taxation, directly or indirectly, and even that return is made only on condition that the State submit to the determination by the Federal Government as to the purposes for which it shall be spent and Federal supervision and control of the State agencies employed to accomplish those purposes. The amount returned to a State in this category is less than the amount taken from it by the Federal taxation and is equal to only the remainder of the Federal taxes collected from the people of the State, after the Federal Government has deducted such amounts as it deems necessary to provide Federal subsidies for other States. To the extent that the grant-in-aid payable to any State is less than the money collected from the people of the State by the Federal Government for the purpose of providing such Federal subsidies in general, the ability of that State to provide for its own people is diminished.

"If the distribution of Federal grants-in-aid was made according to the actual necessities of the several States, as determined by a fair and open study of the situation, there could be little or no objection to them. No one would object to the making of grants of public money to relieve distress in any State that the State itself was financially unable to relieve, but the idea of making such grants, even to the richest and most prosperous States in the Union is hardly compatible with the hypothesis on which the making of such grants is popularly believed to be based. Appropriations have been made by the Federal Government without criticism or complaint for the direct relief of suffering even in foreign countries, and certainly no criticism has been or will be voiced in making appropriations for such relief in this country. But when the Federal Government levies taxes on persons in States not in need, in excess of the requirements of the States that are in need, and then returns the excess thus collected to the State from which it was collected but only on condition that the State subject certain intrastate affairs to the supervision and control by some Federal appointive officer, the entire plan savors strongly of an effort to concentrate power in Washington at the expense of the States."

"Dr. Baker points out that the pending Wagner bill to amend the Social Security Act, if enacted, will make available to the people of Alabama a degree of medical, nursing, and hospital care never known in the past. If there is actual need for a degree of medical, nursing, and hospital care in Alabama that has never been known in the past, and if the State of Alabama is unable to provide it, by all means let it be provided. But even if such a need is shown in Alabama and in some other States, but not in all, the fact does not justify imposing on all States the system of federally subsidized and controlled relief that may be necessary in Alabama and other States similarly situated. Certainly some States are able to look after their own people, without Federal grants-in-aid and Federal supervision and control. It may be claimed, of course, that the Federal Government must deal with every State on an equal footing, although there is no such requirement in the Constitution; but, as has already been pointed out, grants-in-aid such as are proposed by the Wagner bill do not operate uniformly on all States. They place all States equally under Federal supervision and control, it is true, but they result in the taking of money from the people of other States, thus lessening the financial resources of the States from which the money was taken in the first instance for the benefit of other States. The plan seems to be devised for the redistribution of wealth among the States. How far it may go toward promoting a spirit of complaisant dependence among the States, no one can foretell.

"No system of health insurance is contemplated in the bill as a function of the Federal Government, nor is any participating State required to institute such a system. * * * The general program of medical care which a particular State may formulate as best for its own people may be limited, at the discretion of its officials, to persons on relief or, again at their discretion, it may be broadened to include those of nonrelief status. It may be financed entirely by insurance contributions, from tax funds or from both.

"In addition to the health services in the preventive and curative fields already mentioned, the bill provides grants-in-aid to the States to be used in setting up insurance plans by means of which cash benefits may be made available during periods of temporary disability.

"While Dr. Baker's statement concerning health insurance is strictly correct, it hardly gives a true picture of the purpose and effect of the bill so far as health insurance is concerned.

"The bill authorizes appropriations for grants to States for medical care amounting to \$35,000,000 and of \$10,000,000 for temporary disability compensation for the fiscal year ending June 30, 1940, and for unlimited appropriations thereafter. To obtain grants from the appropriation for medical care, a State must have submitted to the Social Security Board State plans satisfactory to that Board, extending and improving medical care. Nothing in the bill limits this proposed medical care to indigent persons or even to persons of moderate means. Nothing in the bill defines the particular type of medical service that is to be provided. The Social Security Board seems to be at liberty to refuse to approve any State system that does not meet its ideas of social economics. It may refuse to approve any proposed system unless it provides for the distribution of medical service by a salaried State staff. It may refuse to approve any system that does not provide for medical service with free choice of physicians, paid on a fee basis. On the other hand, it may refuse to approve any system that is not based on strictly insurance principles, even with State pay-roll taxes and the usual accompaniments of health insurance. Any such system may possibly be styled a 'State' system, but in order to obtain the Federal subsidy it must have the approval of Federal officers and in last analysis such a system is a 'Federal' system or at most a 'Federal-State' system.

"Dr. Baker's statement that the insurance plans proposed in the Wagner bill to provide temporary disability compensation for persons temporarily disabled by illness or injury provide for cash benefits is incomplete, for the bill expressly provides that the Social Security Board 'shall not approve the plan of any State which does not have a plan or plans approved under this act under which the Board finds that reasonably adequate medical services, including preventive services, are available to minimize disability among those covered under the State plan for temporary disability compensation.' This necessarily implies the setting up by the State of a medical service of some kind to care for persons who are temporarily disabled and who are entitled to the benefits under the State plan. Nothing in the bill limits the beneficiaries of a State system of disability compensation to employed or even to employable persons. In fact, the bill expressly provides that disability, to be compensable, shall not have arisen out of or in the course of employment. Here certainly we have the germ of a full-fledged system of health insurance. When considered in connection with the provisions of the bill that authorize Federal subsidies for State systems of medical care (which is defined to include all services and supplies necessary for the prevention, diagnosis and treatment of illness and disability) the provision relating to disability compensation seem to leave the entire matter of health insurance throughout the entire United States to the judgment of the Social Security Board rather than to Congress, where it belongs.

"Nothing in what is here written is intended in any way to reflect on the officers who are now charged with administering Federal laws authorizing Federal grants-in-aid, but officers come and officers go, and what an officer feels today with respect to governmental operations in the field of social economics and the administration of State aid is not necessarily what another officer will feel tomorrow. As a matter of fact, the people of the country have the right to have such matters determined by law and not by the mere judgment of individual Federal executive officers."

Dr. BOOTH. May I say, Senator, that Dr. Baker and I have had many personal conversations about the conditions in Alabama, and I realize that that State needs the help.

Senator WAGNER. May I ask you this: You do favor Federal aid, as I understand it?

Dr. BOOTH. Yes.

Senator WAGNER. But you want it based entirely upon necessity?

Dr. BOOTH. Necessity and local administration.

Senator WAGNER. Well, this provides for local administration.

Dr. BOOTH. Well, to be very frank with you, Senator, I do not think that the central bureaus should have quite such power over the local States as your bill provides.

Senator LA FOLLETTE. What powers, Doctor, would you eliminate from this bill?

Dr. Booth. The main one is these various national groups which decide the matter.

Senator La Follette. I would appreciate it if you would take a copy of the bill and show me what powers you would eliminate from it?

Dr. Booth. I will have to confess, Senator, that I have not read the entire bill critically. I did not read it thoroughly, and I am not a lawyer.

Senator La Follette. Neither am I, so perhaps you can give me some help.

Dr. Booth. You are a Senator, however. Is that the page that you turned to [indicating]?

Senator La Follette. No; I just handed you a copy of the bill. You said that there were certain powers in the bill that you objected to, and I think it would be helpful for you to show us.

Dr. Booth. I think it is in my statement.

Senator La Follette. Your statement is very general, and we are now getting down to a statement of your specific objections, and I would like to have you point out, since I understood you to take the position in response to Senator Wagner's questions that you were not opposed to Federal aid but that you were opposed to the power which would be exercised under the bill. I thought it would be helpful if you could point out specifically some of the provisions which you would like to see eliminated.

Dr. Booth. I read it over this morning, and there is—well, for instance, a provision for an indefinite number of ill-defined advisory councils and the provisions for rules and regulations by various agencies.

Senator La Follette. Do you think it is inadvisable to have the benefit of such recommendations and suggestions as could be made up by a representative advisory committee within a State? Is that one of the things that you would like to see cut out?

Dr. Booth. Well, it all depends upon what the personnel of these advisory committees is.

Senator La Follette. Would you have the Federal official have the authority to veto those people who were appointed on the advisory committee?

Dr. Booth. Yes; of course he would have to have that.

Senator La Follette. Would that not be a further extension, then, of the Federal authority?

Dr. Booth. That would be a necessary Federal authority. I can see that.

Senator La Follette. We would not be, then, helping our situation much if we are trying to curtail the authority and power which the Federal agency should have, would we, if we turned over to them the power of hand-picking the advisory committees?

Dr. Booth. Well, may I ask you who is going to hand-pick that advisory committee? Is it going to be made up of social workers?

Senator La Follette. I am asking you for helpful suggestions.

Dr. Booth. My helpful suggestion in that case would be that physicians in organized medicine ought to know, by the very nature of their business and their work and their professional life, they ought

to know the needs of their community rather than some advisory committee or somebody in Washington.

Senator LA FOLLETTE. Then, would you like to see the advisory committees eliminated?

Dr. BOOTH. Unless it were so erected that it would be a predominant medical man group instead of a social workers' group.

Senator LA FOLLETTE. Then if I understand you, you would be satisfied if it provided that the advisory committee should be made up of members of the medical profession?

Dr. BOOTH. Of the organized medical profession.

Senator LA FOLLETTE. Those who belong to the American Medical Association?

Dr. BOOTH. Yes, sir. Now remember, Senator, that the members who belong to the American Medical Association also belong to their local medical societies.

Senator LA FOLLETTE. I understand that.

Dr. BOOTH. They are the authorities in every community; there is no question about that.

Senator LA FOLLETTE. I understand how it is made up. What other powers or other provisions would you like to see eliminated?

Dr. BOOTH. I would like to see everything eliminated that veers toward compulsory health insurance because I am unalterably opposed to it.

Senator LA FOLLETTE. Let us leave that opinion aside for a moment, because that is a separate proposition, as I understand it, and get down to the more specific provisions of the bill—for example, in regard to the child and maternal care, and so forth. Just take the first title there and tell me what powers are conferred upon the Children's Bureau and the Department of Labor that you would like to see eliminated?

Dr. BOOTH. Well, in that case, of course, I believe an individual like our very good friend, Dr. Eliot, I would personally have every confidence in.

Senator LA FOLLETTE. I was not asking whether you had confidence in her.

Dr. BOOTH. I would in case we had such a person or one like her.

Senator LA FOLLETTE. But, Doctor, as I understood your position, generally, it is that you are not opposed to Federal aid?

Dr. BOOTH. Not where it is an emergency necessity.

Senator LA FOLLETTE. But you are opposed to the powers which are conferred under this bill upon certain administrative officials in the Federal Government?

Dr. BOOTH. Yes, sir.

Senator LA FOLLETTE. Let us take this first title here, title V, as an example, and tell me what powers are here contemplated to be conferred upon the Children's Bureau and the Secretary of Labor which you would recommend to the committee should be eliminated from the measure?

Dr. BOOTH. In that particular service, I would not recommend any other than what you have placed here, except, Senator, that I still adhere to the idea that all health activities of a national order should be under one Secretary of Health.

Senator LA FOLLETTE. Let us get away, if we can, for the moment, from the particular agency or the type and get down to the principles that are involved in your position. What powers here conferred upon a Federal administrative official or officials would you recommend in title V of the pending bill should be stricken from it?

Dr. BOOTH. I have told you, Senator, that I have not read this bill through. I am speaking for the A. M. A. today composed of the board of trustees and other officers, and we would like to have the discussion on these technical details presented by our specialists.

Senator LA FOLLETTE. Well, I do not wish to press you if you do not feel prepared to go on at this time. However, I noted in your prepared statement that you confine your criticisms, if I may so term them of the bill, to those principles which the house of delegates in its September meeting had taken a position on in relation to the technical committee's report?

Dr. BOOTH. Yes, sir.

Senator LA FOLLETTE. Obviously, this bill as I understand it, attempts to carry out some although not all of the recommendations of the technical committee's report. Are you prepared insofar as this measure touches upon those problems that were discussed and voted upon by the house of delegates to discuss this measure and to suggest to us how it could be changed or what provisions of it should be eliminated to bring it into harmony with the position of the house of delegates as you understand it?

Dr. BOOTH. We do not feel that this bill, Senator, is entirely following the recommendations of the interdepartmental committee. Personally, I cannot speak for what the medical profession is going to say about this bill.

Senator LA FOLLETTE. Yes; but you did come here Doctor, this morning—

Dr. BOOTH (interposing). I am giving you criticisms which we have gaged from what has already been pronounced in the house of delegates.

Senator LA FOLLETTE. Yes; but can you go on from there and tell me in what respect say title V of this measure should be changed to now conform to what you understand would conform to the position taken by the house of delegates in September?

Dr. BOOTH. No; I cannot say because I have no authority to speak for the house of delegates on that particular point at this time, not until after the meeting which will be held next week. At that time, I promise you, that the thing will be properly considered.

Senator LA FOLLETTE. Could you do so with regard to any of the other titles of the bill?

Dr. BOOTH. Well, I think I can say something about what we can never agree on; yes.

Senator LA FOLLETTE. Perhaps we could get something that we could agree on if we could understand what you could not agree on.

Dr. BOOTH. I think just what I have read explains that.

Senator LA FOLLETTE. You mean with regard to the so-called compulsory health insurance?

Dr. BOOTH. Yes.

Senator LA FOLLETTE. That is just one phase of this problem, as I understand it.

Dr. BOOTH. We do not feel that the present plan of the distribution of funds is going to produce the effect.

Senator LA FOLLETTE. How would you do that, Doctor?

Dr. BOOTH. I do not want to carp on it, but my plan is that a genuine secretary of health properly equipped with his experts could look this thing over in a broad way, the same as we take care of other things, the Farm Bureau, for instance, and labor questions, and railroad questions, and things of that sort, looking at it from a broad standpoint. If Alabama needs money and people are dying, for God's sake let us give them something; but I do not want to start out with machinery here by which every State will grab for their money to erect hospitals that are not necessary, and have bureaus that are not necessary, and have diagnostic centers that absolutely cannot be carried through. It takes brains to run a diagnostic clinic, and where are you going to get them out in the desert of Utah? Yet Utah might be one of the places, one of the first people to spend money to start diagnostic centers out in the desert.

Senator WAGNER. Do you think that would be a tragedy?

Dr. BOOTH. I am sure it would.

Senator WAGNER. If Utah needs, in its rural areas, for instance, some medical care for the people that are now not cared for?

Dr. BOOTH. We think they now have it, Senator.

Senator WAGNER. The testimony of the representatives of farm organizations testified here the first day.

Dr. BOOTH. Yes; I know.

Senator WAGNER. They were before this committee and they told a tragic story of the lack of medical care. One witness I remember said that the nearest hospital was 50 miles away, and the general testimony was that there was an inadequate provision of hospitals.

Dr. BOOTH. There is a gentleman in the audience who can tell you the exact number of counties in which in these United States they have not got hospitals within an hour's ride.

Senator WAGNER. You do not think there is need in this country for additional hospitalization?

Dr. BOOTH. For what?

Senator WAGNER. For hospitals.

Dr. BOOTH. They are needed in some localities, but the church hospitals in this country and the general hospitals, and the eleemosynary institutions, the hospitals of private development are only about 69 percent occupied at present.

Senator WAGNER. May that not be because there are a great many sick that are not receiving hospital attention?

Dr. BOOTH. Not so many as that committee was led to believe at the conference.

Senator WAGNER. Are there many without medical care because of their income?

Dr. BOOTH. Not in my State, Senator.

Senator WAGNER. I shall not quarrel with you now about that. My statistics are quite to the contrary on that.

Dr. BOOTH. I know it.

Senator WAGNER. We have a very large low-income group that is not getting anything like the medical care it ought to receive. Many lives are lost just because of that. The doctors are doing a noble

work, but they are not all able to take care of these unfortunate cases. I do not want to prolong this, but I just want to ask you one or two other questions. You said something about your being against social insurance?

Dr. BOOTH. Yes, sir.

Senator WAGNER. Whether you are or not, this bill does not provide for any social insurance.

Dr. BOOTH. I grant you that, Senator, but we feel that it is veering toward it; it is the first step.

Senator WAGNER. Therefore, do nothing about medical care because ultimately—

Dr. BOOTH (interposing). No; not therefore. You must not say that, either.

Senator WAGNER. That is your only reason? Is there another reason for your opposing this legislation, that because ultimately some State may set up a health insurance, is that another reason?

Dr. BOOTH. You mean compulsory health insurance? We are not opposed to health insurance.

Senator WAGNER. Say compulsory health insurance.

Dr. BOOTH. The word "compulsory" identifies an entirely different type of animal. We are in favor of health insurance; we are fostering it. We have over 8,000 plans to meet the different localities in the United States.

Senator WAGNER. I know about that, but what I am saying is this: You are opposed to this bill because ultimately it may result in some States deciding to adopt a system of compulsory health insurance?

Dr. BOOTH. Not only in some States, but it will go ultimately to the entire United States if it is developed properly; yes, sir.

Senator WAGNER. Do you remember the constitutional amendment that was submitted in the State of New York at the last election?

Dr. BOOTH. Yes, sir.

Senator WAGNER. I happened to be a member of the constitutional convention which adopted an amendment authorizing the legislature, if it so deemed wise, to enact compulsory health insurance.

Dr. BOOTH. Yes, sir.

Senator WAGNER. And that received the largest vote of any of the nine amendments submitted.

Dr. BOOTH. I realize that.

Senator WAGNER (continuing). For adoption in the State of New York and was overwhelmingly carried.

Dr. BOOTH. Yes, sir.

Senator WAGNER. That is an expression of the people of the State on the subject, isn't it?

Dr. BOOTH. Yes, sir.

Senator WAGNER. But you think it is unwise?

Dr. BOOTH. We believe that the people do not know what is best for them in medicine.

Senator WAGNER. That is another question.

Dr. BOOTH. If I may, I will tell you why they do not. We feel that compulsory health insurance, while it is not germane, and perhaps I ought not to take your time, but I will tell you briefly today, it robs the doctor of his initiative. American medicine is where it is today because they have had a free and untrammeled right—

Senator WAGNER (interposing). Is that not something to fight out in another forum? If there were an effort to provide compulsory health insurance, then that is where you would be heard on the question of its advisability. But we are not doing anything with regard to that. That is being left entirely to the States.

Dr. BOOTH. I only expressed my fear in this matter to you.

Senator WAGNER. Then we should never do anything because it may lead to something else?

Senator LA FOLLETTE. Doctor, don't you get into a somewhat illogical position—I am only asking for information—if you take the attitude as I understand in your paper, generally speaking, that you want all of these problems left to the State, but you say that you are not willing to trust the people of the various States to decide these problems for themselves. Where do we get off in that kind of a situation?

Dr. BOOTH. I think I should modify that to say that it should be at the request of the organized medical units. They know what the country needs in the way of medical care.

Senator ELLENDER. But you are the organized medical unit, and you are against it, so how far would they get?

Dr. BOOTH. Against what, please?

Senator ELLENDER. For instance, this compulsory insurance. The people of New York wanted it. If it had been left to the medical association, the people of New York would never have had it, isn't that true?

Dr. BOOTH. Yes.

Senator ELLENDER. Well, another question—

Dr. BOOTH (interposing). But nevertheless, Senator—

Senator ELLENDER (interposing). Pardon me.

Dr. BOOTH. Pardon me.

Senator ELLENDER. Will you point out in the bill the language to which you have referred that lends you to believe that it will ultimately mean compulsory insurance?

Dr. BOOTH. Yes, sir; I will.

Senator ELLENDER. I wish you would.

Dr. BOOTH. This is another bill—

Senator ELLENDER (interposing). I mean in the present bill.

Dr. BOOTH. I understand. This entire bill is a tendency to centralize the management of medical care in this country in Washington.

Senator LA FOLLETTE. Doctor, how can you say that when you told me in response to previous questions that you were not familiar with the bill sufficiently so that you could go through it with me and tell me how you wanted it corrected?

Dr. BOOTH. Well, Senator, I have simply got that impression because that is the idea of the men who have digested it fully. I am not speaking personally.

Senator LA FOLLETTE. But, Doctor, this committee needs help; it cannot go just on general impressions.

Dr. BOOTH. That, Senator, will be completely cleared up by our technical experts and by possibly myself at the next hearing after I have found out what the house of delegates representing the entire profession of this country wants me to say. I am not speaking personally here.

Senator LA FOLLETTE. No; I understand that. I understood that you were here in a representative capacity; but certainly anyone reading your statement in which you speak in a representative capacity would get the distinct impression, I believe, that you were opposed to this bill in toto, and yet when I have asked you to point out where we could remedy the defects which you see in it, you respond by saying that you have not sufficiently studied the measure so that you can do that?

Dr. BOOTH. No; I have not personally, but I did say that one of our suggestions was that the house of delegates on record refused to foster any system of compulsory health insurance.

Senator LA FOLLETTE. I understand that.

Dr. BOOTH. And the house of delegates—

Senator WAGNER (interposing). We are not doing that.

Dr. BOOTH. That the house of delegates is in favor of a health program in which a secretary of health will be a Cabinet member and can discuss broadly and administer broadly medical care where needed in these United States.

Senator LA FOLLETTE. Suppose, then, Doctor, to try to get a little more clearly your position, suppose that this bill provided for a secretary of health who was to administer all of the provisions of this bill, would you then be for it?

Dr. BOOTH. Not in the present way; no.

Senator LA FOLLETTE. How would you change this? Suppose you had your way in that regard?

Dr. BOOTH. I would assume that that man would know enough to consult the medical men of this country about medical care.

Senator LA FOLLETTE. Let us grant that.

Dr. BOOTH. They have not so far.

Senator LA FOLLETTE. How would you change the measure, then, supposing the person of the type you described would administer it?

Dr. BOOTH. Well, of course, that is a pretty large question, Senator. It is a substitute for the three-way administration of this bill.

Senator LA FOLLETTE. I will reduce the question in compass. Suppose title V were to be administered by a secretary of health, how would you change it?

Dr. BOOTH. I would not change it.

Senator LA FOLLETTE. Now, let us take the next title.

Dr. BOOTH. But I would feel that the secretary of health, a gentleman that was of large abilities, could be the ultimate deciding factor in the need for child welfare.

Senator LA FOLLETTE. Let us take title VI. Suppose that was to be administered under the secretary of health, how would you change title VI, or is it satisfactory under those circumstances?

Dr. BOOTH. Who is that under the administration of? The Secretary of Labor?

Senator LA FOLLETTE. This is under the Surgeon General, but I am assuming now to eliminate this controversy over the administrative agency, that you have now got a secretary of health, and he is to administer this bill, would title VI be satisfactory under those conditions or not, and if not, in what respects would you recommend it be changed?

Dr. BOOTH. On line 8, page 17, "including the direction of personnel," we don't know what that means. We feel that the medical schools can do that, and the postgraduate schools.

Senator LA FOLLETTE. Suppose we struck that out, would the title then be satisfactory?

Dr. BOOTH. It would be more satisfactory. I have not read it all through.

Senator LA FOLLETTE. That is all, Mr. Chairman.

Dr. BOOTH. That would be all right.

Senator WAGNER. It would be all right then?

Dr. BOOTH. Certainly our present Surgeon General, Dr. Parran, I have the highest regard for him. He is a splendid administrator, and he has done an excellent work.

Senator WAGNER. I suppose that really comes down to this, if you could appoint the one to administer this law, you would be satisfied with the bill as it stands now?

Dr. BOOTH. In some ways I would, Senator, except that I am afraid that it is a veering into State medicine, which we are opposed to.

Senator LA FOLLETTE. How does it get into State medicine? Show me the paragraph in it, Doctor?

Dr. BOOTH. There is not any paragraph, Senator, that says that; it is the whole thing.

Senator WAGNER. You suspect me, do you? [Laughter.]

Dr. BOOTH. Not at all. No, sir; I have the highest respect for you, Senator; you are my representative and I am proud of you.

Senator WAGNER. I thank you very much; but, Doctor, let me ask you this: You said the medical profession ought to have a good deal of say, and I have always contended that they ought to guide this whole program.

Dr. BOOTH. Why didn't you ask them then?

Senator WAGNER. You can only provide it by legislation, and one of the reasons for the advisory council is just that very thing, that the medical profession would be able to help guide this work and so it provides, and if you wanted to amend that in some way—

Dr. BOOTH (interposing). Can you tell me where that is?

Senator WAGNER. Page 4, subdivision 5, we provide for an advisory council composed of members of the professions and agencies that furnish services under the State plan, and other persons informed on the need for or provision of maternal and child-health services.

Dr. BOOTH. Well, right there, Senator, to answer that specific question, who is going to decide the proper men who are members of the professional agencies and persons well informed on the need for maternal and child health? How soon do we drop into a political doctor's group?

Senator WAGNER. The health service has been definitely free from politics in New York State—I think that you would concede that—and certainly in the Federal Government.

Dr. BOOTH. Not in some States.

Senator WAGNER. Unless you are talking about medical politics. I don't know anything about that.

Dr. BOOTH. New York State has had the most wonderful health commissioners of any State in the Union, the most wonderful that any State in the Union has had.

Senator WAGNER. I think so.

Dr. BOOTH. Herman Biggs, DeLancy Nicoll, and Dr. Parran, and others; and, mind you, I grant you that, but it is scandalous in some States. It is purely politics.

Senator WAGNER. That is a matter that we are not dealing with.

Dr. BOOTH. They have been a stench in the nostrils in some States.

Senator WAGNER. Each State will have to appoint its directing power.

Dr. BOOTH. From your standpoint it is legislation, but from our standpoint we feel that organized medicine—

Senator WAGNER (interposing). I do not want to keep you too long, but there is just one other question; did I interrupt you?

Dr. BOOTH. This was without consultation of doctors, Senator, in framing this bill. So far as I know, you consulted nobody who represented the majority of the doctors in this country, and nobody connected with the American Medical Association, which is by all credited as the mouthpiece of medicine in this country. I think that we could have gone at it much better.

Senator WAGNER. I am waiting for the amendments which you are undoubtedly going to offer.

Dr. BOOTH. We would like to cooperate with you if you will give us an opportunity.

Senator ELLENDER. Doctor, your association meets in St. Louis this month?

Dr. BOOTH. On the 15th.

Senator ELLENDER. Why don't you get a committee from the association to study this bill?

Dr. BOOTH. We already have it.

Senator ELLENDER. You say that you are personally in favor of Federal aid, and I imagine that you speak also for the A. M. A.

Dr. BOOTH. Where necessary.

Senator ELLENDER. What is that?

Dr. BOOTH. Where necessary.

Senator ELLENDER. That is about all this bill does "where necessary." If you study it and read it, I believe that that is one of the yardsticks, that the money has to go where necessary. If you folks will get together and study this bill and just make up your minds that sooner or later it is coming and help us to draft it, I am sure that the committee will appreciate it.

Dr. BOOTH. I am very glad to hear you say that, Senator, because we would have been very glad to have consulted with you.

Senator WAGNER. We have the benefit of your September conference, in spite of what you say. I think it very closely follows your recommendations at that very meeting where the resolution was adopted. I have it before me.

Dr. BOOTH. The spirit of it is there, Senator, but the administration of it, from our standpoint, would simply cause differences of opinion. We are not in any way opposed to you, understand.

Senator WAGNER. I want to ask you one other question. I hope I have not disturbed you at all.

Dr. BOOTH. Not a bit.

Senator WAGNER. You spoke about centralizing here in Washington?

Dr. BOOTH. That is right.

Senator WAGNER. And later you stated you wanted someone in charge here.

Dr. BOOTH. I wanted—

Senator WAGNER (interposing). May I finish?

Dr. BOOTH. Certainly.

Senator WAGNER. Who would possibly be—one person—somebody that you say has got to be a broad-minded doctor of distinction and all that, and that he was to sit here and have these funds at his disposal and determine which States may need funds for medical care and give those funds to that particular State. Can you think of a greater centralization? That is nothing like what is provided in this bill. There is no centralization here at all, except the law itself provides certain standards which the administrator must follow. In the first instance, you provide for complete centralization and almost dictatorial powers as you state it.

Dr. BOOTH. I possibly misspoke myself—

Senator WAGNER (interposing). He sits here and decides that Louisiana needs \$100,000 and someone else needs \$100,000. You would never get legislation like that adopted, just because it is too centralized a power. The Congress would never, in my judgment, delegate any such power to an individual without providing standards.

Dr. BOOTH. May I ask you, in other lines of business, Senator, who decides where they are going to pay the cotton farmer, for instance?

Senator WAGNER. Very definite standards are set up in the legislation.

Senator ELLENDER. They are in the law.

Senator WAGNER. Right in the law itself.

Senator ELLENDER. The law prescribes the standards there very definitely.

Senator WAGNER. We have a cotton Senator here. [Laughter.]

Senator ELLENDER. Exact and specific standards are prescribed in that law, and they have to be fully complied with before any of that money is paid out.

Dr. BOOTH. And you are attempting to establish some kind of a law here—I take it you approve establishing some technical verbiage in the law that will decide the same thing in medicine by your bill, Senator?

Senator WAGNER. Yes.

Dr. BOOTH. It cannot be done.

Senator ELLENDER. Listen: In distributing the funds, for instance, here is the yardstick that is going to be used, on page 3. I asked Dr. Elliot, "How will the \$8,000,000 be distributed among the States?" And she said that they would use as a yardstick under this proposal, first, the total number of births in the latest calendar year for which the Bureau of the Census has available statistics; a certain amount will be apportioned under that yardstick. Second, the number of mothers and children in need of the service. Again, so much money will be distributed among the States on that basis. Third, the special problems of maternal and child health, and fourth, the finan-

cial resources, that is, the ability of the States to pay. You certainly do not need any technical knowledge there to work out the plan under that yardstick, do you?

Dr. BOOTH. I think you would regarding the special problems and the number of mothers and children.

Senator ELLENDER. What could there be there? What special problems could you conceive under No. 3?

Dr. BOOTH. I have seen enough of it lately where people took money from the Government when they had no right to it and were not entitled to it, in other lines.

Senator ELLENDER. Will you give us an example, please?

Dr. BOOTH. It is so well known.

Senator WAGNER. Did you report the cases?

Senator ELLENDER. Will you report the cases, so that the people can be put in jail?

Dr. BOOTH. The jails are not large enough to hold the number of people that take money that way. It is so well known that it is useless to argue about it. It would happen the same way in medicine.

Senator LA FOLLETTE. Have you any specific criticism, Doctor, to offer of the Children's Bureau and the Secretary of Labor's distribution of the funds under the Social Security Act?

Dr. BOOTH. Not in that particular instance, no. Of course not; that is common sense.

Senator LA FOLLETTE. I mean under the Social Security Act, the way they have distributed them now, do you see anything wrong with it?

Dr. BOOTH. Not that I can specifically state, no.

Senator LA FOLLETTE. Has anybody complained to you about the way in which they have administered these funds?

Dr. BOOTH. They have not complained to me, but—

Senator LA FOLLETTE (interposing). Have you made any complaint about it?

Dr. BOOTH. Yes, I have.

Senator LA FOLLETTE. What was it?

Dr. BOOTH. Oh, I think the people have taken funds from that. I don't know whether it is that particular fund, Senator.

Senator LA FOLLETTE. Well, it is very important. Have you made any criticism of the statistical basis upon which the Children's Bureau has distributed its funds?

Dr. BOOTH. No. I was not referring to that when I said people were taking money. I am speaking generally of the relief agencies.

Senator LA FOLLETTE. We are not talking about relief now.

Dr. BOOTH. And it will be the same with medicine.

Senator LA FOLLETTE. How do you know that? I am just asking you now about the Children's Bureau and the Secretary of Labor. They have already been distributing funds under the Social Security Act, and I have asked you, have you any criticisms of that?

Dr. BOOTH. No.

Senator LA FOLLETTE. Have you any criticisms of the way in which the public health service and the Surgeon General and the Public Health Service has distributed the Social Security funds?

Dr. BOOTH. I have already gone on record as approving very highly of them this morning.

Senator LA FOLLETTE. And there is nothing wrong in the way in which they have done it?

Dr. BOOTH. No.

Senator LA FOLLETTE. And you have no criticism, no suggestion to offer?

Dr. BOOTH. No, sir.

Senator LA FOLLETTE. I would like the record to show that this bill was introduced on February 28.

Senator WAGNER. Mr. Chairman, may I at the end of this testimony of the witness also put into the record the American Medical Association's action on the proposals of the National Health Conference?

Senator MURRAY. Print it in connection with the testimony?

Senator WAGNER. Yes.

Senator MURRAY. It may be so printed.

(The matter referred to is as follows:)

AMERICAN MEDICAL ASSOCIATION ACTION ON PROPOSALS OF THE NATIONAL HEALTH CONFERENCE

The house of delegates of the American Medical Association, assembled in special session in Chicago September 16, 17, 1938, gave detailed consideration to the proposals of the National Health Conference which was held in Washington, D. C., July 18-20, 1938.

The action of the house of delegates was summarized in the report of the special reference committee of 25 signed by the chairman of the five subcommittees which considered the respective sections of the proposals of the National Health Conference. The report of the general reference committee, reprinted from the Journal of the American Medical Association (vol. 111, No. 8 (Sept. 24, 1938), pp. 1216-1217), is as follows:

"REPORT OF REFERENCE COMMITTEE ON CONSIDERATION OF THE NATIONAL HEALTH PROGRAM

"Dr. Walter F. Donalson, chairman, presented the report of the reference committee which, as amended, reads as follows:

"Since it is evident that the physicians of this Nation, as represented by the members of this house of delegates convened in special session, favor definite and decisive action now, your committee submits the following for your approval:

"1. Under recommendation I on expansion of public health services: (1) Your committee recommends the establishment of a Federal Department of Health with a Secretary who shall be a doctor of medicine and a member of the President's Cabinet. (2) The general principles outlined by the technical committee for the expansion of public health and maternal and child-health services are approved and the American Medical Association definitely seeks to cooperate in developing efficient and economical ways and means of putting into effect this recommendation. (3) Any expenditures made for the expansion of public health and maternal and child health services should not include the treatment of disease except so far as this cannot be successfully accomplished through the private practitioner.

"2. Under recommendation II on expansion of hospital facilities: Your committee favors the expansion of general hospital facilities where need exists. The hospital situation would indicate that there is at present greater need for the use of existing hospital facilities than for additional hospitals.

"Your committee heartily recommends the approval of the recommendation of the technical committee stressing the use of existing hospital facilities. The stability and efficiency of many existing church and voluntary hospitals could be assured by the payment to them of the costs of the necessary hospitalization of the medically indigent.

"3. Under recommendation III on medical care for the medically needy: Your committee advocates recognition of the principle that the complete medical

care of the indigent is a responsibility of the community, medical, and allied professions and that such care should be organized by local governmental units and supported by tax funds.

"Since the indigent now constitute a large group in the population, your committee recognizes that the necessity for State aid for medical care may arise in poorer communities and the Federal Government may need to provide funds when the State is unable to meet these emergencies.

"Reports of the Bureau of the Census, of the United States Public Health Service and of life-insurance companies show that great progress has been made in the United States in the reduction of morbidity and mortality among all classes of people. This reflects the good quality of medical care now provided. Your committee wishes to see continued and improved the methods and practices which have brought us to the present high plane.

"Your committee wishes to see established well coordinated programs in the various States in the Nation, for improvement of food, housing, and the other environmental conditions which have the greatest influence on the health of our citizens. Your committee wishes also to see established a definite and far-reaching public health program for the education and information of all the people in order that they may take advantage of the present medical service available in this country.

"In the face of the vanishing support of philanthropy, the medical profession as a whole will welcome the appropriation of funds to provide medical care for the medically needy, provided, first, that the public-welfare administrative procedures are simplified and coordinated; and second, that the provision of medical services is arranged by responsible local public officials in cooperation with the local medical profession and its allied groups.

"Your committee feels that in each State a system should be developed to meet the recommendation of the National Health Conference in conformity with its suggestion that "The role of the Federal Government should be principally that of giving financial and technical aid to the States in their development of sound programs through procedures largely of their own choice."

"Under recommendation IV on a general program of medical care: Your committee approves the principle of hospital service insurance which is being widely adopted throughout the country. It is susceptible of great expansion along sound lines, and your committee particularly recommends it as a community project. Experience in the operation of hospital service insurance or group hospitalization plans has demonstrated that these plans should confine themselves to provision of hospital facilities and should not include any type of medical care.

"Your committee recognizes that health needs and means to supply such needs vary throughout the United States. Studies indicate that health needs are not identical in different localities but that they usually depend on local conditions and therefore are primarily local problems. Your committee therefore encourages county or district medical societies, with the approval of the State medical society of which each is a component part, to develop appropriate means to meet their local requirements.

"In addition to insurance for hospitalization your committee believes it is practicable to develop cash indemnity insurance plans to cover, in whole or in part, the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with State statutes and regulations to insure their soundness and financial responsibility and have the approval of the county and State medical societies under which they operate.

"Your committee is not willing to foster any system of compulsory health insurance. Your committee is convinced that it is a complicated, bureaucratic system which has no place in a democratic state. It would undoubtedly set up a far-reaching tax system with great increase in the cost of Government. That it would lend itself to political control and manipulation there is no doubt.

"Your committee recognizes the soundness of the principles of workmen's compensation laws and recommends the expansion of such legislation to provide for meeting the costs of illness sustained as a result of employment in industry.

"Your committee repeats its conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitalization and establishment of insurance

plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

"5. Under recommendation V on insurance against loss of wages during sickness: In essence, the recommendation deals with compensation of loss of wages during sickness. Your committee unreservedly endorses this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and of recovery, which function should be performed by a qualified medical employee of the disbursing agency.

"6. To facilitate the accomplishment of these objectives, your committee recommends that a committee of not more than seven physicians representative of the practicing profession, under the chairmanship of Dr. Irvin Abell, president of the American Medical Association, be appointed by the speaker to confer and consult with the proper Federal representatives relative to the proposed national health program.

"Respectfully submitted,

"WALTER F. DONALDSON, *Chairman.*
"WALTER E. VEST,
"H. A. LUCE,
"FRED W. RANKIN,
"FREDERIC E. SONDERN,

"It was moved by Dr. Donaldson, seconded by Dr. Arthur J. Bedell, section on ophthalmology, and carried after discussion, that the first section of the report of the reference committee, dealing with recommendation I on expansion of public health services, be adopted.

"The second section of the report of the reference committee, referring to recommendation II on expansion of hospital facilities, was adopted as amended, on motion of Dr. Donaldson, seconded and carried after discussion.

"Dr. Donaldson moved that the third section of the report, with reference to recommendation III on medical care for the medically needy, be adopted. The motion was seconded by Dr. A. T. McCormack, Kentucky, and carried.

"Dr. Donaldson read the fourth section of the report of the reference committee, dealing with recommendation IV on a general program of medical care, and moved its adoption. The motion was seconded by Dr. S. J. Kopetzky, New York. Many recommendations were offered by the delegates, after which Dr. Donaldson suggested that Dr. Fred W. Rankin, chairman, and other members of division 4 of the reference committee, together with those who offered the recommendations, retire for a few minutes to amend this part of the report.

"On motion of Dr. Donaldson, seconded by Dr. S. J. Kopetzky, New York, and carried, the fifth section of the report, referring to recommendation V on insurance against loss of wages during sickness, was adopted.

"The sixth section of the report of the reference committee, recommending the appointment of a committee under the chairmanship of Dr. Irvin Abell, president of the American Medical Association, was adopted on motion of Dr. Donaldson, seconded by several and carried after discussion.

"After a short recess, Dr. Fred W. Rankin, chairman of division 4 of the reference committee, brought in an amended report, which after discussion and amendment was adopted on motion of Dr. Rankin, seconded by several, and carried.

"The report of the reference committee as a whole was adopted as amended, on motion of Dr. Donaldson, seconded by Dr. A. T. McCormack, Kentucky, and carried by a rising vote."

Senator MURRAY. We will resume the hearing at 2 o'clock.

(Whereupon, at 11:50 a. m. a recess was taken until 2 p. m. of the same day).

AFTERNOON SESSION

The hearing reconvened at 2 p. m.

Senator MURRAY. The meeting will come to order, and Dr. Richard M. Smith is the first witness this afternoon. Dr. Smith.

Do you have a prepared statement, Doctor?

STATEMENT OF DR. RICHARD M. SMITH, CHAIRMAN OF THE COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC., BOSTON, MASS.

Dr. SMITH. I have a prepared statement and some documentary evidence here for the committee.

First, I would like to say that I appear on behalf of the committee of physicians for the improvement of medical care. I would like to speak briefly about the organization of this committee and who they are.

The committee grew out of the results of the study of the report of the American Foundation Studies in Government, entitled "Expert Testimony Out of Court." It seemed to a number of physicians who read that report that the matter contained was of sufficient importance so that it ought to receive thoughtful attention of all physicians.

As a result of that a number of physicians drew up certain principles and proposals, indicating the lines along which it seemed to us that further development of medical care might be pursued in order to improve the quality of medical service.

Senator ELLENDER. How many members are there in your association?

Dr. SMITH. The committee started with a small membership. We now have 32. In addition to that, as soon as these principles and proposals were prepared, we circulated them—this was in November 1937—to the county medical societies and asked any physicians who agreed with the principles and proposals to sign the document. About 430 signed at that time, and since that date nearly twice that number have now signed.

We have a little less than a thousand signatories.

Senator ELLENDER. Where are those 32 doctors from?

Dr. SMITH. I have a list here of the committee with their representation.

Senator ELLENDER. But I had in mind the 32 physicians who composed the committee?

Dr. SMITH. They are scattered all over the country.

Senator ELLENDER. How was that appointed—

Dr. SMITH (interposing). It is a self-constituted committee. It started with a small group who found themselves in agreement with relation to certain fundamentals of medical care, and gradually they have added to their number.

Senator ELLENDER. Are all of them practicing physicians?

Dr. SMITH. They are all members of the American Medical Association. They are all in medical work, some of them in teaching positions, university positions, and in that sense they practice. Some of them are in private practice, although most of them have some university connection, not on full time like myself. I am essentially a private practitioner of medicine, although I hold a university appointment.

I would like to say also that what I say I am saying as a representative of the committee, and there are other members of the committee here who would be very glad to be heard if you would like to hear them, perhaps emphasizing some of the points that I will make in my statement.

The original principles and proposals upon which it seemed to us that we might make some progress in improving medical care in this country are included in this statement—

1. That the health of the people is a direct concern of the Government.
2. That a national public health policy directed toward all groups of the population should be formulated.
3. That the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches for their solution.
4. That in the provision of adequate medical care for the population four agencies are concerned: Voluntary agencies, local, State, and Federal Governments.

Voluntary agencies, of course, would include physicians and all people working on their own initiative.

On the basis of those four principles, we enunciated nine proposals, which seemed to us to indicate the lines along which development might take place to improve medical care.

The following are the proposals:

1. That the first necessary step toward the realization of the above principles is to minimize the risk of illness by prevention.
2. That an immediate problem is provision of adequate medical care for the medically indigent, the cost to be met from public funds (local and/or State and/or Federal).
3. That public funds should be made available for the support of medical education and for studies, investigations, and procedures for raising the standards of medical practice. If this is not provided for, the provision of adequate medical care may prove impossible.
4. That public funds should be available for medical research as essential for high standards of practice in both preventive and curative medicine.
5. That public funds should be made available to hospitals that render service to the medically indigent and for laboratory and diagnostic and consultative services.
6. That, in allocation of public funds, existing private institutions should be utilized to the largest possible extent and that they may receive support so long as their service is in consonance with the above principles.
7. That public-health services, Federal, State, and local, should be extended by evolutionary process.
8. That the investigation and planning of the measures proposed and their ultimate direction should be assigned to experts. (And in the introduction to this, we have defined "experts" as physicians who are trained in medicine).
9. That the adequate administration and supervision of the health functions of the Government, as implied in the above proposals, necessitates in our opinion a functional consolidation of all Federal health and medical activities, preferably under a separate department.

And we have added a negative statement:

The subscribers to the above principles and proposals hold the view that health insurance alone does not offer satisfactory solution on the basis of the principles and proposals enunciated above.

Now, from time to time, the committee has issued other statements as matters of national concern were presented. Here is one statement, dated March 2, 1938.

This statement has to do with the national-health bill, which was released to the physicians and to the press today.

Senator ELLENDER. Is that S. 1620?

Dr. SMITH. Yes.

The committee met early in March, and considered in detail this health bill, and we have submitted here a detailed statement of the ideas of the committee, and in the back you will see we have included an abstract of the bill and certain provisions for qualifications under the bill.

Senator MURRAY. The papers which you have submitted will be filed with the committee.

(The documents submitted by Dr. Smith were filed with the committee.)

Dr. SMITH. Now the remarks I wish to make I have abstracted from this statement of the committee, and you must realize—

Senator ELLENDER (interposing). You mean pertaining to the bill under discussion?

Dr. SMITH. Yes.

Senator ELLENDER. All right.

Dr. SMITH. The committee represents various shades of opinion, as you would expect from a group of that number of doctors, but this statement represents an opinion upon which we all agree, and therefore I can speak for the committee as a whole in relation to the remarks that I shall make.

Senator MURRAY. Doctor, I notice that this is printed. Do you have extra copies of that which you might leave with us?

Dr. SMITH. Yes, sir; I will leave you extra copies of all the statements.

Although we do not claim to speak absolutely for the people who signed these principles and proposals, the little less than a thousand physicians, we have no reason to believe that they are not also in agreement with this statement, although they have not been consulted. The committee alone has been consulted.

The committee in the first place recognizes the need for positive action to improve medical care in this country, and we are in sympathy with the objectives of Senate bill 1620. We feel that certain provisions in the bill should be modified or implemented if legislation under the terms of this bill is to improve the quality, and not merely to increase the quantity, of medical care. The sums of money authorized in the Wagner bill, and the methods by which they may be appropriated and apportioned, although important to every citizen in relation to the general economic situation of the country, and a cause of considerable concern to some members of the committee, are not especially germane to the purposes of the committee, and have therefore not been considered in this statement.

In the first place the committee believes that there should be a single administrative authority. Under the terms of the bill, authority is vested in three separate administrative departments. Title V is entrusted to the Chief of the Children's Bureau, titles VI and XII

to the Surgeon General of the Public Health Service, titles XIII and XIV to the Social Security Board.

The committee has in the past repeatedly asserted that the various departments of the Federal Government, having to do with health, should be consolidated. The advantages of coordinated action have been well illustrated by the effective work of the Interdepartmental Committee and its technical committee.

Similar coordination would seem to be essential to the success of a comprehensive health program. It is felt by the committee that all parts of medical care are so closely interrelated that it is very difficult to partition off various sections, and say, "This shall be done so", and "This shall be done in another way", when really all of it is essentially a part of a single health program to improve medical care. And therefore we recommend very urgently that all the titles except XIV, which deals with disability benefits, be placed under a single authority, to be established.

