

# To Establish a National Health Program

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## 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

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### PART 2

MAY 25 AND 26, AND JUNE 1, 1939

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# TO ESTABLISH A NATIONAL HEALTH PROGRAM

THURSDAY, MAY 25, 1939

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

The subcommittee met, pursuant to adjournment, in room 357, Senate Office Building, at 10 a. m., Senator James E. Murray, presiding. Present: Senators Murray (chairman), Ellender, Taft, and Holt. Also present: Senators Wagner and Holman.

Senator MURRAY. Gentlemen, this is the date fixed for further hearings on the Wagner health bill.

Dr. Rock Sleyster, the president of the American Medical Association, I believe, will introduce the witnesses here this morning. If Dr. Sleyster is in the room, I would like to have him come forward.

Dr. SLEYSTER. Mr. Chairman and members of the committee, I am speaking as the president of the American Medical Association. This organization now includes in its membership 113,113 practicing physicians out of a possible 145,000 practicing physicians in the United States.

We come to you with a statement relative to legislation that you have under consideration. This statement was adopted at St. Louis last week at our annual session of our house delegates, a session which was attended by 7,500 members of our organization. The house of delegates of the American Medical Association is the policy-forming body of our association. It is democratically elected by the house of delegates of the various State medical associations, and they, in turn, are elected by the delegates of some 2,000 county medical societies.

The American Medical Association has a headquarters building in Chicago with some 600 employees.

Among the various activities, there is a bureau of medical economics that has been busy for some years assembling factual data on everything that pertains to the care of the sick. We have there the largest amount of information on physicians, hospitals, medical schools, laboratories; in fact, any institution which pertains to sickness, that is available anywhere; in fact, at the time of the World War, the Medical Department of the United States Army came to us for assistance, which we very gladly and willingly gave, and it resulted in 45,000 medical physicians entering the service in the Army, and the Navy, the United States Public Health Service, the selective draft boards, and so forth.

The association has constantly offered to governmental agencies our full cooperation in everything that we might do in meeting these problems, and has offered freely of its facilities at all times. I do not think that anybody would be more interested at this time in helping with preventive medicine where need can be shown and where need is available.

We come to you today offering our cooperation and all of our facilities and our advice.

At this point, Mr. Chairman, I would like to introduce to you Dr. Edward H. Cary, the past president of our organization and chairman of our legislative committee, who will take on the task of introducing our evidence.

**STATEMENT OF DR. EDWARD H. CARY, CHAIRMAN OF THE LEGISLATIVE COMMITTEE OF THE AMERICAN MEDICAL ASSOCIATION**

Dr. CARY. Gentlemen of the subcommittee of the Senate, following the National Health Conference in July, 1938, the house of delegates of the American Medical Association met in special session in Chicago, December 15, 1938. At that time the interdepartmental committee report was taken up and was referred to various committees. The chairman of the committee which had it in hand is here, and at the last meeting of our association at St. Louis, the Wagner bill was taken up and referred to the committee of which he was chairman.

I take great pleasure, Mr. Chairman, in presenting Dr. Walter Donaldson, who will read the action of the house of delegates in St. Louis, May 15.

Dr. Walter Donaldson, of Pennsylvania.

**STATEMENT OF DR. WALTER DONALDSON, SECRETARY, PENNSYLVANIA STATE MEDICAL SOCIETY, PITTSBURGH, PA.**

Dr. DONALDSON. Mr. Chairman and members of the committee, we would like your committee to understand that this report was adopted by our house of delegates after hearings for the consideration of the Wagner bill, conducted just about as you are conducting hearings here on this subject, for the purpose of obtaining opinions, information, and advice from our members and the house of delegates; and I want to have you know that throughout the 2 days and nights that we were in session, our committee was constantly receiving the advice and help of the scores of these delegates.

Senator ELLENDER. Doctor, at this point, was any opposition expressed by members of your association?

Dr. DONALDSON. No; there was—do you mean—

Senator ELLENDER (interposing). I mean was anybody favorable to the bill?

Dr. DONALDSON. To the Wagner bill?

Senator ELLENDER. Yes.

Dr. DONALDSON. There were people that were favorable to certain features of it and they appeared as witnesses before our committee.

I would like, if possible, to complete reading this report, and then answer any questions which you may desire to ask of me.

Senator MURRAY. You may proceed, Doctor.