Senator ELLENDER. With respect to that view by your committee, as to placing the entire subject matter in the hands of one central agency at Washington, or person, how does that differ from what the American Medical Association proposes?

Dr. SMITH. Well, I think in that particular we would agree that there should be a single administrative authority for the whole bill. We have not stated here whether it should be a person with Cabinet rank, or what not. Those are controversial matters, that at the moment are not so important from our point of view as that all the various functions of the bill, as outlined, should be administered by a single authority in order that there might be proper coordination and interrelation and planning.

Senator MURRAY. Would that not add greatly to the cost of the administration of the act?

Dr. SMITH. I wouldn't be able to answer that. Just offhand, I don't see why it would necessarily make it more expensive. If a single agency administered three different units, I actually don't know, but I don't see why it of necessity would increase the cost.

Senator ELLENDER. Would you want that agency to have any say as to how the funds are to be administered after they are apportioned to the States?

Dr. SMITH. No; except that those matters are somewhat covered in my later discussion. I wouldn't expect that he would be a supreme authority; no.

Senator ELLENDER. Well, do you discuss that later?

Dr. SMITH. Yes; in the remainder of my statement.

Senator ELLENDER. All right.

Dr. SMITH. Now, the second matter that we would like to speak about is the advisory bodies, mentioned in S. 1620.

The bill provides for separate Federal advisory councils under each title. The committee believes that it would be advisable to have, under both Federal and State authorities, central advisory councils to promote the integration of the program as a whole. We recognize that it may be necessary to establish, under these central councils—that is, the central Federal council and the central State councils—expert bodies of a similar nature to deal with special aspects of the program.

We believe, just as we believe that administratively it would be of great advantage to have a single authority, it would be of great advantage to have a single advisory body that would be able to look at the program as a whole rather than at one section.

As the bill now provides, the first title, let us say, which has to do with the work of maternity and child health, has its advisory body; and the other titles each have their advisory body. But we believe that a single overhead advisory body—

Senator ELLENDER (interposing). You think they are closely enough connected to be all under one body?

Dr. SMITH. Yes. After all, it is all one problem, is it not, of trying to improve medical care, and, in the opinion of the committee, if you can look at the problem as a whole, you are more likely to properly administer the various parts of it, than if you try to do one part independently of the others.

And it would be a great advantage, just as in the administration, a great advantage in the advisory capacity that the individuals may serve, if there was a correlating advisory body that would have a view of the full problem. Of course, we would recognize that there would have to be other minor advisory bodies on special problems, but if it could all eventually head up in a single advisory body, we believe that that would be very desirable.

Senator ELLENDER. You mean a single advisory body that would have the final say?

Dr. SMITH. Yes.

Senator ELLENDER. And then you would have the subbodies, or smaller committees for each State?

Dr. SMITH. Yes; we might even, in the Federal set-up, have this overhead advisory body, and smaller advisory bodies of experts in particular fields. But nevertheless, they would all clear—crippled children, and maternity health, and general care, through the advisory body which would have a view of the whole problem of health in the country and would be able to relate one title to the other; so it wouldn't be a disjointed, but an integrated program.

And we believe that these councils should contain representatives of all professional groups concerned. The medical delegation should include representatives from educational and scientific organizations or institutions. It may be necessary or advisable to add lay representatives to present the case of the consumer and the taxpayer. But representation of special interests should be subordinated to the more important point of assembling outstanding persons with imagination, intelligence, expert knowledge, and critical judgment. They would make up this advisory body.

Senator ELLENDER. That is a mighty big order.

Dr. SMITH. Yes; this would really be a pretty important group. Of course, that is in line with the set-up of the Wagner bill.

Then we have gone on to a discussion of other matters.

Senate bill 1620 does not differentiate plans for the care of the needy and for the general medical care of the lower-income groups—they are all considered as a whole. The committee has discussed, in its communication which I have just given you, medical care of the needy, feeling that it is highly probable that in most cases plans for

this group will precede development of a program for the lower-income groups, even if plans for the latter should be accepted simultaneously by the legislatures. That is, if you should have enabling legislation, the chances are that in any given community the first group to be attacked would be the needy, the so-called indigent; that probably that group would be considered first as a group.

Senator ELLENDER. If the amount of allocation to the various States is based on the needs of the needy, as it were, necessarily don't you think that they would be taken care of first?

Dr. SMITH. That is what we feel, that that group would be taken care of first.

Senator ELLENDER. How would you write that into the law better than it is already written?

Dr. SMITH. I think that is a difficult thing, but it seemed to us that it would be desirable, if possible, and I have not, I am frank to say, any form that I can submit to you as to how we could change the wording; but it seemed to us that it might be desirable to consider developing the plan first for the needy, because, as we say, experiments in tax-supported care for the needy may provide formulae by which the evils now feared in relation to governmental participation in medical care may be avoided when and if Government-supported care is extended to those higher in the economic scale.

That is, you might work out formulae in this so-called indigent group which would be of assistance in extending it to the income group just above that, still in need of medical care.

In other words, our idea in proposing that was that you would develop this thing experimentally rather than attempting to tackle the whole medical problem at once, which is an almost impossible thing to do. None of us is quite wise enough to devise a plan that would meet every objection, but if a plan were satisfactorily developed for the needy, that plan might then be expanded, and the things that are found unsatisfactory changed, and the things that were successful adopted.

Senator ELLENDER. Do you find anything in the bill that hasn't for its purpose the help of the needy?

Dr. SMITH. No; not at all. It is only a question—

Senator ELLENDER (interposing). Of being sure to do that?

Dr. SMITH. Exactly; and of doing it as intelligently as we can in order to accomplish the results which we all have in mind.

Now, in discussing this care of the needy, we have indicated here several matters which seemed to us important. I would be very glad to read those, or will pass them over and you can discuss them if you like.

The first has to do with the general organization, the importance of public health services being under the control of trained, full-time, salaried experts; and the question of the State health agency that should administer this, whether the State department of health is in every instance the right one. It probably is, but there is little provision in the bill for the possibility of some agency—I mean it might be conceivable in a State that some other agency might be better. That is just a possibility that we raise.

Then we have brought up the question which pertains, of course, to the whole administrative problem, but we have discussed it here

because we are discussing what seemed to us the best plan to develop, namely, the care of the needy, first, that in addition to the advisory councils which we have, that local bodies of experts should be created to adjudicate the questions of competence and discipline where necessary. Although such bodies should include professional representatives, they should be appointed by and responsible to the State authority, not to the medical societies or the private organizations, because experience has shown that it is difficult for organizations to exercise a purely judicial attitude toward actions of their own members. I mean it is quite conceivable in the operation of this plan that differences of opinion might arise between the State or the local society, or in a given community that differences of opinion as to competence might arise; and it seemed to us that there should be some judicial council provided in order to settle those questions, I mean some board of appeal, if you choose to call it that.

Then we discuss the qualifications for individuals who are eligible for aid, that there ought to be some method whereby people will become eligible without too much delay and too much red tape because there is evidence that some, at least, of the unmet medical need among the poorer members of the population arises from the unwillingness of these individuals to submit themselves, unless they are seriously ill, to the administrative delays to which they are often subjected.

I think some system would have to be devised for registration, perhaps, of those entitled to tax-supported care. But methods should be found whereby they may be qualified with expedition and without indignity, so that a person will be eligible for care under this, without too much delay and without sacrificing his feelings, at least.

Senator ELLENDER. In that connection, it might be well to have a list made of those who would be eligible for the service, and then if they happened to need hospitalization, all they would have to do would be to show their card.

Dr. SMITH. That is it, exactly, made in advance and not dependent on the time when he falls ill, because then there may be inevitable delay, and there may be all sorts of questions raised as to whether he is eligible.

Senator ELLENDER. That could be done under the present language of the bill, as a detail?

Mr. SMITH. Yes; but it is an important detail that might be considered.

Senator ELLENDER. I think so, too.

Dr. SMITH. Then we speak about the components of medical care, the adequate public-health services, the services of general practitioners and others.

Then we enter into a little discussion about the methods of payment for services, because it is quite important to know whether you are going to pay the doctor so much every time he sees a patient, or whether you are going to pay him on a per capita basis according to the number of individuals served; or whether you are going to place all the physicians who minister to the needy, on a salary.

There are three ways in which you can do it, and they might properly be given some consideration.

I don't know that you would feel that that ought to be written into the bill.

Senator ELLENDER. In your pamphlet have you discussed those?

Dr. SMITH. Yes; and we would be glad to amplify that if you like.

Then we have made some comments on the questions of hospitals and medical centers. There can be no doubt that there is need for further institutions of this kind. However, every effort should be made to utilize to the utmost the private and public facilities that are already available. The Wagner bill proposes new expenditures for hospitals and health centers. It also recognizes the need for supporting those already in existence; but for this purpose relies on the funds to be derived through the general program for medical care. Since this is merely a grant for maintenance, it would not permit expansion or renovation of institutions, as we understand it.

All new construction is confined to Government-owned institutions and Government-owned additions to existing institutions. In order that existing institutions may become eligible for Government aid, they should fulfill certain requirements, and then we enumerate some of the things that we think are essential as far as quality of service is concerned for hospitals to be eligible for Government aid.

Then we discuss somewhat the question of costs, and I think perhaps some of the other members of the committee, who are here, would like to discuss this more in detail.

But there is some apprehension felt that not enough money has been allowed per capita for the care of the needy; in other words, that an inadequate program may be undertaken so that really satisfactory medical care may not result.

We are not quite clear in our analysis of the bill, but as we understand it, the expenditure of only \$10 per capita is proposed for the needy. We know, from experience in private group clinics that the cost is at least \$20 and perhaps \$30 per person to give adequate medical care, and to embark on a program of care for the indigent on an allowance, let us say, of \$10, means at the beginning that you either will have inadequate facilities, or would not be able to pay enough for the services.

Senator ELLENDER. You may be able to use the money for those most needy, along the line you have discussed earlier?

Dr. SMITH. Yes; but our point is that we want to be sure that if we are going to start to give general medical care to the needy, that we allow a generous enough appropriation so that that care will be adequate and of good quality.

It would be a great mistake to embark on a plan that would give poor care from the outset and would be inevitably poor because we didn't have enough money to pay for it.

I think that is a matter that should be given careful attention.

Finally, we have called attention to the fact that S. 1620 has no provision for the support of general education and investigation, medical education, and investigation. The committee cannot too emphatically insist that without such provisions no program that contemplates expansion and improvement of medical care can be considered satisfactory or complete. Unless you can maintain the quality of medical education and can provide for research—

Senator ELLENDER (interposing). Exactly what do you mean by that?

Dr. SMITH. Medical schools.

Senator ELLENDER. Would you want the Government to undertake the paying of the expenses of educating—

Dr. SMITH (interposing). No; but I think we have to recognize that medical education is very expensive, and that private funds providing for that are less than adequate than they used to be, and may be less available in the future than they are even now; and looking forward toward good medical care in this country as a whole, one of the foundation stones is well-trained doctors.

In other words, you have got to be sure that the quality of the persons who are going to render the care is of a high grade. That can only be done through well-maintained medical schools.

Now, the question is, Where are the funds coming from to do that? You can't expect the students are going to pay for it. It is expensive; you can't raise the price of tuition. It must come from what we have called in the past, endowments and private contributions.

Senator ELLENDER. Well, under your proposal No. 3 here, "That public funds should be made available for the support of medical education and for studies, investigations, and procedures for raising the standards of medical practice"—

Dr. SMITH (interposing). We don't mean for the entire support.

Senator ELLENDER. To what extent would you propose that?

Dr. SMITH. I think that would have to be determined by circumstances and by developments, but that some provision should be made for contributions from public funds toward medical education seems to us essential, and the same thing is true with relation to investigation or research, which has to do with advancing knowledge. That is true in all branches, and I think one of the other members of the committee would like to enlarge on that point.

That is all I have in my prepared statement, but I would be glad to answer questions.

Senator ELLENDER. Quite a few States do provide aid for students to study medicine?

Dr. SMITH. At State institutions.

Senator ELLENDER. I know in my own State, for instance, we have the Louisiana State Medical Center.

Dr. SMITH. That is entirely supported by public funds.

Senator ELLENDER. Is that what you mean?

Dr. SMITH. Exactly, only it wouldn't necessarily always be a State institution, it might be a contribution toward another existing institution, just as we mention in relation to hospitals.

Senator ELLENDER. And that is the kind of medical aid that you speak of and refer to under your proposal 3?

Dr. SMITH. Yes.

I would be glad to answer any questions that I am able to, or would be glad to call on any other members of our committee who are here. I have here the names of certain other members of our committee present, who will be glad to have an opportunity to speak.

Senator MURRAY. Thank you, Dr. Smith.

Dr. William J. Kerr. Will you give your name to the reporter?

STATEMENT OF DR. WILLIAM J. KERR, VICE CHAIRMAN, THE COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC., SAN FRANCISCO, CALIF.

Dr. KERR. My name is Dr. William J. Kerr.

Senator MURRAY. Do you have a prepared statement, Dr. Kerr?

Dr. KERR. I do not have, Senator; no.

Senator MURRAY. Do you wish to make a verbal statement, then?

Dr. KERR. Well, I should like to say first that I am a member of this committee of physicians, and happen to hold office in the committee. I am also a member of the American Medical Association, as I believe all of us are on the committee. I have held office in the American Medical Association as chairman of the section on the practice of medicine, in that organization, and as secretary of that section for a period of 8 years, this being one of the scientific sections of the American Medical Association.

I have also held other offices in national organizations—president of the American Heart Association, the American Rheumatism Association, and the American College of Physicians.

I have just completed these terms, but I am speaking only for myself as a physician.

Senator MURRAY. Are you a resident of San Francisco, Doctor?

Dr. KERR. Yes, sir.

Senator MURRAY. And you practice your profession there?

Dr. KERR. I am a teacher in the University of California medical school, and do a consulting practice only.

The reason I mention two of these organizations, the American Heart Association and the American Rheumatism Association in particular, is because I wish to make some statement concerning the bill relating to those diseases.

I would like to say that I agree entirely with what Dr. Smith has said concerning the bill and its provisions, and would be glad to answer any questions on any of those points, with which I am familiar.

I should like to say that I have read this bill and have only two or three suggestions which might be constructive.

One of them concerns the two diseases I have mentioned, under title VI, I believe, on page 17, with reference to extensions in the public-health field.

It seems to me that some provision should be made for the care of patients with chronic arthritis or chronic rheumatism, because that disease, or group of diseases, causes more disability during the wage-earning period of the life of the individual, or the productive period, than any other disease, and probably more than all the other diseases mentioned here put together. It is a chronic condition which extends over many years.

Heart disease and disease of the blood vessels is not mentioned at all, and that disease or group of diseases, is the cause of more deaths than practically all the other diseases mentioned. In fact, it is far ahead of cancer and mental diseases, and pneumonia, tuberculosis, as a cause of death; and we do have sufficient evidence today that a full understanding of what can be done for people in middle life or

soon after middle life to prevent untimely death and disability, if we would just apply it through proper means, education and distribution of services. Some provision should be made to control those two great groups of diseases.

Also, another group of diseases which I think is important here, is the so-called nutritional diseases, which, while usually associated with conditions of poverty, are not necessarily limited to that. But in certain States of the Union we have many nutritional disorders, and while we may benefit those people temporarily by taking them into good hospitals or good clinics, we may not be able to eradicate some of that without removing other causes such as pauperism and economic conditions.

I am also interested in making some statement concerning education. Dr. Smith has alluded to education in the medical schools. It should be understood, I think, more generally that in many of our medical schools in the country a large number of students are working their way through the medical schools, and you might say their training suffers for this reason, and some of those going through the medical schools are among the most intelligent and promising students we have.

While that isn't true of all medical schools, I think if a survey were made it would be shown that in all our medical schools a very high percentage of the students are working their way through. And medical education is very expensive. The average cost per year per student is somewhere in the neighborhood of \$2,000, that is actual annual cost per student, and that is what it costs the State or some privately endowed institution to provide that, in addition to what the student pays himself, or his family pays; and the total cost of educating a student may be \$10,000, \$15,000, or \$20,000, as it stands today.

Senator LA FOLLETTE. When you speak of \$10,000 or \$15,000 you mean the over-all cost, including the cost upon the institution and the cost from the standpoint of what the student pays, or what his family pays?

Dr. KERR. That is the over-all cost, Senator.

In order to have a steady stream of well-qualified doctors who can give real service, and, after all, that is one of the things the medical profession is most interested in, the quality of the service, we must see that educational standards are kept high and that students are properly trained.

And then there is a period, usually of one or more years, when further training is required, and if we are to elevate our standards and meet the needs which will probably be much greater than any of us realize today, we must have more doctors instead of less doctors in the country.

The next and last point that I want to make is that continuing education or post-graduate education is going to be highly essential not only for doctors but for all of those participating in the care of the sick, and some provision should be made to maintain standards of quality of service, and that can only be done by keeping doctors up to date.

We learned a good deal about that during the Great War, and we saw how difficult it had been for doctors to keep up, out in general

practice, but I think there is a chance there to do some real constructive work.

Those are the only points that I care to make myself.

Senator WAGNER. You favor the legislation, of course?

Dr. KERR. I do, Senator.

Senator MURRAY. Thank you, Dr. Kerr.

Dr. John P. Peters.

Dr. SMITH. Dr. Peters is secretary of the committee.

Senator MURRAY. Is he here?

Dr. SMITH. Yes; he is.

STATEMENT OF DR. JOHN P. PETERS, SECRETARY, THE COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC., NEW HAVEN, CONN.

Dr. PETERS. I am Dr. John P. Peters, secretary of the committee of physicians; also professor of internal medicine at Yale University, where I am especially interested in metabolism, do clinical work as well as investigation and teaching, and conduct clinics for patients of all kinds, as well as work in the hospital.

I have only a few things to say and a very short prepared statement.

I would like to say, first of all, that I think that the committee wants it known that they are generally sympathetic with this bill; that they wish to point out only some things in which they think the bill could be implemented. They are rather mistakes of omission than commission, which we find. We are not uninterested in the financial aspects of the bill, although we have not stressed them. We feel that if every attention is given to seeing that the quality of care is right, and that it is guarded, to seeing that any money that is spent for that purpose is well spent, and that machinery is provided which will guarantee the quality of medical care, we will also protect the public against excessive appropriations.

I should just like to read a few words.

Obviously almost all who offer opinions about a legislative measure are certain to emphasize their objections. The result is that even those who are most kindly disposed may leave behind an impression of disfavor. I should like to preface my remarks, therefore, with the statement that the Wagner bill (S. 1020) is, in my opinion, like the technical committee's proposals, on which it is based, generally commendable and intelligently conceived to meet a demonstrated need. It is conceded, even by those who oppose change of the present system, that the accomplishments of medicine are falling far short of its potentialities; that the benefits of scientific discoveries are not utilized to capacity. It is particularly admitted that they cannot be made available to the neediest portions of the population by present methods, that the burden is beyond the powers of philanthropy. Physicians can no longer give the amount of service needed gratuitously, because the increased costs of medicine arise not from the rapaciousness of physicians, but from the nature of modern medicine. The apparatus, personnel, training, skill, and time required have raised the costs for physicians and hospitals as well as for patients. The Government will undoubtedly have to assume respon-

sibility for the medical care of the indigent and probably will have to lend some aid to that part of the population above the level of true need. From the extent of the deficiency of medical care which has been disclosed by the National Health Survey and other investigations, it seems quite clear that the Federal Government will have to supplement the efforts of the States.

With the economic disparity and the variable social and geographical conditions in this country the immediate imposition upon the whole Nation of a uniform program would be most inadvisable. To leave the development and administration of programs to the States, as this bill proposes, is, therefore, eminently wise. Equally wise is the retention by the Federal authorities of the right to prescribe standards of qualification for the receipt of grants-in-aid by the States. I should like to record my opinion in this connection that if these standards are properly devised and rigidly adhered to there is no need to fear lest appropriations be excessive. There is every reason to believe that expenditures effectively devoted to the conservation of health will be amply repaid. Experience already gained will permit more rapid development along certain lines, especially in the expansion of public-health services. There is wisdom, therefore, in making separate provision for these in titles V and VI of the bill. It is also obvious that, in parts of the country, at least, physical facilities in the form of hospitals and health centers must be established, as provided in title XII, if proper care is to be given. These are essential tools of medicine. The ultimate goal, however, must be the development of such a comprehensive system of medical care as is evidently contemplated in title XIII. If this is to be efficient and economical it must be integrated with the public-health measure of titles V and VI. I should go so far as to say that it must include them. Certainly it must absorb the hospitals and health centers. This is clearly recognized in the bill with respect to every State when it is required that the program of each State—

provide for the administration of the plan by the State health agency or for the supervision by the State health agency of any part of the plan administered by another State agency or by a political subdivision of the State.

To insist upon a single authority in the States and then to make this single authority accountable to three separate Federal authorities is worse than illogical. It may well jeopardize the success of the program. Children, women, and men do not belong in separate compartments in a well-organized health system. Hospitals and medical centers should not be separated from the other instruments of medical care. If reorganization of the administrative agencies of the Federal Government is necessary, then reorganization should be demanded. Consolidation of the health services that are to function together in carrying out the proposals of this bill is absolutely essential. It should be possible to achieve such a consolidation without sacrificing the effectiveness of any of the agencies now in existence. The bill also provides for advisory councils of experts under each title. Here again there must be a coordinating body, a central advisory council, and nothing should take precedence over the constitution of such a council. On the standards that it may establish will depend the success of any program that is instituted.

That grants-in-aid for disability benefits should be given to States only when they have provided a system for the medical care of the beneficiaries, as title XIV provides, seems sound. To grant disability benefits without any assurance that disability will be remedied or minimized would be poor economy. Without such disability benefits no well-ordered system of medical care for wage earners can be truly effective.

As physicians the members of our committee and our signatories are concerned that every effort be made to provide care of a high and continuously improving character. Certain principles that must prevail if this purpose is to be attained will be found in the statement which has just been published and which has been placed on record with your committee and from which excerpts were read by Dr. Smith.

On one point in this statement, to which Dr. Smith has alluded, I should like to enlarge—the demand that legislation include generous provision for education and investigation. To effect a real improvement in medical care, not only the distribution of medical care but also the quality of medical care must be revised. At the present time services that are rendered on the whole fall far short of the actual values that medicine has to offer. The intellectual equipment and technical proficiency required to understand and apply the new weapons that science has given us to combat disease have grown as rapidly or more rapidly than the physical appurtenances. The educational background that was adequate a decade ago is quite insufficient today. Knowledge becomes obsolete as rapidly as apparatus. Greater opportunity must be given not only for initial training of physicians and other professional workers, but also for their continuous education. Already, however, medical education is more expensive and time-consuming than any other kind of education. Medical schools and other educational institutions can not meet their full obligations to the students, internes, and residents entrusted to their charge; much less can they assume the burden of continuing education. Philanthropy is quite as incapable, although the value of extended education has been demonstrated by experiments conducted under philanthropic auspices. Any comprehensive health program will increase the demand for competent men and further overload the already intolerably burdened educational machinery.

It will avail us little to establish standards of merit and competence if no efforts are made to enable men to meet these standards. In fact the practical level of quality in our medical services will ultimately depend upon the educational system. Investigation must also be fostered in order that our means of combating sickness and disability may be enhanced. At first sight these would seem to be luxury expenditures, but they are not. Society can afford to pay much for measures that will curtail or eliminate disability, to save the larger sums that it would otherwise be called upon to spend in support of the results of this disability. The present bill contains commendable provisions for training of personnel and investigation of methods under the public health titles, but no broader provision for general medical education and research under title XIII. It is imperative that this be given consideration.

I may add, in closing, that I think every step of any health program must be scrutinized to see that it will further education and productive endeavors.

Senator MURRAY. Thank you for your statement, Dr. Peters.
Dr. Robert Osgood.

STATEMENT OF DR. ROBERT B. OSGOOD, MEMBER OF THE COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC.

Dr. Osgood. I am a very humble practitioner of medicine, sir, holding no important title whatsoever except the fact that I used to be a professor in Harvard, but I have done away with that now.

Senator MURRAY. You are trying to live it down, are you?
[Laughter.]

Dr. Osgood. I want to talk, if I may, along somewhat general lines. I would like to read to you something that Dr. Smith did not read in relation to the principles and proposals, that he filed with you, but I think it is very important in order to catch the spirit of the small group that first was bold enough to launch these principles and proposals on a somewhat hostile medical world.

It is recognized that the medical profession is only one of several groups to which medical care is of vital concern. Close cooperation between physicians, economists, and sociologists is essential. Nevertheless, the medical profession should initiate any proposed changes because physicians are the experts upon whom communities must depend. Unless the medical profession is ready to cooperate with these other groups, they cannot expect to play successfully the part which they should play, nor can they expect to enlist the sympathetic understanding of legislative bodies.

It seems to us probable that certain alterations in our present system of preventing illness and providing medical care may become necessary; indeed, certain changes have already occurred. Medical knowledge is increasing rapidly and is becoming more complex. Changes in economics and social conditions are taking place at home and abroad. Medicine must be mobile and not static if medical men are to act as the expert advisers of those who convert public opinion into action.

The conviction is general that action should be taken only upon the basis of demonstrated need and an experience accumulates to indicate that such action is likely to attain the ends in a Nation comprising 48 States in which climatic, economic, and social conditions vary greatly.

We have no precedents, gentlemen, in medical experiments thus far that can surely be applied to this country.

In Bunyan's Pilgrim's Progress, Christian, when lost in bypath meadow, sagely remarks, "Then I thought it is easier to go out of the way when we are in it, than to go in, when we are out."

We are all quite convinced that there is great need for more adequate medical care in the United States.

The informal committee believes that the end sought by Senator Wagner's bill, and perhaps other bills, and by organized and unorganized medical groups, is essentially the same. It must be quite evident to you all, as it is to us, that honest differences of opinion exist as to the means and methods whereby these ends may be best realized.

You will probably agree with me that the ends sought cannot be attained without the close cooperation of the vast majority of the medical profession. Physicians must try to heal their patient's souls

as well as their bodies. If they are not allowed to practice as their consciences dictate, they will not serve the public well; their service degenerates in direct ratio to their loss of independence of action.

What many of us fear is not the further socialization of medicine, but the socialization or regimentation of the members of the medical profession.

This leads me to suggest that the appointment of a national general medical council, made up of men nominated, perhaps by approved university medical schools and other nonpolitical groups, is most desirable, and I would go so far as to use the word "essential."

The opinions of such a council would command the respect of both medical men and the laity, and would crystallize public opinion without which no scheme can succeed.

European experiments have fully justified the acute fear of political control of the people's health, which all medical men share. We are in rather deep woods. Both you and we are eager to find a way out. We must be sure that each step not only takes us in the right direction, but is planted on solid ground. Otherwise, these steps, even in the right direction, may lead us into a morass. Once in, valuable time will be lost and emergence is often very difficult, as Christian found in bypath meadow.

Let us go slowly, very slowly, working out an American plan for our American people. We can well afford to go slowly for the evolution of medical care in America has been very rapid. Medical care in this country is probably more adequate than in any other country. Despite this fact it seems to us, of the informal committee, that it should in no way either deter or delay us from bending every effort to make available at the earliest possible moment more adequate care for those who need it, and we believe the need to be great.

Senator LA FOLLETTE. Doctor, what have you to say about this particular bill that we have before us; do you think it goes too fast or too slowly, do you think it goes in the right direction? Have you any specific suggestions about the measure itself?

Dr. Osgood. The informal committee that Dr. Smith represents as president, and Dr. Peters as secretary, has said things much better than I could say them, and I am in hearty agreement with what they have said.

Senator LA FOLLETTE. Have you anything to add to what they have said?

Dr. Osgood. Nothing.

Senator WAGNER. Are you a member of the American Medical Association?

Dr. Osgood. I am; I have also served on one of their councils.

Senator ELLENDER. You referred to a hostile group awhile ago; what did you mean by that?

Dr. Osgood. I referred to a hostile group?

Senator ELLENDER. Yes; a hostile group in the Medical Association, what group is that?

Senator MURRAY. I think he said hostile groups.

Dr. Osgood. No; I think I haven't referred to any hostile groups, sir.

Senator ELLENDER. I must have misunderstood you; that was in what you were reading awhile ago.

Senator WAGNER. You referred to the pioneering endeavors of your committee.

Senator MURRAY. In the face of hostile groups.

Dr. Osgood. I don't remember even where I used the word. If I did, I certainly didn't wish to imply that we were a hostile group. We are a group which doesn't always agree with certain positions that the American Medical Association has taken, nor do they agree with ours. That isn't saying anything bad about either group, perhaps.

Senator ELLENDER. The American Medical Association seems to be very much opposed to a plan such as this.

Dr. Osgood. A plan such as these principles and proposals?

Senator ELLENDER. I am talking about the plan as outlined in the Wagner Act?

Dr. Osgood. Well, Senator, I can't speak for the American Medical Association.

Senator ELLENDER. I say that when I understood you to say awhile ago about the hostile groups, that is what I thought you meant.

Dr. Osgood. I am sorry if I gave that impression, for I didn't mean that at all.

Senator WAGNER. I don't know as we are in a position to say that the American Medical Association is opposed absolutely to this legislation. I think I am correct in that, am I not, Dr. Booth?

Dr. Booth. You are.

Senator WAGNER. They are going to make some suggestions.

Senator MURRAY. Doctor, then you and your associates are in general accord with the bill as it stands, with the exception of the central authority that you advocate?

Dr. Osgood. I think our officers have expressed that.

Senator MURRAY. Thank you for your statement.

(At this point Senator Murray was called from the room and Senator Ellender assumed the chair.)

Senator ELLENDER. Dr. David Seegal.

Doctor, will you give your full name?

STATEMENT OF DR. DAVID SEEGAL, DIRECTOR OF THE RESEARCH DIVISION FOR CHRONIC DISEASES, DEPARTMENT OF HOSPITALS, NEW YORK CITY, N. Y.

Dr. SEEGAL. My name is Dr. David Seegal, director of the research division for chronic diseases, department of hospitals, New York City; assistant professor of medicine at Columbia University, and member of the committee of physicians; and member of the American Medical Association.

I am in entire agreement with the report presented by my colleagues on the committee of physicians.

I should like to amplify a point made by Dr. Smith and Dr. Peters and Dr. Kerr, with regard to the importance of research in the field of chronic diseases.

Although medicine has made great progress in the prevention of so-called infectious diseases, we have run ourselves into the woods, as it were, by having a great many people alive available for the on-

slaught of such diseases as apoplexy, heart attacks, and the like, and we must confess in all humility that our progress there has been very slow indeed.

Now in order to carry out clinical investigation on these chronic diseases, painstaking, prolonged studies of individuals with such illnesses are necessary, in studying the natural history of the disease, and the effects of various agents in either the prevention or the cure of such diseases.

Now the private hospitals just can't do it. They are in no position to keep patients in hospitals over a prolonged period of time. They can't afford it and they rarely do it. Therefore the responsibility is thrown directly into the hands of tax-supported institutions.

Three years ago an enlightened municipal administration in New York City, recognizing this condition, set up what was called the research division for chronic diseases. They selected an advisory council made up of eminent men whose primary interest was intellectual. For 8 years now, this institution has gone along, carrying out an experiment which may be of some interest to you.

There was considerable, and the usual type, of skepticism as to whether tax-supported funds could be used fruitfully in medical investigation. It is obvious to you that if we stop medical investigation today, we know no more about medicine thereafter. If we stopped medical investigation 20 years ago, we wouldn't have had insulin for diabetes, or liver extract for pernicious anemia, and the like.

It is the consensus of opinion of a group of disinterested individuals, coming from other countries than our own, that this experiment in New York City has worked out; that is, that an institution supported in the main by tax-supported funds can add to the sum total of knowledge necessary in the war, if you will, on chronic disease.

Now, we have ample evidence that tax-supported funds may be used for such purpose in this country. I know of no finer place than the National Institute of Health.

In England, during the war and thereafter, tax-supported funds were used to set up the so-called medical research council. The skepticism which was present when that was first talked about was very ample. There is no doubt now that the medical research council abroad has fostered research on as high a plane as exists.

So I should simply like to report to you that I do not fear the skepticism of those who feel that tax-supported funds are thrown away when utilized for medical investigation, particularly in the field of chronic diseases where it is so necessary.

Senator TAFT. Is there a fairly wide private research going on today in most of these chronic diseases?

Dr. SEEGAL. Yes; but the contraction of funds in private institutions is such that I should think that research would have to contract. It is common knowledge that the return on investments of universities and other endowed institutions has dropped from a rate of about 5 percent to that of about 3 percent. Well, naturally that means that there is going to be less investigation.

Senator TAFT. All the important discoveries in this country have practically been made in private institutions, though, haven't they, up to this time?

Dr. SEEGAL. By salaried men.

Senator TAFT. I mean in private institutions without the use of Government money?

Dr. SEEGAL. I should think that the National Health Institute, in terms of the amount of money used there, would stand up as well, if not higher, per dollar used, with any privately endowed place.

Senator TAFT. I am not comparing, I am just saying that there has been a very great development in private institutions without Government help.

Dr. SEEGAL. Right.

Senator ELLENDER. Where that was developed, though, didn't the money come from some gift or other source?

Senator TAFT. An endowment, usually.

Senator WAGNER. Such as the Rockefeller Foundation.

Dr. SEEGAL. Oh, yes; that is the usual way.

Senator TAFT. You have a great cancer research institute now at the Yale Medical School, the child's fund, established 2 years ago?

Dr. SEEGAL. Dr. Peters probably could answer that.

Senator ELLENDER. Are there any further questions?

Senator TAFT. Of course the more you tax to raise the money for the Government, the less likely you are to get private funds, aren't you?

Dr. SEEGAL. No comment.

Senator WAGNER. Doctor, have you participated in any surveys so that you might have some information as to the medical needs of New York City, whether they are being supplied to all, low-income groups as well as others?

Dr. SEEGAL. I wouldn't be able to give you specific figures on that. I think they are available.

Senator WAGNER. I thought you might have some general knowledge on the subject.

Dr. SEEGAL. I wouldn't want to comment.

Senator ELLENDER. Thank you, Doctor.

Now, those are all the witnesses for today.

Senator WAGNER. Mr. Chairman, Dr. Booth is here, and I would like to introduce into the record some extracts from a book entitled "The Hospital Survey for New York," pages 110 to 114, which is a survey indicating the need for a great deal more medical care than is now available. It is the result of a survey in New York City.

Senator LA FOLLETTE. Who made that survey, Senator?

Senator WAGNER. It was by a survey committee, this is "A Summary of the Report to the Survey Committee in Volumes 2 and 3," by Haven Emerson. He is a very eminent doctor, isn't he? And I will put into the record the committees of the hospital survey for New York, a list of the members. It is a long list of doctors who participated in the survey.

I also wish to have another table, or tables, tables 43, 44, and 45, appearing on pages 234, 235, and 236, upon the same subject, inserted in the record.

Senator ELLENDER. Without objection, the data you refer to will be inserted in the record.

(The data is as follows:)

THE HOSPITAL SURVEY FOR NEW YORK

GENERAL COMMITTEE

Mrs. Winthrop W. Aldrich
 Mrs. William Armour
 Joseph J. Baker
 Frank L. Abbott, Jr., M. D.
 George Beahr, M. D.
 Mrs. Courlandt D. Barnes
 Francis D. Bartow
 Mrs. August Belmont
 Mrs. F. Meredith Blagden
 Mrs. Linzee Blagden
 Miss Susan D. Bliss
 E. M. Bluestone, M. D.
 George Blumenthal
 Mrs. Sidney C. Borg
 Rev. Joseph F. Brophy
 Charles C. Burlingham
 Claude A. Burnett, M. D.
 Sheldon L. Butler
 Mrs. Alfred A. Cook
 E. H. Lewinski-Corwin, Ph. D.
 Walter A. Cotton, D. D. S.
 Howard S. Cullman
 Thomas F. Daly
 Neva R. Deardorff, Ph. D.
 Mrs. William K. Draper
 Lester B. Dunning, D. D. S.
 Frederick H. Ecker
 Karl Ellers
 Henry J. Fisher
 Mrs. Mark Fleming
 Clarence E. Ford
 Walter S. Gifford
 S. S. Goldwater, M. D.
 Miss Louise N. Grace
 Mrs. E. Roland Harriman
 John A. Hartwell
 Charles Hayden¹
 Edgar C. Hayhow
 Harold Hays, M. D.
 Charles Gordon Heyd, M. D.
 F. Stanley Howe, M. D.
 Charles E. Hughes, Jr.
 Mrs. Charles E. Hughes, Jr.
 Mrs. John E. Jennings
 John E. Jennings, M. D.
 Mrs. Walter G. Ladd
 William S. Ladd, M. D.
 Mrs. William S. Ladd
 Samuel D. Leidesdorf
 Milton S. Lloyd, M. D.
 Solomon Lowenstein
 George MacDonald
 Hon. Mitchell May
 Edwin P. Maynard

Bernard McDermott
 Thomas S. McLane
 Julius S. Morgan
 Miss Jessie M. Murdock, R. N.
 Peter Marshall Murray, M. D.
 Charles F. Neergaard
 Matthias Nicoll, Jr., M. D.
 Rev. Joseph S. O'Connell
 John H. Olsen
 Miss Jessie Caroline Palmer
 Timothy N. Pfeiffer
 Mrs. Timothy N. Pfeiffer
 Eugene H. Pool, M. D.
 James H. Post
 Miss Blanche Potter
 Harold I. Pratt
 David M. McAlpin Pyle
 Edwin G. Ramsdell, M. D.
 Willard C. Rappleye, M. D.
 Stanley Resor
 John L. Rice, M. D.
 George E. Roosevelt
 William J. Russell
 John J. Rust
 Dean Sage
 William J. Schieffelin
 Joseph J. Schwartz, Ph. D.
 Mrs. John S. Sheppard
 H. Theodore Sorg
 Charles A. Speakman
 James Speyer
 Fred M. Stein
 Medad E. Stone
 Elizabeth Stringer, R. N.
 William B. Symmes, Jr.
 Alec N. Thompson, M. D.
 Miss Janet Thornton
 Miss Ruth Twombly
 Nathan B. Van Etten, M. D.
 Mr. and Mrs. Adrian Van Sinderen
 George E. Vincent, LL. D.
 Miss Lillian D. Wald
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COLLABORATING AGENCIES

American Social Hygiene Association.
American Society for the Control of Cancer.
Hospital Conference of the City of New York.
Maternity Center Association of New York.
National Committee for Mental Hygiene.
National League of Nursing Education.
National Organization for Public Health Nursing.
New York Tuberculosis and Health Association:
 Committee on community dental service.
 Committee on social hygiene.
 New York Diabetes Association.
 New York Heart Association.
 Tuberculosis committee.
Welfare Council of New York City:
 Committee on chronic illness.
 Research bureau.
 Section on medical social service.

REPORTED INADEQUACIES IN SERVICES FOR THE SICK

Through the courtesy and services of the Welfare Council of New York City, the experience of its member agencies was sought with the expectation that their field and office staffs would be willing and able to summarize their experience with families and individuals for whom they have tried to obtain one or more kinds of medical care at little or no cost.

The reported inadequacies in services for the sick in New York City are not different in kind and degree from those coming daily to the attention of hospital and other administrators directly responsible for the institutions and agencies criticized.

The value of the statements made by the family welfare and other agencies participating through the Welfare Council is in the fact that these are more nearly just what the average patient or family complains about in the matter of medical care in this city than could be had from any other equally reliable source.

There are instances where the opinions of the representatives of the welfare agencies and their implications run counter to the conclusions and recommendations of the survey, mainly for the reason that they did not have access to

Information of a city-wide character that was available to authors of some of the other chapters.

This is a one-sided and negative story as reported, no one being asked to comment on the adequacies or excellences of services obtained from voluntary and municipal hospitals and the like.

One hundred and eighty-four of the five hundred and eighty-one agencies replied to the inquiry sent them. Composite reports came from 183 agencies and 51 from the executive officer of the agency, and the greater part of the information was sifted and discussed by committee or staff conferences.

The mass impression of this evidence, like its multifarious nature, cannot be ignored but must be kept in mind through the subsequent discussion of financial and other practical factors upon which improvement or expansion of services for the sick can be determined.

The following were the more important inadequacies reported for each category listed:

Hospitals.—Overcrowding in municipal hospitals; premature discharge of patients; zoning restrictions which interfere with hospital and dispensary admissions; serious shortage in free beds for children needing tonsillectomy; lack of facilities for care of syphilis and gonorrhea in adolescents; insufficient staff to give good medical and nursing care; lack of continuity of medical care in the same institution; diagnostic facilities inadequate in the specialties; poor coordination between in- and out-patient care.

Dispensaries.—Overcrowding, a cause of hurry and neglect in diagnosis and treatment; lack of out-patient facilities in the specialties, particularly in psychiatry; long waits caused by shortage of doctors; different physician seen on each visit; no relation between services in different departments; lack of appointment system and small waiting space; lack of privacy for examinations and history taking and for antisyphilitic medication; not enough night sessions for patients who can keep at work, especially for syphilis and gonorrhea patients; insufficient follow-up of patients to complete treatment; impossibility of getting all kinds of care in one institution and patients there forced to attend several dispensaries.

Medical social service.—Amount of service grossly inadequate and much of it ineffective in voluntary and municipal hospitals; lack of trained personnel prevents cooperative relation with social agencies.

Chronic sick.—Serious shortage of bed facilities; long waiting lists and delays in admissions, especially trying to the homeless; lack of appropriate dispensary care for ambulatory chronic patients; particular needs for advanced cancer, heart disease, syphilis, and tuberculosis; Negroes and children suffer most from lack of accommodations; superficial treatment in many homes for the chronic sick; poor facilities for religious, educational, and social training in institutions for children; difficulty in getting false teeth for the aged.

Convalescent care.—Not sufficient facilities for many who need it, especially for Negroes and Puerto Rican children; complicated situation for admission of dispensary patients and those who have no hospital or dispensary record; no place for the undernourished and debilitated; lack of organization rather than lack of good care; length of stay too restricted, especially for children; poor transportation facilities; unsuccessful follow-up on discharge.

Visiting-nurse service.—More nursing needed for chronic patients at home.

Home medical care.—Physicians needed for many nonpaying patients who do not need hospital care, cannot attend dispensary, and are not eligible for home relief; medical care needed where nurses are called and find no physician in charge; physicians needed for home maternity service, also for medical follow-up of patients after discharge from hospitals; for relief clients free eye and dental care is difficult to find, and special treatment (insulin) is lacking; delays and administrative hindrances to treatment; bad judgment on need of hospital care.

Maternity.—Overcrowding and insufficiency of beds for hospital care; prenatal examinations difficult to get without long delays, and then in a hurried way; too early hospital discharge; need home maternity service for normal multiparae; follow-up for return examination post partum not carried out systematically.

Mental disease.—General lack of dispensary service; psychiatric care needed in general hospitals; convalescent care for mental patients hard to get; need

of observation service for adults and children in general hospitals; difficulty in getting commitments unless patient is violent and therefore accepted by ambulance surgeon.

Tuberculosis.—Shortage of beds for active sputum patients; overcrowding of some dispensaries in Harlem and Bronx; inadequate facilities for pneumothorax treatment.

Syphilis and gonorrhoea.—More bed care for both diseases needed; crowded and careless out-patient services and lack of privacy; shortage of dispensary physicians; poor follow-up to complete treatment; lack of educational help to patients.

Cancer.—Low-cost hospital care needed; only one convalescent home accepts cancer; home nursing not adequate in frequency or duration.

Heart diseases.—Special wards needed, particularly for long time convalescent care of children; convalescent facilities insufficient, causing long delay after acute stage in hospital; need for home medical attention; X-ray and electrocardiographic service very costly.

Dental care.—Universal complaint of lack of facilities in dispensaries; long delays in getting treatment, even for ulcerated gums; limited scope of dispensary care.

Diabetes.—Lack of convalescent care; inability of patients to meet cost of insulin; difficulty in having insulin given to bed-ridden patients at home.

TABLE 43.—New and replacement hospital beds required in New York City to obtain the capacity projected for 1960. (Distributed according to type of medical service)

| Type of medical service | 1935 to 1940 | 1941 to 1950 | 1951 to 1960 | Total |
|---|---------------|---------------|---------------|---------------|
| General medical and surgical care: | | | | |
| Old beds to be replaced..... | 7,319 | 3,298 | 6,368 | 17,015 |
| New beds to be added..... | 2,813 | 5,300 | 6,800 | 14,913 |
| Total..... | 10,162 | 8,598 | 13,168 | 31,928 |
| Mental diseases:¹ | | | | |
| Old beds to be replaced..... | 125 | 201 | 3,889 | 4,278 |
| New beds to be added..... | 2,434 | 1,900 | 2,300 | 6,634 |
| Total..... | 2,579 | 2,161 | 6,189 | 10,929 |
| Tuberculosis: | | | | |
| Old beds to be replaced..... | 718 | 60 | 1,668 | 2,436 |
| New beds to be added..... | 2,632 | 400 | 400 | 3,352 |
| Total..... | 3,270 | 450 | 2,068 | 5,788 |
| Acute communicable diseases: | | | | |
| Old beds to be replaced..... | | 200 | 319 | 519 |
| New beds to be added..... | 216 | 200 | 200 | 616 |
| Total..... | 216 | 400 | 519 | 1,135 |
| All beds in New York City: | | | | |
| Old beds to be replaced..... | 8,192 | 3,800 | 12,244 | 24,245 |
| New beds to be added..... | 8,035 | 7,900 | 9,700 | 25,635 |
| Total..... | 16,227 | 11,600 | 21,944 | 49,780 |

¹ Exclusive of beds serving New York City patients but located in hospitals outside the city.

If definite building projects under way or planned for in 1935 are carried through, 5,200 of the added new beds required in New York City by 1940 will have been provided, leaving only 2,745 to be completed in other new projects before that date.

In addition to beds shown in the foregoing table, it is estimated that 20,280 new beds will be required in the area outside New York City, and that 8,904 of the present beds will have to be replaced.

If careful control is applied to prevent wasteful, superfluous, and competing capital outlay for hospitals, the following estimated investment in replacing and new building of hospitals will be required to meet the needs of the metropolitan area in the next 25 years.