**Dr. DONALDSON.** The following report of the reference committee to the house of delegates was adopted May 17, 1939, without dissenting vote:

Your reference committee has carefully considered the bill designated as S. 1020, 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 service, 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.

This bill was introduced by Senator Robert F. Wagner, of New York, February 28, 1939, and is commonly referred to as the Wagner health bill. The bill itself provides that, if it be enacted, it may be cited as the National Health Act of 1939. The purposes of the bill are sufficiently stated in the title, but the bill itself must be recognized as a proposed amendment to the Social Security Act of 1935. The bill is intended to make effective a national-health program recommended by the interdepartmental committee to coordinate health and welfare activities.

The house of delegates of the American Medical Association, at its special session in Chicago, September 16 and 17, adopted five recommendations made by a special committee that had been appointed to consider and report on the national-health program. It is important that this fact be borne in mind, for the bill now under consideration, which was drafted long after those recommendations were adopted and at a time when they were presumably known to the proponents of this bill, does not recognize either the spirit or the text of those recommendations. Any criticism of this bill by the association is not to be construed, therefore, as a repudiation of any of the principles adopted by the 1938 special session of the house of delegates.

S. 1020 proposes to amend Title V of the Social Security Act—Grants to States for Maternal and Child Welfare, and Title VI—Public Health Work and Investigations, and proposes to add to the Social Security Act certain new titles: Namely, Title XII—Grants to States for Hospital and Health Centers; Title XIII—Grants to States for Medical Care, and Title XIV—Grants to States for Temporary Disability Compensation.

Already some individuals and organized groups in the United States have appeared before the Senate subcommittee which has this bill under consideration, and have urged its immediate enactment. Although the stated objectives of the Wagner health bill are generally recognized as desirable, your committee cannot approve the methods by which these objectives are to be attained.

Repeatedly physicians and all other qualified professional groups have recommended the coordination and consolidation of the health activities of the Federal Government. The Wagner health bill leaves existing and proposed preventive and curative medical services widely scattered through several Federal agencies.

This bill does not in any way safeguard the continued existence of the private practitioners who have always brought to the people the benefits of scientific research and treatment.

It does not provide for the use of the thousands of vacant beds now available in hundreds of church and community general hospitals.

The Wagner health bill proposes an extensive program in the field of "health, diagnostic, and treatment centers, institutions, and related facilities," without defining their functions.

This bill proposes to make Federal aid for medical care the rule rather than the exception, since it does not specifically limit its benefits to persons unable to pay for adequate medical care.

The Wagner health bill does not recognize the need for suitable food, sanitary housing, and the improvement of other environmental conditions necessary to the continuous prevention of disease and promotion of health.

This bill insidiously promotes the development of a complete system of tax-supported governmental medical care, thus undermining and debasing present standards of medical services.

The house of delegates in September 1938 urged compensation for the loss of wages during sickness. The Wagner health bill deviates from this suggestion by proposing to provide medical services in addition to compensation.

The Wagner health bill would authorize an enormous expansion of governmental medical services and therewith ultimately unlimited appropriations for its health program. The funds necessary would be so great as to increase still further the present burdensome general taxation.

The Wagner health bill provides for supreme Federal control. Rules and regulations must be promulgated by the Chief of the Children's Bureau in the Department of Labor, the Surgeon General of the Public Health Service, the Federal Emergency Administrator of Public Works, and the Social Security Board. These Federal agents are given authority to disapprove plans proposed by the individual States.

The house of delegates at its September 1938 session approved the expansion of preventive and other medical services when the need could be shown. The Wagner health bill prescribes no method for determining the nature and extent of the needs for which it proposes allotments of funds.

The provisions in the Wagner health bill that have never been considered by the house of delegates are the authorization of appropriations for studies, investigations and demonstrations, and the creation of Federal and State advisory councils.

The Wagner health bill, as judged by the considerations that have been here presented, is inconsistent with the fundamental principles of medical care established by years of scientific professional medical experience, and in the opinion of your committee it is, therefore, contrary to the best interests of the American people.

For years the health of the people of the United States, as measured by sickness and death rates, has been better than that of most foreign countries, and this improvement has been continuous. The fortunate health conditions in the United States cannot be dissociated from the standards and methods of medical practice that have prevailed under the present system of medical practice.

No other profession and no other organization has done more for the prevention of disease, the promotion of health, and the care of the sick than have the medical profession and the American Medical Association. No other groups have shown more genuine sympathetic interest in human welfare.

The contribution of the individual members of the American Medical Association to medical care is universally regarded as monumental in total volume. The contribution of the American Medical Association, through a program of medical education and the activities of its numerous councils which safeguard medical service, give abundant proof of interest in the problems of the national health. It has given continued consideration to these problems, whereas others show concern with these proposals because of a present but, it is to be hoped, a temporary need for relief. These are the groups which request revolutionary legislative action as indispensable for the extension and further diffusion of health facilities.

In view of its record and in consideration of the responsibility which American social history and the nature of medical care have imposed on the medical profession, the American Medical Association would fail in its public trust if it neglected to express itself unmistakably and emphatically regarding any threat to the Nation's health and well-being.

The American Medical Association must therefore, speaking with professional competence, oppose the Wagner health bill.

Nevertheless, recognizing the soundness of the principles stated in the recommendations adopted by the house of delegates at its special session in 1938, namely, the expansion of preventive medicine and public health where need can be shown, the extension of medical care for the indigent and the medically indigent where the need can be demonstrated, with local determination of needs and local control of measures to supply these needs, your committee would urge the development of a mechanism for meeting these needs within the philosophy of the American form of government and without damage to the quality of medical services.

This question, as it relates to the aid to be given by an individual State to its own counties, municipalities, or other local political units, is not immediately before this association. The answer is to be found in the individual State constitutions and State statutes. Counties, townships, and municipalities are creatures of the individual States and can be molded and guided by the State for its own purposes. The individual State, itself, is not a creature of the

**Federal Government.** The Federal Government is, as a matter of fact, a creature of the individual States.

The fundamental question is how and when a State should be given financial aid by the Federal Government out of the resources of the States as a whole, pooled in the Federal Treasury. Disasters—such as floods, dust storms, fire, and epidemics—have long been recognized as justifying such Federal aid. No State or person has ever been heard to object to the use of funds out of the Federal Treasury for such purposes. No one has ever proposed, however, that because Federal aid is extended under such conditions to a State in distress, a corresponding aid must be extended to every other State, regardless of its need. Nor has anyone ever been heard to say that Federal aid to a State in distress—because of flood, dust storm, fire, or epidemic—shall not be extended, unless and until the suffering State has produced from its own treasury a stated amount of money to aid in affording the relief. The development of such bizarre thinking may be traced to those who have originated within comparatively recent years the granting of Federal subsidies—sometimes referred to as grants in aid—to induce States to carry on intrastate activities suggested frequently in the first instance by officers and employees of the Federal Government. The use of Federal subsidies to accomplish such federally determined activities has invariably involved Federal control. Any State in actual need of financial aid from the Federal Government for the prevention of disease, the promotion of health, and the care of the sick should be able to obtain aid in a medical emergency without stimulating every other State to seek and to accept similar aid and thus to have imposed on it the burden of Federal control.

The mechanism by which this end is to be accomplished, whether through a Federal agency to which any State in need of Federal financial assistance can apply, or through a new agency created for this purpose or through responsible officers of existing Federal agencies, must be developed by the Executive and the Congress who are charged with these duties. Such method would afford to every State an agency to which it might apply for Federal assistance to enable it to care for its own people without involving every other State in the Union or the entire Government in the transaction, and without disturbing permanently the American concept of democratic government.

To summarize:

1. The Wagner health bill does not recognize either the spirit or the text of the resolutions adopted by the house of delegates of the American Medical Association in September 1938.

2. The house of delegates cannot approve the methods by which the objectives of the national health program are to be obtained.

3. The Wagner health bill does not safeguard in any way the continued existence of the private practitioners who have always brought to the people the benefits of scientific research and treatment.

4. The Wagner health bill does not provide for the use of the thousands of vacant beds now available in hundreds of church and community general hospitals.

5. The bill proposes to make Federal aid for medical care the rule rather than the exception.

6. The Wagner health bill does not recognize the need for suitable food, sanitary housing and the improvement of other environmental conditions necessary to the continuous prevention of disease.

7. The Wagner health bill insidiously promotes the development of a complete system of tax supported governmental medical care.

8. While the Wagner health bill provides compensation for loss of wages during illness, it also proposes to provide complete medical service in addition to such compensation.