TABLE 44.—*Estimated investment in property required for new and replacement beds projected to 1960*

| Region | 1935 to 1940 | 1941 to 1950 | 1951 to 1960 | Total |
|------------------------------|--------------|--------------|--------------|---------------|
| New York City: | | | | |
| Old beds to be replaced..... | \$62,944,500 | \$28,808,500 | \$78,379,500 | \$170,132,500 |
| New beds to be added..... | 50,547,200 | 63,870,000 | 60,170,000 | 200,887,200 |
| Total..... | 110,491,700 | 92,678,500 | 138,549,500 | 370,710,700 |
| Outside New York City: | | | | |
| Old beds to be replaced..... | 15,750,000 | 7,321,000 | 23,540,400 | 46,612,800 |
| New beds to be added..... | 32,975,100 | 40,010,000 | 46,610,000 | 119,705,100 |
| Total..... | 48,725,900 | 47,441,000 | 70,150,400 | 166,317,900 |
| Metropolitan area: | | | | |
| Old beds to be replaced..... | 78,695,300 | 36,130,100 | 101,919,100 | 216,745,300 |
| New beds to be added..... | 89,422,300 | 103,960,000 | 126,780,000 | 320,202,300 |
| Total..... | 168,217,600 | 140,120,100 | 228,699,000 | 537,037,600 |

It is estimated for the metropolitan area that it will be necessary to spend at the rate of approximately \$6,500 per bed for replacement of present hospital beds, and approximately \$7,000 per bed to construct new hospitals with the necessary additional beds; thus 40.4 percent of the total investment of \$537,037,600 will be needed for replacement and 59.6 percent for new construction before 1960. The heaviest burden of investment should be undertaken in the immediate future, at the present rate of approximately \$28,000,000 a year, to provide replacement of seriously obsolescent buildings and to provide beds for tuberculous and mental patients.

For New York City, replacement cost per bed is estimated at \$7,000 and new construction at approximately \$7,850, while for the outside area the comparable estimates are \$5,200 and \$5,800 respectively.

The following table offers estimates of investment required for new and replacement beds in three stages to 1960 for New York City.

TABLE 45.—*Estimated investment in property required for new and replacement beds in New York City projected to 1960 (according to type of medical service)*

| Type of medical service | 1935 to 1940 | 1941 to 1950 | 1951 to 1960 | Total |
|------------------------------------|--------------|--------------|--------------|---------------|
| General medical and surgical care: | | | | |
| Old beds to be replaced..... | \$58,792,000 | \$20,384,000 | \$50,944,000 | \$130,120,000 |
| New beds to be added..... | 26,442,200 | 49,820,000 | 63,920,000 | 140,182,200 |
| Total..... | 85,234,200 | 70,204,000 | 114,864,000 | 276,302,200 |
| Mental diseases: ¹ | | | | |
| Old beds to be replaced..... | 862,500 | 1,174,500 | 17,500,500 | 19,237,500 |
| New beds to be added..... | 13,497,000 | 10,450,000 | 12,630,000 | 36,597,000 |
| Total..... | 14,059,500 | 11,624,500 | 30,130,500 | 55,834,500 |
| Tuberculosis: | | | | |
| Old beds to be replaced..... | 3,590,000 | 250,000 | 8,340,000 | 12,180,000 |
| New beds to be added..... | 15,312,000 | 2,400,000 | 2,400,000 | 20,112,000 |
| Total..... | 18,902,000 | 2,650,000 | 10,740,000 | 32,292,000 |
| Acute communicable diseases: | | | | |
| Old beds to be replaced..... | 1,000,000 | 1,595,000 | 2,595,000 | 2,595,000 |
| New beds to be added..... | 1,290,000 | 1,200,000 | 1,200,000 | 3,690,000 |
| Total..... | 1,290,000 | 2,200,000 | 2,795,000 | 6,291,000 |
| All beds in New York City: | | | | |
| Old beds to be replaced..... | 62,944,500 | 28,808,500 | 78,379,500 | 170,132,500 |
| New beds to be added..... | 50,547,200 | 63,870,000 | 60,170,000 | 200,887,200 |
| Total..... | 110,491,700 | 92,678,500 | 138,549,500 | 370,710,700 |

¹ Exclusive of investment in beds in hospitals serving New York City but located outside the city.

Senator ELLENDER. Are there any further witnesses, Senator Wagner?

Senator WAGNER. None today, I believe.

Senator ELLENDER. Then the committee will stand in recess until May 11 at 10 o'clock.

(Whereupon, at 3:10 p. m., a recess was taken until 10 a. m., Thursday, May 11, 1939.)

TO ESTABLISH A NATIONAL HEALTH PROGRAM

THURSDAY, MAY 11, 1939

UNITED STATES SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in the Education and Labor Committee room, Senator James E. Murray, presiding.

Present: Senators Murray (chairman), Ellender, Hill, and La Follette.

Also present: Senator Wagner.

Senator MURRAY. The subcommittee will be in order.

STATEMENT OF LEE PRESSMAN, REPRESENTING THE CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. PRESSMAN. The C. I. O. is wholeheartedly in support of this bill. This bill has its enemies and its friends. Its friends include organized labor, progressive organizations, associations of farmers, women's clubs, progressive public officials, and millions of citizens throughout the country. These friends are the people who believe that the American people at the present time do not receive adequate medical care and that the time has come for action to remedy this intolerable condition.

The enemies of the bill consist of a handful of reactionaries. They are people who believe that no matter how bad things are, nothing should be done about them unless it is done by the people who have done nothing about them in the past. The people who oppose this bill are those who oppose the expenditure of public funds to take care of public needs. They are the people who distrust the processes of democratic government and who doubt that the American people are able to make responsible decisions to take care of themselves.

We do not think it is necessary at this time to restate the facts concerning the health of the American people. These facts have been completely analyzed and set forth in the studies made by the Inter-departmental Committees to Coordinate Health and Welfare Activities. It is useless to use these facts with those who oppose this bill because they blandly ignore the facts.

In presenting our testimony in support of this bill we should first like to meet the objections that have been made and then briefly set forth certain suggestions which we believe would improve the bill.

At the C. I. O. convention in Pittsburgh in 1938, Miss Josephine Roche explained the recommendations of her committee, which this

bill would carry out. The convention proceedings show that at the end of her address: "The delegates and visitors arose and applauded the address of Miss Roche enthusiastically for several minutes." Mr. Thomas Kennedy, secretary-treasurer of the United Mine Workers of America, who was acting as chairman of the convention at that time, stated:

After this wonderful demonstration it is hardly necessary for me to say to Miss Roche that this convention appreciates the splendid constructive thought-provoking address delivered to it this morning. My friends, your reaction to this address is a bid to Miss Roche to carry on in her great work, with the assurance that the Congress of Industrial Organizations will back her up in every particular in carrying on the great work of the President's Committee on Public Health and Welfare.

The convention then passed a resolution which stated as follows:

Resolved, That the C. I. O. wholeheartedly endorses the program of President Roosevelt's Committee on National Health, and urges that immediate action be taken on each of the recommendations made by that committee providing for—

- (a) Extension of existing public health services for so-called social diseases such as tuberculosis, pneumonia, syphilis, and for maternity and child health care, and industrial hygiene;
- (b) Federal subsidies for the construction of hospitals;
- (c) A system of free medical care for families with no income or insufficient incomes to pay for adequate medical care;
- (d) A system of health services which will provide medical care for all of the American people;
- (e) A system of disability benefits for unemployment due to ill-health.

I would like to place this resolution in the record together with the resolution of the C. I. O. convention on industrial hygiene and the C. I. O. resolution setting forth certain general principles dealing with social security along these lines.

(The resolutions are as follows:)

RESOLUTION NO. 31. INDUSTRIAL HYGIENE

Whereas 20,000,000 persons gainfully employed in the United States in the manufacturing and chemical industries and the extraction of minerals, are by reasons of their occupations subject to conditions which cause occupational diseases and increase the incidence of ill-health: Now, therefore, be it

Resolved (1) Appropriations for Federal and State public health services be increased so that methods of control and prevention of occupational diseases may be devised which may then be introduced, backed by necessary legislation;

(2) Workmen's compensation laws be extended to include the many occupational diseases which at the present time are not so covered; and

(3) In order to take care of the ill health of the workers which will continue despite full preventive measures and coverage under workmen's compensation, the program for general medical care of the American people proposed by the President's National Health Committee be put into effect immediately.

RESOLUTION NO. 35. GENERAL PROGRAM OF SOCIAL SECURITY

Whereas the passage of the Social Security Act marked the establishment of the fundamental principle that the American people are entitled, as a matter of right, to a system of adequate protection against the hazards of modern industrial life which leave the worker to the mercies of unpredictable unemployment, old age, and ill health. Much remains to be done to simplify and improve the unemployment compensation laws, to increase the amount of old-age benefits, to make additional appropriations for assistance to needy, blind, and handicapped persons, and to institute a general public-health program. The future of the social-security system will depend upon the principles that guide its development: Now, therefore, be it

Resolved. That the C. I. O. considers the following principles must be adhered to in any system of social security:

(1) That the coverage of the laws be extended to include all sections of the population such as farmers, office and professional workers, employees of State and municipal agencies, seamen, domestic and agricultural laborers;

(2) That in the development of the social-security system, immediate needs be fulfilled upon the basis of minimum benefits adequate to provide a decent standard of living;

(3) That in the administration of the system, organized labor secure complete representation;

(4) That the funds for the payment of social-security benefits be derived from general taxation upon the accumulated wealth of this country, rather than from pay roll and income taxes upon the workers themselves.

Mr. PRESSMAN. As evidence of the interest of C. I. O. in this matter, a national committee on social security was established, and I am authorized to state for this committee that it has found among the workers throughout the country a strong and insistent demand for the passage of this legislation.

The chief objections to this bill have come from certain officials representing the American Medical Association. We would like to point out that the American Public Health Association composed of physicians and the Committee of Physicians for the Improvement of Medical Care appeared in favor of the bill. The article by Dr. J. N. Baker, of the American Medical Association, in favor of this bill is further proof that a substantial number of doctors in this country are in favor of the bill.

We believe that the opposition of Dr. Booth to this bill merely represents the opposition of a small group of officials of the American Medical Association. We have no quarrel with the doctors of this country.

After noting the principles of public health adopted by the special assembly of the American Medical Association of September of last year, we were surprised to read Dr. Booth's testimony opposing this bill in its entirety.

Senator ELLENDER. Mr. Pressman, in that connection, and in justice to Dr. Booth, I think that the main objection that he urged to the measure in September was based on the proposition that there may be forced contributions to maintain this work.

Mr. PRESSMAN. You mean forced contributions from workers?

Senator ELLENDER. I mean forced insurance contributions.

Mr. PRESSMAN. He claims, as I understand it, that this bill in effect does the same.

Senator ELLENDER. You are a lawyer—and I understand a very good one—and I am sure that you have read the present bill very carefully. Is there anything in the bill that would lead you to believe or is there anything in it to intimate that this would lead us into forced insurance?

Mr. PRESSMAN. I do not think any provision in the bill, Senator, gives any basis for that feeling or that supposition.

Senator ELLENDER. I think that was the main opposition at that September meeting to which you have just referred.

Mr. PRESSMAN. I understand in his testimony he intimated or stated that he thought this bill would lead to that.

Senator ELLENDER. But he acknowledged that he had not read the bill throughout and had not studied it, and as a matter of fact he was not familiar with all of its details and that he would probably present the views of the association after it met in St. Louis on the 15th of this month.

MR. PRESSMAN. I would like to address myself to four principal objections that Dr. Booth set forth, because he probably reflects or indicated the arguments that will undoubtedly be used by those who may oppose the bill.

Dr. Booth raised four principal objections to this bill. He claims that the bill does nothing about furnishing adequate food, clothing, and shelter to the American people but only provides for furnishing them medical care. There is perhaps no one more concerned with adequate food, clothing, and shelter for the American people than the C. I. O., but we are also in favor of this bill. We suppose that this bill is only concerned with improving the medical care of the American people and that it leaves to other agencies and other activities the problem of supplying other wants.

We call the attention of the committee to the study made by the Bureau of Cooperative Medicine on Medical Care in Selected Areas of the Appalachian and Bituminous Coal Fields. Many miners told the investigators, and I quote from the report: "An improvement in medical conditions would mean more to us than a raise in pay." We think this sufficiently answers Dr. Booth's first objection.

Dr. Booth's second objection is that this bill was inspired by Federal agencies. If Dr. Booth meant by his statement that the bill was of Federal origin and did not come from the consciousness of labor's needs by labor itself, he has failed to read the speeches made at the National Health Conference in July of 1938.

If Dr. Booth means to imply that the Federal Government has provided the experts who have furnished us with the correlated studies and statistics, we say that this contribution by the Federal Government to the welfare of the American people is precisely one of the things that makes the New Deal a progressive force in this country.

Dr. Booth's third objection to this bill is that it would lead to governmental interference with medical care which would degenerate into political corruption and bureaucracy. Dr. Booth simply distrusts the democratic processes. He even went so far as to fear that mothers and infants receiving the services provided for in title V of this bill would take money to which they had no right. The challenge which Dr. Booth has given to the responsibility of the American people will be met by organized labor. We are prepared to meet it and we think that Dr. Booth's objection in this respect should be relegated to the obscurity which it merits.

The fourth objection made by Dr. Booth was that this bill would call for the expenditure of public funds at a time when the country can ill afford it. This is the one objection to this bill which we are warned may prevent its passage at this session of Congress. But at the same time it is the one objection which, frankly, we can least understand. The facts covering medical care convincingly demonstrate that the investment of \$100,000,000 or \$300,000,000 in the health of the American people would repay itself a hundredfold.

The Federal Government will appropriate this year at least \$1,800,000,000 for building battleships and guns and military equipment. We think it can also appropriate for this year \$90,000,000 to take care of the health of the people.

As for the future, we see no reason why the Government cannot now undertake to increase its health program so that by 1942 it will be spending about \$234,000,000. When the time comes that we cannot assume that this country is going to increase and expand the social services which it provides for the masses of the people, it will be time to consider more radical measures for the reconstruction of our economic society than this bill proposes.

Finally, Dr. Booth asserts that if there is to be any medical program it must be completely in the hands of doctors such as himself without any participation by the people who are to receive the benefits. We believe that any medical program will require the closest cooperation from the doctors of the country, and that the doctors of the country will give that cooperation. But by the same token, we say that the American people and organized labor are entitled to representation and responsibility in the administration of a program for improving the medical care of the American people. We are willing to give that cooperation and assume that responsibility.

I should now like to present some suggestions which we believe may lead to improving this bill.

First. We want to make it clear that we have a general criticism to make in regard to the entire bill; that is, that it does not by any means go far enough.

Comparing the provisions of the bill with the needs for medical attention and medical care as set forth in the reports of the inter-departmental committee, we do not think that really the provisions of this bill meet those needs.

Senator ELLENDER. Do you mean as to the amount of money?

Mr. PRESSMAN. Exactly.

Further, it does not prescribe sufficient Federal standards; it does not offer a specific program for health services to the entire population which needs the medical care. We realize that the failure to embark on a more comprehensive and specific program is in part due to the opposition of the reactionary officials of the American Medical Association, such as Dr. Booth. We realize further that we must accept this bill as a beginning, while we pledge ourselves to continue every effort to expand it.

As to the problem of industrial hygiene: We recommend that a separate title be added to the bill which would provide for Federal grants-in-aid to the States which carry out measures for removing the causes of occupational diseases. In many States, the State department of labor is in a position to prescribe measures to be introduced in industries that will tend to eliminate occupational diseases. This kind of a program is to be distinguished from the general medical investigation in the occupational diseases and industrial hygiene such as is provided for in section 611.

In other words, in section 611, the general problem of medical investigation into such problems as industrial hygiene and occupational diseases is taken care of, but the entire major problem of providing for specific State programs to receive Federal aid for the elimination or the introduction of procedures for the elimination of occupational diseases is not taken care of.

Our suggestion has rather to do with what we might call the mechanics of industrial hygiene, the various devices and methods of

carrying on operations in plants that would tend to reduce the ill health that is directly due to the occupations in which workers must engage.

Next, in regard to extension of public health work: One of the defects in the present social-security system is the absence of any guarantees in the administration of the various benefit schemes against discrimination of any kind, whether due to race, color, creed, or political beliefs, union activity, or otherwise. We think this standard should be placed in the Federal law in each of the titles of this bill as a requirement with which the States must comply.

In regard to Federal supervision over administration: At the National Health Conference the C. I. O. took the position that a health program should be organized on a Federal basis. While everyone concedes that this would be an ideal situation, this bill makes an obvious compromise and sets up the program upon the basis of Federal grants-in-aid to the States, leaving the primary responsibility to the States. However, there is one step which could be taken which would be extremely helpful. At the present time the only control which the Federal Government has, to see to it that the States comply not only with the Federal law, but with the standards in the State law, is for the Federal Government to cancel the Federal grant. Unfortunately, this type of control is extremely difficult to enforce because it is the kind of a remedy that kills the patient in an attempt to cure him.

As a matter of practice, under the existing social-security laws, where a few State officials have decided to carry out their responsibilities in an improper way, the penalty of withdrawing Federal funds does not affect them but only affects the hundreds of beneficiaries in that State. It has been a practically impossible penalty to enforce. We urge that instead, the Federal agency should be given the power to actually administer for a temporary period the State plan where the State officials fail to comply with Federal standards. This would mean that the program would continue without injury to its beneficiaries while the evils are corrected. We had precisely that problem in the Social Security Act in connection with the administration of old-age pensions in the State of Ohio.

Senator MURRAY. What about the legality of such a provision?

Mr. PRESSMAN. Mr. Chairman, we had that very type of a law enacted by Congress in 1933 when the first relief act was enacted creating the Federal Relief Administration, which we called at that time the F. E. R. A., which provided in effect that the Federal Government should give grants to the States having administration relief. There was a provision contained in that act that wherever the Federal Administrator discovered after investigation that the administration of relief was not being done in the proper fashion, that he had the authority to establish in that State a Federal administrator. During that entire history of the F. E. R. A., which lasted from 1933 to 1935, when there was established the Works Progress Administration, I believe all told that the Federal Administrator had to establish Federal administration in the States in about 3 or 4, a maximum of 4, out of 48 States, indicating that such a provision does not lead to Federal administration ad lib but permits the type of control that avoids the situation that we have where the Federal Government has the alternative of either going

along with maladministration in the States or eliminating the grants, thereby actually doing injury to the beneficiaries, who have nothing to do with the maladministration.

In regard to health insurance: This bill generally tends to extend the health services for the so-called medically indigent. It contains no specific provision, and only in a general way, provisions for extending medical care to those who are not indigent but who are unable to pay for medical services at their present prices. Dr. Booth objects to this bill because he fears that it will lead to health insurance. Frankly, if we have any objection to this bill, it is because it does not provide for extensive health insurance.

Within the limitations of this bill there is one change which should be made in title XIII. Section 1304 now imposes a limitation of \$20 as the maximum benefit which each individual may receive in medical care to which the Federal Government will make a contribution. The bill adopts the principle of variable grants, with which we are in favor, in order to provide the poorer States with more money, and it is only fair that there should be no limitation upon the amount of benefits which the richer States may pay and still receive the Federal subsidy.

In regard to temporary disability: It is extremely important to note that this provision of the bill providing for temporary disability suffers from the same absence of sufficient Federal standards for the amount of benefits and their duration. We think there should at least be a provision for a minimum benefit amount and a guaranty that the sums will be paid so long as the person is entitled to them, under the theory and concepts of temporary disability. In view of the fact that this bill does not impose any Federal taxes as does the unemployment compensation system, we see no reason why the term "employment" must exclude any class of workers. Surely if a State should decide to include domestic or agricultural workers, there is no reason why the Federal Government should refuse to subsidize that program.

In conclusion: Ever since the interdepartmental committee submitted its report to the American public and ever since the National Health Conference, in July 1938, all sections of the American public have made clear their desire for immediate action on the problem of national health, and there has been a demand for some specific legislation. S. 1020 marks a fulfillment of the promises of the interdepartmental committee report and of the National Health Conference, subject to a few of the suggestions that we have made. However, it is only a beginning. Experience will show the necessity for more Federal standards as we continue with this program. The record shows that each year 70,000,000 sick persons lose more than 1,000,000,000 days from work; that industrial workers die at least 8 years sooner than nonindustrial workers; that over 1,000,000 workers are exposed to the hazards of silicosis; that 35 percent of those on relief had no doctor's care when they were seriously ill last year; that 50,000,000 Americans are in families that have less than \$1,000 a year income—sickness and death rates increase as incomes go down; that at least 62 percent of the workers do not have proper health protection on the job; and that two-thirds of the rural sections of America have no child-health centers or clinics.

For all these reasons we strongly urge favorable and immediate action at this session of Congress on this bill.

Senator MURRAY. Mr. Pressman, you are very familiar, I assume, with the extent of industrial diseases in the country. Is there a serious effort being made now in the various industries to overcome those conditions?

Mr. PRESSMAN. In only a few States, Mr. Chairman, has any serious effort really been made by some State labor departments.

Senator MURRAY. Is it not true that many of these industries are voluntarily undertaking to cope with those conditions?

Mr. PRESSMAN. In a few industries; yes.

Senator MURRAY. Haven't they made very excellent progress in overcoming the diseases in some instances?

Mr. PRESSMAN. Oh, yes. In several industries, the management has undertaken to really start to introduce processes for the elimination of these industrial diseases, but we must recognize that during the past several years, with the difficulties that industry has had and the economic distress that we have had, that one of the first things which they mark off from their operating costs is this very problem that we are now talking about, that is, the expenditure of funds for this kind of thing.

Senator MURRAY. These industrial diseases have developed in various industries of the country, and account in a very large measure for the need of medical care among that class of people?

Mr. PRESSMAN. That is true.

Senator MURRAY. And if those methods were developed and carried out by the various industries, it would contribute very largely to curing the situation?

Mr. PRESSMAN. That is right.

Senator MURRAY. Thank you for your statement.

Senator WAGNER. May I ask a question?

Senator MURRAY. Certainly, Senator.

Senator WAGNER. Did you notice in the papers this morning that there was an account of a discussion among the Federated Women's Clubs of America, and after a discussion of this very pending legislation, those women representing not merely industrial workers but the general subject of health, by an overwhelming majority favored the enactment of this legislation and pointed out that particularly in the rural areas, there was a terrific lack of medical care, not only of chronic illness, but many cases which they said by proper medical care could have been prevented. That is a very prominent public body, that is, public in the sense of being interested in public questions, and they endorsed this bill.

Mr. PRESSMAN. Mr. Senator, I would like to say that I do not think that there is any other problem that really has such an overwhelming sentiment in favor of legislation of this description to meet that problem as this health situation. I think the opposition to this bill is just absolutely negligible, and it is probably confined to a few individuals who may appear from the hierarchy of the medical associations, and contribute the same performance of Dr. Booth.

Senator WAGNER. You were asked by the chairman as to the efforts of States to deal with this problem. I notice in some of the States,

and I know it is so in New York, that they have increasing groups which may be compensated for occupational diseases, but that is only a small phase of this particular matter.

Mr. PRESSMAN. That is right.

Senator WAGNER. But insofar as these compensations that are given for occupational diseases, the employers in many cases have been somewhat more astute to prevent the occupational diseases, because the premium which they pay depends, of course, upon their experience, and thus if they can reduce the occupational diseases in their particular industry, it is an economic proposition, besides being a humanitarian proposition.

Mr. PRESSMAN. Senator, before you arrived, I made a suggestion that there might well be incorporated an additional title which would provide for the Federal grants-in-aid to States which have programs for taking care of the subject of industrial hygiene specifically, and it was in reference to that that I was asked a question as to some States having actually initiated some program of meeting the problem of industrial hygiene. We ought to encourage that very thing by having this kind of Federal grants-in-aid programs.

Senator WAGNER. I have been told that as the State enlarges the number of groups that may be compensated, so do our occupational diseases diminish.

Mr. PRESSMAN. That is right.

Senator THOMAS. Is this the Dr. Booth that said something about the desert out in Utah?

Mr. PRESSMAN. Yes.

Senator THOMAS. I would just like to tell him that it just happens that probably the two highest authorities on the public health in the whole United States today are men who were born on that desert out in Utah, and that the desert having produced those two men, it can rest quite contentedly for some time by doing what it has done for public health in America. I cannot help but say that, Mr. Chairman, because evidently that Utah desert is going to be the thing which we are going to discuss and not the public-health bill.

Senator MURRAY. The next witness is Dr. C. L. Palmer.

STATEMENT OF DR. C. L. PALMER, REPRESENTING THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA

Dr. PALMER. I have no prepared statement, but I am prepared, however, to hand the committee some items of interest as to the work that is going on in Pennsylvania.

I come here, gentlemen, representing the Medical Society of the State of Pennsylvania, and as such I expect to be linked with those that are opposing this measure.

Now, you have a measure here based upon the report of the technical committee under the interdepartmental committee, which has a very enticing, sincere, and enthusiastic title. It provides for the general public welfare in order to enable the several States to provide for more adequate provisions for the public health service, the treatment and cure of diseases, child and maternal health service, care of sickness, the building and maintenance of needed hospitals, disability insurance, and so forth.

Now, that is a very plausible, a very enticing title, but there is in this measure considerable room for controversy as to its effect upon the Government of the entire United States. It provides for an appropriation in 1940 of about \$8,000,000 for maternal and child-health service, and in 1941, \$20,000,000, and in 1942, \$35,000,000, and thereafter sufficient to meet the needs of the purposes of this measure.

At the present time, under the present Social Security Act, the Federal Government is spending \$3,800,000 for this purpose. The State of Pennsylvania has received their share according to the pro-rata amount.

The Pennsylvania State Department of Health has a maternal and child-health service with 167 well-baby clinics, and 7 prenatal clinics.

In Pennsylvania we have in addition 387 child clinics under the supervision and sponsorship of private organizations.

In addition to that, the bill provides for crippled and physically handicapped children to the extent of \$13,000,000 the first year, \$25,000,000 the second, and \$35,000,000 the third, and thereafter enough to meet the needs.

At the present time under the present Social Security Act, the Federal Government is spending about \$3,800,000 for maternal and child-health service and about \$2,850,000 for crippled children.

We have in Pennsylvania a crippled children's division of the department of health with a well-equipped accredited hospital at Elizabethtown, taking care of many thousands of patients. We have in addition, 11 zones in Pennsylvania that are headed by recognized orthopedic surgeons for the purpose of diagnosing and operating upon these indigent children.

We have arrangements made through various social agencies and the department of public health provisions for gathering these children up throughout the State and bringing them to these diagnostic clinics.

We have received some of the contributions from the Federal Government in addition to matching them according to the Social Security Act. Then we have an addition for public-health extension work in this measure, in the neighborhood of \$15,000,000 for the first year, \$25,000,000 for the second, and about \$60,000,000 for the third.

At the present time the Federal Government is spending \$8,000,000 under the present Social Security Act. We have received some help along that line and have a conservation of health bureau in our State department of health, which is operating very satisfactorily in State epidemics and sanitation and in the State quarantine regulations, and so forth and so on, and the training of personnel which is already provided.

Then, in this measure that you have before you today, you have for hospitals, needed hospitals as it is expressed sincerely in the bill, an appropriation of \$8,000,000 for the first year, and I believe \$50,000,000 the second, and \$100,000,000 the third year, and I believe enough thereafter to meet the needs.

Then you have provisions in this measure for \$35,000,000 appropriation for the care of the indigent sick and \$10,000,000 for the creation and development of a rather vague type of disability insurance in the States, but nevertheless coupled with that hidden coercive factor of granting to the States this money under Federal supervision.

Now, all in all, there are provisions in the measure which are comprehensive and very many of them vague, very many of them are of such a nature that regulations and rules could be made that would destroy a great many of the beneficial things that are going on now in health. In other words, in Pennsylvania we have a system of care for the indigent under our department of public assistance, in which we expect to spend \$2,100,000 for the coming biennium. I shall be glad to give you a careful and brief description of this work in Pennsylvania.

Senator ELLENDER. Doctor, before you go into that phase of it, you stated that various departments in Pennsylvania have received from the Social Security their pro rata share of certain funds which are furnished by the Government. Does that fund have any tendency to destroy the aims and purposes of the State health department?

Dr. PALMER. No; but it has the very definite tendency, Senator, to be coupled with the fact that the Federal Government wants to send in people to direct these activities for the State of Pennsylvania. We have had that, and we have it right now, and that of course is provided for in the law.

Senator ELLENDER. Can you point out any action in the law to show that these various State institutions that are now being maintained by the States will be under Federal control?

Dr. PALMER. We have it right now. We have the United States Public Health Service man in Pennsylvania supervising pneumonia control, and we do not need it in Pennsylvania. We have plenty of medical men, and we have the Medical Society of the State of Pennsylvania, and have operated for many years and have brought the State of Pennsylvania to the level where it is at the present time.

Senator ELLENDER. You say that you are president of the Pennsylvania Medical Association?

Dr. PALMER. No; no; I am chairman of the committee on public health legislation of the Medical Society of the State of Pennsylvania.

Senator ELLENDER. Is this medical society affiliated with the American Medical Association?

Dr. PALMER. Yes; it is.

Senator ELLENDER. It is one of its members?

Dr. PALMER. As I said in the beginning, I am here lined up with the medical profession in opposition.

Senator ELLENDER. You read Dr. Booth's statement, did you not?

Dr. PALMER. No; I did not read Dr. Booth's statement.

Senator ELLENDER. Is not one of the underlying oppositions of the medical profession that the doctor's revenues may be in some way curtailed?

Dr. PALMER. Not at all; not at all; our revenues will be increased.

Senator ELLENDER. So that that argument—if any there be—there is nothing to it?

Dr. PALMER. In my opinion, there is nothing to it.

Senator ELLENDER. In other words, you feel that the opposition of the doctors of this country is not based on the probability that if this program goes through as planned, that it will not affect their pocketbooks?

Dr. PALMER. It will affect them in this way—that it will improve their financial return.

Senator ELLENDER. How do you figure that?

Dr. PALMER. Well, because there will be certain systems set up where they will be sure of getting paid, to a certain extent. We are not concerned with our financial return in any way; we are concerned with the effect of these measures upon State supervision, upon State rights, and upon the general Government. That is what we are concerned about.

Senator ELLENDER. Suppose that we should amend this bill so as to make it certain that the money will be furnished to the States and be spent under their own management, would that make you change your mind as to this bill?

Dr. PALMER. No; that sounds very nice; but wherever there is money concerned, there are always strings that more or less always tie it in.

Senator ELLENDER. Would you say that the Public Health Service rendered by the Federal Government under Dr. Parran has been a failure or has had a tendency to make the doctors of the Nation make more money?

Dr. PALMER. Of course, the United States Public Health Service has not been a failure. We admit the good work that the United States Public Health Service has done, but it has got plenty to do in Washington.

Senator ELLENDER. What is that?

Dr. PALMER. It has plenty to do in Washington.

Senator ELLENDER. In what respect has it failed in any way, do you know?

Dr. PALMER. I do not say that it has failed; but there is room for improvement in Washington, according to the statistics of your health findings here.

Senator MURRAY. You mean in the District of Columbia?

Dr. PALMER. In the District of Columbia.

Senator WAGNER. Do you think that their activities ought to be confined to the District of Columbia?

Dr. PALMER. No; I do not think so, but I do not think that they should go out to the States where they have recognized and able departments of health, and through these financial means try to supervise these State departments of health. That loses State rights and State identities—in a subtle sort of a way.

Senator WAGNER. Is it your view that your State should not have accepted any Federal aid at all—financial aid?

Dr. PALMER. We did not need any Federal aid. We accepted it because of the natural trend of the public to think that we should have it, but we have maintained all the way through until the recent time that we should have the administering of these departments as they have been done without any administration on the part of the Federal Government.

Senator WAGNER. You mean you accepted it against your will?

Dr. PALMER. No; we did not accept it against our will, exactly, but we did accept it with the provision that we manage it as we have managed it, but we can see in it a tendency all the way through to have it managed by Federal agencies.

Senator WAGNER. Would you do away with the aid which is given under the social-security law to the States?

Dr. PALMER. Now, when you ask me that, it gives me an opportunity to suggest something here. In a democracy such as we have,

we have a rather sick individual in Uncle Sam. Everybody admits that. He is suffering from economicitis and politicalitis. That has resulted in a very marked anæmia. His financial circulation is very low. According to statistics, he is in the red.

Senator THOMAS. Do you think Uncle Sam is worse off than Russia, for example?

Dr. PALMER. How is that?

Senator THOMAS. I asked you if you think that Uncle Sam is worse off than Russia, for example?

Dr. PALMER. I think the United States is better off than Russia as far as health is concerned.

Senator THOMAS. Worse off than Germany?

Dr. PALMER. Better off than Germany.

Senator THOMAS. Worse off than China?

Dr. PALMER. Better off than China.

Senator THOMAS. Worse off than Japan?

Dr. PALMER. Better off.

Senator THOMAS. Worse off than France?

Dr. PALMER. Better off.

Senator THOMAS. Worse off than Italy?

Dr. PALMER. It has the best—to cover the whole question—it has the best mortality and morbidity rates in the world under present systems.

Senator THOMAS. Now, may I ask this question—

Dr. PALMER (interposing). Senator, excuse me. That is admitted right in the President's address of January 1939—and admitted by all of the authorities—in which he says that it is very gratifying—or words to that effect—that it is very gratifying to know that the length of life has increased in our country and that the average level of health has increased. It is admitted right in the first sentence of the technical committee report.

Senator THOMAS. I am happy over that, as you are, but these two questions come naturally to my mind. If Pennsylvania has been doing so well, was the average person drafted in the World War from Pennsylvania on a higher average of health than any other State?

Dr. PALMER. I would not say that; no.

Senator THOMAS. Let us come down to modern times. Was the average boy who came into the C. C. C.—did he reflect the fine health that you have in Pennsylvania so that he stands out above the average of the boys from the other States?

Dr. PALMER. I don't know anything about the health records of the C. C. C., but I do know the workings of the State department of health, and I know the workings of the other agencies in Pennsylvania, but I can give you no statistics about the state of health of the boy when he went into the C. C. C.

Senator THOMAS. I assume, of course, that Pennsylvania must have an outstanding record from what you state.

Dr. PALMER. We believe we have a pretty fair record.

Senator ELLENDER. Doctor, how many hospitals are there in Pennsylvania that are maintained entirely out of State funds?

Dr. PALMER. There are only about 10 or 12, Senator.

Senator ELLENDER. How many beds?

Dr. PALMER. Well, I would say in the neighborhood of 600 or 800 beds in all of them.

Senator ELLENDER. Six or eight hundred beds?

Dr. PALMER. Yes.

Senator ELLENDER. What is the population of Pennsylvania?

Dr. PALMER. Ten million people.

Senator ELLENDER. How many hospitals have you that are maintained entirely by counties and by municipalities?

Dr. PALMER. We do not have very many hospitals maintained entirely by counties and municipalities, but we have 800 hospitals that accept, some of them, partial State aid and private aid.

Senator ELLENDER. Who maintains those?

Dr. PALMER. Private agencies, mostly, with the acceptance of some State appropriation.

Senator ELLENDER. Where do those private agencies secure their funds?

Dr. PALMER. From the community funds and from the general public, through various avenues.

Senator ELLENDER. Is there any kind of insurance provided for so as to maintain some of these hospitals?

Dr. PALMER. Well, there is insurance provided for in the group-hospitalization plan, but that does not necessarily maintain the hospitals; it helps.

Senator ELLENDER. Is it your view that Pennsylvania has done enough for its indigent people in that respect?

Dr. PALMER. No; they have not done enough. We can always do more.

Senator ELLENDER. Why has it not done that in the past?

Dr. PALMER. How is that?

Senator ELLENDER. Why has it not done it in the past?

Dr. PALMER. We have met the circumstances as they arise.

Senator ELLENDER. Judging from your statement—that the great State of Pennsylvania, which I suppose is rich in natural resources, or as rich as any State in the Union, can boast of only 800 beds maintained by the State—I say that you have made a failure.

Dr. PALMER. You may think so, but those State hospitals are largely owned by the State; they are largely in the mining districts. Now, there are 300 hospitals—

Senator ELLENDER (interposing). I may digress here to say that in our little State of Louisiana, since 1928—we had prior to that time two fine charity hospitals maintained by the State—today we have seven maintained by the State.

Dr. PALMER. Entirely?

Senator ELLENDER. Yes; entirely maintained by the State out of public funds. The Charity Hospital in New Orleans was rebuilt, is now practically completed, and was erected at a cost of about \$14,000,000, with 2,500 beds in it, all to be maintained by the State. We have one at Shreveport with 1,000 beds, all maintained by the State, and others in different sections of our countryside, and besides that we have 10 dental clinics maintained by the poor State of Louisiana. Now, compare that with the great State of Pennsylvania, and I do not think that you have gone anywhere. What we are trying to do is to encourage you to do more for the indigents of your State.

Dr. PALMER. That is true.

Senator ELLENDER. And I think this bill might do it.

Dr. PALMER. I do not agree with you.

Senator WAGNER. Doctor, you said a moment ago that you are being overrun now by Federal inspectors, or something to that effect?

Dr. PALMER. No; I did not say we were being overrun, but we have now individuals coming in there who are supervising certain plans or certain activities, and what we have done there previously, what we have been able to supervise ourselves very effectively.

Senator WAGNER. You mean where Federal money is being spent?

Dr. PALMER. How is that?

Senator WAGNER. Where Federal money is being spent?

Dr. PALMER. Yes.

Senator WAGNER. Do you know whether they imposed themselves on the State, or are they requested by the State?

Dr. PALMER. It has been my experience that they have been coming in there without being asked in some instances, at least, in the past.

Maybe this one at this time has been asked for—I don't know—but in the past it has been my experience that they have come in.

Senator WAGNER. My information is, and I have always thought, that the contrary is true; and I think Dr. Parran is in the room. May I ask him, Mr. Chairman?

Senator MURRAY. Yes.

Senator WAGNER. Is Dr. Parran here?

Dr. PARRAN. Yes.

Senator WAGNER. May I ask a question?

Senator MURRAY. Certainly.

Senator WAGNER. Dr. Parran, when you send investigators or medical assistants into a State, is that at the request of the State that you do that?

Dr. PARRAN. Yes, Senator; the witness has referred to an officer of the Public Health Service, a doctor who is in the State of Pennsylvania supervising the development of the pneumonia control program. He is there because the State health director of Pennsylvania made a personal visit to Washington to request that he be sent there, and that visit was followed up with a letter, which I should be glad to submit for the record, asking that he continue there.

Senator ELLENDER. What authority has he over the affairs of the State insofar as health is concerned?

Dr. PARRAN. He acts entirely under the direction of the State health commissioner.

Senator MURRAY. Have you received any complaints from the State criticizing his activities in any way?

Dr. PARRAN. None at all except the complaint I here hear this morning.

Dr. PALMER. May I say something? May I ask something here?

Senator MURRAY. You may ask any questions that you desire.

Dr. PALMER. Thank you. How about the individual doctor who was sent into the State of Pennsylvania by the United States Health Service to make a survey and to use industrial plant employees in Pittsburgh, that is, employees of those plants, as guinea pigs as to a serum for pneumonia?

Dr. PARRAN. In response to that, the Public Health Service has broad authority to investigate diseases of man and the conditions pertaining thereto. As a part of the program of pneumonia study,

a number of areas were selected for testing the value of the serum. The value of the serum which has been referred to has proven to be very great. I think most of you are familiar with the reports which have come from the reports of results in the Civilian Conservation camps, for example. This pneumonia program was started only after consultation with a group of 10 or 12 of the leading doctors in the United States, the leading experts in this field, who advised us as to the nature and the extent of the studies which seem most indicated in order to prove or to demonstrate the value of serum vaccination and other methods in the control of pneumonia. In making such studies, we do not feel that it is necessary to request and secure in all instances the specific approval of the State department of health. It is purely a scientific research with which the Federal Government is concerned.

Senator ELLENDER. Just like you do if an epidemic of smallpox or yellow fever or anything else would break out, you would feel concerned to try and get something to remedy that situation?

Dr. PARRAN. In an epidemic, you can go in only on request and the control of the health authorities. If it is to carry out scientific research, the location of that research we have felt is not of so much interest to the State authorities. If it is, however, for control, then our people can go in only when requested by the State health department.

Senator WAGNER. In other words, these efforts are to find cures for diseases?

Dr. PARRAN. Preventions and cures; yes, sir.

Senator MURRAY. And those activities do not interfere in any way with the State medical administration?

Dr. PARRAN. None whatsoever. We exercise no administrative control of the States in regard to these matters.

Senator ELLENDER. How do you go about getting the patients to agree to help you in carrying out these scientific investigations?

Dr. PARRAN. Through the cooperation of the city health commissioner, the chief of the medical staff of the hospitals, and the other physicians of the community.

Senator ELLENDER. There is no force of any kind?

Dr. PARRAN. None whatever.

Senator ELLENDER. Just a request?

Dr. PARRAN. Yes.

Senator ELLENDER. Have you anything to add to what Dr. Parran said, Dr. Palmer?

Dr. PALMER. He has answered it pretty well, but he does admit that in certain instances the United States Public Health Service takes advantage of certain powers and prerogatives that they have to go into the States.

Senator ELLENDER. Don't you think it is a good idea? You believe in medical research, don't you?

Dr. PALMER. Yes.

Senator ELLENDER. Have you any criticism to offer as to what they have done or the cures that they have found?

Dr. PALMER. They did not find the Felton serum. They simply wanted to experiment on that in Pennsylvania, and the Department of Health refused to allow them to do it, because we have plenty of

research men in Pennsylvania that can work these things out, and the thing I want to call attention to is the fact that when you accept Federal funds, that means that there is always a little string to that, that they must have some supervision on the part of the Federal Government bureaus.

Senator ELLENDER. How would the medical profession or the people of Pennsylvania lose out by these experiments carried on through the United States Public Health Service?

Dr. PALMER. Well, we lost some of our identity.

Senator ELLENDER. You wanted to get publicity and credit—

Dr. PALMER (interposing). No; we did not want full credit. We simply wanted to maintain our independence and our State rights and our identity.

Senator WAGNER. Do you think that seeking a cure for a disease within a State is an interference with State rights? If we discover the cure by the prevention, aren't we aiding the State?

Dr. PALMER. Of course you are, but we have plenty of bureaus and efficient ones to administer it.

Senator MURRAY. You said something a moment ago about Uncle Sam suffering from a severe case of economicitis—is that what you call it?

Dr. PALMER. Economicitis and politicalitis.

Senator MURRAY. Yes; your objection to this bill, then, is due to your feeling that Uncle Sam should not spend any money in the States because he is already heavily in debt?

Dr. PALMER. Well, now, you have got a pretty sick man in Uncle Sam, and you propose by this measure to give him a sugar-coated pill, and it has got a lot of pretty strong stuff in it that might throw him.

Senator ELLENDER. Don't you think it might be best for Uncle Sam to be the sick one rather than the entire Nation to be sick?

Dr. PALMER. I mean by that that the entire Nation is economically sick.

Senator ELLENDER. Maybe so; but it could have been "wusser," as the darky says.

Senator MURRAY. Prior to 1929, it was not suffering from any such sickness?

Dr. PALMER. Oh, this started some time ago. I don't know when it started, but it results in a rather low state of financial circulation.

Now then, in a case of that kind, there are a lot of doctors that are attempting to give him his sugar-coated pill and tell him "Now, we will fix you up all right," but you ought to, there ought to be some conservative men in the picture. When an individual is that way, we usually let him rest. Ten years in the life of a country is not very long. If he could rest up for about 10 years, inasmuch as the mortality and the morbidity rates in this country are pretty good—we have often heard this statement made that the operation was successful, but the patient died, or that he kept on improving but he died.

Senator MURRAY. Your objection to the bill is economic? It does not coincide with your notions of economics?

Dr. PALMER. There is not any money now to spend on it, and the mortality and the morbidity rates in this country are the best in the world, which is admitted by everyone. There is no need to hurry about this thing; this thing can go on for a little while, and I would

like to suggest, Mr. Chairman, if you would like to have a suggestion, that a good, practical, hard-headed bipartisan commission of the Senate and the House be appointed to study this question a little further.

Senator MURRAY. That is what this committee is doing now.

Dr. PALMER. Yes; but we need other than social workers and people of that kind to study this question, with the idea of correlating these health activities into one department. You have them scattered all over the Federal Government, and you have added one more by this measure, the Social Security Board, or you will if this is passed. Why don't you do that and set up a division of the Department of Health under this Bureau and make it a division, a competitive thing, and relieve Uncle Sam a little of some of these taxes; let us get this thing straightened out accordingly. There is no great rush about this thing.

Senator MURRAY. Don't you realize that there is serious distress in some of the States of the Union that are not so rich as the great State of Pennsylvania?

Dr. PALMER. I do not believe that the distress is as serious as many people would make you believe it is. I think that is done for a purpose.

Senator MURRAY. Did you hear the testimony of the witnesses who were here a short while ago, representing the rural sections of the country?

Dr. PALMER. No; I was not here.

Senator MURRAY. You do not know who they are?

Dr. PALMER. I do not know who they are.

Senator MURRAY. And you do not know whether their statements were true or not?

Dr. PALMER. I don't know.

Senator WAGNER. Well, they stated that they represented, I suppose, all of the principal national and local farm organizations of the country, and their testimony is the result of a survey made within their States of medical needs. They painted a very tragic picture of the need of medical care and the inadequacy of medical care in their particular communities. I remember one witness testified that the nearest hospital, I think, was between 40 and 50 miles from their particular locality. And I think that all of the surveys that have been made differ from your complacent attitude on this whole thing.

I was going to ask you this—your last suggestion apparently contradicts your former attitude. You say now that we ought to have a central health department in Washington to carry on these activities?

Dr. PALMER. Yes.

Senator WAGNER. Then what is your objection? Is it that you do not want any aid to come from the Federal Government to the States or is it that you are not satisfied with the particular set-up in the Federal Government here of those engaged in the health activities?

Dr. PALMER. I think there should be done in the way of classification and instruction and encouragement, a great deal, but when you get to appropriating funds to the States, then there is always the control in the Federal Government which federalizes these things. That always happens.

Senator WAGNER. What would be the Federal Government's activities?

Dr. PALMER. Under a very capable department of health with proper authorities at the head of it, with a very rigid system; a merit system to insure individuals who want to get into public health of their security in their jobs, and make them better so that they will render better public-health service to the people, you could develop many systems without any coercive effect.

Senator WAGNER. You are the first one that I have heard criticize the United States Public Health Service under Dr. Parran.

Dr. PALMER. I am not criticizing the United States Public Health Service, Senator.

Senator WAGNER. Their work has been almost universally commended, and one very prominent doctor testified the other day that the research work done under Dr. Parran was equal to any private-research activity in the country.