9. The Wagner health bill provides for supreme Federal control; Federal agents are given authority to disapprove plans proposed by the individual States.

10. The Wagner health bill prescribes no method for determining the nature and extent of the needs for preventive and other medical services for which it proposes allotments of funds.

11. The Wagner health bill is inconsistent with the fundamental principles of medical care established by scientific medical experience and is therefore contrary to the best interests of the American people.

12. The fortunate health conditions which prevail in the United States cannot be dissociated from the prevailing standards and methods of medical practice.

13. No other profession and no other group have done more for the improvement of public health, the prevention of disease and the care of the sick than have the medical profession and the American Medical Association.

14. The American Medical Association would fail in its public trust if it neglected to express itself unmistakably and emphatically regarding any threat to the national health and well-being. It must, therefore, speaking with professional competence, oppose the Wagner health bill.

15. The house of delegates would urge the development of a mechanism for meeting the needs for expansion of preventive medical services, extension of medical care for the indigent and the medically indigent, with local determination of needs and local control of administration, within the philosophy of the American form of government and without damage to the quality of medical service.

16. The fundamental question is how and when a State should be given financial aid by the Federal Government out of the resources of the States as a whole, pooled in the Federal Treasury.

17. The bizarre thinking which evolved the system of Federal subsidies—sometimes called grants in aid—is used to induce States to carry on activities suggested frequently in the first instance by officers and employees of the Federal Government.

18. The use of Federal subsidies to accomplish such federally determined activities has invariably involved Federal control.

19. Any State in actual need for the prevention of disease, the promotion of health, and the care of the sick should be able to obtain such aid in a medical emergency without stimulating every other State to seek and to accept similar aid, and thus to have imposed on it the burden of Federal control.

20. The mechanism by which this end is to be accomplished, whether through a Federal agency to which any State in need of Federal financial assistance can apply, or through a new agency created for this purpose or through responsible officers of existing Federal agencies, must be developed by the Executive and the Congress, who are charged with these duties.

21. Such a method would afford to every State an agency to which it might apply for Federal assistance without involving every other State in the Union or the entire Government in the transaction.

22. Such a method would not disturb permanently the American concept of democratic government.

Mr. Chairman, may I submit this report to be incorporated into the record?

Senator MURRAY. The report will be submitted. Do you wish to supplement your prepared statement by any other statements, Doctor?

Dr. DONALDSON. Not at this time, because I think we are fully represented by others on the program who will present evidence on its various aspects.

Senator ELLENDER. Dr. Donaldson, you said that before your house of delegates in St. Louis, you heard witnesses just the same as we are now hearing before this committee. I would like to know who were those witnesses? Were they all members of the American Medical Association?

Dr. DONALDSON. There were three witnesses who appeared representing hospital associations.

Senator ELLENDER. Were the witnesses who appeared doctors?

Dr. DONALDSON. I believe not.

Senator ELLENDER. Was any opposition expressed before the house of delegates? I mean was anybody who appeared before the house of delegates in favor of the bill?

Dr. DONALDSON. That appeared before our committee in its hearings?

Senator ELLENDER. Yes.

Dr. DONALDSON. Before our reference committee; yes.

Senator ELLENDER. As I understand, the resolutions adopted were unanimous?

Dr. DONALDSON. Yes; there was no objection raised when our report was submitted to the house of delegates.

Senator ELLENDER. I would be interested, Doctor, if you could tell the committee how it would be possible for the States to receive aid under the proposition which you advanced on page 8 of your statement which says:

Any State in actual need of financial aid from the Federal Government for the prevention of disease, for the promotion of health, and the care of the sick, should be able to obtain aid in a medical emergency without stipulating every other State to seek and to accept similar aid and thus to have imposed on it the burden of Federal control.

Dr. DONALDSON. Well, I would say that those who advised and discussed that feature of the thing at our hearing had in mind some such agency as now exists in the Federal system here for obtaining grants for approved activities. Perhaps they had in mind the Reconstruction Finance Corporation, the R. F. C.

Senator ELLENDER. Did you have in mind also the Public Health Service of the Government?

Dr. DONALDSON. I am afraid I will waste the committee's time, because we have with us here all of our advisors, who are much more familiar with this feature. I can undertake to go ahead in my own way, but I think that you will save the committee's time if you will wait until the others are on the stand.