Dr. PALMER. Do not misunderstand me, Senator; excuse me. I am not criticizing Dr. Parran. Dr. Parran is an employee of the United States Government and he is doing the best he can. He is doing a fine job, but I am criticizing the system; I am not criticizing any individual.

Senator WAGNER. What I am trying to get—I do not want to pursue this too long, because I can see that you have definite convictions about this.

Dr. PALMER. Maybe I can be changed, Senator; you go right ahead.

Senator WAGNER. That may be. But what I wanted to find out was this: Now, you propose a National Health Department of some kind. As a matter of fact, reorganization would put them all in one department. Now, if they are not to aid the States, what is their activity to consist of?

Dr. PALMER. Well, they have plenty of activity. They will have the work of the United States Public Health Service—

Senator WAGNER (interposing). That is aiding the States, isn't it?

Dr. PALMER. It never has particularly in the past. It has always been a general organization for the purpose of studying epidemics, sanitary regulations, and research work along certain lines.

Senator WAGNER. Do they not give the States the benefit of that?

Dr. PALMER. Never before the Social Security Act did we ever have any coercive Federal funds sent into us.

Senator WAGNER. The State does not have to take these funds.

Dr. PALMER. If they take them, they have to do certain things.

Senator WAGNER. Then you are finding fault with your State for accepting these funds in aid of their medical activities?

Dr. PALMER. I am not particularly finding fault with them under present conditions, but I do feel that the coercive part of it, that those things are not right.

Senator WAGNER. To begin with, there is not anything coercive because a State does not have to take the funds. How can you call that coercive? There is not a thing in this bill which compels a State to do a certain thing.

Dr. PALMER. The implication is that if you don't take them, then the public suffers.

Senator WAGNER. Then we are—well, I will give it up.

Senator MURRAY. You may continue your statement if you have anything further to say.

Dr. PALMER. I do not believe, Senator, that I have anything further to say except to make those few suggestions and call attention to the danger of breaking down a democracy in this country by such measures. If you will go into the history of these things, you will find that in Germany in 1850, and what is it now? A dictatorship. [Laughter.]

Italy, the same.

Senator MURRAY. Do you think that dictatorship resulted from that?

Dr. PALMER. Part of it. That is a part of the whole thing.

Senator EILENDER. As a matter of fact, Germany has never been a democracy, has it? It has always been under a king or a supposed president. It was not a real democracy, was it?

Dr. PALMER. No; there is not much of a step between where they were to where they are now, but it is a great step in this country, the centralization of government from where we are now.

Senator WAGNER. England has very widespread, you might say, health activities. They have health insurance, as a matter of fact. Do you criticize their system?

Dr. PALMER. They have not as good a mortality and morbidity rate as we do here.

Senator WAGNER. Is that your answer?

Dr. PALMER. Yes; my answer is that under these systems, you do not get as good results. It seems to me there is a better and more American system to do this thing.

Senator MURRAY. Doctor, if you are through with your statement, I hope you will continue to study the problem and read the records of the hearings when they are finished.

Dr. PALMER. I will be glad to, Senator. Thank you very much.

Senator MURRAY. Thank you for your statement. The next witness is Mr. Matthew Woll.

STATEMENT OF MATTHEW WOLL, CHAIRMAN, COMMITTEE ON SOCIAL SECURITY OF THE AMERICAN FEDERATION OF LABOR

Mr. WOLL. Mr. Chairman, and members of the committee, speaking on behalf of the American Federation of Labor, I wish to express our complete accord with the principles underlying the proposal of Senate bill 1620. We join with all other groups in soliciting the immediate enactment of the provisions of this bill into law.

No one is more conscious of the importance of good health than the worker. Upon the maintenance of health depends his job and his living. A period of illness or an injury may mean not only the staggering costs of medical care but the temporary or permanent loss of job and income.

Inability to pay for adequate medical care has often meant permanent undermining of health—and therefore loss of earning capacity. Life itself either partially or totally, is tied up with adequate medical care. The group I represent, approximately five millions of wage earners, and those dependent on them, have never had adequate

medical care, so that they were free to have a doctor whenever needed. We do not have the medical or the living conditions that would avert disease. When sickness comes we wait, hoping its development may be checked and expense avoided. Because of need for economy, children's diseases and afflictions are neglected, mothers are made invalids, premature old-age cuts off useful persons' lives, adults in their prime drop at their work.

All these things that workers know in their daily living were confirmed by the revealing studies by the committee on costs of medical care and by the United States Public Health Service which have made it clear that illness strikes with more devastating force the families of those least able to bear the expense. The number of days of disability per person per year from disease, accidents, and other impairments for all age groups is materially higher for families on relief than for nonrelief families, and for every age group except that under 15 years, the number of days of disability is greater for nonrelief families with incomes below \$1,500 than for those above that figure. The great majority of wage earners receive less than \$1,500 per annum.

Might I stop here to say that there is an intolerable burden of expense involved in taking care of the ill and the destitute by the wage earners. This problem of illness and impairment of health and consequent loss of job and unemployment is ever present, and the wage earner, the one least able to bear it, has been compelled to bear it. We hope that that burden may be more fairly distributed and in a way by which health will be advanced and will not be continued in an impaired position. So that when we speak of economy and speak of getting our Nation out of the red, we believe that this bill is well designed to accomplish that purpose.

Senator MURRAY. In the past, Mr. Woll, the working people have been compelled to bear the burden and the brunt of even the industrial diseases?

Mr. WOLL. There is no question about it. The record of all of our national and international unions will indicate the great amounts of money spent for the health services rendered by them. Even today there is a wave for hospitalization service of the wage earners through the group method, again a burden upon the wage earner and we hope that by the enactment of this bill, it will take that burden away from private enterprise and put it on the public services and rendered without cost to the worker, at least without the element of profit involved.

Senator MURRAY. In many States of the Union, nothing whatever was done?

Mr. WOLL. Nothing whatever is done today in some communities.

Senator WAGNER. May I interrupt for one question, because I know the many years of study that you have given to this question, Mr. Woll. The doctor who just preceded you upon the witness stand said that there is no need for further activities now and that we could just call it off for 10 years.

Mr. WOLL. It is a most unwarrantable statement from a doctor that I know of, because great improvements have taken place in the medical and the surgical world, and will continue to do so, and by the doctors themselves.

Accidents are more frequent and more serious, judged in time of disablement among persons in relief families and nonrelief families with incomes below \$1,500 than in better income groups. There is more illness and for longer periods among the unemployed than among the employed. Obviously there is a close relationship between employment, income, and health. Ill health may force an otherwise self-sustaining family to accept relief, and persons on relief or unemployed can afford little either of preventive measures or of care for those needing it. The consequence is plain in the longer duration and more frequent ailments.

Chronic diseases lay a heavy burden on the economically weaker families. The National Health Survey of 1935-36 revealed that the relief group suffered 87 percent more chronic illness than families with incomes over \$3,000, and nonrelief families with incomes under \$1,000 had an illness rate 42 percent higher than the \$3,000 group. Over half the persons for whom chronic diseases was reported were under 45 years of age. This means temporary or perhaps permanent disability for many wage earners.

In spite of the fact that more illness is suffered by persons of low incomes, medical expenses are greater for those of better incomes—indicating of course that those of greater incomes receive more adequate medical attention; that those of low incomes and more urgently in need of medical attention receive comparatively less attention in that direction and that of course is by reason of their failure to have the means by which to secure those services.

It is clear that the well-to-do are not receiving more than adequate medical service. The average wage-earner's family receives less than it should have of all such services. Surveys have pointed out repeatedly the need for more specialized care such as that for eyes and teeth. The limiting factor is income. The family cannot afford more attention for its members, even though the absence of early treatment may mean prolonged or disabling illness later.

Our labor unions have attempted to help our membership with the problems of sickness. For the year 1937 we paid out over $2\frac{1}{4}$ million in sick benefits, but this was only a drop in the bucket.

And might I stop here to say that I could have presented the record of the various national and international unions, those that maintain tuberculosis homes and homes for the aged and homes for their sick, in addition to providing weekly benefits for those unable to work by reason of sickness. The picture is an astounding one, of a burden now being carried by the wage earners themselves, so that when we deal with this question, it is merely a question of shifting the expense rather than increasing or lessening the expense, although we feel that in this bill, the provisions if enacted into law and were put in operation for several years, will tend toward lessening the cost for the maintenance of those ill and disabled because there will be the incentive to prevent the development of illness and also care in preventing disablement.

The payment of unemployment compensation to aid such persons as are available for work seems to emphasize the plight of the sick workers whose need for income is even greater. Voluntary plans cannot meet the problems of providing adequate medical care for all the people. There must be national planning and appropriate

legislation. Plans must be national in scope and must provide for the physical facilities for medical care, the financial resources for assuring social security for the sick as well as adequate professional services.

We are not alarmed at the statement made that this bill will centralize more or less medical care and attention, or that the principles of democracy shall be weakened by a greater National Government than we have experienced heretofore. Certainly labor is as much concerned as any other group in our whole political life that we do not make out of our Federal Government an organic government and destroy the conception of our various State rights and State governments, and yet we realize also, as practical men, that in the daily affairs of life, the artificial line of demarcation of one State line to another does not however affect these national problems of health or conditions of unemployment, and that the only efficient method of dealing with them is from a national point of view, giving of course the direct administration to the State governments, but nevertheless maintaining some sort of regulatory control so as to make the scheme really one national in character and to bring equal benefits to the citizens of all of our States no matter where situated and no matter how richly one State may find itself against the other.

The cost of medical care should be lowered so that it is within the reach of that large part of the population which has less than \$1,500 income. The hospital facilities and available professional competition in some areas that the doctor and nurse cannot make a reasonable income while other areas are left entirely without hospitals or expert medical service within each call. We recognize several complications. The average cost of medical care would not be staggering to the family of average income. Unfortunately, the burden is not reflected in average costs. A serious illness may equal or exceed the family's income, and many a family runs hopelessly into debt to meet the heavy expenditures ill health forces on it suddenly. Even if costs are lowered to a minimum, many families could not finance illness.

There will need to be Government assistance for any satisfactory program. The American Federation of Labor is thoroughly in sympathy with extending our national health program. At the National Health Conference in July 1938, President Green, speaking on behalf of the Federation, urged the improvement and extension of preventive public-health services and research, of hospitals and medical centers, of maternal and child-welfare services, of programs of medical care for those families whose income is insufficient to allow them to buy proper protection for themselves, and the provision of a temporary disability insurance to supplement the limited protection now available under workmen's compensation laws.

It is important in extending social responsibility in these fields not to neglect the contribution which private medical agencies and professional men have made to handicapped persons, and not to block the road to continued private initiative and research. We believe that the medical profession must be kept free from time consuming and wasteful administrative detail. It is also important that the free relationship between physician and patient be maintained. For this reason we approve a system which allows the individual wide

latitude in the choice of professional services, and all reasonable safeguards against undesirable political influence in establishing the certified lists of institutions and professional men who will receive part of their income from Government funds. We believe that the health of the Nation is so obviously not a matter bounded by State lines that the standards for the health services and medical programs which are partially financed by Federal funds should be established in the national law. Differences in type and number of services available will, of necessity, continue and may properly be related to differences in needs depending on the density of population and particular needs. But there should be equitable treatment for all persons within the Nation and this can be secured only by defining the standards to be met by all States which receive Federal grants.

The federation believes that increased hospital facilities and other medical services which Federal grants will help support should be made available to persons with small incomes at fees commensurate with their ability to pay for service as well as free to those who can make no payment. The worker needs to have medical care available within the reach of his purse. He does not want the charity of free service. He cannot afford adequate care at the present costs. A national program should aid those of moderate and small means in proportion as they need it. The assurance of such reduction of medical costs should be given in the Federal standards adopted.

Even if costs are reduced a serious illness will throw many a family into hopeless debt or dependency. The average costs distributed over a period of years might be borne by many who are not able to pay a large amount in 1 year. We believe, therefore, that health insurance should be added to the program of social insurance already enacted. The federation believes that a health-insurance program should be on a national scale. We should avoid the wastes and inequities of 48 separate systems which may be adopted in the absence of national standards. And in so doing we certainly do not advocate either communism, nazi-ism, or fascism.

It is true now that many workers could not afford even the average annual costs of medical care. The insurance premiums would be too great a burden on low-paid and irregularly employed workers. Any system of health insurance would need to be financed in part by Government payments. The taxes for that purpose should be chiefly general, not pay-roll taxes. Health is a national problem, going far beyond the responsibility of industry. The economy of preventative medical care is only partially a saving for industry. We know that adequate provision for the Nation's health can save millions of dollars in unnecessary expense and working time lost. Insurance against that loss should be on a Nation-wide basis, financed largely by general taxation, and administered under Federal standards equitably established for the country as a whole.

Payment of compensation for loss of pay to persons unemployed because of temporary disability is a necessary addition to the regular unemployment-compensation system. The unemployed man needs the payment as much, if not more, when he is unable to work. Health insurance to cover costs of illness goes further. The federation believes we should continue to expand social security toward this more complete goal, but not at the expense of other parts of the program. Of immediate importance is assistance to put medical care and health

services within the economic reach of the millions of families whose incomes are too low to permit them to buy adequate care now. Of equal importance is finding ways to increase economic security of the worker, the assurance of a job and income. Then from that income the worker can pay something toward a national program of health insurance in order that he may not be totally unprepared for the costly disability which may come unexpectedly.

The Federation approves the enlargement of public health and medical service programs with safeguards that the Federal money shall be spent under such standards that people in poorer sections shall be fairly dealt with, that opportunities may be equalized and health dealt with as a truly national problem.

While there must be coordinated planning in order to have a national health program we respectfully point out and insist that the administration of any part which involved the rights of labor should be lodged in the United States Department of Labor and the various State departments. This is especially true of industry hygiene which is a part of the field covered by workmen's compensation. Where the administration of laws dealing with occupational diseases has been removed from departments of labor, workers have been hindered instead of helped in their efforts to get their rights under workmen's compensation. Compensation for occupational disease involves proof of hazard on a specific job—obviously a technical problem beyond the capacity of a worker even if he had right of entry to carry on investigations.

On behalf of the American Federation of Labor I wish also to emphasize what labor regards as a fundamental: Social security is primarily a problem in which wage earners and small salaried persons are concerned. When these groups are barred from employment, income should be provided under fixed conditions. Wherever rights of labor are involved the administration of these rights should be lodged in the Department of Labor. The American Federation of Labor urges as our ultimate program a Federal Department of Labor charged with full responsibility for aiding in the advancement of labor's rights and interests. The Federation feels that the administration of old-age insurance, the employment service and unemployment compensation and health insurance should be in the Department of Labor.

That, gentlemen, is the presentation of the American Federation of Labor in generalized brief form. As to the necessity for the enactment of this legislation, as I have stated previously, the experience of the wage earners not only as manifested in the records of the various municipalities and State governments, but also in the records of our various local and international unions indicate clearly that this is a grave problem to the great mass of our people, the wage-earning class as well as the small-salaried income class. By bringing relief to them, we bring relief to the great majority and accomplish a really great social service that in the ultimate will not mean additional expenditures on the part of our people in the form of taxation, but rather a lessening of expense and the enlargement of a great deal of happiness because of the lessened suffering entailed.

Senator WAGNER. Mr. Woll, you referred to the occupational diseases. I wanted to ask you just one question. Since 1913, when we enacted in Albany the workman's compensation law, year after year

there were groups added which were originally not under its protective provisions.

Mr. WOLL. That is true.

Senator WAGNER. And we have increased the occupational diseases now coming within the law, and I have been informed by constantly including these occupational diseases under the act so that the worker may be compensated when he suffers the occupational disease, that attention has been focused upon the prevention of these occupational diseases much more than before.

Mr. WOLL. There is no question about it.

Senator WAGNER. It has been a financially advantageous thing for the employer to do that, because his premiums are determined by his experience of the year before, and thus we have had not only a financial benefit to the employer, but a great benefit to the worker.

Mr. WOLL. That is true, Senator. We must bear in mind also that the attention of the worker has been more directed to these particular ailments and through his organized efforts he too has contributed largely in the formulation of policies within the factory or within the shop that have tended to reduce the elements entering into the particular occupational disease; in other words, industry as a whole, and not only the employer moved by the incentive of reducing his insurance premiums, but likewise the employee has cooperated in the effort to embrace occupational diseases.

Senator WAGNER. What I meant to bring out was that as our attention is focused upon these problems, we begin to cure them.

Mr. WOLL. There is no question about it.

Senator WAGNER. While disability, temporary or permanent disability, may arise from causes beyond the scope of employment, yet when we begin to think about it a little, we find means of alleviating the conditions.

Mr. WOLL. That that motive is constantly in operation is unquestioned. We find that industry is greatly concerned in giving more employment to their workers and seeking, of course, to have some relief under the tax requirement, indicating very clearly that they are moved by the incentive of economy to bring about improved conditions, and that is particularly true in health measures.

Senator WAGNER. Some of the opposition to the present bill reminds me of those days in Albany and the opposition to the workmen's compensation law, but the very people who opposed it recognized it in a few years as a great blessing.

Mr. WOLL. May I say that what I desired to point out as to the occupational diseases was that we believe that it should be administered by the Labor Department instead of by the Health Department.

Senator WAGNER. That is so in New York.

Senator LA FOLLETTE. Mr. Woll, have you any other suggestions with regards to the pending bill other than contained in your statement?

Mr. WOLL. No; we have purposely refrained from going into a detailed discussion of standards, because while we may differ with some of the standards proposed, and would like to see them improved, we know that this is newly proposed legislation, and that as such it is bound to be imperfect in a number of instances. While we should like to see perfection we are first concerned in seeing that it is enacted.

Then upon experience we can more intelligently offer recommendations as to its perfection.

Senator WAGNER. As a matter of fact, the American Federation of Labor for years has been very fervent in its advocacy of health legislation.

Mr. WOLL. I might say to you, Senator, that we were for health legislation prior to having favored unemployment compensation legislation.

Senator WAGNER. That is right; I remember that.

Senator MURRAY. Thank you very much for your statement.

The next witness is Jacob Baker, president of the United Federal Workers.

STATEMENT OF JACOB BAKER, PRESIDENT OF THE UNITED FEDERAL WORKERS OF AMERICA

Mr. BAKER. Mr. Chairman, and gentlemen of the committee:

I will only take a few minutes, because I wish to reiterate the support of the Federal workers to the bill as expressed in the support indicated by the Congress of Industrial Organizations with which we are affiliated. It occurred to us that there are a few experiences out of the Federal workers' organization and their dealings with the health program that might be of use to the committee and that, particularly, I should like to present.

The Federal worker stands at an economic level a little bit higher than the average wage-earning employee in the country, but the experience of the Federal Government with sick leave is exactly confirmatory of the opinions stated in other researches. Recently the Civil Service Commission examining sick leave finds that it is exactly related to the level of pay; the least paid people require the greatest amount of sick leave. In the case of Federal employees, there are about 60,000 who earn less than \$100 a month, and it is in that group and the group immediately above that that we find the greatest amount of sick leave required; in other words, the greatest amount of illness, and for that reason even these workers in the clerical and white-collar occupations as they go up the wage scale, find illness and disability a very serious burden.

The average expenditure made by Federal employees under \$2,000 a year for medical services runs under \$75 a year, which obviously is not enough in relationship to the ordinary requirements, that the committee and other evidence presented to the committee has made clear.

As the National Health Survey has overwhelmingly demonstrated, and as the Committee on the Costs of Medical Care, appointed by President Hoover showed a few years ago, the greatest amounts of illness and disability lie in the great mass of people in the lower income level. Those in families getting less than \$1,000 a year have twice as much sickness and disability as those in the higher income brackets, where family incomes are \$3,000 a year or over. Not only are the people with lower incomes sick more often, but when they are sick their illnesses last longer. They go much more often without any doctor's care in illness; when they do see a doctor he makes fewer visits per illness; and they go much more often

without needed hospitalization than those who are financially better off.

Even among those who are moderately well off, who have family incomes of from \$1,200 to \$2,000 a year, a serious illness is a financial catastrophe.

In addition of course to the loss due to illness, there is another very serious loss that is also illustrated in the experience of these federal workers in the records of the Civil Service Commission, and that is that there is a definite increase in continuing disability as a result of illness. Once they begin to get ill, if they do not take care of it well, it is apt to cumulate and apt to build up, and that seems to be borne out by the experience of the Federal Government.

Bills for medical care and hospitalization are generally not exorbitant in terms of the service rendered. But they are enough, frequently, to ruin family budgets for years, to exhaust a lifetime's savings, perhaps sacrifice a home or the education of the children in the family. That is largely because illness is unpredictable and a comparatively small proportion of all these families must bear a high share of all the cost of sickness when it strikes. Thus 5 percent of the families in the \$1,200 to \$2,000 annual incomes class bear 32 percent of all the costs of sickness in that group.

This is reflected in the experience of Federal employees, and the result is a heavy cost to the Federal Government in loss of time and efficiency. The Federal Government has recognized its interest in the good health of the military forces, but despite the obvious inability of the civilian employee to purchase decent care, nothing is done for him. It is notorious that sick leave is much more of a problem among lower-paid Federal employees than among the higher-paid workers.

Another thing that we have some information about specifically concerning Federal workers that should be interesting to the committee is the relationship of medical costs to debt. I think that some evidence has been presented, and in the report of the Interdepartmental Committee last summer, there was reference to this fact. So far as we are able to get information as the result of inquiry concerning credit union debts and other debts that the Federal workers engage themselves in, it would appear that a recent study of 19 credit unions revealed the fact that 18 percent of all personal loans was for medical service.

The largest item was for refinancing outstanding debts, which accounted for 20 percent of the loans. Of those debts refinanced, some 18 to 20 percent were for medical services. Standing at less than these were all of the other reasons for borrowing money. Household expenses, 11 percent; clothing, 10 percent; automobile purchase and repair, $7\frac{1}{2}$ percent; and so on. The personal-loan departments of commercial banks find that much of these loans are for medical services, this accounting for 80 percent of the personal loans of the National City Bank.

All workers' debts rest in large degree on physical disability. The loss of earning power due to sickness, as well as the cost of medical care, add to the debt burden of workers. Federal workers, like all other workers, borrow money to pay doctor bills. We have some

statistical facts concerning workers right here in Washington on this subject, which indicate that the need is just as great among Federal workers as among any other workers. Nineteen and four-tenths percent of all loans by credit unions in Government departments were for the purpose of paying medical, hospital, and dental expenses. In addition, there is another 4 percent, or thereabout, on old doctor bills that were refunded by credit-union loans. A total of nearly one-fourth of the debt of the Federal employees was built up by physical disability and the very great hazard of medical expense.

The largest single cause of debt, so far as we have any information about, the chief reason that people go into debt, the chief debts that hang over them, the chief concern that they have to settle when they borrow from a credit union to straighten out their affairs is medical costs. That, it seems to me, is a very important thing, because as we observe it among Federal workers, we find that it is an over-hanging old worry as a result of medical debt that, coupled with the loss of energy and ability and physical strength due to illness, the two taken together result in lowered morale, lowered working ability, and recurrent illness.

Another fact that we have in connection with the Federal employees which seems to us rather striking is the fact that the workers retired due to disability do not live very long. That is to be expected, of course, because their disability may be illness, but another fact that is involved is the fact that their income is very low. They are sufficiently disabled so that they are not able to work efficiently, and, consequently, are retired with a retirement allowance that will always be proportionate to the amount of time that they have worked for the Government, and will always be less than the \$900 that the Government allows in the case of 30 years, or \$1,200 under other circumstances. In other words, so far as we are informed, although there are not any exact figures at the Civil Service Commission, the disability allowance and retirement allowance and the four, five, or six hundred dollars a year are what their income is. Last year, in 1938, 2,400 people were retired. A great many of them were ill at the time of the retirement, but the fact that 50 percent of them have already died seems to us to indicate that those people needed medical care; they needed help, and they did not get it, and it was not there, so they are dead. That, I think, is a particularly important answer to the previous witness that we can rest for 10 years. When a man is ready to die, when he is ill, when he needs help, he needs help, and to rest for 10 years does not meet the situation.

Now, what can workers do for themselves concerning health?

Our Federal workers have shown a great deal of interest and made a good many efforts to provide health services for themselves through union insurance plans and sick and disability funds. Federal workers have participated in very great numbers in group hospitalization plans and throughout the United States, Federal workers constitute one of the important groups supporting various types of group and cooperative medical practice.

The Group Health Association of Washington is made up solely of Federal employees. This organization, set up by Federal workers themselves for the purpose of providing them and their families

with a full range of medical service, provides these services in a very effective manner, with a definite plan of agreed prepayments, so that every member knows what his total medical obligations for the year will be. A full and competent group of specialists constitute the staff. After a period of long and vicious discrimination on the part of hospitals, the association has at last obtained access to a sufficient number of hospitals in the community so that it can take care of its members. The organization is thriving. Undoubtedly, other such organizations will develop, and the existing ones will continue to expand. The experience of the group health association has indicated that some initial financial aid is necessary for the effective, reasonable development of a cooperative medical association. No grants or subsidiaries are necessary, but working capital on loan is needed.

The group health association and the medical cooperatives generally, throughout the United States, prove another very important point, and that is that prepayment of medical service and continuous provision for paid-for medical examinations results in a total change of health and health habits of the persons concerned.

The group health association perhaps has not fully demonstrated that as yet, but it is in the way of demonstrating it.

The emphasis swings from cure of the desperately sick to the prevention of illness of the moderately well. The moderately well get very well, and there are less and less of the desperately sick.

Cooperative medicine, however, does not meet the needs of the very poor. It makes possible understanding of what can be done. Use of the clinic of the group health association in its year or so of existence indicates that there must be a great need for medical care which is not being met. People are visiting this clinic and seeing its doctors at home at the rate of about 10 visits per person per year; yearly figures of the committee on the cost of medical care indicated that the average number of doctors' calls or office visits which people got were only about 2.6 per year. In other words, with such a plan, the folks got four times the service.

Techniques are now being developed in the medical cooperatives that have the widest application. Recurrent periodic examinations and overhauling and all the other facilities of preventive medicine are proving their worth in the cooperative groups. But to be applied to the persons in the lowest half of our income brackets we must have public aid and provision of public facilities.

The Federal Government has demonstrated effective work in the public health field. The far-flung Veterans' Administration, with hospitals and other facilities operated over the whole of the United States, has done the most remarkable job in the protection of health of disabled persons that this or any other nation has ever seen. Considering the rigors of the World War, the terrific shock of the men under fire, the drastic injuries by gas and explosives, to have repaired these men, to have maintained them during this whole generation, in reasonably useful occupations, is a remarkable achievement. Commendation should be given to the marine hospitals of the Public Health Service, and to the whole hospital service in the Military and Naval Establishments. These great agencies have demonstrated beyond doubt that the public service can provide the facilities for public health.

S. 1620 involves none of the elements of the medical profession that have so often been attributed to it. It merely provides grants-in-aid to States for purposes related to the advancement of health—and leaves to the States the development of the precise relationships between doctors and patients. Federal workers, as participants in Government administration, know enough about the provisions of this bill and the nature of the American Government to regard as grotesquely unfair such comments on the bill as those which say:

Do you want the men who control your city hall or county courthouse or Washington bureaucracy to take your health money and control your family's relation with your physician? (reprint by National Committee to Uphold Constitutional Government).

As a matter of fact, this bill provides the only method whereby we can have widespread development of those "controlled experiments" in methods of distributing medical care for which the American Medical Association has called. The expenditures contemplated are nominal compared with other expenditures. For the first year no more than \$100,000,000 is authorized. This would represent nothing more than a new way of distributing expenses which we are already incurring and the cutting down on the total of such expenses. Increased public-health work would mean more prevention of disease, more taking care of it in the early stages, instead of waiting for the unhappy end results to present themselves. For example, a recent United States Public Health Service statement shows that expense of treatment and care for an estimated 21,600 cases of blindness due to syphilis, plus loss of these people's earning power, amounts to more than \$10,000,000 a year. It is simple common sense; it is good economics; it is efficient democracy, as well as humanitarian principle, to make clinics and medicines available in the early stages of all disease instead of waiting for the sufferers to contract blindness, heart disease, and other permanent and irremediable disabilities. The \$100,000,000 for the first year will be of tremendous importance as an element of national defense within the next 3 years. Whatever our national situation, we must have reasonably good health on the part of the men upon whom we would depend for the building up of armed forces. This \$100,000,000 would have positive value in building up the military arm of the Government. Its value may even outweigh similar expenditures in actual naval or coast-defense construction. In fact, the enlargement of our defense will finally come to no avail unless we have the men to man them.

Senator WAGNER. Mr. Baker, I wanted to ask you a question. You said something about national defense?

Mr. BAKER. Yes, sir.

Senator WAGNER. Do you happen to know what the experience was in the draft period during the war, when the individual who was drafted was medically examined for fitness?

Mr. BAKER. No, Senator; I have not that at hand. I think perhaps some of the other witnesses can furnish that.

Senator WAGNER. Do you remember what the percentage of disqualification was of those who were conscripted during the last war?

Dr. PARRAN. It was 19.1 percent of the men rejected as being totally unfit for military service for the first 2,000,000 draftees.

Senator WAGNER. Was there any other percentage of those partially disqualified to limit the character of their service?

Dr. PARRAN. One of the leading students of physical records during the war recently has published a statement to the effect that a total of 45 percent of all the men examined at the time of the draft were suffering from some physical handicap. Of that 45 percent, 19.1 percent were rejected as being totally unfit for military service.

Senator WAGNER. Thank you very much.

Senator MURRAY. Thank you. That will conclude the hearing for the day. We will resume tomorrow at 10 o'clock.

(Whereupon, at 12:05 p. m. a recess was taken until the following day, Friday, May 12, 1939, at 10 a. m.)

TO ESTABLISH A NATIONAL HEALTH PROGRAM

FRIDAY, MAY 12, 1939

UNITED STATES SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON EDUCATION AND LABOR,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 o'clock, Senator James E. Murray presiding.

Present: Senators Murray (chairman) and Ellender.

Also present: Senator Wagner.

Senator MURRAY. The subcommittee will be in order.

Dr. Louis T. Wright will be the first witness this morning. If Dr. Wright is here, we will proceed with him.

STATEMENT OF DR. LOUIS T. WRIGHT, CHAIRMAN, BOARD OF DIRECTORS, NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE

Senator MURRAY. Will you state your name and whom you represent?

Dr. WRIGHT. Louis T. Wright, graduate Harvard Medical School, 1915; Visiting surgeon, Harlem Hospital; former surgical director, Harlem Hospital; fellow, American Medical Association; member of special committee on hospitals and dispensaries, Medical Society of the County of New York; lieutenant colonel, Reserve Medical Corps, United States Army; police surgeon, rank of inspector, city of New York; fellow, American College of Surgeons; chairman, Board of Directors, National Association for the Advancement of Colored People.

Representing: National Association for the Advancement of Colored People, Manhattan Medical Society, and Central Harlem Medical Society.

Senator MURRAY. Do you have a prepared statement, Doctor?

Dr. WRIGHT. Yes, sir.

Senator MURRAY. You may proceed.

Dr. WRIGHT. Fundamental position: Support the bill, but ask certain safeguards against discrimination.

Negroes' position in the program.—(a) Bill designed to provide adequate medical care for 40,000,000 American people unable to pay for such care; 12,000,000 of the 40,000,000 people are Negroes.

Negroes constitute 30 percent of the persons affected by this bill.

(b) Fundamental position is that no public-health program can accomplish wide results unless it is administered fairly and carried

to all elements of the population without discrimination as to sex, creed, race, or color. Disease is not color conscious.

Negroes represent a sizable minority in the group of those intended to receive benefits under this bill. Past experience in the administration of State and Federal funds by States where separate institutions are maintained proves that unless safeguards are placed in this bill the real purpose of the bill will be destroyed and a sizable minority will be deprived of its just benefit.

The following amendments are proposed:

Suggested amendments to the bill. The following new subsections as amendments are suggested in the sections on requirements of State plans:

(1) At page 5, starting at line 18:

(9) In States where separate public-health facilities are maintained for separate races, provide for a just and equitable apportionment of such funds to carry out the purposes of this part of this title for maternal and child-health services for minority races, without reduction of the proportion of State and local moneys expended during the fiscal year ended in 1938 for such health services for minority races except moneys expended for the construction of hospitals or other buildings for health services.

(2) At page 13, line 10:

(9) In States where separate health facilities are maintained for separate races, provide for a just and equitable apportionment of such funds to carry out the purposes of this part of this title for medical services for crippled and other physically handicapped children of minority races without reduction of the proportion of State and local moneys expended during the fiscal year ended in 1938 for such health services for minority races except moneys expended for the construction of hospitals or other buildings for health service.

(3) At page 20, line 16:

(9) In States where separate health facilities are maintained for separate races, provide for a just and equitable apportionment of such funds to carry out the purposes of this part of this title for public-health work and investigations for minority races without reduction of the proportion of State and local moneys expended for the construction of hospitals or other buildings for health services.

(4) At page 29, line 23:

(11) In States where separate health facilities are maintained for separate races, provide for a just and equitable apportionment of such funds to carry out the purposes of this part of this title for hospitals and health centers for minority races without reduction of the proportion of State and local moneys expended during the fiscal year ended in 1938 and for such health services for minority races except moneys expended for the construction of hospitals or other buildings for health services.

(5) and (6) At page 47, line 11:

(8) The term "minority race" shall mean any race or racial group that constitutes a minority of the population of the United States and for which separate health facilities are maintained in any State affected.

(4) A just and equitable apportionment or distribution of the several funds, provided under this Act, for the benefit of the minority racial group in a State which maintains separate health facilities for such minority and racial groups, means any plan of apportionment or distribution which results in the expenditures, for the benefit of such minority groups, of a proportion of said funds not less than the proportionate need that each minority racial group in such State bears to the needs of the total population of that State, with the further provision that such funds are never to be in smaller proportion to the whole sum than the minority bears to the total population.

There is one point that relates to discrimination in salaries and wages:

Discrimination in salary and wages:

We are familiar with the established practice and policies of several of the States to discriminate in the payment of salaries and wages to employees on the basis of sex and race or color. Such discrimination is directly opposed to the spirit of the bill and of the principles of the Federal Constitution. We, therefore, ask that provisions be placed in the bill preventing discrimination in salary or wages paid by the several States for services under the bill.

Senator ELLENDER. What amendments do you propose?

Dr. WRIGHT. I am going to read them now.

Each section of the bill should have a provision that:

No discrimination in the salary or wages of personnel in the same classification and doing the same or equal work shall be made on account of sex, creed, race, or color.

Relative to records, to make the records public.—There are no provisions in the bill for (1) making the reports of the several States public, or (2) for making public the proposed plans of the several States before or after they are approved by the Government.

Proposed amendments.—(a) Provision should be made in the bill that all reports made to the several departments under the bill and the proposed plans become public documents and be made available to the general public a reasonable time before the plans are adopted so that the citizens of the several States shall be able to examine them and to challenge them.

(b) No proposed plan shall be adopted unless and until public hearings shall be had and opportunity given to file objections to the several proposed plans.

(c) Provision shall be made for at least an annual report to Congress of each department under the bill (provisions similar to those in the Federal education bill) S. 1305, known as the Harrison-Thomas-Fletcher bill, provides section 604, starting line 21 page 42, as follows:

The Commissioner shall publish annually full and complete reports showing accurately the status of education in the United States. In all such reports relating to the status of education in States where separate educational facilities are maintained by law for any minority racial group, data relating to such separate educational facilities shall be separately reported. The Commissioner shall also make an annual report in writing to the Congress, giving an account of all money received and apportioned by him under this Act.

Since the health bill is divided into sections a similar provision would have to contain a statement that "all departments" be required to publish annual full and complete reports. For example, this would obtain regards in grants to States for maternal and child welfare, the Chief of the Children's Bureau or the Secretary of Labor would make such reports, while in regards to public health work and investigations and also in the case of grants to hospitals and health centers, the Surgeon General of the Public Health Service would make such reports and provide for the public hearings. And in the case of grants to States for medical care and also in grants to States for temporary disability, the Social Security Board would make such statements and provide for public hearings.

Justification:

The bill seeks to be the basis of a comprehensive program, State and national. As to the State agencies and State plans, opportunity is given the State agency in each title of the bill to appear and defend its State plan. But through oversight no opportunity is provided for members of the public and private agencies performing health services to appear and criticize proposed health plans. (For example, take sec. 515, p. 15.) We feel sure that Congress does not intend that the State officers shall have the right to defend any proposed State plan, but that the citizens of the same State who may be affected by such plan shall not have the same opportunity for full and frank discussion and criticism of the plan. This would violate every basic principle of a democracy in government.

Relative to advisory councils:

There are provisions in the bill for the establishment of both Federal and State advisory councils. In order to carry out the spirit of the bill it is necessary that members of sizable minorities be included in these councils.

Not being familiar with legislative procedure and the drafting of bills I do not know if it is possible to include a provision in the bill that at least on the federal advisory councils there should be representation of sizable minority groups, particularly those who have been historically disadvantaged in public-health services, as Negroes; if history sheds any light on what will be the administration of this act by the States then we are serving notice that unless representation is given to sizable minority groups which have not received the benefits of public-health services in proportion to their needs then the community hazards caused by discrimination against these minority groups will continue and the health of the community in general will be jeopardized.

Senator ELLENDER. You are interested, as I understand, in getting your race as well taken care of under this bill as the white race?

Dr. WRIGHT. They are all American citizens.

Senator ELLENDER. Do you know that records show in the State of Louisiana, especially New Orleans, that although the Negro population is only 28 percent, that 40 percent of the inmates of our charity hospitals are Negroes? Do you know that?

Dr. WRIGHT. I do not doubt it.

Senator ELLENDER. I just wanted to point out to you that as a matter of fact. I believe that all of the States show little or no difference as to race when providing facilities for the indigent.

Dr. WRIGHT. May I answer that, Senator?

Senator ELLENDER. Yes; surely.

Dr. WRIGHT. I would like to say this—I grant that there is no distinction made in the charitable institutions as regards Negroes, but because of the long period of disadvantage, because of economic distress and racial discrimination, the Negro has an infinitely greater need than the charity hospital statistics would ever indicate.

Senator ELLENDER. Still they are provided for in proportion to their need, and I would say to the same extent—I am speaking for Louisiana—as are the white who are in like poor circumstances. That I know.

Dr. WRIGHT. Well, of course, I cannot go into that, but I do know that as far as the Negro population goes, I feel that they do not scratch the surface as far as the need goes for medical care.

Senator MURRAY. If all of the other States treated the Negro as well as Louisiana, do you think that there would be any need for the precautions which you are suggesting?

Dr. WRIGHT. Yes, sir.

Senator MURRAY. You think that if all of the States treated the Negro exactly as Louisiana, you still think that those amendments should be incorporated in the bill?

Dr. WRIGHT. Yes.

Senator MURRAY. I cannot understand that in view of the statement just made by the Senator from Louisiana that you get better treatment in Louisiana in proportion to the population than the whites do.

Senator ELLENDER. I have that, Mr. Chairman, in the Congressional Record of January and February 1938. Those figures can be found there. I put them there so that everybody could study them.

Dr. WRIGHT. Not for a second am I questioning the Senator's statistics. I do not mean that, but I am stating that from the past experience greater hazards of living conditions, poor financial income, and economic distress are present. One-third of the people affected by this bill are Negroes, and there is great need, unless the ultimate aim of the bill is defeated, that certain safeguards be given by the National Government.

Senator MURRAY. Do you think if this bill is passed it would be a great step forward?

Dr. WRIGHT. Yes, sir.

Senator MURRAY. But on account of your experience or the experience of your people in the administration of laws of this kind, you are fearful that it would not be administered equitably or fairly unless specific measures were included in the bill to require it; is that right?

Dr. WRIGHT. That is right.

Senator MURRAY. We have your statement.

Dr. WRIGHT. May I submit an editorial from a leading Negro magazine which bears on the same point? I will either read it or submit it for the record if I may.

Senator MURRAY. You may submit it for the record.

Senator ELLENDER. How long is it?

Dr. WRIGHT. It is only about one page.

Senator MURRAY. You may file it.

Dr. WRIGHT. And may I request permission to file further memoranda or statistics on this point?

Senator MURRAY. Yes.

Dr. WRIGHT. I thank you very much, gentlemen.

(Editorial from the magazine Opportunity, May 1939, is as follows:)

THE AMERICAN MEDICAL ASSOCIATION AND THE NEGRO

Not a few Negro physicians and surgeons have been moved to follow the leadership of the American Medical Association in its opposition to socialized medicine. They have eagerly embraced and repeated the arguments advanced

by the leaders of the conservative and ruling group of this association, to the effect that socialized medicine will destroy the initiative of the individual physician, that it will retard scientific advance, that it will toss medical practice into the arena of partisan politics, that it will violate the sanctity of the relationship between doctor and patient, and that it will neither ultimately extend life expectancy nor reduce the death rate.

It is generally conceded that the American Medical Association is the most powerful body in the medical profession, wielding wide and in many cases controlling influence on the practice of medicine in America today. For that reason it would be well for Negro physicians and surgeons to examine its attitude and its policy toward the Negro in the profession before accepting its leadership in regard to such a vital question as that of socialized medicine.

No group in America is in greater need of medical care than the Negro. There are hundreds and thousands of Negroes who are born and who die without attendance of a physician or even a practical nurse. There are millions of Negroes who can never hope to secure the benefits of scientific medical care, to whom hospitalization is forever unavailable. The general mortality rate of Negroes is higher than that of any other racial or national group, and unquestionably one of the causes is the inability of Negroes to secure proper medical care. Sheer poverty precludes the great mass of Negroes from enjoying decent and adequate medical attention. And where poverty is not the principal factor, race prejudice makes a measurable contribution to the appalling and disgraceful mortality rate which the Negro bears in America.

This racial prejudice denies Negro students the opportunity to enter the medical schools of America save in few instances. It denies opportunity for Negro graduates, of even the medical colleges where they are allowed to study, the opportunity for internship in municipal, States, and general hospitals supported by taxation of Negro citizens as well as white, not to speak of private hospitals, many of which are tax exempt. It is the force that excludes Negro physicians from the staffs of these hospitals and young Negro women from the nursing schools.

If in the history of the American Medical Association there has ever been an attempt to break down racial prejudice in medical practice, it would be well if it could now be revealed. The germs of disease are not color conscious. And the deliberate neglect of the health of Negroes is indirect but effective sabotage of the program for health betterment of the whole Nation. "Until we can destroy the reservoir of tuberculosis in the Negro," said a distinguished American physician recently, "there is no chance that tuberculosis will be eradicated in America."

What has the American Medical Association ever done about these things? When has it ever made an effort to enable Negro physicians to secure the clinical experience by which they might improve their efficiency?

The American Medical Association could have used its influence to break down the racial barriers which exist in medical schools in America. It exercises tremendous power in shaping the policies and plans of public hospitals, but if it has ever taken a step to secure for the Negro physician his rights to participation on the staffs of these hospitals, we have yet to hear of it.

The outstanding act which the American Medical Association appears to have taken recently in regard to Negro physicians was to place after the names of the Negro members of the association the letter (*c*), designating them as colored. There was no (*j*) to designate the Jewish members, or (*g*) to designate the German members—no racial or national designation of any group save Negroes.

This little gesture of racial discrimination is indicative of the interest which the American Medical Association has taken in the problems of the Negro physician and patient.

Senator MURRAY. The next witness is Miss Mollie Dowd, representing Women's Trade Union League, Huntsville, Ala.

STATEMENT OF MISS MOLLIE DOWD, REPRESENTING THE NATIONAL WOMEN'S TRADE UNION LEAGUE OF AMERICA

Senator MURRAY. Will you give your name in full?

Miss Dowd. Miss Mollie Dowd.

Senator MURRAY. Whom do you represent?

Miss Dowd. Southern representative of the National Women's Trade Union League, and a member of its executive board.

Senator MURRAY. You may proceed with your statement.

Miss Dowd. It is scarcely possible—and I am representing Alabama here—that Alabama, or indeed, most of the Southern States will be able to improve health conditions among workers without Federal aid. The Southern States rank high in the amount of money the State and local governments appropriate for public health work, as compared with their rank among the 48 States, according to per capita income. For example, Alabama, which ranks forty-sixth in per capita income, ranks eleventh in the amount of money appropriated in 1939 by State and local governments for public health work. There are only 12 States in which State and local funds for public health total \$1,000,000 or more. Among these 12 States are found Alabama (eleventh), Georgia (tenth), and North Carolina (ninth). North Carolina ranks forty-third in per capita income; Georgia ranks forty-second, Louisiana, which ranks thirty-seventh in average per capita income, 1935-37, ranks fifteenth in the amount of funds appropriated by State and local governments for public-health work.

Alabama is in the lowest quarter of States with regard to the number of registered general and special hospital beds per 100,000 population, having less than 264 per 100,000. Alabama is also in the lowest quarter of States with regard to the number of mental hospital beds, having less than 286 per 100,000 population.

Now, I have a great many statistics here, and after all I think that bare statistics are somewhat cold. I have had a great deal of personal experience. I am in the conciliation service of the Alabama State Department of Labor, which takes me out into all of the districts in the State. We are a textile State, and I meet a great many people in the health service.

Alabama is not lax in her medical care of her people, but it is not enough, as we have not the funds to do what we should do for our people, both white and colored. Like Louisiana, we try to do our best, without discrimination, for both races, because after all, health is something that reacts on the white people if it lacks being administered to the colored, and we try to be as fair as we can.

Senator MURRAY. Do you find any widespread discrimination against the Negroes?

Miss Dowd. Not any more than there is against the poorer white people.

Senator MURRAY. You think those conditions are improving in all of the Southern States?

Miss Dowd. Yes; I am sure that they are improving in all of the Southern States.

Senator ELLENDER. How many charitable hospitals do you have in Alabama? When I say "charitable," I mean those entirely maintained by the State. Do you know?

Miss Dowd. I would say that there are now about 10 in the entire State. There is one in Mobile, I know; and Montgomery; and, of course Birmingham—I know there is one there.

Senator ELLENDER. Maintained exclusively by the State?

Miss Dowd. By the counties.

Senator ELLENDER. I meant the State.

Miss Dowd. The State does not have one.

Senator ELLENDER. Would you say in those hospitals maintained by the counties, that in proportion to the population, the Negroes get about the same treatment as the poorer whites of their communities?

Miss Dowd. Yes; I think so. I do not think it is enough for either group, but I think that, as nearly as it is possible to serve, they are served. I know they are in Birmingham, Ala. I think sometimes they do not have the room to take them. It is not a case of discrimination, but it is a case of lack of facilities.

Senator ELLENDER. I noticed in your statistics wherein you said that the per capita income of the people in Louisiana was greater than in Georgia and in Alabama, and that the State got more money from the Federal Government for health aid than did Alabama and Georgia. Is that correct?

Miss Dowd. Yes; I think so.

Senator ELLENDER. Is that not due to the fact that Louisiana has probably more facilities than those two States and can therefore use up the money to more advantage?

Miss Dowd. Exactly. In the districts where there are so many mills, there are a great many isolated places where the only industry there is the mill, and the facilities are not there. There are no hospitals within several hundred miles of these places. In obstetrical cases, we have a great deal of trouble getting medical aid to the prospective mother and for the proper taking care of the baby afterward, and in some cases they still resort to the old-fashioned midwife—both white and colored. We have a great deal of trouble with that, both in the loss of life and in neglected medical care, and it is not because we are not trying to get rid of that sort of a situation but it is because we just do not have the funds to give us the facilities to take care of it. I am here as a southerner knowing that the Southern States—not only our State but many of the other Southern States—need exactly what this bill will be able to give us. It is for that reason that I am here to make a plea for the bill.

I do not think there is any discrimination. I heard the plea for that. If anybody thinks there is, certainly as a southern white woman,

I want to see fairness and justice given to the health program of the colored race in my particular State.

Senator ELLENDER. Is Alabama having much difficulty at this time to raise sufficient funds to match the funds that are now being offered for public health by the Federal Government?

Miss Dowd. Yes.

Senator ELLENDER. Don't you think that the same situation might prevail if this bill should go through, in that, that the funds may be hard to raise so that the State of Alabama could match them?

Miss Dowd. No; I think they would make every effort to raise them for a health program; I think that they would do that.

Senator ELLENDER. You think there is advantage enough in this bill to cause them to raise the funds?

Miss Dowd. I believe that the citizens and the members of the legislature are very keen on the subject of meeting as much as they possibly can for public health, and they have been doing that for a number of years.

As I said before, this is not a case of our being lax in our duties, but without aid from the Federal Government, we are not going to be able to make the progress in this public health work program that we could with it.

May I file a statement by the National Women's Trade Union League?

Senator MURRAY. Yes.

(The following is the statement referred to:)

NATIONAL WOMEN'S TRADE UNION LEAGUE OF AMERICA

Washington, D. C., May 12, 1939.

Hon. JAMES E. MURRAY,

Chairman, Subcommittee on Education and Labor,

United States Senate, Washington, D. C.

MY DEAR SENATOR MURRAY: The National Women's Trade Union League of America, with a direct and affiliated membership of more than a million, has gone on record in favor of the national health program which was presented before the National Health Conference in July 1938. We agree with, and endorse, the principles underlying the program and the objectives embodied in the several recommendations made by the President's Interdepartmental Committee and its Technical Committee on Medical Care. We believe that the Wagner health bill, in general, carries out the principles expressed in the national health program, namely:

- (1) Federal grants-in-aid to the States;
- (2) State administration of the programs which would originate in the States;
- (3) Wide latitude to the States in their choice of program; and
- (4) The provision of Federal technical advisory aid to the States.

The National Women's Trade Union League is strongly in favor of plans for disability compensation. We realize only too well, however, that disability compensation alone, even should full compensation for wage loss be paid, will not solve the sickness problems of working people—and especially of working women. The average annual earnings of women in many States and in many industries place them continuously in the category of the "medically needy" as defined in the national health program—that is, their incomes are not sufficient to permit the purchase of adequate, if any, medical care.

For example, in 1935-37, the average year's wages of women in manufacturing in Michigan was \$605; in Delaware, \$590; in West Virginia, \$670. In Arkansas, during the same period, the average annual earnings of white women in manufacturing was \$535; and in Tennessee, \$615.

There are some 461,000 women in the textile industries. In 1935, the annual earnings of the worker in cotton goods was \$642; in silk and rayon, \$758; and in hosiery, \$870.

Women in the service occupations are even less able to finance their own medical care. In 1935, waitresses averaged \$275 a year; chambermaids, \$548, and cooks—the highest-paid group—\$800 a year. The average annual wage of a woman worker in hotels and restaurants is a little over \$450.

For these reasons, we believe that working women—and indeed, all workers—will be no better cared for in illness under a disability compensation program unless the State program also includes provisions for medical care and public health services. Therefore, we call special attention to the provision in title XIV of the Wagner health bill (p. 42, line 21, through p. 43, line 2) and urge that every effort be made to guarantee wide coverage of workers under the disability-compensation program and the provision of adequate medical and preventive services.

The National Women's Trade Union League has been continuously active in support of maternal and child-health legislation ever since the Sheppard-Towner bill was introduced in 1921. We are, therefore, heartily in accord with the provisions of the Wagner bill which provides for the expansion of the maternal- and child-health services so ably administered by the Children's Bureau.

Our interest in the maternal- and infant-care program, however, does not permit us to lose sight of the fact that maternity is not the only health problem of women workers. According to the national health survey, conducted by the Public Health Service, women workers of all ages experience more sickness than do male workers of all ages. In a study of the members of industrial sick benefit associations, most of which pay benefits only for diseases common to both men and women, it was shown that women workers had 50 percent more disabling illness lasting for more than 1 week than did male workers. In other studies of industrial workers, it has been shown that women workers have more absences from work because of sickness than do male workers, and that this is true for all causes, except accidents. For example, respiratory diseases among women workers cause an absence rate 75 percent higher than among males, and digestive diseases caused more than twice as many absences among the women as among the men.

Women workers are exposed to many occupational hazards. In the shoe industry, for example, it was found in Massachusetts that women workers are usually susceptible to benzol poisoning. In 1936, one-fifth of the occupational diseases investigated by the Massachusetts Department of Labor occurred among women workers.

The National Women's Trade Union League is deeply interested in the development of industrial hygiene services. In title VI, part 1, section 601 (pp. 16 and 17), States will be allotted funds for the expansion of the public-health programs, including industrial hygiene activities. We would like to see that some provision is made where industrial-hygiene divisions are being administered by State departments of labor that funds be allotted directly to those departments for such services to the workers.

Because we are convinced of the acute need, among women especially, for the services outlined in the several titles of the Wagner bill, and because we know that the States with the most need are least able to provide these services from their own funds, we respectfully urge a favorable report on S. 1620.

Yours sincerely,

ROSE SCHNEIDERMAN, President.

Senator MURRAY. The next witness is Dr. Leonard Greenburg.

**STATEMENT OF DR. LEONARD GREENBURG, EXECUTIVE DIRECTOR,
DIVISION OF INDUSTRIAL HYGIENE, NEW YORK STATE DEPARTMENT OF HEALTH**

Senator MURRAY. Doctor, will you state your name and whom you represent?

Dr. GREENBURG. I am Dr. Leonard Greenburg, the executive director of the Division of Industrial Hygiene of the New York State Department of Labor.

Senator MURRAY. You may proceed with your statement.

Dr. GREENBURG. I am very grateful for this opportunity to appear before the committee, because we in New York State are very deeply interested in this whole problem of health and the protection of the health of the workers.

The need for such health protection is very great. I think few of us really realize what the needs are. The statistics are very difficult to arrive at, and very often the real and true significance is clouded because of the origin of the statistics. One can get an appreciation of the extent of the effects of industrial accidents and industrial diseases by looking at compensation costs. Compensation costs are supposed to reflect in a fair way the costs or the burden on industry of accidents and disease.

We hear a good deal of talk about the enormous costs of unemployment insurance, running from 1 percent to 3 percent, but the cost of compensation insurance in the building trades in New York is about 50 percent; in other words, for every \$100 of pay roll \$50 must be paid to the insurance company to cover the premium cost for health and safety protection in building construction. In building demolition the cost is about 60 percent, and in many industries it runs pretty high.

Senator ELLENDER. Do you mean to state to the committee that if a company seeks to build a building in New York that the premium for insurance is 50 percent of the labor cost?

Dr. GREENBURG. Yes, sir; I do. I mean to tell you, sir, that if a company puts up a steel structure in New York, that for every man who gets \$100 out of the pay roll in his pay envelope the company gives the insurance company \$50 or \$55 to cover the cost of compensation insurance.

Senator MURRAY. The insurance companies must make a pretty big profit on that.

Dr. GREENBURG. Well, if you look at their reports it does not seem to be so, but these are the essential facts in round numbers. In building demolition the costs naturally run higher; they are, I believe, in building demolition, around 60 percent.

Senator ELLENDER. Is there any difference in the premiums due to the type of building that is being erected?

Dr. GREENBURG. Oh, yes; there may be some variations in that, and there may be some variations from one company to another, based on their past record, but I am just giving you the approximate round figures.

Senator ELLENDER. Has the cost of the building anything to do with it, or is it based on the wages paid?

Dr. GREENBURG. Oh, no. The premium is based on the wages paid.

Senator ELLENDER. Solely?

Dr. GREENBURG. Yes, sir; it is a pay-roll figure.

Senator ELLENDER. That to me seems exorbitant. I hope you are wrong in your figures.

Dr. GREENBURG. Well, sir, I think I am right. They will bear looking up, if you will.

Senator WAGNER. Is there a rule in New York—I think there is in reference to the State fund, and I am not sure that it is in reference to the insurance companies—that at the end of the year, if there has been an exceptionally good experience, there is a reimbursement of part of the premium paid?

Dr. GREENBURG. In the State fund, of course, there is, Senator; and there is also in the mutual insurance companies. They very frequently pay back a premium at the end of the year. Some companies, of course, are self-insured, and in that case they put up a deposit to cover any demands which may be necessary; but the private companies, the stock companies, to the best of my knowledge, do not pay dividends back at the end of the year.

Senator MURRAY. Well, Doctor, the companies that are self-insured, certainly would be saving money by being self-insured, would they not? They would not pay out 50 percent of the labor cost for accidents, would they?

Dr. GREENBURG. Well, Senator, they might save money. On the other hand, if they had a bad experience on a job, they might go in a good deal deeper.

Senator MURRAY. But, generally, you would expect them to save money on that kind of a system.

Dr. GREENBURG. Well, as a rule I would expect a high-class company with perhaps a man in charge of its safety work and a physician in charge of its medical work to come out a little better; yes, sir.

Senator MURRAY. Is the building trade the most hazardous industry in the country?

Dr. GREENBURG. No; I would not regard it so. I think that perhaps mining operations and excavations in rock is a good deal more hazardous.

Senator MURRAY. I was going to suggest that.

Senator ELLENDER. The building of tunnels?

Dr. GREENBURG. Yes; I was going to come to that.

Senator WAGNER. There are other rates than those you have given?

Dr. GREENBURG. Oh, yes; I just cited an extremely high rate. For instance, clerks in department stores and clerical workers in offices, the rate there is very, very low.

Senator ELLENDER. This 50 percent cost that you mentioned, do they cover accidents only?

Dr. GREENBURG. That covers accidents, but the occupational diseases rate would be very low in that kind of an industry. Is that what you had in mind?

Senator ELLENDER. I am talking about the building trades.

Dr. GREENBURG. In the building trades the rate really covers only accidents, because that is their chief loss in funds.

Senator ELLENDER. If a person should get sick on the job, he gets nothing? He simply goes to bed, and when he gets well he comes back to work and he is not paid in the meantime?

Dr. GREENBURG. If he becomes ill due to an occupational disease, he would get compensation.

Senator ELLENDER. Yes; I understand that, but I am talking about the ordinary illness, such as a bad cold or the like.

Dr. GREENBURG. He gets no compensation for that. That is something entirely separate and is his own private affair at present.

Senator ELLENDER. The rate that you are just giving us there, to me just sounds incredible.

Dr. GREENBURG. Well, it is a very easy thing to check up, Senator.

Senator ELLENDER. I am not trying to say it is not so, and I am not even insinuating that you are not telling us the truth about it, but I never realized it could be that much.

Dr. GREENBURG. I do not mean to say that the figure is exact, but that is the figure in round numbers. It varies between different types of buildings, and it might vary between contractors, but in general that is the figure.

Senator MURRAY. You may proceed.

Senator WAGNER. I should like to ask a question if I may.

Yesterday, we had a doctor here representing some medical association from Pennsylvania, and he suggested that we ought to have a sort of a 10-year moratorium on all of this health activity, to just leave it alone for 10 years and do nothing about it, no more than what we are doing now. Would you subscribe to any such condition as that?

Dr. GREENBURG. Absolutely not. I do not know what prompted him to say that, but I certainly would not subscribe to it.

Senator WAGNER. Would you regard that as an astounding proposition?

Dr. GREENBURG. I would, yes; I cannot understand what the reason might be for such a statement.

Senator WAGNER. He said to spend no more money for a while for health.

Dr. GREENBURG. Well, I am certain that these facts certainly speak a different language. I should like to present a few more to you.

In 1937 there were approximately 19,000 occupational deaths in the United States; that is, deaths primarily from occupational injuries. There were 127,000 permanent injuries, and slightly less than 1,700,000 temporary injuries, according to estimates of the United States Bureau of Labor Statistics. The time lost was roughly 4.3 days for every worker employed during the year.

I think with reference to the problem as a whole, it is fair to say that this problem is important not alone in any one State, but it is of tremendous importance all over the United States. It would take quite a while to present to you some reasoning to show that many of our categories of death returns are swollen by the effects of employment in various industries, but that in my opinion is a true statement. However, we must pass that for the time being.

I do not intend to speak about health insurance. I did not come here for that, and I do not think I was invited to speak about that, but I merely want to speak about industrial hygiene as it is presented in title VI of the proposed Wagner Act.

Throughout the United States, industrial hygiene work is carried on by subdivisions of State health departments or State labor departments, and in a few cases, perhaps one, or two, or three cases, both departments have some such activity. In New York State, industrial hygiene is conducted solely and completely by the labor department. A few years ago, when Dr. Parran was health commissioner of the State of New York, he and Elmer Andrews, then labor commissioner, entered into an agreement to conduct some joint studies, but, aside from that, the State department of labor conducts all of the industrial hygiene work in the State of New York.

At the present time we are spending between \$125,000 and \$150,000 a year for this purpose. I think it probably represents the largest State expenditure in the United States.

This industrial hygiene work as I shall point out to you later, is completely interwoven with the labor law of the State of New York. They are part and parcel of each other, and the duties of the commissioner of labor are primarily set forth so as to protect the health and safety of workers in industry, and that is one of the chief duties of the labor commissioner of the State of New York. At the present time we have more than 2,000,000 workers in the State, and a total State population of over 14,000,000, as you know.

We have a tremendous number of large jobs. I would like to cite one of them for you. We started out about a year ago to construct an aqueduct in New York State, 85 miles long, from the east branch of the Delaware River to New York City, averaging 24 feet in diameter, and completely taken out of solid rock. Last night I roughly computed that this will require the removal of 8,000,000 cubic yards of solid rock in the State of New York. This, together with our other mining operations in the State, of which we have several, our large number of excavation projects, our tunnels, such as the East River tunnel and the various tunnels around New York City, and road building, make silicosis a real hazard in New York State. We have spent a great deal of time in developing techniques for meeting this hazard.

The point I want to make is that in spite of the fact that we spend \$125,000 or \$150,000 a year, we have not adequate funds to meet this job. The Delaware aqueduct started about a year ago and we approached the Governor for more funds. He was very cordial and receptive, but he pointed out to us that the legislature was not in a mood to give us more funds for any purpose. Just before leaving the office, I had the good news that my own budget was to be cut \$13,500 starting July 1 coming.

Now, in the face of these enormous tasks and in the face of the demands for work on the part of many agencies, which I shall point out later, we find ourselves unable to cope with the problem in a way which the workers of New York State deserve.

Under the present Social Security Act, we have received no money. We made application for money in the usual fashion through the State commissioner of health, but we did not succeed in obtaining any funds, and to the best of my knowledge no State wherein industrial hygiene is done in a labor department has received any money from the present Social Security Act.

Under the proposed Wagner Act, we feel that we would be very much in the same boat that we are now, that we would again be met with the refusal of funds, and we believe that this will again place us in a very unsatisfactory position. The way the Wagner Act is at present worded would make it necessary for the State commissioner of labor to have an approval from the State commissioner of health on his approach to this problem before getting any money from the State commissioner, who is in a State organizational plan on an equal footing with him. The law says that a State plan to effectuate the purposes of this title shall (1), (2), (3) provide for the administration of the plan by the State health agency or for the supervision by the State health agency over any part of the plan administered by another State agency or by a political subdivision of the State.

In other words, this plan which we have developed in New York State, which has been going on continuously since 1911 or perhaps before that, we have it now coming under the supervision or meeting with the approval of the State Health Commissioner who up to this time has done no industrial hygiene in the State of New York.

Senator ELLENDER. I raised that point, I think the first day that we had hearings, with particular reference to the State of Louisiana. We have in the State a hospital board, and since this bill deals with hospitals, and the care of the sick, and so forth, it was suggested that either an agency of that kind or a health officer in the State be selected. What would be your suggestion so as to cover your case? What would you propose?

Dr. GREENBURG. Well, I believe that money should be allocated from the Federal Treasury to the Federal Department of Labor, and in turn passed down to the Labor Departments who are doing or who can set up an approved plan for carrying on the work on special health conditions its various aspects.

Senator ELLENDER. Do you find that in the State of New York various agencies have been established to deal with health that are antagonistic to each other? Is there not cooperation of some kind?

Dr. GREENBURG. Well, I should say to the best of my knowledge there is cooperation; yes, sir.

Senator ELLENDER. What reasons do you have to lead you to believe that you will not obtain your just proportion of this fund, or whatever part is allocated to your State?

Dr. GREENBURG. The best reason I have, Mr. Senator, is that we applied for money and did not get it, so I think that is a fairly good reason.

Senator ELLENDER. Is the bill under which you applied worded the same as this one?

Dr. GREENBURG. To the best of my knowledge it is in general the same. It is the present Social Security Act.

Senator MURRAY. Do you think that silicosis and these dust diseases are so serious and widespread that there should be a special title or section in this bill making provision for the care of that situation?

Dr. GREENBURG. Well, I think that pulling out one separate category of disease, such as silicosis, might make it wise to set up another bill, although I do not know much about bill drafting. The point I do want to make, Senator, is that under the present Social Security Act, in spite of our urgent need for money and in spite of the fact that with due modesty I think that we are doing a pretty good job, we have not succeeded in obtaining any money, and I feel that we are likely to fare the same way under the new Wagner bill; and, therefore, I would suggest that it be appropriately amended so as to take care of such departments as my own, and there are several of them in the United States, and there may be possibly more.

Senator ELLENDER. For the record, exactly how does your work differ from that of the health officer in your State? Is it a different type of work that you have?

Dr. GREENBURG. We do everything pertaining to the health of the worker in industry.

Senator ELLENDER. What does the health officer do?

Dr. GREENBURG. The health commissioner of the State of New York has no jurisdiction over such work.

Senator ELLENDER. Why should he not have? Why should you have duplication?

Dr. GREENBURG. There is no duplication now. It is all in the Labor Department.

Senator ELLENDER. Why have two separate departments? I am just wondering?

Dr. GREENBURG. I do not think there should be two; I think it should remain in the labor department.

Senator ELLENDER. In other words, each for himself?

Senator WAGNER. Let me ask you there, Doctor—you are working under a department that was also a labor department?

Dr. GREENBURG. Yes, sir; I was going to come to that in a few minutes.

Senator WAGNER. You are dealing, however, only with the industrial worker, are you not, and his health in his employment? There is that limitation, is there not?

Dr. GREENBURG. Yes, sir; I should say so.

Senator WAGNER. The health department has a much wider field, hasn't it, and it does not intrude at all upon your field, does it, in the State of New York?

Dr. GREENBURG. No, sir.

Senator WAGNER. They are absolutely separate, so that there is not any conflict there at all?

Dr. GREENBURG. That is right; yes, sir.

Senator WAGNER. And you are able to get along very well in New York State in your respective fields without any conflict or interference; is that correct?

Dr. GREENBURG. Yes, sir.

Senator ELLENDER. Either could do the work of the other, could he not?

Dr. GREENBURG. Perhaps we will come to that in a minute, but have I answered your question, Senator Wagner?

Senator WAGNER. Yes.

Dr. GREENBURG. There is no conflict in the State of New York. It is clear that all of the industrial health work is in the labor department.

Senator MURRAY. And properly so.

Dr. GREENBURG. In my opinion; yes, sir.

Senator ELLENDER. But why could that same work not be handled by the health department of the State rather than your department, or vice versa, let us say?

Dr. GREENBURG. There are some people who contend that it can. If I may postpone answering that question for a few moments, I should like to outline why I think it logically belongs where it is and can do a better job where it is. May I do that?

Senator MURRAY. Yes.

Dr. GREENBURG. This exclusive conduct of industrial hygiene, or more or less exclusive conduct of industrial hygiene, in New York by our labor department has not in any way interfered with the cooperation with the State department of health or local departments of health. I should like to make myself clear on that score. As I

pointed out before, Commissioner Andrews and Commissioner Parran entered into this agreement to do cooperative studies, and we have been working along those lines ever since that agreement was signed.

Senator MURRAY. The effort to combat those industrial diseases such as silicosis originated in Labor's ranks originally, did it not? No attention whatever was given to it by the health officers of the country; isn't that true?

Dr. GREENBURG. That is true in New York State. In some States it might have been first done by health departments.

Senator MURRAY. In fact, they refused to recognize that there is such a disease as silicosis for many years, and it was only in recent times that they tried to do anything for it. As far as my own experience is concerned, out in Montana we had that disease out there very seriously, and it was widespread. No hospitals were set up for it in the early years, and the individual miners who contracted the disease had to take care of themselves, and I believe that was true in many sections of the country until more recent times.

Dr. GREENBURG. I believe that is.

Senator MURRAY. We had a very serious epidemic of silicosis right here near Washington in some construction work on a tunnel, Gawley's tunnel, where the men were affected by the disease very quickly and died like flies, I understood. The papers here carried on quite a lot of publicity with reference to that situation. So it seems to me that there should be a separate section set up or an independent measure enacted for the purpose of carrying on some work in handling this disease, which is serious and has a tremendous effect on the workers of the country; don't you think so?

Dr. GREENBURG. I think it would be a great contribution; yes, sir.

Senator WAGNER. Doctor, you remember that I was chairman of the factory commission in 1911, that exposed all of these conditions in our State that were absolutely neglected, of occupational diseases. But since that time has not the Labor Department addressed itself to that?

First, we had legislation—about fifty-odd laws passed between 1911 and 1918 to deal with all kinds of hazards, including occupational diseases, and it has resulted in New York, has it not, in the elimination, or at least the reduction, of a great deal of the occupational diseases?

Dr. GREENBURG. I would not say, Senator, that it has resulted in a great reduction of occupational diseases, and I believe that we have built up a very construction department to deal with these problems. I cited the case of the Delaware aqueduct. We have at the present time two engineers working on that project, and we have dust and ventilation completely under control, and toxic gases after blasting, and we think if we are permitted to carry on by having a sufficient amount of money that we will not repeat the Gawley Bridge in New York State.

Senator WAGNER. You say that there has not been any elimination. I recall distinctly—I am not going to mention the names of the factories—but in the western section of New York we discovered a particular industry in which there was a good deal of dust involved in the activities of the industry. When we went in there it was so thick that we could not see a man 10 feet away, and he was absorbing and breathing in all of this dust. The doctors who were on our com-

mission with us informed us that a man in that work could not last more than 3 or 4 years without going into a tuberculosis institution. Nothing had been done along those lines before that; there were no adequate laws, and before then the labor department was a very insignificant department in the State of New York. Now, I think it is the most important of all. That has been corrected by legislation, because I have been there since and that condition does not exist at all. So far as that particular industry is concerned, or those conditions, they certainly have been eliminated, and the occupational diseases resulting from the breathing in of this dust have been greatly reduced.

Dr. GREENBURG. Oh, yes. I think our program from 1911 up to the present has gradually rounded this out and succeeded in doing a very constructive job in the elimination of many hazards. There is still a great deal to be done.

Senator WAGNER. Oh, yes.

Dr. GREENBURG. There are new things coming up all the time; there are new chemicals, and new poisons, and new techniques, and new operations, and new construction work. In New York City, for example, at the present time on that East River tunnel, we are working under the highest pressure, or we were up to 2 weeks ago, that was ever used around New York City—not quite 40 pounds of air pressure above atmosphere. Never before has a high pressure like that been used around New York.

Senator MURRAY. How long can a man remain under that pressure?

Dr. GREENBURG. We have had a remarkably good record on that particular job. We are now compiling the figures on the cost of compensation on that particular job—that particular risk. We believe that it will come out to be a very low figure.

I should like, if I may have a few minutes, to refer to the report of which Senator Wagner spoke. This committee of which Senator Wagner was chairman was organized in about 1911 as the result of the two serious fires in New York State. The vice chairman of the committee was Alfred E. Smith, and some of the members were Samuel Gompers, Mary Dreyer, Simon Brentano, and Charles M. Hamilton. This series of reports of the New York Factory Investigating Committee, starting in 1912 and continuing to 1915, is a landmark in New York State factory legislation, and I think that, so far as I can see, everything that that report pointed out at that time still holds good and true. I should like to quote a few pages from this particular report, which is the thirteenth report, volume 1.

One very peculiar thing about it is that apparently this committee or commission never at any time during the course of its deliberations ever considered the subject of switching industrial hygiene and health and turning it over to the health department. To me that is very significant. I scanned the reports very, very carefully and tried to find out if they had deliberated that particular phase of the subject. They apparently concluded that it was logical to put the protection of the health of the worker in the labor department and surround the worker with all the necessary safeguards and give the labor department adequate legal backing and money for that purpose.

The report says:

Laws enacted to protect industrial workers and to improve their condition are of little value unless adequate machinery of government be provided to administer them intelligently and to enforce them effectively. The labor department

is charged with administering the statutes dealing with the health and safety of the men, women, and children employed in the factories of the State. There are in the State over 40,000 factories, in which 1,250,000 workers are employed. If to these is added the many thousands of employees in mercantile establishments, the workers in tenement houses, those employed in tunnels, mines, and caissons, and those engaged in the construction of public works, it is safe to say that the department of labor is directly responsible for the well-being of upward of 2,000,000 workers. The department of labor should therefore be one of the great departments of the State. Up to the present, however, this department has occupied a minor position, and until recent years practically no attempt has been made to raise it to a position of prominence commensurate with its important duties and functions. In this, the greatest industrial State of the Union, but little attention has been paid to the preservation of the State's most precious asset—the workers within its bounds. Consequently very little attention has been given to the department which is charged with the responsibility for safe and sanitary working conditions.

I must not take up too much of your time, but I have one other extract from the conclusion and report which I should like to read to you:

The most important recommendation that the commission presents deals with the reorganization of the department of labor. Furthermore, the most important feature of this reorganization is the proposed creation of the Industrial board. To this board are given large powers for regulation of industry—powers that permit the board, with due discretion and reliance both on personal knowledge and the advice of its experts, to make particular regulations with reference to the special industries involved. Through this plan of reorganization, the Department of Labor will be an effective instrument to safeguard the workers of the State. It will be not only an enforcing authority but, through its division of industrial hygiene, it will also be an investigating body which shall study specific dangers and their remedies. Above all, in the industrial board, the Department will have an agency to frame standards and regulations applicable to varying conditions of industry.

I would like to read many more extracts from this most enlightening document—and, so far as I know, there is no more enlightening document in the American literature or in any other literature on the subject of the health and safety and protection of workers in industry than this report of the Factory Investigating Committee of New York State.

Senator ELLENDER. Who did you say is the author of that report?

Dr. GREENBURG. Senator Wagner was the chairman.

Senator WAGNER. I concede all of that. [Laughter.]

Dr. GREENBURG. As the result of this report and the gradual development over a period of years, we have developed a division of industrial hygiene which supplies technical service to the Department of Labor, and our division of industrial hygiene is based on the recommendations of this report. We have a staff of 5 physicians, exclusive of the director, 7 chemists, about 10 or 11 engineers—a total staff altogether of 35 persons; and, as I told you before, we spend approximately \$135,000 or \$140,000 a year for the cost of our department.

So much for the division of hygiene, but I should like to point out some of the interrelations of the division of hygiene with other divisions of the Department of Labor, which make it seem reasonable, in my opinion, that this work should be in the Department of Labor and not in the Department of Health primarily—it should be fostered in the Department of Labor in order to achieve the end in which we are all interested.

In the first place, in our Department of Labor we have a statistical office. This statistical office does not compile death rates on the or-

dinary population, but statistical facts on the preparation of statistics on the number of accidents in the State and the number of accidents for which compensation is applied, and the number of cases in which compensation is secured, and the amount of compensation, and this office also does the same function for occupational diseases, so that we immediately have at our disposal important statistical figures and indices which we require in our preventive efforts. Moreover, this statistical division has a very unusual office in which we have a card representing each factory in the State of New York, and on this card is listed every claim for compensation against that factory for any cause, so that if the Division of Hygiene gets suspicious about any industry or if we get suspicious about any one plant in this industry, we can turn to the records in our Statistical Division and immediately tell what their performance has been. That immediately tells us whether we need to go up there to make a hurried investigation or what we need do or need not do in connection with that plant.

So far as I know, no health department has such service, and they cannot have it as a rule because they are not tied up with a compensation division about which I should like to speak next.

The compensation division in the New York State Department of Labor compiles all of the records and has files of all cases where claims are made for compensation, and, of course, this is of enormous value to the Division of Industrial Hygiene, because we can turn to these records and find medical histories and medical testimony and other evidence concerning the effect of the materials on the health of workers, and from that we can do something more. We serve to aid in the adjudication of compensation cases by having one of our experts—one of our medical experts—at every hearing of this particular part of the compensation calendar. When a man makes a claim for compensation for an occupational disease we get a record of his claim and our medical expert goes to the factory where he works, he sees the process at which the man was engaged, he takes sample of the material to which the man was exposed, and he brings it back to the chemical laboratory for analysis, and finally he writes a report based on the medical findings, and the chemist writes a report on the material analyzed, and they go into the compensation folder as evidence showing whether or not there is causal relation, in the opinion of our expert.

This, I think, is of enormous service to the compensation division, and we, in turn, get enormous value back from them in our ability to go over our batch of compensation files and cull out all of the material in which we are interested. We have an enormous case record file of occupational-disease claims and occupational-disease findings which no department of health, to the best of my knowledge, in the United States has.

Senator ELLENDER. Do all compensation cases pass into your department?

Dr. GREENBURG. No, sir; all compensation cases go into the Compensation Division, and the claims for compensation for occupational disease come to our division.

Senator ELLENDER. Is the evidence you gather used to help out the person to collect his just dues?

Dr. GREENBURG. Well, the evidence which we gather is presented by our impartial experts for whatever it may be worth, one way or the other.

Senator ELLENDER. And you consider that a service, of course, to the employee?

Dr. GREENBURG. We consider it a great service; yes, sir.

Senator MURRAY. In many States of the Union they have no compensation laws for occupational diseases, such as silicosis?

Dr. GREENBURG. That is correct; yes, sir.

Senator MURRAY. Do you think that there ought to be such laws in every State where they have those diseases?

Dr. GREENBURG. I certainly do, sir. I cannot see any philosophical reason why if a man gets his hand cut off he should get compensation, but if his lungs are ruined that he should not. I cannot see any particular reason why one is not just as justifiable a cause for compensation as the other.

In addition to this Statistical Division and the influence of compensation on industrial hygiene and the influence of industrial hygiene on compensation, I should like to point to another condition which we have in the Labor Department, which I think and feel is of enormous value in attaining this end, and that is the Inspection Division. We have in New York State about 170 inspectors now, factory inspectors, whose duty it is to go out to the factories and inspect them at least once a year and more often if necessary. When they are there, they make inspection of the whole factory, the lay-out from the point of view of fire protection, safety hazards, occupation-disease hazards, poisonous substances, or anything else bearing on the problem which is included in many of the codes of the Department. This inspection service is important. I do not think that anybody can wave it off with one wave of the hand. If it is to be neglected and put in the background, it has to be done on the basis of logical cold reasoning.

I should like to draw a parallel for you. In the State department of health the State health commissioner is confronted with the control of milk, or let us assume that he is, and for the control of milk he has a certain number of inspectors who go out to the various dairy plants and pasteurizing plants and see that the conduct of their work is satisfactory. Now, doing industrial hygiene work without a similar staff of inspectors is like doing milk-control work without inspectors—one is quite as impossible as the other, in my opinion. How could any division of hygiene with a staff of 50 or a staff of 75 or 100 do research work, each problem of which requires a great deal of study, and expect to cover 50,000 factories in a State such as New York, and in addition its many tunnels, mines, quarries, and other hazardous employment? It is just impossible to say that that can be accomplished, and I am of the opinion that we might as well admit it right away if we want to face the facts. No health commissioner in the United States would accept the responsibility for the milk of the State if he did not have inspectors to inspect the milk, at least he would be sitting on a keg of dynamite if he did; and no city health commissioner would accept the quality of the milk unless he had his own inspectors or unless he were covered by State inspectors; and I do not see how any health department can expect to function unless it has a staff of factory inspectors, and, if you switch industrial hygiene or support the health

department, you should logically switch all of the factory inspectors over to the health department in order to carry the problem through.

The next division we have in the department of labor which is of invaluable assistance is the division of codes. This division prepares the standards which were originally called for by the Wagner commission, which are flexible and relate to various separate industries for the control of their hazards. For example, in the last couple of years—we have promulgated—in 1937, to be exact, we promulgated the code on rock drilling, and we are now enforcing a code on the control of dust in rock drilling. In New York State last week our advisory committee reported out a code on stone cutting. On the 17th we are having a meeting on our foundry code, and in a couple of weeks after that on a stone-crushing code which cover our four essential and hazardous dusty trades in New York State. Without these codes it is quite impossible, in my opinion, to do any industrial hygiene.

Some people will tell you that the health department doesn't need codes, and they will also tell you that the health departments do not need police power, but anybody who says that a health department does not need police power does not understand what the public health law is based upon, because it is based upon the police power of the State; and if anyone says that a labor department does not need codes, ask him how he administers his act relating to pasteurization and control of milk, and you will find there plenty of codes controlling milk and other communicable diseases and various other problems with which the health department is confronted.

Don't let them say that the health department don't take people into court the way the labor departments do. Because the city of New York, to the best of my recollection, takes about 30,000 people into court each year, and that includes a large number of industries, in fact it is mostly industrial groups.

Senator WAGNER. I would like to ask you a question there, Doctor. The point you are trying to make, as I understand it, is that the money for the industrial hygiene is to be allocated for use by the department of labor rather than the department of health?

Dr. GREENBURG. Yes, sir.

Senator WAGNER. But outside of that, so far as the general provisions of the bill are concerned, don't you favor Federal aid to the States?

Dr. GREENBURG. Oh, yes; I am very much in favor of Federal aid, Senator. I do not want to give any other impression. I do not see how we can get around these enormous problems we have otherwise. I do not see how we can control silicosis at this time.

Senator MURRAY. The principal way to combat some of these diseases is mechanical, is it not? Take, for instance, silicosis; one of the chief methods of combating silicosis is through mechanical means in the properties where the disease occurs?

Dr. GREENBURG. Yes, sir; by engineering and techniques of various kinds.

Senator MURRAY. So that your idea is that a subject of this kind should be handled through the Labor Department that has the inspectors and where they are able to make the studies and carry out the program that really will take care of the situation?

Dr. GREENBURG. Yes, sir; I am trying to show that the services and devices which are normally present in a good labor department or which can be put in a good labor department will so reinforce these preventive techniques that the ultimate result which should be achieved will be greater than by doing anything else or by carrying on the work in any other way, and I have tried to point out that one of those resources is the inspection division; another is the statistical division, our compensation division, and our code division.

Finally, we have two more divisions in the department which examines plans, one for new buildings, the engineering division, in order to see that they are satisfactorily built in the first place, and second, the plant division which we have in the division of industrial hygiene which examines plans on ventilating systems for the control of hazardous materials in industry.

All of these additional services are not present in the department of health and are present in a good department of labor or can be put in a good department of labor and can reinforce and strengthen the preventive techniques in industry, and that is the only way the problem can be licked, in my opinion.

I shall not bore you by reading any contributions which I think our department has made up to the present time. I believe we have made a great many, and I think that students of this problem and workers in the field of industrial hygiene in general will agree that we have made some significant contributions in this field. But I just want to dwell on one or two mooted questions which I hear spoken of from time to time by some of the workers in the field.

Senator ELLENDER. Doctor, before you go into another phase of the bill, as I understand title VI of this act, it does provide that the money is to be allocated to the States according to their need for carrying on work in industrial hygiene. Is that true?

Dr. GREENBURG. Yes, sir.

Senator ELLENDER. Would it not be reasonable to assume that in any plan that is worked out by a State, that any amount of money allocated to a State has an industrial hygiene department, as New York has, that it would be natural for that money to be spent under the direction of the head of such department?

Dr. GREENBURG. It might seem so; yes, sir.

Senator ELLENDER. How could it be otherwise? The bill is very specific.

Dr. GREENBURG. I cannot tell you how it can be otherwise, but I should like to state this fact: That the Public Health Service has given out, to the best of my understanding, approximately \$500,000 or \$600,000 in the last year for industrial hygiene. I believe the figure is \$550,000 in round numbers. In spite of the fact that New York State applied for some of this money, we have not gotten it. That is the answer to that question, it seems to me.

Senator ELLENDER. Dr. Parran, would you mind answering the question, please? Why is it that in the distribution of the Federal money for hygienic work in the State of New York it was not utilized by the head of the department of industrial hygiene in New York?

Dr. PARRAN. I am sorry; I cannot speak for the present health commissioner of New York State. We have approved all of the requests for the allocation of moneys submitted by the State of New

York. Under the present title VI that means the State health commissioner. I think the point might be a bit clarified if I were to point out that the language in the present pending bill is very much broader and is much more specific than the present title VI. Title VI at the present time uses only the term "public-health work." Dr. Greenburg this morning has gone to some length to prove that the work that he is doing is not public work but an activity of the Department of Labor, and therefore industrial hygiene. From a practical point of view, a State health commissioner is confronted with the relative need; after all, the Governor determines, I should assume, the purposes for which the Federal funds are to be spent, and in New York State the important task of administering to the health of school children is under the department of education. I think it is likely the department of education also wished to have some of these rather limited moneys now being made available under the Social Security Act. Similarly, there is a department of mental hygiene, and none of us denies the great importance of mental disease, and yet none of the present limited funds has been spent for that purpose. Under the language of the pending bill mental hygiene and industrial hygiene are particularly mentioned as an object.

Senator ELLENDER. That is why I was stating to Dr. Greenburg here that I do not see how he could escape from obtaining money under this bill as it is presently drafted. Do you?

Dr. PARRAN. I agree with your statement.

Senator MURRAY. Proceed, Doctor.

Dr. GREENBURG. Some people will tell you that one of the great defects in doing industrial hygiene work in the Labor Department is the fact that you do not get cooperation of industries and other groups. In the first place, I would like clearly to state for the record that we get complete cooperation from labor, employers, and industry.

The second thing we find is that we get a tremendous amount of cooperation from insurance companies. They have to deal with compensation cases, and they come in to consult with us about the origin of some of these cases and how they may be prevented; and we get finally an enormous amount of cooperation from labor unions, and we have dealings with most of them.

I should like to read you, in this connection, a statement prepared at one of the meetings of the New York State Federation of Labor by the Pressmen's Union and sent to the Governor of the State of New York. They speak about an investigation disclosing 138 cases of poisoning, and part of the resolution which they adopted reads as follows:

Whereas there are no existing laws in the State of New York prohibiting the use of benzol as a solvent in rotogravure printing inks; and

Whereas the prompt action of the State department of labor in discovering this health hazard and in getting the employer to discontinue its use until safe methods can be found to resume its use has no doubt been responsible for saving the lives and preserving the health of many members of the printing trades; and

Whereas the whole-hearted cooperation rendered by the State department of labor in this situation is but testimony to its great work in behalf of labor and deserves the united praise of the printing trades of New York State: Therefore be it

Resolved, That this Forty-second Annual Convention of the New York State Allied Printing Trades Council, convening at Buffalo, N. Y., on July 25, 1938, go on record, in recognition of the efficiency of the State department of labor for its timely action and inquiries, which resulted in the discontinuance of the use of

this poisonous material and in providing the means and the facilities for expert medical examinations and treatment of the unfortunate victims of this industrial hazard, and that we commend the excellent public service in that connection of Industrial Commissioner Andrews—

And so forth.

That is from the New York Pressmen's Union.

Finally, I should like to read another resolution. Some people will tell you that industrial health workers in the labor department do not get the cooperation of the medical profession; and if I may have the privilege at this time, I will state the substance of it and file the resolution. I will just read one clause, if I may.

Senator MURRAY. You may submit the resolution.

(The same is as follows:)

RESOLUTION URGING CONTINUED SUPPORT FOR PREVENTIVE HEALTH PROTECTION ACTIVITIES IN THE STATE OF NEW YORK

Whereas many workers in industry are exposed to conditions conducive to occupational injuries and occupational disease; and

Whereas the workers of New York State are entitled to protection against such conditions in order that their health may be preserved at all times; and

Whereas local communities do not possess facilities for the conduct of such work; and

Whereas the only health and safety protection in New York State is lodged in the State department of labor, division of industrial hygiene; and

Whereas this unit of the State government has performed most commendable work and has contributed greatly to the protection of workers against accidents, silicosis, and occupational poisoning; and

Whereas the physicians of the State of New York feel these efforts are deserving of the full support of the State of New York: Therefore be it

Resolved, That the Medical Society of the State of New York, through its house of delegates, goes on record in favor of the continuation of these preventative health measures on behalf of the employed population of the State of New York, and for the full support of these preventative measures; and be it further

Resolved, That this action by the house of delegates be forwarded to the appropriate State governmental authorities.

Passed unanimously, April 25, 1939.

Senator MURRAY. Do you wish to propose a formal amendment, Doctor, on this point?

Dr. GREENBURG. I have not prepared any such amendment, Senator.

Finally, in closing, I should like to summarize by saying that the facts which I have outlined to some extent, at any rate, justify the labor department in expecting money for aid with this problem which we consider so important. We believe that the Federal Government does not intend to interfere with the functional arrangement of the State set-up. We do not believe that the Federal Government intends to make the State commissioner of labor appeal to the State commissioner of health for funds, nor do we think that it is exactly reasonable, and we believe that the present Wagner bill should be amended so as to make provision so that labor departments throughout the United States can obtain money if they are prepared to do any conscientious preventive work in this field.

Section 608 of the proposed Wagner Act, S. 1620, devoted to the approval of State plans, reads as follows (pp. 18 and 19):

Sec. 608a. A State plan to effectuate the purposes of this title shall, * * *

(8) Provide for the administration of the plan by the State health agency or for the supervision by the State health agency of any part of the plan administered by another State agency or by a political subdivision of the State.

It is apparent from paragraph 3 above that in order for the State department of labor to receive Federal aid for industrial hygiene work under this act, the supervision of any such industrial hygiene work would have to be provided by the State health agency.

Supervision may be defined as "the action or function of supervising, oversight, superintendence." In other words, according to the terms of paragraph (3), the State commissioner of labor would be required to yield "oversight" and "superintendence" of such industrial hygiene work paid for by Federal funds in the State of New York, to the State department of health. It is hardly necessary to point out that this would not be agreeable to the State industrial commissioner nor would it be legally possible for, by law, in the State of New York the State industrial commissioner is charged with this superintendence and cannot relinquish it at will.

It must be clear to anyone viewing these facts that S. 1620, proposed by Senator Wagner, would fail to advance the cause of industrial health in the State of New York.

I thank you.

Senator MURRAY. Thank you, Doctor.

The next witness is John M. Falasz.

STATEMENT OF JOHN M. FALASZ, REPRESENTING THE DIRECTOR OF LABOR OF THE STATE OF ILLINOIS

Mr. FALASZ. I should like to have the record show that I am appearing here instead of Mr. Martin P. Durkin, director of labor of the State of Illinois.

Now, Mr. Chairman and Senators, it so happened that I came in here this morning with Dr. Greenburg, having met him at the Department of Labor Building, although I was scheduled to appear before this committee this afternoon, and it is fortunate that I came in inasmuch as I will not take as much time as I anticipated, for Dr. Greenburg has covered most of the points which I had in mind and which I intended to bring out before this committee.

The set-up in our labor department is very much similar to that at New York. We have an industrial hygiene commission which is a unit of the Division of Factory Inspection, and the Division of Factory Inspection is a unit of the Department of Labor. The functions of the Industrial Hygiene Division of Illinois are very much similar to New York, and I shall not go into them except to say that the main purpose is for the prevention of occupational diseases.

But I wish to bring out this point to this committee. In Illinois the division of factory inspection is particularly empowered by the legislature of the State to enforce all safety methods pertaining to the health and safety of workers in industry. There is no other agency in the State with the exception perhaps of some municipalities who may enact their own city codes, but as far as the State at large is concerned, the division of factory inspection is empowered to enforce all health and safety legislation. Consequently, the Division of Industrial Hygiene functions and coordinates and cooperates with the Division of Factory Inspection.

Now, I might call to the attention of this committee that the Public Health Service of Illinois because of allocation of funds committed

by the United States Public Health Service has a separate unit termed an Industrial Hygiene Unit. Our work in the Industrial Hygiene in Illinois, as I mentioned before, is for the prevention and elimination of any hazards that might be found in industry. As I understand their work, they are aiming toward the same end. However, our division is the only law-enforcing division in the State. The Public Health Service if it enters a plant, some factory, does so only by courtesy of the Labor Department; in other words, whatever right of entry they may have is given to them as a courtesy by the Department of Labor to carry on whatever work they may do.

It is our experience, likewise, from information that we have received from time to time from written reports of the Hygiene Unit of the Public Health Service that their work has primarily been concerned with surveys.

Now, I want to sell this committee's attention to this fact, that the Industrial Hygiene Unit of the Department of Labor carries on not only a survey work in its inspection work, but likewise under the code has the right under the law to right directory orders for the correction of any particular hazards that they may discovery in their inspection work.

Senator ELLENDER. Will you answer a question for me, please?

Mr. FALASZ. I will, Senator.

Senator ELLENDER. Under what department in your State is this industrial hygiene work that is carried on in the State of Illinois?

Mr. FALASZ. Department of Labor.

Senator ELLENDER. And has the hygiene or health department of the State any jurisdiction at all over it?

Mr. FALASZ. None whatsoever.

Senator ELLENDER. No connection?

Mr. FALASZ. No connection.

Senator ELLENDER. Do they do separate work? Do they cooperate in any way?

Mr. FALASZ. Only to the extent of giving us a typewritten report, sometimes consisting of three to four to five pages on an ordinary letterhead to inform us that they have inspected a particular plant, and found so many employees, found particular conditions existing there, and maybe some particular points, and to inform us what they are, and so on.

Senator MURRAY. You would already have that information, wouldn't you?

Mr. FALASZ. If we had not we have to send out our chemist or our ventilating engineer or a factory inspector to cover that plant and go over and do that work again.

Senator MURRAY. So there is complete duplication?

Mr. FALASZ. Right.

Senator ELLENDER. You say that the Public Health Department of the State of Illinois has a hygiene unit whose business it is to make surveys only?

Mr. FALASZ. That is from our experience as nearly as I can get.

Senator ELLENDER. What would be the objection in having under the Public Health Department a department for industrial hygiene, the same as you have under the labor department? What would be the objection to that? Why have it under the Labor Department, in other words?

Mr. FALASZ. Because the labor department is the only agency in the State that is empowered by the legislature to make these inspections.

Senator ELLENDER. Could not the legislature do the same thing in giving the same power to the industrial hygiene department if it is put under the Public Health?

Mr. FALASZ. Then you would have two units doing the same work and a duplication of the exact work.

Senator ELLENDER. My idea would be to probably combine the hygiene unit under the public health or expand it so that it will do the work of industrial hygiene, as well?

Mr. FALASZ. Well, then, I believe they would have to set up practically the same department as we have in the department of labor; in other words, you have a complete division of factory inspection in the hygiene division of the Department of Public Health.

Senator ELLENDER. That is why I am suggesting it, because all of it would naturally be for public health, and to have one under labor and the other under public health, I cannot see why you could not accomplish the same result as I suggest.

Mr. FALASZ. They probably could if they had the same set-up.

Senator ELLENDER. And probably do as fine a job?

Mr. FALASZ. Probably would. We have in the division besides this unit, 46 factory inspectors who cover the entire State of Illinois. The factory inspectors have assigned to them the different districts throughout the State, and they are working closely coordinated with the hygiene division; in other words, the factory inspector very often is compelled to resort to advice and other informational service from our unit, our hygiene unit. Consequently, all of this work for the prevention of any of these hazards is within the Department of Labor. It is found there, and it has existed there.

Senator MURRAY. The workers of this country would vigorously oppose any effort to take that out of the Labor Department and set it over into some other department?

Mr. FALASZ. They would.

Senator MURRAY. All of the leaders of the labor organizations, I take it, take that stand. Mr. Woll was here the other day and made a statement to that effect.

Mr. FALASZ. That is correct. And in saying, I am likewise expressing the sentiments of Mr. Derkin, who is the Director of Labor.

Senator ELLENDER. Don't you think that should any plan be submitted to Washington and any money should be allocated to do industrial hygiene activities, that any money distributed would be placed at the disposal of that department in the State that has to do with industrial hygiene activities?

Mr. FALASZ. The Labor Department?

Senator ELLENDER. I say, would that not naturally follow?

Mr. FALASZ. Right. If we can be sure that the Labor Department can have this privilege of having this money allocated to them.

Senator ELLENDER. Under title 6, the money can be specifically allocated for that purpose, and necessarily—I say necessarily with the view that if a State performs that service under the Labor Department, a department that does this industrial hygiene work, the money would have to be spent under the jurisdiction of that department.

Mr. FALASZ. Well, it so happens at this time, Senator, there are two separate units operating in our State.

Senator ELLENDER. I know, but one is just—I would not know how to differentiate—but one is just hygiene and the other is industrial hygiene?

Mr. FALASZ. They are both industrial hygiene units, Senator; one within the Public Health Department and one within the Department of Labor.

Senator ELLENDER. I cannot help but contend that you are bound to have duplication.

Senator WAGNER. Don't you think that your State is neglectful there in having the same activities in two different departments? There is bound to be overlapping.

Mr. FALASZ. I know that Mr. Derkin has asked the consolidation of both of those units in order to expand the activities of the hygiene unit in the Department of Labor. Whatever rules there may be within the United States Public Health Service to prevent that I don't know. Nevertheless, it was necessary that they operate under the circumstances under which they are operating now. We have attempted to cooperate in the State, but because of the fact that they are located in two different places, several miles apart, and because we have no connection with them except perhaps by correspondence, we find very often, as I stated, that our paths would cross, and we find constant duplication of work which we hope we can eliminate if under this act any allocation of money is to be made to the Labor Department.

Senator WAGNER. There is a large field of hygiene outside of industrial hygiene, isn't there?

Mr. FALASZ. Oh, yes.

Senator WAGNER. So that the hygiene work outside of industrial hygiene could very well be done through a health department?

Mr. FALASZ. That is right.

Senator WAGNER. It is the fact as the chairman suggested a moment ago that labor organizations have been interested in the question of industrial hygiene, the health of the worker, for a long time, haven't they? They are quite active in that?

Mr. FALASZ. Yes.

Senator WAGNER. I suppose that they have been in contact with your department in that regard?

Mr. FALASZ. They have.

Senator WAGNER. Interested in following your activities?

Mr. FALASZ. In reporting to us conditions from time to time that they know to exist, and in calling our attention to them and sponsoring legislation and so on.

Senator WAGNER. Mr. Woll said yesterday, and I know it is a matter of history myself, that labor organizations have interested themselves in industrial hygiene even before they did in industrial insurance.

Senator ELLENDER. In reading title 6, section 601, if I am to interpret that correctly, the only hygiene activities that are recognized are industrial hygiene activities.

Senator WAGNER. For Federal aid?

Senator ELLENDER. Yes; Federal aid. That being true, then you would be doubly sure of getting any money that is allocated for that

purpose, so I cannot see why you should worry about changing any phase of this act in order to assure it.

Mr. FALASZ. What we had in mind in appearing here was to call the committee's attention to the condition that we have now, and, if possible, to see that we would not be confronted with a recurrence of the same situation that we have. It is quite clear, as I see it, and I am reading from lines 5 and 6, on page 17. I see that language.

Senator WAGNER. Dr. Parrin made it clear a while ago that the language was much broader in this bill than it is under the present law, and, as I interpret that section, you folks would get all of the money that would be allocated to Illinois for industrial hygiene activities, and if a State plant is submitted asking for funds, it would have to be spent by the department established for that purpose in Illinois.

Mr. FALASZ. Which we intend to do when that time comes.

Senator WAGNER. Exactly.

Mr. FALASZ. And I hope that the Senator is right in his interpretation, so that when our time comes to call for it that we won't be confronted with a refusal.

Senator ELLENDER. You can cite our colloquy as authority.
[Laughter.]

Mr. FALASZ. I have practically covered the field as far as I intended to in view of the fact that Dr. Greenberg has spoken at great length and has covered practically all of the phases that we have in Illinois.

Senator WAGNER. It is implicit in your language, but you did not specifically say whether you favored the enactment of the bill.

Mr. FALASZ. We are in favor of the bill and hope that we can get it through in Illinois. We are in need of it as much there as any other State in the Union. Chicago, with its large metropolitan center, needs that care that is provided for in the bill. There is not any question about needing it and the benefits that the people will get in the matter of health as the result of it.

Senator WAGNER. You are not afraid of any invasion of States rights?

Mr. FALASZ. Well, not right now.

Senator MURRAY. Thank you.

The next witness is Mary Luciel McGorkey.

STATEMENT OF MARY LUCIEL McGORKEY, CHAIRMAN, HEALTH COMMITTEE, NEW YORK STATE INDUSTRIAL UNION COUNCIL OF THE CONGRESS OF INDUSTRIAL ORGANIZATIONS

Miss McGORKEY. Gentlemen, the 700,000 members of the New York State Industrial Union Council eagerly await the passage of this bill. We are convinced that it will supply the large lack today in social security for the people. It seems reasonable of course to assume that the wealthy State of New York would necessarily have adequate hospital and health facilities, and it is true that New York undoubtedly—and I do not say this with any local pride—leads the Nation and perhaps the world in medical science, medical institutions, medical centers, and all the rest of it, and we in New York are very proud of the wonderful work that we have done. However, these very large institutions, the advances that have been

made, have caused a great many people to say, "Well, since we are so very good, the facilities must necessarily be adequate and therefore New York needs nothing at all, and that to put through the Wagner health bill would be to tax New York for the people away out in the foreign parts of the country like the West, the South, and the North."

We are not of this opinion, and we believe that if the people who think along those lines were to read the Fifty-seventh Annual Report of the New York State Department of Health, they would find that they were laboring under an illusion. Recently one of the opposition witnesses before your committee, a medical doctor, characterized the equalizing of health opportunities as a "seductive phrase." As a nurse, I am surprised by this diagnosis and can only infer that the good doctor has stepped outside of his specialty. For he ought to know that no one has ever been seduced by a phrase. I do not think that you gentlemen are interested in phrases.

I do think that you might be interested in some of the facts regarding conditions in the hospitals in New York State. I realize that I am slightly at a disadvantage, because I am a nurse, and I have worked in many of these hospitals, and unfortunately there is quite a definite policy that a nurse who tells what actually happens within four hospital walls is pretty much in the same category as the gentleman who kisses and tells, and so it is with a bit of fear that I give you my experiences in some of the hospitals, and the opinions of the members of the nurses' union whom I visit daily. I visit many of the hospitals within a month.

In the voluntary and the private-charitable institutions in New York it has been estimated by a survey of New York, that over \$25,000,000 has been spent in construction, and that there has been no return in the form of services on this expenditure; that only 44 percent of the private beds were occupied in the year 1936; that only half of the semiprivate beds were occupied; and that the wards were almost always full—80 percent of the ward beds.

There is no free care. The patients that are hospitalized in the private hospitals who cannot pay are paid for by the city of New York, or the local treasury, supplements the cost which, however, is not sufficient to cover the expense of caring for that patient, it is claimed. However, there are a great many beds, from 8,000 to 7,000 empty beds, in private and voluntary hospitals within Greater New York alone that are not used throughout the year, not because these hospitals are not equipped to take care of any kind of a physical ailment, because they are. But it will depend—if you break your leg and you had a compound fracture, they would have everything to take care of you providing your pocketbook did not have a compound fracture. If it did, the chances are that you would be sent elsewhere. I will cover that under another point. You probably will be sent to a city hospital, and under Mayor LaGuardia's administration within 6 years, we have had more hospitals, more clinics, more baby health stations, more nurses, a shortening of the working day, more soap, more bed clothing—not enough yet—not nearly enough—in spite of the expenditures. There is great howling on the part of these people who feel that they are paying the bill. They usually could afford the best of care and found it none too good, and got the best because it is purchasable if you have the money. But, on

the other hand, hospital wards remain overcrowded and the facilities and personnel are in many instances taxed beyond capacity.

In city hospitals wards constructed to hold 30 patients are occupied by 60. This often necessitates placing the sick not on ward beds but on cots in corridors, drafty halls, in front of elevators, and treatment rooms. Beds are placed so close together as to make it impossible to maintain the most elementary sanitary conditions. We have patients, and cancer patients, too, who are housed in a hospital that is over 75 years old, with beds not more than a foot apart; we have old people housed in dilapidated wooden buildings—we have a new hospital under construction, which is not completed yet. We have wards, where beds—the foot of the beds in the old women's pavilion flush together this way [indicating] all the way down the ward, so that in order to get out of bed you crawl over the foot of it. That is not a new technique, and it is not recommended by anybody, but it is necessary, and so they do it in some of our city hospitals. It is considered wrong to tell our patients that they are not getting the right care. We are supposed to assume that they do not know it, when they are flat on their backs and they may not, but we know better than that. We have wards built to hold 28 beds that have 60 and 70 beds in them. You do not get a bed if you happen to be No. 32 or No. 50, but you get one of these cots that I just spoke about, and that is where you go no matter how sick you are if you happen to be one of the overflow and you find yourself in a city hospital today. True, this is not true of every division nor on every floor nor in every hospital, but these things are true in specific divisions of every hospital, not only in the city hospitals but in other hospitals as well.

We have a situation where on night duty a nurse very frequently has 40 patients to take care of. And sometimes 80, and it has happened that we have had one nurse with 101 patients at night. Not all of them required care, but you know you only need one hemorrhage to require all of your time. So that means that if you are No. 101, and you have a hemorrhage, you are really in luck because you will have the attention of the nurse, but if you happen to be one of the other people who just need a glass of water or a treatment or a bedpan, you can wait. Organized nurses particularly today have awakened to the fact that we are not nursing patients, that we almost never have nursed patients. I had a nurse say to me the other day from the Postgraduate Hospital: "Luciel, I simply cannot go on, I cannot do it. I have had to forget everything that I was ever taught about nursing. I cannot give simple comforting care, I feel as though when I walk into a ward with a bottle of alcohol in one hand and a box of talcum in the other, all I can say is 'Hello, everybody, this is supposed to be an alcohol rub, and I hope that your back is more comfortable now.'". There just is not time for any kind of real care in a hospital, and you feel that all of the forces of evil in the world are plotting to make you uncomfortable and unhappy in your work.

In our State hospitals, we have a more serious situation. At the present time—I am not even anticipating what is going to happen when the new budget goes into effect—in the State hospitals a great many of our workers are attendants, some of them trained and some untrained. We have as many as 127 violent patients to one

female attendant at night. In the daytime, the average case load is 1 to 20 or 30. The State regulation calls for 1 to 6. If you divide up those working in the kitchen and the man plowing in the field you find that you are probably within the regulation and you can somehow figure out 1 employee to every 6 patients, but on ward services the actual patient care is increased to a case load of anywhere from 20 to 127 patients. This exists today at Creedmoor State Hospital, and the Rockland County State Hospital. It is not strange, not a strange thing or a new thing. It is not because Commissioner Tiffany does not know his department or know how to run it, any more than the department of hospitals in New York is the result of inefficiency on the part of Commissioner Goldwater; in fact, he is one of the ablest men in the world in his field.

But these things cannot be done without money, and the personnel constantly nurses a budget, forgetting the patient. We have to. If you don't have soap, if you don't have sheets, if you don't have bed jackets, and the like, you cannot possibly give a patient a bath and change his linen, and if you have 50 people crying for you all at once, you cannot give treatments and medications on time. In the State hospitals surgical dressings are done by people who have no training whatsoever. Is that because Commissioner Tiffany thinks that they are qualified to do it? Not at all; it is only because his budget won't permit him to employ trained people.

The salaries of the attendants in the State hospitals are \$54 a month. One of the regulations is that if a patient is in restraint—some call it a straitjacket, but I don't like that term—we do not use restraint with mental patients unless we have to, but if you are one attendant with 127 patients, if you have 20 suicidals, and anywhere from 15 to 20 homicidals, you would have to use quite a bit of restraint, and then disregard all the other varying needs for attention of all the other patients. These patients are supposed to be removed from restraint every 2 hours. I am not saying that they are not. I have done psychiatric work, and I know that they are not. I do not have to be in every State hospital to know that it is not done. I know that no one is going to take a violent patient out of restraint when they have 127 people for whom they are responsible and risk—well, the attendants at these hospitals have broken fingers and arms and gashed heads, and sometimes the patients, themselves beat up the other patients, so there is no care being given to the mental patients either.

The cost to the State of New York per day for mental patients in State institutions is \$1. The cost of a meal per mental patient is 6 cents. Commissioner Tiffany has estimated under the proposed budgetary cut, which is over \$3,000,000 in his department, that it will be necessary to let 1,600 employees go; it will be necessary to decrease the food, the fuel, the clothing, and so forth; there will be no construction or repair work possible, and he is frankly, well, in a state about this, because he knows that this will mean more deaths in State hospitals; he knows for certain that it is not going to mean increased research in mental diseases. Today the Psychiatric Institute where there is some money—not nearly enough—for research work into the cause and perhaps the cure for mental diseases. He

knows that he is going to have chaos in his department. Again it is just the funds, as those of us who work in the hospitals and know these conditions know. To put it mildly, we get pretty hot under the collar when we hear people like Frank Gannett tell us that if the United States Government were to aid the hospitals and the nurse would really be able to treat human beings like human beings that we would be interfering with perhaps the cure of mental patients or cancer or other evils—well, we want that kind of Government interference to effect those cures. We believe that there is no other way that we can cure it. We know that under the present set-up we are not getting it; despite the terrific expense to the State, we are not getting nearly as much out of the hospitals that already exist as we might if there were sufficient funds to employ sufficient trained personnel to really do this job.

Senator ELLENDER. Is it your opinion that the State of New York is putting up as much money as it can afford?

Miss McGORKEY. I would not think that; no. I think the State of New York could definitely assign funds to match anything that the Federal Government could give them, and they need it.

Senator ELLENDER. Let us forget the Federal Government. Do you think that the State of New York—

Miss McGORKEY (interposing). I think that will stimulate it.

Senator ELLENDER. All right; yes; but do you think that the State of New York is at present providing sufficient funds in proportion with its wealth?

Miss McGORKEY. Well, of course, I would like to be honest with you; I know nothing about finances. However, I do believe that if it were to mean a new tax, it is the kind of a tax that would benefit 90 percent of the people of our State, and that they would get the money somewhere and in return get care, health, and life. I think that it would certainly be possible, although, as I say, I know nothing about finances.

Senator WAGNER. Mr. Gannett says, if this is passed, it will destroy the Federal Government and the State Government together.

Miss McGORKEY. He would rather have the American people just die off quietly, I suppose?

Senator WAGNER. I don't know. But that is the crusade that he is carrying on.

Senator ELLENDER. You spoke of State hospitals and city hospitals?

Miss McGORKEY. Yes, sir.

Senator ELLENDER. Would you be able to tell us the number of State hospitals that there are in the State of New York that are entirely maintained by the State?

Miss McGORKEY. Twenty-four.

Senator ELLENDER. How many beds? I mean normally—do not include those cots that you have been speaking about.

Miss McGORKEY. The average patient-load per day, I think, is 86,250.

Senator ELLENDER. Eighty-six thousand per day?

Miss McGORKEY. Yes.

Senator ELLENDER. How about the city hospitals?

Miss McGORKEY. There are 28 city hospitals. The city hospitals have a bed capacity of 18,886, and functions at 98 percent capacity

at all times. The average patient load per annum is estimated at 266,892.

Senator ELLENDER. I thought perhaps since you mentioned the city hospitals and the State hospitals, that you had statistics on them, but I won't bother you about it.

Senator ELLENDER. How much money does the city and State contribute? Can you give us that?

Miss McGORKEY. The 1938 budget for New York City hospitals is \$26,356,000 and for 1939-40 is \$28,443,011. State mental hygiene budget for 1939-40 is \$34,096,000, which is 3½ million dollars less than the department's request.

Senator ELLENDER. You might separate the city from the State.

Miss McGORKEY. Very good. I would like to speak briefly on public-health nursing in the city, with which I am only fairly familiar, and in the State. The information I have on the health service there I have gleaned from the report of the commissioner of health, but it has been estimated that adequate public-health nursing service would do much to relieve the burden on hospitals, and would prove an economical way to provide care for the sick poor who do not require institutional care, and who could be cared for in their homes, providing nursing and medical care were made available to them. It is estimated that \$2.40 per day would provide a daily visit by a nurse, and a visit every three days by a doctor, as compared to the cost of hospitalization in the municipal hospital, which is \$3.90 per day, and in the voluntary hospital, which is \$5.72 per day.

In many of the rural communities in up-State New York, hospitals are very few and far between—and the same applies to clinics and health centers. Despite the brave and sincere effort of our health commissioner to improve this situation, we find people traveling 50 or 100 miles to get a shot of deep ray for cancer because there are not facilities or funds to erect any kind of health facilities within small communities. I have met with committees of up-State people, and it is perfectly true that they lack clinics and hospitals, not because the people are healthy; they need medical care very desperately. It is just because there are no funds with which to do this work.

There is one other point that I would like to bring before your committee, and that is the plight of the industrial worker. Throughout the years, of course, we have had almost a closed-eye attitude to the problem of health in the factory, with the exception of the work in this State where we have our department of labor, which carries on their work effectively and splendidly to the extent that they can within their budget, but always in every given instance, whether or not the people get care, any kind of care depends solely upon the budget and not upon the availability of health workers or the need but the budget.

As the first step, solution of this problem, would recommend a Nation-wide application of the type of work that is now being done by our own New York State Department of Labor at the request of the Furriers' Union. This union, with the very fine cooperation of Dr. Greenburg, who has appeared before you here today, is conducting a survey of the entire membership. This industry is over 40 years old and has never been surveyed. They are doing a survey for chest, allergy, and skin conditions and working

conditions. Of course, we feel safe in saying that when this type of survey—the possibility of obtaining this type of survey—becomes known, Dr. Greenburg will certainly not be able to handle it, because every union in the State will be after the Department of State to give them the benefit of such of a survey and find out why the workers cannot eat after 2 hours in a certain room in a chemical factory, and why it is a little different in another factory. We know that they will want to know this; we know that our unions are going to fight for it, and Dr. Greenburg will want to do it, but when it comes to money, it will be a very grave problem because it won't be possible to do it for many of the industries that really need it desperately today. But, after all, I do not think that medical history has ever recorded one instance of a cure by survey. We feel that the best thing to do is to establish State and National industrial clinics which will do not only preventive work for the factory worker but curative work, so that we could have all of this knowledge and then really use it for the health of the working people of our country.

We make this proposal, and we feel that it would very nicely fit under the activities of industrial hygiene as contemplated in sections 601 and 603, where we see the possibility of industrial hygiene really spreading out and becoming industrial clinics throughout the country.

The next problem, we feel is the problem of health education. In New York State the C. I. O. has attempted, and quite successfully in many areas, to bring health education with the cooperation of the department of health and the Department of Labor to our unions, and we have found a great interest in health; that is, people want to really do something about flat feet after years of suffering, because they know that there is something they could do; people are having Wassermann tests today. We are giving lectures showing movies that we received from the department of health to educate the people to health and how they can conserve their health and how to avoid future ills. We found, however, that this is not enough, and never will be enough. We think that for health education we should have trained health workers to do this highly important educational work, and it would be a splendid job, again, for the State department of labor and for our State department of health if they had the funds. They would like nothing better than to do it, but they do not have the money to do it today.

Many of the people who are doing public-health work today are not trained. People visit families taking case histories in New York City who are not trained nurses, and yet they are telling the mother how to take care of a child in a given situation—not because they would not like to have a trained nurse there, but just because it is not financially possible to have a trained nurse.

At the present time I would like to refer to standards of care, since this has definitely been mentioned within Senator Wagner's bill. We believe, first of all, that the interests of the 1,000,000 trained to provide medical service and the 128,000,000 receiving these services are closely interwoven. Those of us who are looking ahead and are seeing Senator Wagner's bill already written into the law and the good work that will come from it, see today a very dangerous trend in the nursing field. In several States there are bills—in about nine different legislatures in the United States today to license a semitrained nurse

to be known as a practical nurse or a nurse's aid, or a nurse attendant, or what have you. These people receive 9 months' training. This is now the law of the State of New York, and when the bill was originally introduced and sponsored by our own State Nurses' Association and at the behest to some extent of some of our large private hospitals, because they said, "We cannot continue running with graduate nurses; we have got to get some cheap labor here." Their premise the first year that they introduced the bill was that the poor could not get grade A nursing care, and you had to give them something; and so you gave them third-rate care. Today, in our city hospitals, approximately one-third of the nursing personnel is untrained, or semitrained, we fear that the time is going to come, if Federal funds are not available for doing the job, and for really staffing hospitals, when the graduate nurse is going to be ringing the hospital's door bell while the practical nurse is trying to control a hemorrhage and not able to do it. This would displace women who can do the job with those who cannot because they are cheaper. They say, "We cannot run our hospitals with graduate nurses, and we have to get the others. Fifty years ago we used them, and why can't we use them today?" And this at a time when we are actually looking forward to bringing health to the large masses of people.

So we are very optimistic that this bill is going to actually make it possible for those of us who want to be a real party to the whole plan, and by that I mean to really serve and be able to serve, and really have things to work with in a hospital, to be able to do post-graduate work, and to keep up to the last minute work in our own profession. This is perhaps one of the finest things for us as health workers, and something that we appreciate very much.

I would like to mention just one other thing in the bill, which states that the wages paid laborers and mechanics in the construction of hospitals erected under this bill should not be less than the prevailing rate of wages in the community. Well, gentlemen, I would like to give you a slight idea of the prevailing rate of pay for hospital personnel.

The average salary for graduate nurses in New York State—it is lower in some of the other States, including Pennsylvania—but the average salary is \$75 a month with maintenance. You start at that and you stay 10 years—you won't, but if you do you would still be at the same salary, the chances are. We do not all become superintendents, of course; some of us continue to do the bedside work. The average salary of a porter, a maid, kitchen man, the man who does a very important job—the man who keeps insects out of the place, the exterminators, receive in private hospitals as low as \$25 a month, and without maintenance \$30 a month. The maintenance is room and board, and it is better left undescribed.

In the city hospitals it is \$35 a month with maintenance. Sometimes we have clean and sanitary living quarters, but in other cases—well, one night there was a fire over the garage, and upon investigation they found that it started in the quarters above the garage where the men were actually burning, trying to burn, the insects out of the mattresses—simply walking away with the mattress.

The skilled worker, the X-ray technician, laboratory technicians, earn anywhere from \$40 a month, in the private hospitals, to the

average of \$80 or \$90 a month. These salaries are without maintenance.

In the department of mental hygiene, the minimum, and everybody begins at the minimum—if you are an attendant—is \$54 a month. Over 75 percent of the attendants in the entire department of mental hygiene in the State of New York earn \$66 per month. With these salaries, we wonder that anyone questions the turn-over in personnel. Recently, Miss Effie Taylor, dean of the Yale School of Nursing, in lamenting the horrible turn-over in hospitals—and this was a national survey and it applies to every State just as much as New York—the turn-over in nursing personnel was as high as 100 percent in many of the leading hospitals in the United States. She said that she felt in part it was due to the indifference of the nurse, to her independence, and to her desire to go elsewhere. However, later in her report, she stated that the graduate nurses themselves in attempting to answer this question said that the hours were too long—the 12-hour day for nurses prevails throughout the United States for staff nurses with the exception of perhaps 12 hospitals in the whole country, and with the exception of New York's City hospitals, where we have the 8-hour day. The nurses answered, however—and I think it was a very direct answer—that the hours were too long, the salaries were too low, the case load too high, the living conditions poor, the food unpalatable, and satisfaction found in work well done completely lacking under existing circumstances.

And so I think that the nurse could well say to you that we want to serve, and we want to serve very much under a real health program, and even have soap, which we do not have today. We do not tell the patients that, or the patients' visitors. We say, "Get us a cake of scented soap," and make believe that we have Ivory soap, when we have none.

I note that Dr. Booth, the chairman of the board of directors of the American Medical Association, has told your committee that this bill is an invasion of States' rights, and that it coerces the States into participating with the Federal Government in the war for better health. It is hard to see what the doctrine, the concept of States' rights has to do with the concrete problem of the people's health. It is not the States which suffer pain or undernourishment but the citizens of the States. It happens that, under our form of government, every citizen of every State is also a citizen of the United States. I do not think that Dr. Booth was considering that.

It would seem safe to leave it to the Supreme Court to sustain the delicate balance between local and national sovereignties so far as it is necessary to our federated Republic. Since I am not a constitutional theorist this is not my cup of tea. For me it is enough that the Supreme Court has already upheld the national legislation for the control of communicable diseases of cattle, and cattle have this in common with all of our citizens, that they are not more immune to germs than they are to States' rights.

We believe that the argument that the Wagner bill threatens coercion upon the States only presents another debating point of constitutional law. I am not a lawyer. For that matter, neither is Dr. Booth. It may be that he would not consider national health legisla-

tion enacted as an amendment to the Social Security Act as being governed by the Supreme Court's decisions upon the Social Security Act itself or upon the Unemployment Compensation Act.

I would like to quote a Supreme Court decision—

Senator MURRAY (interposing). Pardon me, but may I inquire how long you will take? It is past the time when we usually adjourn and the Senators are anxious to go to the floor of the Senate.

Miss McGORKEY. Then I will not read the quotation, but may I hand it in and have it put into the record?

Senator MURRAY. Yes; you may do that.

(The quotation is as follows:)

It is necessary to repeat now those considerations which have led to our decision that the Social Security Act has no such coercive effect. As the Social Security Act is not coercive in its operations the Unemployment Act cannot be set aside as an unconstitutional product of coercion. The United States and the State of Alabama are not alien governments. They coexist within the same territory. Unemployment within it is their common concern. Together the two statutes now before us embody a cooperative legislative effort by State and National Governments for carrying out a public purpose common to both, which neither could fully achieve without the cooperation of the other. The Constitution does not prohibit such cooperation.

Miss McGORKEY. I would like to say in closing that we believe that States rights, whatever they are, will not achieve health for the people without the fullest cooperation of the Federal Government. We believe that this bill to thousands and even millions of American citizens means not just care; in many instances it means life itself. You gentlemen have it within your power to do this great service for your fellow human beings, and we of the C. I. O. in New York State hope that this bill will pass.

Senator MURRAY. I want to congratulate you upon your statement. It is a very excellent statement, and it will be very helpful to us.

Miss McGORKEY. I shall send the figures that were requested, to you, sir?

Senator MURRAY. Yes; send them to the committee.

We will reconvene at 2 o'clock.

(Whereupon, at 12:20 p. m., a recess was taken until 2 o'clock of the same day.)

AFTERNOON SESSION

Senator THOMAS. The committee will be in order.

Dr. Grulee, please.

STATEMENT OF DR. CLIFFORD G. GRULEE, AMERICAN ACADEMY OF PEDIATRICS, EVANSTON, ILL.

Senator THOMAS. Doctor, will you state what you want to appear in the record about yourself, please?

Dr. GRULEE. My name is Clifford G. Grulee. I am secretary of the American Academy of Pediatrics, and clinical professor and head of the department of pediatrics, Rush Memorial College, Chicago.

I should like, first, to tell you what the Academy of Pediatrics thinks about this bill, and I want to say that the chief trouble that the academy has in making people realize that pediatrics pertains to children and not to feet.

Some weeks ago I sent a letter out to each of the State chairmen of the Academy of Pediatrics. The Academy of Pediatrics has over 12,000 members, the vast bulk of them are practicing pediatricians, and I asked them to state their reactions to this bill. I am happy to inform you that, as I read the replies, I find that of 35 replies which I received, 29 of them are favorable to the bill, 3 are doubtful, and 3 could be classed as against it. If you will allow me, I should like to read excerpts from some of the letters of these State chairmen. They are all appointed as the outstanding men who look after the pediatric interest in their State.

Senator THOMAS. Do you have branches in every State, Doctor?

Dr. GRULEE. Every State except Wyoming. There are no pediatricians in Wyoming. We have them in the District of Columbia, and we also have them in the Hawaiian Islands, but there are no pediatricians in Wyoming, and none in Alaska and Puerto Rico, so we have none there.

I shall read, first, excerpts from two of the letters which I should like to offer you, that I interpret as being rather opposed to the bill. The first is from Dr. Eugene H. Smith, Ogden, Utah, and he states:

In answer to your inquiry regarding the Wagner bill, I suppose it is presumptuous of me to suggest anything more than is contained in the resolutions passed by the house of delegates—

That is the house of delegates of the American Medical Association—

I would only say this, that if the Government takes over all care of healthy children and leaves only the sick for the physician, it will absorb probably two-thirds of the work now being done by the pediatrician. I should think that an effort should be made to limit all free governmental care to those unable to pay for medical service.

I take it he did not understand the bill. The second is by Dr. Oliver L. Stringfield, of Stamford, Conn. He states:

It happens that I had previously read this bill and must say I was not favorably impressed. I have reread title V, as amended, and still feel there are too many loopholes, especially in the administration side. In reading it, I cannot help but think of the statement of some writer recently who said, "When we give the State the power to do something for us, we, at the same time give the State power to do something to us."

Now, in contradistinction to those—and I will say I am talking only for the maternity and child-health side, because I feel I have no right to talk about anything else; that is the only part of medicine that I know—from Henry E. Utter, of Providence, R. I., I have this reply:

I have read the bill S. 1620, and certainly seems to fulfill the specifications in a more detailed form than did the original Wagner bill. I am in accord with the act and I am glad you are going to represent the academy.

I have the reply from Dr. H. C. Joesting, of Butte, Mont., which states:

In accordance with your request for a reply on the Wagner health bill, and the amendment to title V of this bill, there seems to be no serious objections from the men in this part of the State.

From Louisville, Ky., Dr. Philip E. Barbour:

I thoroughly approve of the Wagner health bill, and especially with the amendments and recommendations that are now under discussion as far as it concerns the policy of the Children's Bureau.

From Dr. Clifford Sweet, of Oakland, Calif.:

I do support the section of the Wagner Act which deals with child-health and maternal welfare. I think the work that is being done by the Children's Bureau will in the end be a very beneficial one.

Now, a somewhat longer one which I would like to read to you in toto, if I may, from Dr. Harvey F. Garrison, of Jackson, Miss.:

I am just in receipt of your letter of April 18, relative to the Wagner bill. If you kept up with the proceedings of the special session of the house of delegates of the American Medical Association last September, you probably remember seeing a resolution introduced by the two delegates from Mississippi, Dr. Felix J. Underwood and myself. The principal features of the resolution were adopted as the sentiment of the house of delegates in regard to the recommendations of the interdepartmental committee.

Apparently, Senator Wagner has left out of his bill the main objectionable features which were incorporated in the first recommendations of the inter-departmental committee, namely, the compulsory health insurance.

There are quite a few other things about the Wagner bill which I think could be changed, which would make it a more desirable bill. First, there are too many governing heads incorporated in the bill, and the wording of the authority vested in each is apparently ambiguous. However, I feel that these things can be easily ironed out in the committee room. Personally, I believe the bill, if passed even in its present form, would go a long way toward relieving a very much-needed class of people.

There is not the slightest question of a doubt in my mind but that the medical profession needs to be relieved of some of the financial burdens that it has been carrying for these many years, in regard to the medical care of the indigent and the lower income group. There is definitely a great need for some financial relief to the profession, and I sincerely believe that a health program can be worked out where that the chief function of the Federal Government will be furnishing the finances but not in any sense disturb the "doctor-patient" relationship, nor the right of the individual to choose his own physician.

I believe that if Senator Wagner will rely on the advice of physicians who have had a great amount of experience in the practice of medicine, as well as experience in shaping of policies which would not be objectionable to the medical profession, that his bill can be worked out to where it would not be objectionable, and would not only be satisfactory to the profession, but would go a long way toward solving our health program.

Now, if you wish me to, I shall leave the various letters that I have received from the State chairman here, or they may be entered into the record, if you wish.

Senator MURRAY. You may file them.

(The letters referred to were filed with the committee.)

Dr. GRULEE. I have spoken just now only as secretary of the American Academy of Pediatrics. I think I may sum up in that respect and say that the American Academy of Pediatrics is behind this bill. They are satisfied that the whole is a step in the right direction, and I am sure I can say they are especially pleased with the way that the whole matter has been handled by the Children's Bureau in the past, and that that is an earnest of what is likely to occur in the future.

Now, there are one or two things which I would like to say, if I may, from a personal standpoint, and these are not to be taken as academy views. I should very much hope that this committee would see fit to include in the crippled children's program the care of the rheumatic and cardiac child. It is a big problem. Most of the children are of indigent families. That is, to be true, more a city than a country problem, but so much can be done for them if they

are properly cared for at the right time, and I think you can do a great deal, gentlemen, if you included them in your group.

Senator ELLENDER. What class of children?

Dr. GRULEE. The heart case, the cardiac case.

Now, I should like to, if I might, say something regarding the child in the hospital. I feel that I am right in talking to you about this, because, as chairman of the academy committee on hospitals, we made a survey some time since with respect to three classes of hospitals—the children's hospitals, the children's departments in general hospitals, and the contagious-disease hospitals. The children's hospitals are, in this country—and we took in Canada as well—among the very best hospitals that you can find. They are well manned, well equipped, their laboratory facilities are excellent. There are only about 85 of them. They mostly are charity or in connection with medical schools.

The interesting thing to me about these hospitals was this: Dr. Graham Mitchell came to me some time since, and he said, "Clifford Grulee, I am worried because we do not get 5 percent of our income for running our children's hospital in Cincinnati from our patients." "Well," I said, "you need not worry. I do not think that there is a single children's hospital in the United States or Canada that derives 5 percent of its income from the pay patients, or from the money that it gets from patients." In other words, all those children's hospitals are essentially charity hospitals. I am not speaking now of orthopedic hospitals, only of the children's hospitals. That has a direct bearing on what I will say next, which is with respect to the general hospitals.

We then made a survey of the general hospitals. This survey was conducted in this way: We found out from our State chairmen what hospitals had good children's departments. We wrote to those hospitals and found out that they had 25 beds or more under the direction of their pediatric staff. Then we made a survey at those hospitals. There were only at that time—and that is 3 or 4 years ago, and I think conditions have not changed since—there were only at that time 265 hospitals—I may be a few hospitals off one way or another, but practically that in the whole country—that had what we regarded as an adequate children's department among the general hospitals.

That may not mean so much to you, but what it means is this—that there are very few places where either physicians or nurses can get the proper sort of training for medical care of children. Now, I have been told—and I cannot substantiate this—that even in the city of New York there are not enough children's beds to give this service; and I know from my connection with the Children's Bureau here that they have the greatest trouble getting nurses who have been properly trained in children's work for their health work. So that there is that lack. In the rural communities especially that is true. You may have hospitals, but you do not have hospitals that will train your personnel to take care of children unless you have a proper set-up to do it.

Then comes the third category, and that is the category of children's contagious hospitals, and on that I am well within reason when I say that in practically no instance in the United States is there a hospital outside of a large center which is designated a contagious hospital, that is anything but a pesthouse. It is a place where you want to keep

the patient away from somebody else; it is not a place where you would take him for treatment.

Now, then, what is the answer to this? The answer is "money." The reason that there are not children's departments in general hospitals is that the departments do not pay. I work in a general hospital. We have 45 beds for children, 3 private rooms, and practically all those 45 beds, outside of the private rooms, are charity beds, and so regarded. That is true also with respect especially to contagious diseases. Now, that can be met, in my opinion, by allowing, or by encouraging, general hospitals in those communities to set aside a portion which can be used for contagious diseases. It can be done. Different kinds of contagious diseases are put in the same hospital, and rarely do we have crossed infections when they are properly cared for. There is no danger, but it is an expense because that portion of the hospital would have to be kept for that purpose.

I think that is all I have to say to you.

Senator MURRAY. Thank you, Doctor.

Dr. Davis.

**STATEMENT OF DR. M. EDWARD DAVIS, ASSOCIATE PROFESSOR
OF OBSTETRICS, UNIVERSITY OF CHICAGO, CHICAGO, ILL.**

Senator MURRAY. Dr. Davis, you may state your name and occupation.

Dr. DAVIS. Dr. M. Edward Davis. I am associate professor of obstetrics and gynecology, University of Chicago. I am a fellow of the American Medical Association and a fellow of the American College of Surgeons.

I appear before you today in behalf of the continuation of the support for maternal and child care in the United States and its extension, as provided in title V, part 1, of Senate bill 1620.

For at least 15 years I have been interested in the problems of maternal care. As a physician and educator, these special problems have been my particular concern. Our institution—the Chicago Lying-in Hospital—has pioneered many of the improvements and advances in the care of mothers during pregnancy and labor in order that childbirth be made safer for mother and child. Reproduction is the most important physiologic function, for on it depends the continuation of our race. It is, therefore, of vital interest to society to make that function as safe as it is humanly possible.

Childbirth costs the lives of many mothers and babies every year in these United States. In 1935, 12,544 mothers died as a result of the diseases associated with childbearing, and in that same year over 125,000 babies died as a result of these same causes. What is even more important is that much of this loss of life has been regarded as needless, unnecessary, and preventable. Since 1930 a number of carefully planned studies have been carried out by special committees composed of physicians in various parts of the country to determine the causes of maternal and fetal deaths. Such a report from New York City listed 65 percent of the deaths as preventable; a Philadelphia report, 55 percent; the Alabama report over 80 percent, as preventable deaths. Thus it can be seen that the accidents of childbirth can largely be prevented. Proper medical and nursing care during pregnancy and labor and proper facilities for the care of the complications which

arise can remove many of the hazards confronting our mothers and babies.

The loss of life is only one measure of the effectiveness of our care. Far more difficult to evaluate and to tabulate are the thousands of mothers who suffer serious and irreparable injuries and are destined for a life of invalidism. These physical and mental wrecks disturb the orderly American family life, thereby contributing to some of the major social problems. Many thousands of babies are injured as a result of abnormal, unattended, or poorly conducted birth processes. Many of these children survive to fill our institutions for the subnormal and feeble-minded. These physical and mental defectives add to the ever-increasing load of tax-supported institutions. Thus the lack of proper medical and nursing care during pregnancy and labor may not only result in death, in needless suffering, and chronic invalidism, but in an increasing economic burden to society.

There are certain minimum requirements in the medical care for mothers during pregnancy and labor. These are absolutely necessary to safeguard the welfare of the mother and her unborn child. Maternal care is largely preventive medicine, for in obstetrics it is much easier to prevent than to cure. Every mother should be seen by a physician at periodic intervals during her pregnancy. These examinations will detect complications in their incipiency, when they are still amenable to simple therapy. The health of the unborn baby depends to a large extent on the mother's health and her diet during pregnancy. At the time of confinement she should be provided with a competent physician, for he alone is capable by training and experience to render her safe care during this critical period. The uncomplicated patient may be confined safely in the home or in the hospital, but where complications arise, suitable maternities become necessary to provide proper medical attention.

It is a far cry from these simple safeguards to the care which a large number of mothers actually receive. The ability to render good medical care varies in different parts of the country. It is easiest to provide in urban centers, where an ever-increasing number of women are confined in well-equipped maternities, wherein all the safeguards of modern medicine are available in their behalf. It is most difficult to provide adequate care to our mothers in rural areas, remotely removed from physician and hospital. You have undoubtedly heard about our families who live 40 and 50 miles from the nearest physician and hospital. I could even tell you about a large county in New Mexico where a population of 14,000 has 8 telephones. Approximately half of the infants dying in this same State during the last year received no medical care. There are vast, sparsely settled areas in which it is economically impossible for a physician to survive. These physical and economic barriers seriously interfere with providing medical and nursing care to many of our mothers and babies.

During the last 4 years I have had an opportunity to study at first hand some of the problems confronting the mother, the family, and the doctor. I have visited 10 States and the Territory of Alaska in the interests of obstetric education. I have given hundreds of medical lectures to physicians and to nurses and visited their medical institutions. I saw at first hand the many handicaps which exist in our vast country that seriously hinder and even make impossible the rendering of adequate medical care to some of our people.

Of 2,000,000 babies born in the United States, annually, over half are delivered in their own homes. These abodes are certainly not pretentious, for they belong largely to that third of our population that is poorly housed, underfed, and underclothed. They are largely in our rural areas, often far removed from transportation and urban advantages. In 864 rural counties no live births occurred in hospitals. In 1937, in 718 counties, 25 percent of the births were not attended by a physician. Thus the lack of suitable facilities, the inability to obtain medical care, often contribute to the serious complications of childbirth.

The provisions of title V, part 1, of the bill under consideration do not propose the allotment of funds for experimental procedures. Years ago the problems of maternity and infancy received special study by your legislative branch, and these studies resulted in the Maternity and Infancy Act of 1921-29. The groundwork for much of our present work was laid at that time. Educational studies continued during the years, and slowly but surely the profession and the people gradually became cognizant of the many problems of childbirth. The excessively high maternal and infant death rate, the needless loss of life, and the methods of prevention were gradually brought home to all of us. Some 3 years ago funds were made available to the States by the Social Security Act, which made it possible to provide maternal and child health services on a national scale. The various State health departments set up divisions of maternal and child health, provided nurses for the care of mothers and babies, provided doctors to render medical care, and organized concentrated educational programs to acquaint our people with the necessary care during pregnancy and labor. At the present time competent organizations for maternal and child care are functioning in all States in the Union and in Alaska, Hawaii, and the District of Columbia. I can testify to the value of these State organizations, for I have seen them function at close range. I have helped with their educational programs to physicians, and I have seen the results of their efforts.

All the efforts in behalf of maternal and child care through the years and their correlation and extension in the past 3 years have begun to bear fruit in the form of a definite decrease in the annual waste of mothers' and babies' lives. Whereas in the decade before 1935 there was only a small reduction in our maternal mortality, in 1937 over 1,400 fewer mothers died as a result of childbirth than in 1936, and tentative figures for 1938 reveal the fact that over 3,000 fewer mothers lost their lives in 1938 than in 1936. This represents a 14-percent reduction in maternal mortality in 1937 and probably an ever greater reduction in 1938. These concrete figures emphasize the value of education, more adequate medical care, and increased and improved facilities.

The birth rate in America has steadily decreased so that it is rapidly reaching a point beyond which it cannot continue to decrease and our population remain at its present level. In 1915 the birth rate was 25 and had the population been equivalent of what it is today there would have been over 8,000,000 births in the United States. Last year this number had decreased to something over 2,000,000, the birth rate having decreased to less than 17. In a period of little more than two decades our birth rate has decreased almost a third. To remain in a stationary population it is necessary that each family have

at least 2.6 babies. It is not only necessary for the husband and wife to reproduce themselves, but they must provide for the inevitable loss of life that occurs prior to full maturity and for those members of our society who do not reproduce. The birth rate in America will soon reach that critical figure, for in 1937 it was 17 per thousand population—the lowest ever recorded. This decreasing birth rate must have a profound influence on our social and economic structures. It is already making itself manifest in many ways. The schools in several of our metropolitan centers have many vacant seats in the first, second, and third years, for there are not enough little children to fill them. As the years go by we will find more vacant seats for older children, for there will not be enough youngsters to fill the available school facilities. We must provide very facility at our command to make child-bearing more safe, to decrease the hazards of birth and to assure the children that are being born a safe conduct into the world. Whereas foreign nations subsidize the birth of babies so that there may be a plentiful supply of cannon-fodder, we here are interested in the delivery of normal healthy children who will carry on the peaceful pursuits of democracy.

The future of America does not rest on our unique territorial isolation, on our vast lands, our unlimited natural resources, nor on the special ingenuity of our people to provide the many physical comforts to help make life easier and more pleasant. The future of this great country rests on the welfare of our mothers and the babies of today and tomorrow and tomorrow. They are the citizens of the future. Bring them into the world safely, with healthy bodies and healthy minds, and we need never worry about the destiny of our great land.

Senator ELLENDER. Doctor, you said that the birth rate has decreased one-third?

Dr. DAVIS. Approximately one-third; yes, Senator.

Senator ELLENDER. Since when?

Dr. DAVIS. In the period of about 13 or 14 years, more markedly although, it has been declining somewhat since the late part of the nineteenth century.

Senator ELLENDER. Do you anticipate a further decrease as time goes on? Suppose it is on a yearly basis.

Dr. DAVIS. Yes; there has been a steady decline, and will continue to do so.

Senator ELLENDER. Can you, in a few words, give us the main causes for the decrease in birth rate? You may supplement your answer by telling us in a few words whether or not this bill would help, and to what extent, if it is not too big an order for you.

Dr. DAVIS. There have been a number of studies in recent years that have attempted to arrive at some explanation for this decrease in the national birth rate. It is an interesting observation that the declining birth rate is not limited to the United States, but it likewise has been present in foreign countries—England, France, and until recent years in Germany and in Italy. It is apparently a rather world-wide decline in the birth rate.

Now, many factors have been advanced to try and explain why this decrease is taking place. One of the important factors is probably economic. It is apparently becoming more difficult to raise large

families and so many people use some means for the prevention of pregnancy and thereby limit their families. But that, apparently, is not the only explanation. Studies have been made of the increased use of contraceptive measures in an attempt to use that as an argument for the decrease in the birth rate. However, that likewise fails to explain the gradual downward curve in our birth rate. There is no good explanation at the present time. It probably, in the United States, is partly economic and perhaps partly because of the fact that we expect to do more for our children. Society is becoming more complex, and as society becomes more complex it is more difficult to raise families the way one would like to raise them, and so many families undoubtedly limit the size of their families for these reasons.

It is of interest to note that college graduates have fewer children than people who have not been to college. College people marry late in life, and many college women, approximately 40 percent, never have families. That likewise contributes to the decrease in the birth rate.

It is not a simple question that I can answer, Senator, for there are many, many factors.

Now, this bill, the particular provision in which I am interested, should do considerable to salvage many lives that are lost, thereby combatting the declining birth rate.

Senator ELLENDER. It would not necessarily increase the birth rate, but it would protect those that are born?

Dr. DAVIS. That is true, sir. We know that there is a loss of approximately 150,000 lives every year, largely preventable, and if we can salvage half of those lives, we will do at least something concrete in maintaining our population at the present level.

Senator ELLENDER. Did you make any study of the difference in the salvaging, if I may put it that way, of children born alive, let us say, in the last 14 or 15 years in comparison to prior years when the birth rate was higher?

Dr. DAVIS. I doubt that I understand your question, Senator.

Senator ELLENDER. In other words, what I mean is this: You say that in the last 14 or 15 years the birth rate has decreased about one-third?

Dr. DAVIS. Yes, sir.

Senator ELLENDER. Was the death rate greater prior to that 15-year period than it is now among children?

Dr. DAVIS. Very much so.

Senator ELLENDER. Would you think it is possible for us to raise the standard of health so that the death rate among children will be lowered to such an extent that with our lower birth rate we can save and raise more children than years ago?

Dr. DAVIS. Unquestionably that is true. Some 18 or 20 years ago it was rather a common thing to have a woman enter our institution who had a family of 15 or 18 or 20 babies. Today she has become very rare, indeed. The average woman who enters the Chicago Lying-in Hospital has had one or perhaps two babies previously. This decrease is obvious. The large family is becoming rather a rare phenomenon in American life.

Senator ELLENDER. Doctor, would you be able to give for the record the percentage of deaths, let us say, per 100,000 of babies prior to 15 years ago in comparison to what it now is?

Dr. DAVIS. We have excellent tables available giving all these statistics. I shall gladly leave them with the Secretary for the record.

Senator ELLENDER. Fine. Are they lengthy?

Dr. DAVIS. No; they are just single sheets. Many are in diagram form, so you can visualize them at a glance.

Senator ELLENDER. In answer to the question I just asked?

Dr. DAVIS. Yes.

Senator MURRAY. They may be filed.

(The tables referred to were filed with the committee.)

Senator WAGNER. I was dying to ask you one or two additional questions.

Dr. DAVIS. Go right ahead, sir.

Senator WAGNER. Don't you regard this reduction in our birth rate a very serious question, or it may become a serious question in this country?

Dr. DAVIS. I certainly do think it is a serious question. When we first began to be concerned about the steadily decreasing birth rate we gave very little attention to it. We felt that this was a large country and it contained many people and we need never worry about the population, but year by year it has gained in importance, and so today a great many people, and a great many organizations are concerned over this decline in the birth rate.

For instance, in your own State, Senator, the school system found last year, and the year before, that there were many empty seats in the first and second year and third year grades.

Senator WAGNER. You took the words out of my mouth.

Dr. DAVIS. They found that they had overbuilt on these primary grades. It has not affected the older grades as yet.

Senator WAGNER. Someone informed me a short time ago there were about a million less in the primary grades now than there were a year or 2 ago.

Dr. DAVIS. That is probably true, Senator. I do not have the figures.

Senator WAGNER. If that keeps on we would very soon reach the stage of a stabilized population; and then, of course, we would go down, would we not?

Dr. DAVIS. Unless you brought people into the country, or unless the length of life could be increased.

Senator WAGNER. They want to put them out of the country.

Dr. DAVIS. Yes. Now, the interesting thing is that the length of life cannot be increased at a rapid rate. We might increase it by a half year every decade or a year. We made great progress in increasing the length of life in days gone by, but now we will proceed slowly. In order that the population remain at the present fixed level we have to have 2.6 babies per family. You have to have a baby, and Mrs. Wagner has to have a baby [laughter], and you each—

Senator WAGNER (interposing). I have got one but he is a member of the State legislature now. He is cooperating on this very same subject in the State legislature.

Dr. DAVIS. You each have to have .3 more, and between you and Mrs. Wagner you have to have .6 more to maintain the general average.

Senator WAGNER. Don't demand too much of me [laughter].

Senator MURRAY. Doctor, I have qualified. I have five.

Dr. DAVIS. You made up for Senator Wagner.

Senator WAGNER. I was going to ask you another question on the economic features. Of course, if this continues and we have less of the young and more of the old, with our old-age-pension system and other things to take care of the old, the burden is going to be terrific.

Dr. DAVIS. It will be. The economists are very much concerned about the steadily increasing old-age population with a decreasing young population who will have to look after the increasing ageing group.

Senator WAGNER. In other words, while we have not talked about it much, it is a serious problem that is now confronting us?

Dr. DAVIS. Yes; at the present time.

Senator WAGNER. And we ought to begin to think about the problem?

Dr. DAVIS. Undoubtedly, sir. Last year the birth rate was 2.7 per family. The dead level is 2.6. You can see how close you are to that very critical period.

Senator MURRAY. Do you think the economic conditions constitute the principal factor in bringing about this lower birth rate?

Dr. DAVIS. It certainly is a major factor. Now, whether it is the most important factor or not, I do not know.

Senator MURRAY. It would seem to me to be the most important factor.

Dr. DAVIS. I think so, too. Young people find it more difficult to earn a living, they marry late in life, and many of those young couples either have one child or no children at all.

Senator MURRAY. For many years even prior to 1929 these economic conditions were developing in the country which were responsible for the gradual reduction in the birth rate, even prior to the depression?

Dr. DAVIS. That is correct, sir. The course downward began as far back as 1913 or 1914, before the war.

Senator MURRAY. I think you are right.

Thank you, Doctor.

Dr. DAVIS. Thank you, sir.

Senator MURRAY. Dr. George W. Bowles.

STATEMENT OF DR. GEORGE W. BOWLES, NATIONAL MEDICAL ASSOCIATION, YORK, PA.

Senator MURRAY. Doctor, state your name.

Dr. BOWLES. Dr. George W. Bowles, president of the National Medical Association. I am chairman of the executive board of the Pennsylvania State Medical, Dental, and Pharmaceutical Association; fellow of the American Medical Association; and chairman of the advisory board of the National Negro Health Movement.

Senators Murray, Ellender, and Wagner, I wish to express my appreciation and the appreciation of the officers and members of the association I represent for this opportunity of appearing before the Senate committee to give our views on the national health bill. I ask the indulgence and tolerance of this committee that they might permit me to bring before them certain angles of the proposed national health bill that affects the Negro doctor, dentist, pharmacist, and nurse in a very particular and specific way. I speak as president of the National Medical Association with a membership of approximately 5,000 Negro doctors and as spokesman for 2,000 Negro dentists, 1,000 Negro pharmacists, to which cognate professions is delegated to a large measure the responsibility for the health education and the health security of 13 million Negroes.

In my remarks before the National Health Conference, I said:

The Negro is so intricately involved in the question of medical care and he is so greatly and directly affected by the socio-economic system under which he exists, that the National Medical Association cannot logically or consistently hesitate to subscribe to a program that is designated to reduce his incidence to tuberculosis and syphilis, his infant and maternal death rate and all other diseases and health hazards of which he is a victim.

On November 22, 1938, in the auditorium of the United States Public Health Service Building, a special committee of the National Medical Association sat in joint conference with the technical committee of the Interdepartmental Committee. This conference was held for the specific purpose of bringing before the technical committee our specific problems and to offer some concrete suggestions for the solution of the same. The National Medical Association recognizes that a large proportion of the population of the United States is without medical care. We are in accord with the high benevolent purposes of the President of the United States and the Technical Committee on medical care to supply that deficiency.

Having acquainted ourselves with the recommendations of the Technical Committee on Medical Care, we approve in general, recommendation 1, which provides for expansion of public health activities; recommendation 2, expansion of hospital and diagnostic facilities; recommendation 3, medical care for the medically needy, and recommendation 5, insurance against loss of wages during sickness. We are sure that recommendation 4 has the same high altruistic purpose as the other recommendations.

We are in full sympathy with this large self-respecting middle class, many of whom would starve and die rather than beg. We are alert to what it means to this class when severe or prolonged illness including operations and hospital bills are unexpectedly thrust into the picture. They, too, need and must have relief. Prepaid hospital insurance goes a long way in meeting the problems of many. Its success has been demonstrated. Now that the American Hospital Association has boldly fostered prepayment in medical fees, it will give great impetus to this form of medical care. The other phases of the health program are of such vital importance to the health of the people of this country that the successful launching and prosecution of this program should not be jeopardized at this time by a program of such a controversial nature.

Many of the benefits intended under recommendation 4 will necessarily accrue to this group when the other features of this program

are introduced. With municipal, State, and Federal relief definitely providing for the indigents or all those below a certain income level, and the upper one-third fully able to provide for themselves, prepaid hospital and now medical insurance will take care of a large number of the middle class. But the remainder of this group who spurn indigency and yet are unable to meet unexpected sickness needs, we feel sure that definite, satisfactory local provisions, approved by the Federal Government, will be found. The National Medical Association speaks of this as citizens of the United States.

But, my mission here would be worthless and even false if I did not bring to your attention the racial aspect of this great subject. It is with considerable reluctance that the National Medical Association must appeal to the fairness of the Government in matters of this nature. But the fact remains, that while a health problem is not of necessity a race problem, yet the elements of race and racial discrimination are so frequently interjected and perpetrated upon our group that the National Medical Association does not feel that it is premature in its apprehension of a possible conformity to precedent. Our racial plea is, that whatever form this National Health Program shall take, that its activities will be devoid of any discriminatory practices; and that this provision will be made one of the Federal conditions of subsidy. We are forced to inject this issue because in some sections of the country this high altruistic attitude does not exist. The National Medical Association and the National Dental Association are anxious to have a part in this great humanitarian program; not merely because of its fundamental importance to the entire Nation, but specifically because of our special interest in sponsoring the health, happiness, and health security of 13,000,000 Negroes of whom we are a part.

In the program for the care and eradication of tuberculosis and venereal diseases, which program is supported by tax funds, Negro professionals have found it difficult to participate and in most instances have been systematically excluded. All over the United States—North, East, South, and West—Negro medical men are excluded from more than 99 percent of the hospitals—tax supported and otherwise. It will thus be seen that it is a very simple matter to exclude the Negro professional from participation in this service on the ground that they are not members of local societies nor on the staff of local hospitals.

The National Medical Association contends that any national health program, to be successful, must contemplate not only the Government subsidy but the entire medical, dental, pharmaceutical, and nursing professions, down to the humblest practitioner in the Delta of Mississippi, the Everglades of Florida, the Black Belt of Alabama, and every other section and locality. Therefore, it is our desire:

1. That the Negro doctor, dentist, pharmacist, nurse, and social worker shall not be denied the privilege of treating and caring for his own racial group and that he will receive therefrom the same compensation as provided for others for like services. In other words, it is our expressed desire that there will be no discrimination shown in these regards.

2. Assuming further, from past practice, that the United States Public Health Service will stand between the United States Treasury

and the final distribution of these funds, that in the acceptance of funds the administrators will give to the United States Public Health Service assurances that these regulations will obtain.

3. That the United States Public Health Service will provide that in the event these fundamental conditions are violated the continuance of funds will be withdrawn until there are assurances that discriminatory practices will cease.

We especially recommend and urge that Negro physicians be appointed to responsible positions in the bureaus charged with the administration of this program; for the purpose of advising and co-ordinating to the end that 18,000,000 American citizens shall be assured of receiving the full and fair benefits as intended by the Government. We subscribe to the principles enunciated in the report of our committee on medical economics, adopted by our house of delegates at Hampton, Va., August 1938, a copy of which was placed in the hands of the technical committee, and I am submitting a copy to this committee to go on the record. We further subscribe to and concur with the resolutions and principles set forth in *A Plea for a Square Deal in the Administration of Medical Care in America*. These resolutions of the Allied Negro Medical Professions of Chicago, a constituent society of the National Medical Association, who have formulated the Chicago plan, which opinions and principles represent that of the combined national organizations, a copy of which I am presenting for the record.

In conclusion I wish to give you the summary of this plan, which summary is based on the assumption that the National Medical Association includes itself as a vital member of organized medicine, and on the further assumption that a national health program will be adequate only as it is equitable and inclusive of the full rights of all citizens. No chain is stronger than its weakest link. Any national health program initiated to achieve its objective must be:

1. Well coordinated; with the collaboration and representation of all groups of organized medicine.

2. It must be economically and efficiently administered.

3. It must be free from discrimination in act or spirit, and should alleviate such arrangements (Federal, State, and local) where inequities now exist.

4. The free choice of physician and dentist should be assured all classes of citizens.

5. The care of the indigent should be borne by taxation of all citizens, and services rendered to them by the professional groups should be paid for out of such taxation. The national and local medical societies should collaborate with local disbursing boards in providing adequate and prompt treatment to the patient and prompt remuneration to the professionals.

6. Post-graduate centers should be established and Federal subsidies provided for the training of personnel needed in any program of health expansion, and proportionate and equitable opportunities afforded to all professionals of all rates for training.

7. Voluntary insurance, as opposed to compulsory insurance, is the method of assisting the low-income groups in providing for emergency illness.

8. Education on a national scope of the public, to a health will and consciousness, is a necessary preliminary to such a program.

9. Slum clearance is likewise a national problem that must be solved if the health of the Nation is to be permanently improved.

10. The problem should be evolutionary, not revolutionary, and the status of the health of Americans today, which stands preeminently above that of any other nation, is a testimony of the gradual, yet decided, progress made through well-established and tried agencies of the past.

The National Medical Association subscribes in principle to Senator Wagner's bill, with the reservations as stated. Again, Mr. Chairman and members of the Senate committee, in behalf of the officers and members of the National Medical Association and the National Dental Association, I wish to thank you for this courtesy.

I would like to submit the report of the committee on medical economics of the National Medical Association, adopted by its house of delegates at Hampton, Va., August 1938.

Senator MURRAY. It may be inserted in the record.

(The paper referred to is as follows:)

THE REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS OF NATIONAL MEDICAL ASSOCIATION, ADOPTED BY ITS HOUSE OF DELEGATES AT HAMPTON, VA., AUGUST 1938

1. The increased cost of medical care due to the expansion of diagnostic and therapeutic facilities, together with the lessened ability of the general public to pay for medical service because of low income and lack of employment, increasing the incidence of illness, has had a very definite influence on the cost and distribution of medical service in the United States. This disparity has been accentuated in practically all of our metropolitan centers because of improper, overcrowded, and unsanitary housing conditions and the unequal distribution of physicians, especially in rural communities.

Rural America has suffered from inadequate medical care, and this association, representing as it does Negro physicians, dentists, and pharmacists from a majority of the States of the Union, cannot be unmindful of the fact that more than half of the Negro population of the United States lives in rural areas. Here are found the same conditions that persist in our urban centers, namely: Inadequate housing, unsanitary living conditions, high infant mortality, high material death rate, high incidence of tuberculosis and syphilis and other infectious diseases. The unequal distribution of Negro physicians, dentists, pharmacists, and nurses has been keenly felt in these problem areas.

Because of the aforementioned conditions there is a definite trend toward State and Federal control of medical care, supplemented by various forms of subsidized health-insurance contracts and group hospital insurance.

2. The demand for a form of governmental medical aid had its inception years ago. Possibly at a time when the medical profession and the laity realized that medical science had more to offer both in prophylaxis and treatment of disease than it was possible for a large section of the public to purchase because of low economic status. This realization has been accentuated during the recent years of the depression. At the present time it is one of the most pressing questions that faces the medical profession and the American public.

3. The Federal Government has proposed a program broad enough to include adequate medical service to all the people. Its main objective seems adequate, with the exception that in our opinion the upper limit should be fixed at such a sum as will include only those not able to pay for regular medical service.

4. All matters of health must of necessity be of serious concern to the medical profession. Therefore organized medicine must play an important role in the conduct of this phase of the security program.

5. While we should like to look at this from the standpoint of the people only and not as affecting any particular class except the needy, practice and expe-

rience through the years have demonstrated that the Negro people are too often not contemplated in all the people, but in the final analysis are too often treated as a separate and, we regret to state, at times an inferior group. The National Medical Association, representing the interests of 5,000 Negro doctors, and not losing sight of the dentists, pharmacists, and nurses, would be remiss in its duties did it not at this time make a plea for this minority group.

6. We stand with other bodies in our demand for a continuance of that prized and respected patient-doctor relationship. No system of medicine and medical practice should be set up that robs the individual of his choice of physician.

7. It is our desire that all registered regular physicians in all parts of the United States will be considered equally and that they will share alike in the services and emolument from this administration.

8. To be more specific, in those States or parts of States where there is a definite separation of the races, where there are separate schools, transportation facilities, and all social activities that the above-named practices will be made consistent in the professional administration to the indigents of the Negro race.

9. To be more specific still, it is our desire that the Negro doctors, dentists, pharmacists, nurses, and other social workers will have the privilege of treating and caring for their people and will receive therefor the same compensation as provided for others for like services. In other words, it is our expressed desire that there will be no discrimination shown in these regards.

10. Assuming further from the past practice that the United States Public Health Service will stand between the United States Treasury and the final distribution of these funds, that in the acceptance of funds, the administrators will give to the United States Public Health Service assurances that these regulations will obtain.

11. That the United States Public Health Service will provide that in the event that these fundamental conditions are violated the continuance of funds will be withdrawn until there are assurances that discriminatory practices shall cease.

Recognizing the existing exigencies, the National Medical Association recommends to its affiliates the acceptance of the principles enunciated in this outline:

C. A. Whittier, M. D., Chairman; John A. Kenney, M. D.; Numa P. G. Adams, M. D.; George W. Bowles, M. D.; A. N. Vaughn, M. D.; Ulric C. Pryce, Phar. D.; A. W. Dumas, M. D.; Roscoe C. Giles, M. D.; Marcus B. Hutto, D. D. S.; W. F. Boddie, M. D.

Dr. Bowles. I also would like to submit the report of the National Medical Association meeting with the interdepartmental committee to coordinate health and welfare activities, dated November 22, 1938, and a pamphlet entitled "A Plea for a Square Deal in the Administration of Medical Care in America."

Senator Murray. They may be filed.

(The pamphlets referred to were filed with the committee.)

Senator Murray. Thank you for your statement.

The next will be Morris A. Bealle.

STATEMENT OF MORRIS A. BEALLE, PUBLISHER, PLAIN TALK MAGAZINE, WASHINGTON, D. C.

Senator Murray. State your name.

Mr. Bealle. My name is Morris A. Bealle.

Senator Murray. Whom do you represent?

Mr. Bealle. I am the editor of the Plain Talk Magazine, but I came here today to make a plea for some millions of citizens who have been left out of the Wagner bill altogether.

Senator Murray. You represent the Plain Talk Magazine?

Mr. Bealle. Yes, sir.

Senator Murray. And through that you represent the readers of your magazine?

Mr. BEALLE. The readers of my magazine. I refer to the patients of some 50,000 drugless doctors in this country.

Senator ELLENDER. What is that?

Mr. BEALLE. I refer to the patients of about 50,000 drugless doctors in this country who are not provided for in the bill.

Senator MURRAY. The patients of drugless doctors?

Mr. BEALLE. Yes.

Senator MURRAY. Whom do you mean by "drugless doctors?"

Mr. BEALLE. The osteopaths, chiropractors, Christian Scientists, and naturopaths.

Senator MURRAY. You represent them?

Mr. BEALLE. I am not representing them, I am making a plea for them. They are left out of the bill.

Senator MURRAY. There are hundreds of witnesses who are seeking to appear here and give lengthy statements, and each one of those professions will represent themselves.

Mr. BEALLE. I am not giving a lengthy statement. My statement can be made in about 3 minutes.

Senator MURRAY. Each one of those professions, of course, will desire to be heard here and make an argument on behalf of their particular profession, so we do not want to go over the same territory too many times.

Mr. BEALLE. I do not think you will.

Senator MURRAY. Proceed with your statement.

Mr. BEALLE. In order to shorten it, I will read something I intended to speak extemporaneously on. I have studied this subject for 7 years. I am in favor of medical freedom, the right of choice of one's own physician, but I fear under this bill the very medical freedom which was first advocated by Dr. Benjamin Rush, when the Bill of Rights was being drawn up, the rights of a good many million Americans to have the doctor of their choice would be interfered with, if not actually abrogated.

Since 1874 drugless doctors have been curing people of what ails them, but the United States Government never recognized this fact until Senator Burke, of Nebraska, in 1938 drove through an amendment to the Federal Employees Compensation Act granting all those entitled to Government compensation the right to consult or be treated by an osteopath. Senator Burke's bill was a start in the right direction, but it left out the millions of patients of chiropractors, naturopaths, and Christian Scientists.

Now, this 85 percent I referred to is based on two surveys, one by the Chicago Medical Society, and one by the medical examiner of the Pasadena, Calif., Y. W. C. A. The medical examiner, Dr. Alice M. Cutler, examined 1,200 women and girls for admission. She asked each one what kind of doctor attended them when they were sick. The answer she got was that 772 went to osteopathic physicians, 120 went to chiropractors, 187 went to Christian Scientists, and 125 to medical doctors.

Dr. Charles J. Whalen, editor of the Illinois Medical Journal, was and is an orthodox allopathic physician highly respected by his colleagues all over the United States. Dr. Whalen went into detail and told of the examination of 6,772 persons in all sections of the city.

From this total, Dr. Whalen's agents found only 931 said they had never been to drugless doctor and of this 931 only 384 would vow they would stick to medicine until they died. Dr. Whalen also felt that a most significant part of the survey was that the percentage of those who used drugless doctors was higher in the silk-stockings district of Chicago than it was in the stockyards section.

Dr. Whalen's report is very, very interesting. It takes up six pages of this book, and if it saves the committee's time, if you wish it, I will turn it over to the stenographer to put it in the record.

Senator MURRAY. That may be done.

(The matter referred to is as follows:)

The reason for the appointment of the committee was the falling away among certain of your patients of quacks and cults and practitioners of little value—the vast fund of misinformation which the layman at large has about the politics and achievements of the medical profession.

Now, if the average businessman, selling service to the highest known grade, found numbers of his potential customers not only utilizing that service but using others, far less meritorious at a far greater price, he would immediately send out trained workers to make a trade survey.

We gathered together volunteer workers, traveling salesmen, city salesmen, office people who had much contact with the general public, the welfare worker in one of the biggest Middle Western industrial concerns, a club woman on the South Side, a society woman on the North Side—people who would come in contact with laymen in every walk of life. There were a few paid workers, too, who went up the highways and byways.

We asked them to do this: To find out from as many as possible "What did you do the last time you were sick?" and wherever it could be done gracefully "What led you to do that?" for that would not only have robbed the reply of its spontaneity but it might have cast considerable suspicion upon the motive of the inquirer.

Replies were grouped under general heads from 5,719 persons in Chicago and from 1,053 persons out of Chicago—a total of 6,772. From this total only 931, or 12½ percent, had never dabbled in any cult or pseudo-science. Of the 931 with a perfect record, only 384, or 5 $\frac{1}{17}$ percent, had no curiosity about any of the said cults and no intention of experimenting just a bit with them.

Of the 5,841 who were directly against the physicians, directly for the other fellow (which is quite a different matter), or who had at some time or other been interested in the other fellow to the point of investing money in his healing methods, only 7 percent of them were directly opposed to the physician on account of some fault of his own; that is, malpractice, either real or imagined, or his failure as an individual to adapt himself to a situation. But 93 percent of them had these visions I was telling you about due to confused impressions about you, your relationship with one another, your significance in social, economic, and scientific progress, and your long and arduous preparation for practice.

We have all classes represented here, from day laborers to society leaders, with just about a 50-50 break between those above and those below middle class in property holding. And we found what to us was a rather interesting fact—that the semi-foreign communities out on the West Side of Chicago showed a smaller percent experimenting with doubtful healing practices than the exclusive Hyde Park and North Shore residential districts.

The following 22 groups of answers, we are told, are given merely as an indication of the spontaneous comment of nearly 7,000 persons. The fact that most of the statements made are untrue, that many of them are inconsistent one with another, would to the businessman simply be an indication that he had better put the truth about himself and his service into mediums where these people can find them. Here are the groups:

1. There is a large group of people who will tell you that the physician is negative. He tells you what you must not do, warns you of ensuing fatalities; the osteopath and chiropractor does something concrete to you. The mental reaction is better.

2. There are others who will tell you that the physician has too good a graft. He looks at you once and charges you \$5 for a prescription which he gets from

a book on the shelf. You can do quite as well by going to the corner drugstore.

3. There are those who say the doctors resent questions. They either shut you up summarily or overwhelm you by an utterly incomprehensible explanation.

4. Others say that doctors set themselves up as wiser, less fallible than other people. One woman said the last doctor she had was as pompous as a New Zealand devil dancer.

5. It is said that doctors habitually criticize treatments and healing methods of which they know nothing. How many doctors have questioned carefully a patient who has been helped by a chiropractic treatment? How many of them have even seen a treatment? Yet they criticize it, regardless.

6. Some people said that the chiropractic schools at Davenport had really amazing equipment; and that the students there worked so hard they must be very competent when they came out.

7. Others say that physicians are not consistent in their ethical practices. The man who goes after business by the business method of advertising is likely to be thrown out of his society. Yet the doctors with a spectacular patient, and with enough of a graft with a city editor to exploit him, becomes a high-priced specialist, and everybody is anxious to call him into consultation.

8. Numbers of people commented on the osteopathic advertisements which have been running in national magazines and claimed to have been interested to the extent of trying out the treatments.

9. Another group says that the doctors' attitude toward one another is about as friendly as two strange bulldogs in a back yard. Suppose you dismiss one physician from a case and call another. He will come in, inspect you sorrowfully, shudder with horror as he sniffs at the bottle of medicine his predecessor left, and say in a deep voice, "you did well to send for me; in another hour you would have been no more, but I shall cure you."

10. There are people who misunderstand your ethical ideals. They say that an honest man will protect a crook; that if another doctor has blundered on a case you will do absolutely nothing to prevent his repeating the performance on any patient who may stray into his office.

11. There are those who believe that successful doctors use for their patients parts of the very same treatments that make the drugless practitioners successful—diet, massage, adjustment, and letting Nature do the work; but they drag it out longer, clutter it up with useless medicines, make it cost more, and don't tell the truth about it.

12. Others think that when you actually get down to cases the doctors do the same thing they revile in their competitors. There is a famous clinic in the Middle West which is so prosperous that nobody in the profession dares criticize it. Yet they used to flood all that part of the country with advertising literature, report has it, and later entered into a deal with a railroad to advertise the town as the home of that clinic.

13. The cults—science, new thought, and a dozen others—make you a factor in your own healing. It is subjective. Medicine treats you merely as an objective—a clod of a thing to be worked on.

14. Another group says that doctors are always a bar to progress because they fight social legislation, such as the Sheppard-Towner bill, and the only news stories to be found in the public press show their motive to be a selfish and financial one.

15. Others say that doctors won't talk competition from a fair angle. They will never admit any good in mental or related aids, and their attitude bears the stamp of a narrow outlook, because such great movements as Christian Science could not exist so long or flourish so wonderfully without a foundation of truth.

16. The cults—and this comment was made of many—draw upon forces that are greater than man. The doctors' resources are human and mechanical.

17. There is a large group which refuses to believe that only the doctor who has studied allopathic medicine was competent to practice healing. Yet the doctors have never given the slightest degree of approval to anything which did not originate in their own ranks.

18. Another group wondered if anyone interested in healing methods hadn't better read the exposé of the medical profession recently appearing in a popular magazine. It showed how little most doctors know about the drugs they prescribed.

19. Another group said that since doctors seem to be responsible for the vast group of drug addicts so much discussed now, it is dangerous to let yourself be given drugs for any kind of illness, and drugless healers are therefore best.

20. Another group says: "The last doctor I went to gave me the wrong treatment and I nearly died. I went to an osteopath" (or a naturopath or a chiropractor, as the case may have been) "and was cured."

21. Others say that there are too many specialists. It is too expensive to be handed around from one to the other for each separate thing that they might think might be the matter with you. It is better to go to someone who can take care of everything at once.

22. And, finally, there is the group that says there is no way of telling which is the good doctor and which is the bad one, and it is too dangerous to experiment with them. Osteopathy—or each man's favorite practice—can't hurt you, and has cured every difficulty so far.

Gentlemen, you have been very much amazed by several of these things. You were not half as much amazed as we were in getting them together. It doesn't make any difference how wrong the people are or how much they are at fault in not knowing that they are wrong. It is a fact that almost 7,000 people honestly believe these things, and that these 7,000 people are not confined to ditch diggers or dish washers or common laborers. Every one of them is likely to call you frantically at 2 o'clock in the morning if there was something considered a real emergency.

Medicine is on profession in the world where a man takes an independent attitude with a humanitarian point of view. It is the one profession in the world where you have constantly cut down your income by constantly striving for preventive medicine.

Here is one of your biggest jobs. Whatever plan you have designed for your committee on educational propaganda, I think the dense ignorance of 7,000 people would be worth while putting the general public straight on. Now, to most of you educational propaganda means a distorted form of advertising. But there is no advertising on earth of the display type merely that is going to work a reform in people's minds. They will discount it as mere propaganda. It would be hard to make it readable. It would be hard to make it say anything and stand out apart from the much disliked practices who started out in the display game.

There are other, more effective, ways of reaching people humanly and of going ahead along the line of telling the truth about medicine. If the things are true about you men that your leaders say are true, the story of medicine has enough punch in it to make one of the best, one of the most interesting stories ever told in America. And it seems to me that professional men can no longer afford, either practically or for the sake of their patients, to have people ignorant.

It means 98 percent of these people do not care to come to you unless they think they are going to die. It means that they are actively interested in other things. The modern mind is a little bit overstimulated. If I were a businessman and had invested a large sum of money, together with 7 or 8 years of my life, in preparing myself to do the sort of service you are able to do, and if the quality of my service was from year to year increasing, and if the potential customers for that service from year to year, country-wide, was decreasing in proportion to the wealth of the country and the population of the country, then I think I would do something, and I think I would do it quick.

Finally, I want to say for the bill S. 1620, I am neither advocating the bill nor opposing it, excepting this feature of it. In 21 places is mentioned "medical care," and in not a single place does it mention osteopathic, naturopathic, chiropractic, or Christian Science care. In 61 places it mentions the State set-ups and the Federal set-ups which will be run by medical men, and in not a single place does it provide for any of the drugless doctors on any of these boards.

That is the sum of my statement.

Senator MURRAY. I thank you for your statement. The next witness will be Dr. Emerson.

**STATEMENT OF DR. KENDALL EMERSON, MANAGING DIRECTOR,
NATIONAL TUBERCULOSIS ASSOCIATION**

Senator MURRAY. State your name.

Dr. EMERSON. I am Dr. Kendall Emerson, managing director of the National Tuberculosis Association.

The National Tuberculosis Association is a voluntary health association, consisting of their central office in New York and an affiliated State association in each of the States, each of the State associations having a number of locals, so that altogether there are about 2,000 tuberculosis associations scattered over the country. The central association is controlled by a board of directors of 100 members, two-thirds of whom are physicians, all of them members of the American Medical Association. The membership consists of about 1,600 individuals in the national membership, about half of them physicians. The membership of the State associations and the locals runs into many thousands, and reckons among its membership many physicians, dentists, and nurses, public-health nurses, public-health officials; however, the balance being those citizens interested primarily in preventive medical work.

I am here, sir, to testify on behalf of the National Tuberculosis Association. It is sympathetic with the aims and objectives of the Wagner national-health bill.

Senator MURRAY. Your organization is the only national organization carrying on activities of this kind, is it?

Dr. EMERSON. It is the only national organization interested directly in the prevention and control of tuberculosis. There are other similar organizations interested in other preventive medical subjects, such as cancer, heart disease, and so forth.

Senator WAGNER. Incidentally, Doctor, you have a fine record. I mean you have been reducing tuberculosis in the country.

Dr. EMERSON. Yes, sir. You are very gracious to say we have been reducing. The rate has been reducing very rapidly since 1900.

Senator WAGNER. I have noticed some of the activities of your association.

Dr. EMERSON. From 1900 until the present time, the reduction is from 200 deaths annually per 100,000 population to under 50 deaths annually, according to the tentative reports for 1938, not yet official. Perhaps, unfortunately, the national health bill was introduced in the Congress just a week after the annual midwinter meeting of my board, so that we had not an opportunity to make a formal pronouncement by the national association on that particular bill. I believe, however, that I am entirely within my rights as managing director to make the statement that at that time a bill was approved by the board of directors of the National Tuberculosis Association, bill S. 471, introduced during January, which makes similar provisions as those under the national health bill, along the line exclusively of provision for tuberculosis prevention and work.

We also at that time adopted a bill of our own, which has been submitted to the author of the bill S. 471, and through his courtesy some modifications may be made to reconcile the purposes of the two bills, both of which coincide with the general purposes of the national

health bill. It, therefore, seems to me that I am entirely within the bounds of propriety if I consider myself as speaking on behalf of the National Tuberculosis Association, and I have only two or three brief remarks to make in that capacity.

As regards the several titles of the bill, there is no disagreement with the purposes of title V. I think, however, I should fairly make the statement that so far as I can get the pulse of our medical directors, there is a very general feeling toward the consolidation of all Federal health matters under one department of the Federal Government rather than their allocation under several different departments. That has not been formulated in any formal manner, but I am sure, from my knowledge of my own board of directors, that that tendency is prevalent in their thinking. The objectives, however, of title V we can take no exceptions to, and the procedure of administration, with the single exception cited. Title VI and title XII receive in the same measure our full agreement, as to their objectives and, in general, to their method of administration.

We believe, however, in connection with title XIII, that the administration of the medical-care program should be placed under the Public Health Service rather than under the Social Security Board. In defense of that statement I would like to be recorded as believing that the actual treatment of disease is so intimately bound up with prevention that the two are inseparable.

Treatment today is the most important factor in the control of the most important causes of disability and death, as for example, heart disease, tuberculosis, pneumonia, venereal diseases, maternal and infant mortality. This is particularly true of tuberculosis, in which my association is primarily interested, where the chief hope of further reduction in the death rate, and in preventing the spread of infection, lies in the early diagnosis of cases before they have infected others, and by isolating them in hospitals where they will receive adequate and effective treatment.

A final word on this subject and then I am through. I have the privilege of referring to the testimony of my colleagues, Dr. Grulee and Dr. Davis, one a pediatrician and the other an obstetrician. In both of their representations to you they specify particularly the inseparability of preventive treatment and curative work, and their particular specialties demonstrate that perhaps more vigorously and vividly than others, but I can assure you the same is true in the treatment and preventive activities in connection with tuberculosis.

Senator MURRAY. Thank you.

Senator WAGNER. Mr. Chairman, the other day Dr. Palmer testified that he was head of the Medical Association of Pennsylvania, that Pennsylvania was taking care of its health needs and did not require Federal aid, and that we should "rest up for about 10 years" on this health program. The following reports show a tremendous need for health service in the State of Pennsylvania:

1. "Medical care in the public assistant program of Pennsylvania," report by a special advisory committee on medical care, issued in June 1937, of which committee Dr. Palmer himself was chairman.

In a State report made in 1919, to show facilities for health and sickness needs in Pennsylvania, and in many reports since that time, the standard of 5 beds per 1,000 population has been set as the number to meet needs for hospital services.

Pennsylvania does not meet this standard, and there are large areas where hospitals are not available without miles of travel.

The total number of beds, including those in general hospitals and those caring for special diseases and conditions, were 88,267.

This gives a rate of 8.77 beds per 1,000 Pennsylvania inhabitants. The generally accepted yardstick for beds per 1,000 population, for all types of illness, is 11 or 12 beds. Pennsylvania does not meet this standard.

The National Organization for Public Health Nursing in its 1934 survey reports that the minimum essential in establishing adequate public-health nursing service for individuals is a ratio of 1 nurse to every 2,500 persons in the population. There are now available for bedside nursing care throughout the State approximately 500 public-health nurses.

For an estimated relief load of approximately 1,500,000 persons, 600 public-health nurses would be required, according to the above ratio, to take care of the indigent alone. The remaining 8,500,000 persons in the State who are not on relief would require 3,400 additional public-health nurses. This clearly shows the inadequacy of nursing facilities in the State at the present time.

From the records of the Emergency Child Health Committee, the incidence of dental caries, as discovered by physicians in their routine health examinations, was 42.2 percent. This figure was obtained from examinations of 118,018 children, of whom 49,011 showed easily recognizable dental caries. The figures of these two studies show the almost unbelievable need for dental attention among Pennsylvania's future citizens.

2. Article entitled "Syphilis Must Go," in a publication called "Pennsylvania's Health," a monthly bulletin of the department of health, May 1937, issue:

With the aid of additional funds received under the Social Security Act the Pennsylvania Department of Health is now taking steps that we hope will lead to the eradication of this neglected disease.

Until recently the department had had insufficient funds to attack the problem of syphilis control in a sane and rational way. Now a program that gives promise of success is being put into operation, made possible through the Social Security funds.

3. Child Health Program, a report of the Pennsylvania Department of Health:

This year, with a State biennial fund of \$250,000, we have been able to examine one-half of the grades in each school, and the remaining will be examined next year. This will enable us to do a complete medical inspection once in every 2 years.

The purpose of these inspections is to discover the more obvious and apparent physical defects such as in the eyes, teeth, heart, tonsils, obstructions of the nasal passages, malnutrition, and other conditions.

Inspections are made by physicians at an established rate for each child examined. The reports of these examinations are sent to the central office of the Division of School Medical Inspection of the Department of Health, from which cards noting the defects of each child are returned to the teachers, to be given to the parents of the children.

On the surface such a system would appear to be adequate. The child is examined; defects are discovered and the parents are notified so that steps may be taken to obtain corrections. There has been one flaw, however. Nowhere is provision made for medical, dental, and surgical treatment for children of indigent parents.

Consequently much of the value of school medical inspection is lost, since the vast majority of children of school age who are defective come from families which are either indigent, or so near the economic border line that they are unable to provide for medical care except where it is absolutely necessary.

The result has been that throughout the years the percentage of corrections obtained as a result of follow-up after school inspection has been discouragingly small. In the rural districts the results have been most discouraging. Approximately 500,000 children were examined this past school year; 74.1 percent of these children had one or more of the physical defects I have mentioned. Of these, corrections were obtained for only 22 percent. In the other school dis-

tricts the percentages of corrections obtained were: For the first class, 47.4 percent; second class, 54.6 per cent; and third class, 40.3 percent.

In the more concentrated areas of population, the children are better cared for from this standpoint than in the rural districts. In the cities, the children of poor parents can obtain treatment at various public clinics, hospitals, or through the aid of public-spirited organizations and agencies. These facilities are not available to the same degree in our rural communities, and the 800,000 children in the fourth-class school districts suffer accordingly.

4. Report of Committee on Maternal Welfare, Philadelphia County Medical Society (1934). This survey covering years 1931, 1932, and 1933, showed that 56.7 percent of all maternal deaths in Philadelphia were preventable.

5. National Health Survey, United States Public Health Service. Data on unmet health needs in Pennsylvania:

(The excerpt is as follows:)

MEDICAL AND NURSING CARE OF DISABLING ILLNESS IN A 12-MOTH PERIOD—A PRELIMINARY REPORT ON THE EXPERIENCE OF FOUR PENNSYLVANIA CITIES CANVASSED IN THE NATIONAL HEALTH SURVEY, 1935-36.¹

SUMMARY

In the winter of 1935-36, the United States Public Health Service conducted a house-to-house survey of illness and its medical care in a 12-month period among approximately three-quarters of a million families. The surveyed urban population, drawn from 88 cities in 18 States, gives adequate representation to each geographic area and to cities of varying size.

The preliminary results of the National Health Survey in four cities of Pennsylvania—Philadelphia, Pittsburgh, Lebanon, and Duryea—are considered in the present report. The conclusions may be summarized as follows:

When the frequency rates of disabling illness among families classified by relief status and annual family income were compared, it was found that disabling illness occurred with greatest frequency among relief families. Surveyed persons in non-relief families with an annual income below \$1,000 experienced a lower frequency rate of illness than relief families, but a generally higher rate than families in the upper income groups.

Within a given city, the proportion of cases of disabling illness receiving care from a physician (exclusive of hospital medical care) was lowest in relief families and in non-relief families with annual income below \$1,000. The proportion of cases attended by a physician tended to increase with rise in family income.

In the large surveyed cities (Philadelphia and Pittsburgh), the proportion of illnesses which were hospitalized did not show marked variation according to income class, due to the fact that general hospital facilities available to these two metropolitan communities meet or exceed the standard which represents adequacy of accommodations. In comparison with Philadelphia and Allegheny Counties, the hospital facilities of Lebanon and Luzerne Counties are less adequate. As a result, the proportion of illnesses receiving hospital care among surveyed families in Lebanon and Duryea showed variation according to economic status, hospital care being most frequent among the sick in the upper income groups, and least frequent among relief and non-relief marginal income families.

Bedside nursing care of illness by a private-duty nurse was negligible among relief and self-sustaining low-income families, but bedside care by a visiting nurse was relatively frequent among the poor.

The results of the National Health Survey in the four cities of Pennsylvania show general agreement with those for the cities of the Eastern area, comprising four States—Massachusetts, New Jersey, New York, and Pennsylvania—and for the entire urban population of 88 cities in 18 State.

¹ From the Division of Public Health Methods, U. S. Public Health Service.

PRELIMINARY REPORT

The National Health Survey was a house-to-house canvass made by the United States Public Health Service in the winter of 1935-36. Records of the incidence of disabling illness and the receipt of medical and nursing care in a 12-month period were obtained from a surveyed population drawn from 83 cities and 23 rural counties in 18 States. The population of each geographic area was adequately represented, and cities of varying size were included. A complete canvass of all families was made in 51 small cities, and in 32 large cities, a representative sample of families was canvassed.²

The present report relates to illness and medical care as observed in 4 of the surveyed cities located in Pennsylvania—Philadelphia, Pittsburgh, Lebanon, and Duryea. Comparative data are included for the entire Eastern area, comprising 21 cities in 4 States—Massachusetts, New Jersey, New York, and Pennsylvania.

The information concerning disabling illness and its medical and nursing care was obtained by specially trained enumerators from the housewife or other responsible lay informant, who reported the illness history of members of the family. Records were obtained only for illnesses which caused loss of time from school, work, or other usual activities for at least 7 consecutive days in a 12-month period preceding the date of the visit. An exception to this definition was made for deaths, confinements, and hospital cases, which were enumerated without reference to the duration of the disability. At the time of the interview, information was also obtained concerning the family's income and its status in regard to receipt of relief in the survey year. It is therefore possible to classify the families canvassed according to relief status and income, and compare the frequency rate of disabling illness and the proportion of disabling illnesses receiving medical and nursing care among families of varying economic status. The scope of this preliminary report does not permit a detailed analysis of the results. Within a given city, comparison of the frequency rates of illness as between persons of different economic status is warranted. However, inter-city comparison of the frequency rates is not made here since the variety of factors which lead to variation in the incidence of illness cannot be considered in this summary.

I. THE EXPERIENCE OF FOUR CITIES IN PENNSYLVANIA

Frequency of disabling illness

Disabling illness occurred with greatest frequency among families on relief. In Philadelphia the frequency rate of disabling illness was 198 per 1,000 persons in relief families, compared with a rate of 124 in families with an income of \$3,000 and over. In Lebanon the frequency rate in relief families was 200 per 1,000 persons, and 105 per 1,000 persons in the class with income over \$3,000. These rates are shown in table 1, together with the rates for Pittsburgh and Duryea.

Surveyed persons in nonrelief families with an annual income below \$1,000 experienced a lower frequency rate of illness than relief families, but a generally higher rate than that of families in the upper-income groups. The higher frequency of disabling illness observed in the relief group and in self-sustaining but marginal income families (with annual income under \$1,000), is a fact of some importance when considered in relation to the income distribution of the surveyed families and their illnesses. Thus, in Philadelphia, 34 percent of the canvassed population, and 41 percent of the cases of sickness, occurred in families who had been on relief or had received incomes of less than \$1,000 in 1935. In Pittsburgh 45 percent of the surveyed population and 50 percent of the cases of illness fell in these two lowest-income groups.

²The method and scope of the survey has been described in a preliminary bulletin. See *A National Health Survey, 1935-36—Significance, Scope, and Method of a Nation-Wide Family Canvas of Sickness in Relation to Its Social and Economic Setting*, Division of Public Health Methods, National Institute of Health, U. S. Public Health Service, Washington, 1938.

Medical care

Physician.—The cases of sickness in surveyed relief and marginal income families (with income under \$1,000) were less frequently attended by a physician in the home, office, or clinic than were cases in families with an income of \$3,000 and over. In Philadelphia 73 percent of the disabling illnesses in relief families and 75 percent in nonrelief, marginal-income families, received care from physicians outside the hospital, compared with 87 percent for families above the \$3,000-income level. The percentages shown in the upper section of table 2 indicate that the tendency toward less frequent medical attendance of the illnesses of low-income families was apparent also in Pittsburgh and Lebanon. In Duryea the number of cases of disabling illness in families at the upper end of the income scale was too small to permit this comparison.

Hospital.—The proportion of illnesses which received hospital care must be interpreted with reference to the hospital facilities available to the surveyed families. The following table shows the number of hospital beds per 1,000 population in local general hospitals classified as governmental (i.e., supported by public funds) and nongovernmental (i.e., maintained by nonprofit organizations, or proprietary) in the counties in which the surveyed cities were located: the records are as of 1935:

| County | Surveyed city included | General ¹ hospital beds per 1,000 population in hospitals classified by control | | |
|-------------------|------------------------|--|-------------------|---------------------------|
| | | Total | Govern- mental | Non- govern- mental |
| Philadelphia..... | Philadelphia..... | 6.68 | 2.14 | 4.55 |
| Allegheny..... | Pittsburgh..... | 5.01 | .88 | 4.15 |
| Lebanon..... | Lebanon..... | 1.94 | ----- | 1.94 |
| Luzerne..... | Duryea..... | 2.82 | .64 | 1.98 |

¹ Exclusive of beds in all Federal hospitals, hospitals for the tuberculous and mentally diseased, and special institutions (prisons, penitentiaries, etc.). Data from a special tabulation based on the 1935 Census of Hospitals of the American Medical Association. Table 5 shows for each county the number of hospitals and hospital beds in local general hospitals classified by control.

The proportion of illnesses which received hospital care in the families canvassed in these Pennsylvania cities in the health survey is shown in the lower section of table 2. In Philadelphia and Pittsburgh, the rate at which illnesses were hospitalized does not show marked variation from one income class to another. Reference to the figures presented in the table above indicates that residents of these metropolitan centers in 1935 had access to relatively abundant general-hospital facilities—6.7 beds per 1,000 persons in Philadelphia County and 5.0 beds per 1,000 persons in Allegheny County, compared with the ratio of 4.5 per 1,000 persons, which represents adequacy according to professional opinion. In Philadelphia County, the ratio of beds to population in governmental hospitals alone was 2.1 per 1,000.

In the smaller cities, Lebanon and Duryea, the results show a different picture. In Lebanon, 25 percent of the illnesses in relief families received hospital care during the survey year, compared with 30 percent, for families above the \$3,000-income level. In Duryea, 19 percent of the illnesses in relief families were hospitalized, compared with 28 percent for families with an income between \$1,000 and \$2,000. The hospital experience of families in Duryea above the \$2,000-income level cannot be reported because of the small number of cases of illness enumerated.

These results for Lebanon and Duryea are consistent with the facts concerning hospital facilities in the counties in which these communities are located. In Lebanon County in 1935, there was no governmental hospital, and beds in non-governmental hospitals were available in the ratio of 1.0 beds per 1,000 persons. In Luzerne County, a total of 2.6 beds in all general hospitals were available per 1,000 of the population.

Bedside Nursing Care

Table 3 summarizes the results of the health survey relating to bedside nursing care of disabling illness.

The services of the private-duty nurse are paid for from individual income, while the services of the visiting nurse are free to those unable to pay for this care. The health-survey results are consistent with the conditions under which these two types of nursing service are rendered. The percentage of disabling illnesses attended by a private-duty nurse was negligible in relief and self-sustaining marginal income families, and increased gradually with rise in family income. Visiting-nurse service, on the other hand, was most frequent among low-income families.

II. THE EXPERIENCE OF 21 CITIES IN THE EASTERN AREA

(Massachusetts, New Jersey, New York, and Pennsylvania)

The combined experience of surveyed persons in 21 cities of the four States of the eastern area canvassed in the National Health Survey indicates that the results of the survey of Pennsylvania cities are typical of the eastern area as a whole. These comparative data are shown in tables 6 to 9.

The higher-frequency rates of disabling illness occurring in the relief and marginal (nonrelief, income under \$1,000) income families, as compared with those in the upper-income groups, in the Pennsylvania cities were also observed in the large, intermediate, and small surveyed cities of the entire eastern area.

The tendency toward an increase in the proportion of illnesses attended by a physician with rise in family income observed in the Pennsylvania cities was characteristic also of the surveyed cities of the eastern area. In the large cities of the eastern area (those with a population over 100,000), the variation in the receipt of hospital care with income resembled that observed in Philadelphia and Pittsburgh, the proportion of hospitalized illnesses varying within relatively small limits in the various income classes. Likewise, the results for Duryea, Pa., are typical of the small cities of the eastern area (those with a population under 25,000) in which the proportion of illnesses receiving hospital care was lowest among the relief and marginal income classes, and increased as family income increased. Lebanon, Pa., falls in the class of cities with population between 25,000 and 100,000. However, the income variation in the proportion of illnesses hospitalized in this community resembled that of the eastern cities under 25,000 population, rather than that of the eastern cities of its appropriate population class.

Receipt of bedside nursing care, both from the private-duty and visiting nurse, showed essentially the same type of variation with income in the Pennsylvania cities as in the cities of the eastern area.

TABLE 1.—*Annual frequency per 1,000 persons of disabling¹ illness, according to economic status—White persons in 4 cities in Pennsylvania canvassed in the National Health Survey, 1935-36²*

| City | Annual family income and relief status | | | | | |
|-------------------|--|--------|---------------|--------------------|--------------------|------------------|
| | All incomes | Relief | Nonrelief | | | |
| | | | Under \$1,000 | \$1,000 to \$2,000 | \$2,000 to \$3,000 | \$3,000 and over |
| Philadelphia..... | 138 | 108 | 146 | 126 | 115 | 124 |
| Pittsburgh..... | 167 | 216 | 166 | 147 | 147 | 161 |
| Lebanon..... | 143 | 200 | 145 | 123 | 123 | 105 |
| Duryea..... | 178 | 203 | 161 | 139 | 124 | 83 |

¹ Disabling for a week or longer. Sole and primary causes only.

² The number of surveyed persons and of disabling illnesses according to economic status is shown in table 4.

TABLE 2.—Percentage of disabling¹ illnesses which received medical care of specified type according to economic status—White persons in 4 cities in Pennsylvania canvassed in the National Health Survey, 1935–36

PHYSICIAN

| City | Annual family income and relief status | | | | | |
|-------------------|--|--------|---------------|--------------------|--------------------|------------------|
| | All incomes | Relief | Nonrelief | | | |
| | | | Under \$1,000 | \$1,000 to \$2,000 | \$2,000 to \$3,000 | \$3,000 and over |
| Philadelphia..... | 76.7 | 72.6 | 75.1 | 76.0 | 83.8 | 86.8 |
| Pittsburgh..... | 74.3 | 69.7 | 71.8 | 78.2 | 82.1 | 82.9 |
| Lebanon..... | 86.1 | 83.3 | 85.2 | 87.9 | 93.6 | 90.2 |
| Duryea..... | 70.2 | 69.3 | 70.1 | 71.6 | (1) | (1) |

HOSPITAL

| | | | | | | |
|-------------------|------|------|------|------|------|------|
| Philadelphia..... | 35.6 | 35.3 | 35.1 | 36.2 | 35.9 | 33.7 |
| Pittsburgh..... | 26.8 | 27.7 | 24.4 | 27.7 | 25.3 | 27.8 |
| Lebanon..... | 25.3 | 24.9 | 23.9 | 28.3 | 29.4 | 39.0 |
| Duryea..... | 20.8 | 18.6 | 20.5 | 27.9 | (1) | (1) |

¹ Disabling for a week or longer. Sole and primary causes only.² The number of disabling illnesses is too small to permit the computation of rates.

TABLE 3.—Percentage of disabling¹ illnesses which received bedside nursing care from nurse of specified type, according to economic status—White persons in 4 cities in Pennsylvania canvassed in the National Health Survey, 1935–36

PRIVATE DUTY NURSE

| City | Annual family income and relief status | | | | | |
|-------------------|--|--------|---------------|--------------------|--------------------|------------------|
| | All incomes | Relief | Nonrelief | | | |
| | | | Under \$1,000 | \$1,000 to \$2,000 | \$2,000 to \$3,000 | \$3,000 and over |
| Philadelphia..... | 3.0 | 0.6 | 1.6 | 2.6 | 5.1 | 13.2 |
| Pittsburgh..... | 3.0 | .9 | 1.4 | 2.7 | 5.0 | 14.6 |
| Lebanon..... | 2.2 | 1.1 | 1.4 | 2.9 | 3.7 | 8.5 |
| Duryea..... | 1.5 | .5 | 2.2 | 2.7 | (1) | (1) |

VISITING NURSE

| | | | | | | |
|-------------------|------|------|------|------|------|------|
| Philadelphia..... | 3.0 | 4.7 | 2.5 | 2.8 | 2.2 | 1.1 |
| Pittsburgh..... | 13.9 | 19.8 | 12.7 | 12.2 | 12.4 | 10.1 |
| Lebanon..... | 7.3 | 12.3 | 7.1 | 4.3 | 4.3 | 8.7 |
| Duryea..... | 3.4 | 4.4 | 2.5 | 1.1 | (1) | (1) |

¹ Disabling for a week or longer. Sole and primary causes only.² The number of disabling illnesses is too small to permit the computation of rates.

TABLE 4.—*Annual number of disabling¹ illnesses and number of persons surveyed, according to economic status—White persons in 4 cities in Pennsylvania canvassed in the National Health Survey, 1935–36*

| Size of city | NUMBER OF DISABLING ¹ ILLNESSES | | | | | | |
|-------------------|--|--------|---------------|--------------------|--------------------|------------------|----------------|
| | Annual family income and relief status | | | | | | |
| | All incomes | Relief | Nonrelief | | | | Income unknown |
| | | | Under \$1,000 | \$1,000 to \$2,000 | \$2,000 to \$3,000 | \$3,000 and over | |
| Philadelphia..... | 14,615 | 2,061 | 3,013 | 5,874 | 1,407 | 884 | 416 |
| Pittsburgh..... | 12,371 | 3,625 | 2,909 | 3,950 | 971 | 643 | 573 |
| Lebanon..... | 3,462 | 828 | 1,252 | 1,919 | 187 | 92 | 94 |
| Duryea..... | 1,490 | 888 | 365 | 188 | 21 | 5 | |

| NUMBER OF PERSONS SURVEYED | | | | | | | | |
|----------------------------|---------|--------|--------|--------|--------|-------|-------|--|
| Philadelphia..... | 106,144 | 14,055 | 20,663 | 46,461 | 12,810 | 7,101 | 4,064 | |
| Pittsburgh..... | 74,053 | 15,123 | 17,886 | 26,823 | 6,591 | 3,992 | 3,578 | |
| Lebanon..... | 24,208 | 4,141 | 8,652 | 8,253 | 1,515 | 783 | 804 | |
| Duryea..... | 8,370 | 4,385 | 2,287 | 1,310 | 160 | 60 | 173 | |

¹ Disabling for a week or longer. Solo and primary-causes only.

TABLE 5.—*Number of hospitals and hospital beds in local general hospitals classified by control, 1935—4 counties of Pennsylvania in which cities canvassed in the National Health Survey were located*

| County and surveyed city included | Number of hospitals classified by control ¹ | | | | | | Number of beds in hospitals classified by control ¹ | | | | | |
|---|--|-------|-------|-------|--------|-----------------|--|-------|-------|-------|--------|-----------------|
| | Governmental | | | | | Nongovernmental | Governmental | | | | | Nongovernmental |
| | Total | | Total | State | County | | Total | | Total | State | County | |
| | Total | | | | | | Total | | Total | | | |
| Philadelphia County (includes Philadelphia city)..... | 62 | 3 | 1 | ..... | 2 | 80 | 13,037 | 4,166 | 506 | ..... | 3,600 | 8,371 |
| Allegheny County (includes Pittsburgh city)..... | 33 | 2 | ..... | ..... | 2 | 31 | 6,882 | 1,180 | ..... | ..... | 1,180 | 5,702 |
| Lebanon County (includes Lebanon city)..... | 2 | ..... | ..... | ..... | 2 | 130 | ..... | ..... | ..... | ..... | ..... | 130 |
| Luzerne County (includes Duryea city)..... | 9 | 3 | 2 | ..... | 1 | 6 | 1,104 | 283 | 271 | ..... | 12 | 804 |

¹ Exclusive of all Federal hospitals, hospitals for the tuberculous and mentally diseased, and special institutions (prisons, penitentiaries, etc.). Data from a special tabulation based on the 1935 Census of Hospitals of the American Medical Association.

TABLE 6.—*Annual frequency per 1,000 persons of disabling¹ illness, according to economic status and size of city—White persons² in eastern cities canvassed in the National Health Survey, 1935–36*

| Size of city | Annual family income and relief status | | | | | |
|------------------------|--|--------|---------------|--------------------|--------------------|------------------|
| | All incomes ³ | Relief | Nonrelief | | | |
| | | | Under \$1,000 | \$1,000 to \$2,000 | \$2,000 to \$3,000 | \$3,000 and over |
| All sizes..... | 154 | 214 | 164 | 138 | 120 | 123 |
| 100,000 and over..... | 151 | 212 | 162 | 134 | 123 | 121 |
| 25,000 to 100,000..... | 155 | 205 | 165 | 139 | 133 | 121 |
| Under 25,000..... | 183 | 238 | 198 | 165 | 160 | 147 |

¹ Disabling for a week or longer. Sole and primary causes only.

² Exclusive of the experience of families with income unknown and persons of unknown age.

TABLE 7.—*Percentage of disabling¹ illnesses which received medical care of specified type according to economic status and size of city—White persons² in eastern cities canvassed in the National Health Survey, 1935–36*

| City | Annual family income and relief status | | | | | |
|------------------------|--|--------|---------------|--------------------|--------------------|------------------|
| | All incomes ³ | Relief | Nonrelief | | | |
| | | | Under \$1,000 | \$1,000 to \$2,000 | \$2,000 to \$3,000 | \$3,000 and over |
| All sizes..... | 73.8 | 70.8 | 71.1 | 74.3 | 79.0 | 82.0 |
| 100,000 and over..... | 73.1 | 69.8 | 69.6 | 73.6 | 79.5 | 82.0 |
| 25,000 to 100,000..... | 76.6 | 74.6 | 78.8 | 75.1 | 80.3 | 82.3 |
| Under 25,000..... | 76.7 | 75.2 | 73.2 | 78.3 | 83.4 | 82.2 |

HOSPITAL

| | | | | | | |
|------------------------|------|------|------|------|------|------|
| All sizes..... | 31.3 | 32.8 | 29.3 | 31.5 | 31.1 | 30.6 |
| 100,000 and over..... | 32.3 | 34.0 | 30.9 | 32.4 | 31.4 | 30.4 |
| 25,000 to 100,000..... | 32.3 | 35.3 | 28.5 | 32.3 | 34.2 | 33.4 |
| Under 25,000..... | 23.8 | 22.9 | 21.8 | 24.7 | 26.2 | 30.6 |

¹ Disabling for a week or longer. Sole and primary causes only.

² Exclusive of the experience of persons of unknown age and unknown income.

TABLE 8.—*Percentage of disabling¹ illnesses which received bedside nursing care from nurse of specified type, according to economic status and size of city—White persons² in eastern cities canvassed in the National Health Survey, 1935-36*

PRIVATE DUTY NURSE

| Size of city | Annual family income and relief status | | | | | |
|------------------------|--|--------|---------------|--------------------|--------------------|------------------|
| | All incomes ² | Relief | Nonrelief | | | |
| | | | Under \$1,000 | \$1,000 to \$2,000 | \$2,000 to \$3,000 | \$3,000 and over |
| All sizes..... | 3.1 | 0.9 | 2.1 | 3.1 | 6.6 | 12.0 |
| 100,000 and over..... | 3.0 | .7 | 1.8 | 2.8 | 5.3 | 11.9 |
| 25,000 to 100,000..... | 4.0 | 1.4 | 2.8 | 5.4 | 5.8 | 12.6 |
| Under 25,000..... | 3.8 | 1.5 | 2.8 | 4.1 | 8.7 | 13.2 |

| VISITING NURSE | | | | | | |
|------------------------|-----|------|-----|-----|-----|-----|
| All sizes..... | 7.6 | 11.6 | 7.4 | 6.5 | 5.1 | 3.4 |
| | | | | | | |
| 100,000 and over..... | 7.7 | 11.8 | 7.6 | 6.4 | 5.1 | 2.4 |
| 25,000 to 100,000..... | 8.8 | 12.4 | 7.8 | 8.1 | 5.4 | 4.0 |
| Under 25,000..... | 6.8 | 8.7 | 6.3 | 6.0 | 4.6 | 2.5 |

¹ Disabling for a week or longer. Sole and primary causes only.² Exclusive of the experience of persons of unknown age and unknown income.

TABLE 9.—*Annual number of disabling¹ illnesses and number of persons surveyed, according to economic status and size of city—White persons² in eastern cities canvassed in the National Health Survey, 1935-36*

NUMBER OF DISABLING ILLNESSES

| Size of city | Annual family income and relief status | | | | | |
|------------------------|--|--------|---------------|--------------------|--------------------|------------------|
| | All incomes ² | Relief | Nonrelief | | | |
| | | | Under \$1,000 | \$1,000 to \$2,000 | \$2,000 to \$3,000 | \$3,000 and over |
| All sizes..... | 126,553 | 32,678 | 25,213 | 47,174 | 13,752 | 7,706 |
| 100,000 and over..... | 101,707 | 20,285 | 18,881 | 38,112 | 11,731 | 6,788 |
| 25,000 to 100,000..... | 10,251 | 2,717 | 2,599 | 3,712 | 850 | 350 |
| Under 25,000..... | 11,502 | 3,670 | 3,763 | 5,330 | 1,165 | 568 |

NUMBER OF PERSONS SURVEYED

| Size of city | All incomes ² | Relief | Nonrelief | | | |
|------------------------|--------------------------|---------|---------------|--------------------|--------------------|------------------|
| | | | Under \$1,000 | \$1,000 to \$2,000 | \$2,000 to \$3,000 | \$3,000 and over |
| All sizes..... | 621,114 | 152,655 | 153,603 | 342,069 | 109,075 | 62,722 |
| 100,000 and over..... | 675,407 | 123,798 | 116,881 | 283,739 | 95,133 | 55,946 |
| 25,000 to 100,000..... | 66,293 | 13,275 | 16,747 | 26,909 | 8,459 | 2,903 |
| Under 25,000..... | 70,324 | 15,352 | 20,065 | 32,321 | 7,483 | 3,873 |

¹ Disabling for a week or longer. Sole and primary causes only.² Exclusive of the experience of persons of unknown age and unknown income.

Senator MURRAY. The next witness is W. D. Moore.

**STATEMENT OF W. D. MOORE, AMERICAN CAST IRON PIPE CO.,
BIRMINGHAM, ALA.**

Mr. MOORE. My name is W. D. Moore. I come from Birmingham, Ala. I am president of the American Cast Iron Pipe Co., a corporation that employs normally a thousand people, and presumes to look after the health of all of those people and their dependents, representing a family of about 5,000 people.

I should like the privilege of giving you a brief statement of some of our practical experiences in the field of public health, and to make a few comments and suggestions with reference to the proposed legislation.

I list below my personal qualifications to speak on the subject of public health.

My direct experience in the field of human relationships and public health dates from 1908, as I entered the service of the American Cast Iron Pipe Co., having approximately 1,000 employees.

The State is Alabama, the county, Jefferson; the city, Birmingham; the community, Acipco. In 1908 the company, under the leadership of John Eagan, president, inaugurated a new and constructive program in the broad field of human relationship in industry, and the outstanding feature was a beginning in the field of health for the workmen and their dependents, a total group of approximately 5,000.

Modern bathhouses and locker rooms were provided, and a full-time doctor was employed. The work in the field of health was expanded and grew very rapidly, until in 1924, at the time of Mr. Eagan's death, we had a capital investment in buildings and equipment of approximately \$50,000, with an annual budget for operating expenses of approximately \$45,000 and a staff of approximately 10 people.

By 1937 this had been expanded to a capital investment of approximately \$125,000, with an operating budget of \$75,000 and a personnel of approximately 25 people. The current operating budget is approximately \$90,000.

All fees for this health service were eliminated in 1922, and the service is now rendered as a part of the regular facilities offered by the company to all of its employees and all of their dependents without charge.

The number of employees involved is approximately 1,000 people, practically all adult men—heads of families. Approximately 40 percent of the group is white and 60 percent Negroes. Our entire family group, including dependents, numbers approximately 5,000. Their homes are not concentrated about the plant, but are scattered all over the Greater Birmingham district, covering a radius of 10 to 15 miles from the plant.

The challenge in this health department is to render complete medical service, including hospitalization, to all of these men and all of their dependents.

We have refrained from going into the hospital business. We use the regular commercial hospitals for all hospitalization cases.

Senator MURRAY. Mr. Moore, what is the character of your industrial activity?

Mr. MOORE. We produce cast-iron pressure pipe used in the distribution of water and gas. The market, of course, is throughout the Nation, and with considerable export business.

We provide at the plant a complete medical clinic facility for taking care of all phases of the work which do not require actual hospitalization, and the regular work at the clinic is followed up in the home by our full-time doctors and nurses. Our present staff includes the following:

One full-time medical director.

Three full-time physicians.

Six full-time nurses.

Five full-time clerical and miscellaneous help.

Two half-time dentists.

Ten specialists on part time, with a minimum of approximately 1 full day's time per week delivered piecemeal during the week in conducting regular clinics at the plant and in taking care of the work in the hospitals.

One full-time laboratory technician.

We are doing what we believe to be a fairly good job in the field of health involving approximately 5,000 persons, at a per-capita cost of approximately \$20 per year and with a per capita capital investment of approximately \$25 in clinic buildings and equipment.

The physical facility is sufficient, if it could be made available to the public, to take care of a group of approximately 20,000 people without additional capital investment. Our group of 5,000 people are truly representative of the total population in Jefferson County.

My rough estimate of the per-capita cost of this service on a basis of 20,000 people to be served is approximately \$15 per year.

I will now discuss the health problem and make some recommendations relating to the proposed legislation.

The health program at Acipco is what we would set up as a reasonable standard for a public-health program in the South. We are not rendering any unnecessary service. The department is open for inspection, and you have a standing invitation to make a close-up study.

I call your particular attention to the fact that not more than 25 percent of this service involves the use of a hospital despite the fact that we make a very liberal use of the hospitals. Seventy-five percent of the work in this field is and should be done entirely apart from the facility and atmosphere of a hospital. Hospitals are designed to deal with advanced cases, while the primary job in the field of public health is to prevent the development of major breakdowns. The amount of hospital work required is a good way to measure our failure to function in the field of health.

Let's have hundreds of hospitals; yes; but let's have literally thousands of relatively small clinic facilities conveniently located with reference to the people to be served and where a constructive use can be made of professional medical talent which we now have in abundance.

Under the Eagan plan of business administration, which has been in effect at Acipco now for more than 15 years, we have solved the health problem for our group of 5,000 people.

We believe that it is good business and is economically sound. What we have done at Acipco can be done in the other major industries of Jefferson County with equal efficiency and economic soundness. Smaller industrial units could form into groups and do the same thing, and thus we might solve the health problem for a relatively large group of industrial workers and their dependents in Jefferson County, which is highly industrialized, but this process will not get us anywhere when we face up to the total health problem, which is to make available to the entire population of Jefferson County a reasonable standard of health service such as is now provided at Acipco.

Statistics will show that for every person directly related to the larger industries in this county there is at least one person who is not so related, and in this latter group we find the low-wage group and the unemployed. It is evident that if this large group are to have a reasonable degree of health service, and we believe they should have, then the problem becomes one of public interest and responsibility.

Now, it should be evident that if all industry in Jefferson County provided the same relative physical facility as we have at Acipco, there would be more than enough to take care of the entire group if it could be made available to the public.

By the same logic, if this facility were provided on a public basis, it would be sufficient to take care of both groups and thus save industry the expense and trouble of such an investment and operating charge.

It is evident from the above that if we are to make progress, a substantial part of the job must be dealt with directly by public agencies. The amount of money required to provide adequate facility and service, such as we have at Acipco, is far beyond the ability of local groups to pay, therefore, it becomes a charge to be dealt with in part at least out of public funds.

The provisions of the National Health Act of 1939, which is now under consideration, seems to me to provide the most logical and best approach to making a start at this relatively large undertaking.

In my judgment, the principle of Federal grants-in-aid to the States is the best possible approach as of this time, and if the service is to be rendered where the need is the greatest, the most flexible provisions of matching funds must be provided. The flexible provisions as now set up in title XII of the proposed legislation are not too liberal, and I would venture a suggestion that careful consideration be given to a further liberalizing of this feature. The spread provided for is not comparable to the ability to pay when you check the well-to-do States with the poorer States.

The flexible provisions, as set up in title XIII, seem to allow sufficient latitude to allot the funds where they are needed most.

In the light of our experience at Acipco, over a period of 30 years, I venture a suggestion to the effect that you either broaden title XII to include provision for medical clinic buildings and equipment, independent and apart from general hospitals, or that this item be provided for by an additional title.

In addition to making provision for the building of general hospitals and relatively small decentralized clinic units such as we have

at Acipco, I would urge you to also provide for the building and operating of relatively large State medical clinic units, these units to be patterned after the Mayo Clinic at Rochester, Minn.

I think that each State in the Union should have its Mayo Clinic just like each State has its university in the field of education. With a Mayo Clinic in each State, proper hospital facility in each county, and a reasonable provision of Acipco clinics, the physical side of the picture would be adequately provided for. We could then expect to make a constructive and economic use of the available personnel which would be required to work in this field of public health.

It is my opinion that the money invested in medical clinic facility such as we have at Acipco, and the Mayo Clinic at Rochester, Minn., will pay dividends 10 to 1 from the beginning over the same amount of money spent for general hospitals under title XII. To illustrate: At this very moment in Birmingham we are constructing a \$2,000,000 hospital such as would be built under title XII of this proposed legislation. This \$2,000,000 would build and equip 20 units, approximate duplicates of the one at Acipco. These 20 units could be operated for equal or less money than it will cost to operate the new hospital. They could be located at the places of need throughout the county. Twenty such units in Jefferson County would be more than enough to start with, and the constructive work which they would do, when compared to the work of the hospital, would look like a dollar over a dime.

I am not making an argument against hospitals. I am pleading with you to provide the proper tools and facility in some reasonable balance, so that the people in the field can have a chance to deal with the problem in its beginnings and not have them spend all of their time and money dealing with the problems in its final stages, where the hospitalization is absolutely essential.

I boldly suggest the spending of \$2 in clinic buildings and facilities for each dollar spent for general hospitalization facilities during the first period of 10 years in this new and most worthy undertaking.

The Jefferson County Medical Society has already completed a study of the actual conditions within the county and their findings have been published in the American Medical Journal of January 1939. They are on their toes, looking this problem squarely in the face and are lending themselves in a constructive way to finding a proper solution. I quote from their report two brief items to illustrate:

There is no great difference of opinion between physicians, dentists, and the various social and health agencies as to the inadequacies of facilities and the present circumstances under which medical care is not available.

Physicians and dentists (of Jefferson County) in home, office, and institutional practice on very conservative estimate, cared for 100,000 to 110,000 charity patients (during the year). Despite this tremendous charity load carried by the professions, it appears that present facilities are inadequate and that many needy persons were unable to obtain medical care.

The spirit is willing but the service is limited by the lack of necessary facility and operating funds.

The public agencies, such as city, county, and State, are sympathetic and are conscious of the need. The extent of their activity in this field is limited only by the lack of the necessary funds. As

evidence of this fact, I am pleased to tell you of the first Acipco public clinic unit which they have just completed with the aid of W. P. A. funds. This clinic is located in Birmingham, Ala., in the center of one of the numerous Negro blighted areas called Slossfield, and it is designed to serve this Negro community insofar as funds are available. This is the first of its kind that I know of and indicates clearly to me the spirit and intent of the public agencies. Eight pictures are presented to illustrate the working of this first public clinic unit.

(The pictures referred to were filed with the committee.)

Senator MURRAY. Your theory is to have the clinics to make it possible to get along without going into the hospital business so much?

Mr. MOORE. It would materially limit the functioning in the hospital. The functioning in the hospital is the most expensive thing we can do, and the objective is to eliminate it as far as possible.

It is much cheaper, much more efficient, and much more satisfactory.

Senator MURRAY. What is the population of the community where you are operating?

Mr. MOORE. There are 1,200 families within a stone's throw. There are 75,000 Negroes within a radius of 2 miles of this center.

Senator MURRAY. What have you to say with reference to the treatment of the Negroes down there? Do you find that they are being given proper consideration in health measures of this kind?

Mr. MOORE. Their ability to pay and the lack of public facility has made the rendering of service very limited in its realization. We have 600 Negro families, representing 5,000 people total, and we are giving 110 percent service to those Negroes.

Senator MURRAY. You do not find any tendency to discriminate against them?

Mr. MOORE. No, sir. The primary basis of discrimination is the lack of funds and facilities.

Senator MURRAY. Thank you for your statement. Dr. McCord.

STATEMENT OF DR. C. P. McCORD, DIRECTOR OF THE BUREAU OF INDUSTRIAL HYGIENE OF THE STATE OF MICHIGAN, DETROIT, MICH.

Dr. McCORD. I have not heard any of the other speakers and only lately have I come into this room. I do not know the procedure. I do not know that I should be sworn or not sworn.

Senator MURRAY. If you have a statement to make, you may state your profession and whom you represent, and then if you have a prepared statement you may give it, and if you have not, you may discuss orally the measure that is being considered. You are familiar with the bill that we are considering?

Dr. McCORD. I may not say that I am fully familiar with the bill. I am familiar with some portions of it.

Senator MURRAY. First state your name, your profession, whom you represent, and then follow your own ideas of how you wish to discuss it.

Dr. McCORD. Thank you, sir. My name is C. P. McCord, M. D. My residence at this time is in Detroit, Mich. I am the director of the bureau of industrial hygiene of the State of Michigan, which bureau is located in Detroit. At the same time I am the director of the bureau

of industrial hygiene of the city of Detroit. These two groups are combined as far as quarters, laboratories, and facilities of that character are concerned. In addition, I function as the professor of occupational diseases in Wayne University, which is located in the city of Detroit. In times past I have served as the counselor to labor unions on problems of industrial hygiene and occupational diseases, and have served industrial and trade organizations and groups of that sort in the same capacity.

It is my own appraisal that having served in connection with industrial and State groups, having served as a college professor both in Wayne University and earlier in the University of Cincinnati, having worked with labor groups, also with employer groups, I am fairly well acquainted with some of the problems that have arisen and may arise in connection with the conservation of the health of the worker.

By way of a little further qualification, I would like to point out that I have been in this type of enterprise for something over 19 years' time, about 19 years and 6 months, and I personally have worked on more than 2,000 distinct problems relating to the conservation of the health of industrial workers.

Senator MURRAY. I think you qualify very highly, Doctor. You can proceed to discuss the bill.

Dr. McCORD. You are very kind, sir. I have here a prepared statement which I would like to read, if I may.

Senator MURRAY. You may.

Dr. McCORD. This is my general thesis, that any activity related to the conservation of the health of industrial workers should be very closely associated with the general public-health activities of that community, or of that State, for this very definite reason: Industrial hygiene may not be disassociated with other aspects of public-health work. It is impossible to carry out a good type of program in industrial hygiene without facilities to bring the workers in that division in contact with almost every other division of public-health activities. For example, in every community there is or should be a division of tuberculosis in the city or State department of public health. It is almost inconceivable that an industrial hygiene division may function without close contact with that tuberculosis division. The same statement might be made with reference to almost every other division that is usually found in every public-health department, whether they be city or State health departments.

My earnest belief is that industrial hygiene should be tied in and integrated with other public-health activities such as may be carried out, or, on the other hand, if any other agency takes over the responsibilities for industrial hygienic activities, that for their own good—that is, for the good of industrial hygiene work—that this other agency take over all of the other activities that ordinarily go on in a public health department.

I desire to point my remarks specifically to title VI of this bill, which I endorse without qualifications. This section of the bill allows for further expansion for programs which have been carried out under the administration of the Social Security Act and which are progressing very satisfactorily. I would like to discuss, particularly, suggestions made before this committee yesterday by Mr. Woll, American Federation of Labor, and Mr. Pressman, of the C. I. O., in regard

to their proposal that another title be added to this bill which would provide for Federal grants and aids to the States which carry out measures for removing the causes of occupational diseases. As I interpret this bill, it would be possible for a department of labor or other agency to promote measures for the protection of workers. It would merely be necessary for them to set up a program and have it approved by the State health officer responsible for the allocation of funds provided by this bill. As a health official I look upon this bill as a health measure which should not be diluted with other interests. It should further be the purpose of Congress to consolidate administration in the health agency. If labor interests feel the need for Federal funds to aid in nonmedical aspects of environmental control in industry, such as routine factory inspection, control of hours, et cetera, we should favor another act and the approach should not be a part of this health bill, but should be identified with basic labor legislation.

Industrial hygiene is that branch of medical science having to do with the preservation and improvement of the worker's health. While the control and prevention of occupational disease constitutes a very important part of the work undertaken by the industrial hygienist, it by no means covers the entire field. Various surveys and studies which have been made indicate that the worker's lost time due to general illnesses is more than 15 times that lost due to occupational diseases and industrial accidents. Much of this illness causing lost time is preventable provided proper public-health measures are applied, and those public-health measures that need to be applied do not directly fall into the category of industrial hygiene, such as are limited to occupational diseases, and certain of these activities cannot be applied by labor departments unless they take over the entire health departments.

It is also true that many chronic degenerative diseases affecting wage earners as a group may also be aggravated or at least be made less amenable to treatment as the result of occupational exposure. Parenthetically, I would point out that some of the poisons in industry are race poisons. That is, not only the mother is involved by this damaging agent, but her possible and prospective offspring, if there be such, may be influenced by this poison, and obviously the offspring is not an industrial worker, and the problem of this unborn and newly born offspring falls into the category of child conservation and protection and the other provisions of health of any public-health unit. For this reason State health officers in their efforts to protect our adult population must study the development of these illnesses in relation to industrial exposure incident to their employment. Furthermore, there is frequently a definite relationship between specific occupational diseases and their complications which affect workers and the health of other persons in the community. An example of this is shown in the report by the Public Health Service of pneumonia affecting steel workers. In this study it was found that the incidence of pneumonia among women in a steel-producing community was 15 percent greater than the rates for women in the same age group in communities where industrial pneumonia affecting workers was not a problem. Another example is the excessive rate of tuberculosis among children in the

Vermont granite areas as compared with other areas in the State where silico-tuberculosis is not a problem.

Senator MURRAY. How do you explain that, Doctor?

Dr. McCORD. In several possible ways. Assuming that these workers may have been in the steel mill, exposure to different temperatures might have been responsible for the pneumonia. If I as a man worked in a steel mill or a foundry, where the temperatures are quite high, I sweat a great deal, and then the time comes when I leave my work, go out into a cold atmosphere 10° above zero, and that one thing is the cause of a great deal of industrial pneumonia. That has nothing to do with this statement with reference to the women, but in steel-mill towns there are apt to be many gases in the air—smoke, fog, shutting off sunlight—in some measure it is probable that the absence of adequate sunlight, or as much sunlight as would be found in other communities, may be responsible for that higher incidence of pneumonia.

Senator ELLENDER. How could folks who live in a community of that kind become more affected than others that do not actually work in the steel mill?

Dr. McCORD. The gases would be in the whole community, sir.

Senator MURRAY. Everybody living in that area would be affected in the same measure, whether they are husbands working in the mill or in some of the city stores.

Dr. McCORD. And, furthermore, there is an equal important, perhaps more important angle. Pneumonia is a communicable disease. The husband gets it in the factory and the wife nurses him. He gets his pneumonia because of occupational conditions, the wife gets it because she is brought in immediate contact with this man and the bacteria of the diseases are transferred from the man to the woman.

Senator ELLENDER. You have answered the next question that I was going to propound to you.

Dr. McCORD. I am glad I did.

The United States Public Health Service has for more than three decades conducted studies dealing with the relationship of the worker's industrial environment to his health and the health of the community, and has formulated recommendations for engineering and medical control programs, and that does not mean that those programs are separate and distinct. As I use the language here, "engineering" and "medical" means combined activities. To a certain extent prior to and in a marked degree since the enactment of the Social Security Act, State health departments have made definite progress in the development of comprehensive industrial hygiene activities. Today 30 States and several cities—that includes my city of Detroit, Baltimore, St. Louis—have industrial hygiene divisions in their State health departments. These industrial hygiene divisions are staffed with reasonably well trained engineering and medical personnel who are actively engaged in the solution of industrial-hygiene problems. And when I say "reasonably well trained," I mean to imply that the best available personnel is utilized, but there is a dire need for a better training, or more extensive training both of physicians, engineers, and others in this field. We are doing the very best we can in this recent surge of interest in industrial hygiene, and it must be admitted that wherever the work be carried out,

whether it be in cities or States, or under labor agencies, or anywhere else, there is not a full complement of highly skilled personnel, either doctors, engineers, or anyone else.

Senator ELLENDER. Doctor, you said that the industrial-hygiene activities in Michigan are under the public health department?

Dr. McCORD. In the State of Michigan?

Senator ELLENDER. Yes.

Dr. McCORD. Are in the public-health department?

Senator ELLENDER. Yes.

Dr. McCORD. That is right, and in Detroit under the city department of health there is still another bureau, because Detroit is the outstanding industrial city of the country, and the problems are so concentrated that there must be a special group there.

Senator ELLENDER. Are you familiar with the history of the enactment of the law?

Dr. McCORD. I think I should not say that I am. I would rather say most meagerly am I familiar with such.

Senator ELLENDER. There were two witnesses who testified this afternoon, one from New York and one from Illinois, who took the position that these industrial hygiene activities were carried under the labor departments and not under the public health departments of their respective States.

Dr. McCORD. My earnest feeling, and if my advice is sought, it is just to the contrary. This matter of industrial hygiene is public health. May I extend that just one moment by putting out that in large plants with large groups of workers, with 2,000 and 3,000 workers, the organization itself, the management may do many things in bettering the working conditions, but in this country we must realize that somewhere around 99 percent, certainly over 98 percent of our factories and working places are small ones, the 25-men size, or 50-men size, or 100-men size. Now those places cannot work out their own salvation in providing technical industrial hygienic measures. They must look to the public-health agencies of the cities and the States to guide them, to guide their workers, to protect their workers, and to make sure that nothing goes on in these small places that is inimical to the health of these workers.

Senator MURRAY. Would it not be very difficult for the health department to supply the personnel that would be necessary to engage in activities to prevent industrial diseases?

Dr. McCORD. Sir, last year in the bureau in Detroit we saw in that year one-fifth of all of the 8,500 plants in that city. That is quite a lot of work for us. It is going to take us 5 years to get around, unless we have more personnel and more money, but we are making a very fair showing in at least detecting the problems that exist and advising the management that betterment may be procured along these lines.

Senator MURRAY. Would not the labor organizations in these industrial places, and the departments of labor, be in a better position to look after the interests and the welfare of the workers than a health department?

Dr. McCORD. To my mind, no. Labor groups come to us, present their problems; we know that they are real at times, but we have to go to the management of these factories and present these prob-

lems as public health problems. After all, it is the manufacturer, it is the employer who must pay out the moneys necessary to bring about acceptable working conditions in order to eradicate the exposures that have been brought about.

Senator MURRAY. I am thinking only of my own situation. I know in the mining industry, for instance, the only agitation for assistance to the miners has been made by the miners themselves, by the mine organizations and by the labor departments. The health organizations have given no attention to it whatever, and it is only in very recent years that they began to do anything to undertake to combat those dangerous conditions in the mines that create silicosis.

Dr. McCORD. I can well agree with you that that is true in many States, or was true up until recent years. Neither State departments of health, nor departments of labor, were widely concerned in these matters of occupational diseases, or the more fundamental matters of the general conservation of the health of the worker, but during the last 3 or 4 years enormous strides have been made in the departments of health, and in some places in departments of labor.

Senator MURRAY. We have been seeking in Montana for many years to get compensation for miners who incur this disease of silicosis, and the corporations have constantly fought legislation of that kind and have succeeded in preventing it, and we have no compensation today for miners who incur the disease of silicosis.

Dr. McCORD. Which is unfortunate.

Senator MURRAY. So you see where in many of these States the big industrial organizations control the State and the State legislatures are usually unable to pass legislation of that kind unless it meets with the approval of the industrial organizations.

Dr. McCORD. Your statement which I do not question one iota, would apply more with regard to labor departments applying such measures as occupational hygiene than with State departments of Health. In my opinion the industrialist—and I do not condone his activities—in blocking or attempting to block activities of this sort might be more disposed to cooperate with the program carried out under the auspices of a State department of health than he would with the State department of labor.

Senator ELLENDER. Why should he? That is really the point at issue. I am just wondering if the reason why the labor people suggest that the work should be done under the labor department rather than the public health was that they might be able to have their policies carried through more readily if labor backed it than if the public health department backed it.

Dr. McCORD. May I answer your question?

Senator ELLENDER. I am just asking if you do not think that may be the reason.

Dr. McCORD. I would like to state it my way, if I may, rather than precisely agreeing with you.

Senator ELLENDER. Proceed.

Dr. McCORD. It is unfortunately true that many of the problems that are brought to the attention of the manufacturer by labor departments are disagreeable. It is a matter of hours of work, rates of pay, in some instances, matters of settlements of strikes, until we all know that the employer is reticent in some instances in its rela-

tions with the department of labor representative, because they feel it may mean just one more difficult problem. On the other hand, the State department of health for the most part has had no background of disagreeable problems to bring to the attention of the manufacturer, and in my opinion at the present time the manufacturer, without expecting any favors from the State department of health whatever, would be disposed to go along with any program carried out under its auspices to a much greater degree of willingness than the department of labor.

Senator ELLENDER. Doctor, in that connection, have you had any difficulty whatever in having the various employers of yours in Michigan carry out the suggestions made by the public health department.

Dr. McCORD. Sir, I am in a very good position. We have not had to resort to the use of our legal authority on one single occasion during the approximately 3 years that this work has been going on, and that does not mean that we have not gotten results, but by education, by suasion, by laying the plan before them, we have gotten not 100 percent of correction of the evils, but we have gotten 100 percent of cooperation that will eventually bring about the elimination or the reduction of these evils.

Senator ELLENDER. Did you have to use much persuasion in some cases, or was it done without much difficulty?

Dr. McCORD. We worked rather gently.

Senator ELLENDER. Giving to them piecemeal.

Dr. McCORD. Shall I proceed?

Senator MURRAY. You may proceed.

Dr. McCORD. I wish again to emphasize that this bill is a health measure. Our Nation's progress in the development of activities designed to protect the public health has resulted from close coordination in the work of those concerned with medical care, and official health agencies—local, State, and Federal. It is obvious we should favor a continuation and expansion of this closely coordinated program in matters relating to health.

For many years advancement of community sanitation and water supply in industrial and other areas has been the responsibility of local and State departments of health. This has necessitated study of plant conditions, with particular reference to cross-connections between public and industrial water supply and waste disposal. Health department personnel have long been engaged in problems associated with air conditioning and with the development of better systems of control. Certainly no increased efficiency will result from duplication or division of this responsibility. These activities are truly a part of necessary programs designed to control industrial health hazards and prevent occupational diseases.

Experience has shown that most illnesses resulting from injurious industrial environment are chronic and seldom acute; that they usually result from months and years of exposure. It is seldom that the cause of a specific occupational disease is revealed by mere routine visual inspection. The effects of industrial environment on health are most completely revealed by the systematic collection and technical analysis and interpretation of sickness data. By this I mean more complete protection of the industrial population will result

from attacking the problem by well-known public-health methods, namely, locating and scientifically interpreting the problem and then applying appropriate preventive and curative measures.

The problems of industrial hygiene require no substantially different technique in the procedure for public-health work. It does create the necessity for different types of information, but the method of attack is in no large measure different to those procedures that are used in solving other public-health problems.

Our present programs of industrial hygiene as conducted by State and local departments of health are now rendering a service of this kind. Thus it may be seen that the solution of industrial health problems necessitates integration with all medical-care programs. A large majority of our workers are employed in small plants maintaining no extensive medical supervision. Effective control of environmental conditions in these smaller plants is largely dependent upon our knowledge as to where illness is developing. To this end, we must develop an effective system of securing reports of illness from those rendering medical services. Since adequate machinery now exists for the collection of this data relating to vital statistics in the State health department, duplication should not be made.

From the viewpoint of economy and administrative difficulties, another reason for objecting to the development of industrial hygiene units in State departments of labor and industrial commissions is evident. To organize and carry out this work in another agency would call for the establishment of extensive laboratory facilities which are now readily available in all well-operated health departments.

I may go further. In case these measures for the protection of the health of the workers be turned over to the Department of Labor, there must inevitably be carried out measures of the same sort in the Department of Health in these various States, although the situation may make it impossible to call this work industrial hygiene because it had been taken over by another agency, and the work, in a large measure, must be also continued or introduced into these health departments. Inevitably, if departments of labor are given responsibility for these enterprises there is going to be duplication, and there is going to be an unnecessary expenditure of public moneys.

Industrial health forms an integral part of the health of the community and our approach to industrial hygiene in this public-health bill must be from the public-health viewpoint. We must look upon industrial hygiene as adult public health. Because of the fact that many general and degenerative illnesses such as tuberculosis, cancer, pneumonia, and heart disease are frequently affected by the worker's industrial environment, because there is a close relationship between occupational diseases and the general health of the individual; and because the health of the worker and the health of the community are interdependent, we favor combining administratively industrial hygiene activities with the general public-health services, and this, we believe, may be accomplished effectively through provisions contained in section VI of the Wagner bill as it now stands.

And, lastly, I would point out to you that industrial hygiene work, that is the protection of people who go into factories and make their living there, constitutes the most neglected aspect of adult public

health. The medical profession needs training, the industrial management all over the country needs training, the industrial worker himself needs to be educated as to the dangers that may exist in his trade, and measures for his protection. I strongly urge that industrial hygiene work belongs in the public-health department. I do point out that wherever such measures may be carried out there is a very genuine need for it.

Senator MURRAY. Thank you, Doctor. You have given us a very admirable statement.

We will adjourn now until the 25th of May. The next hearing will be had on the 25th.

(Whereupon, at the hour of 4:18 p. m., the hearing was adjourned to Thursday, May 25, 1939.)

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