Senator ELLENDER. You made the statement, so I thought that perhaps you could in a few words tell us how it could be done. But if you have somebody else to answer that question, that is agreeable to me.

Dr. DONALDSON. I am sure we have.

Senator WAGNER. Mr. Chairman, I should like to ask a few questions.

Senator MURRAY. Certainly, Senator Wagner.

Senator WAGNER. You mentioned the restriction of financial grants. Just how did you consider that a State which needed aid would proceed or what legislation would be necessary to provide it?

Dr. DONALDSON. I should think that the State represented by its health officer would come here accompanied by others who were interested in the health problems of the State, and make their proposal to an agency already set up, and—

Senator WAGNER (interposing). What agency, for instance?

Dr. DONALDSON. A new agency which I would describe as being similar to this Reconstruction Finance Corporation.

Senator WAGNER. You mean to borrow money from the Federal Government?

Dr. DONALDSON. Borrow money or receive a grant. As I understand it, Federal money has been given in instances where there have been great disasters, without any expectation of its being returned.

Senator WAGNER. Then you are not opposed to Federal aid, are you, to the States, to help preserve the life of the people within the State?

Dr. DONALDSON. If it has been properly presented by the local representatives.

Senator WAGNER. In view of what you have said, then you would not regard that sort of a procedure as destructive of our Federal Government?

Dr. DONALDSON. I beg your pardon?

Senator WAGNER. I understood that the statement you read stated among other things that this bill, that its procedure is un-American and destructive or contrary to our whole form of government. I wanted to get from you, if I could, what was destructive in the bill, as you yourself now advocate some other procedure by which the State is to receive aid from the Federal Government for the protection of the health of its people or the prevention of disease and all of these other activities.

Dr. DONALDSON. I think the plan perhaps should involve but a single State, while on the other hand it was the opinion of our committee that the Wagner bill may involve all of the States.

Senator WAGNER. Then do I understand you to say, Doctor, that if there were a procedure which would provide aid to all of the States that that would be contrary to our democratic form of government, but if the law provided for aid to only one or two States, then it would be consonant with our form of government?

Dr. DONALDSON. Such as proved their needs on an individual State basis.

Senator WAGNER. Very well; that is your idea.

Senator HOLMAN. Mr. Chairman, may I ask a question?

Senator WAGNER. May I continue? I want to ask some further questions.

Senator MURRAY. Senator Wagner has the witness.

Senator WAGNER. Do you mind if I ask you these questions?

Dr. DONALDSON. As I have stated, we have other witnesses more likely to conserve your committee's time.

Senator WAGNER. Do you think that I am wasting time by asking you any questions? If you do, I will stop.

Dr. CARY. Senator Wagner—

Senator WAGNER (interposing). The witness is a very competent doctor and a very eminent doctor.

Dr. CARY. Would you allow me to say this, that it is quite evident that all medical men are not experts in the legislative field and legislative matters, but we really have a representative here that we would like to have answer such questions.

Senator WAGNER. A doctor?

Dr. CARY. Yes. You don't mind?

Senator WAGNER. Not at all.

Dr. CARY. Then let me present him.

Senator WAGNER. I am not conducting the procedure.

Dr. CARY. Mr. Chairman, can I do that?

Senator MURRAY. Are you through with your questions?

Senator WAGNER. The doctor says that I would only waste time and he cannot answer me, and I do not want to do that.

Dr. CARY. It is not the idea of the waste of time, Mr. Chairman, but the only point is that that involves some comprehensive new legislation which in all probability Dr. Donaldson has not considered at

all, and if it is more in line with the type of thinking that we have here, I should like for the other witness to answer.

Senator WAGNER. If the distinguished witness does not care to answer the questions, I am perfectly willing to desist, but I assumed that when a doctor appeared here before a Senate committee to present a report and he was the one chosen to present the report, that he would be able to tell us something about the report and the reasons for the conclusions reached. If the doctor says that he is not competent to do that, I shall not question it.

Dr. DONALDSON. I do not say that at all, Senator, but I state that we had before our committee hearings, people representing our own legislative and legal bureau, and those same persons are in the room today.

Senator WAGNER. I was going to seek some information with the consent of the committee, but if you say that you would rather not have me ask you questions upon the ground that it would be wasting time, I shall not press it. That is what I am trying to find out now.

Dr. DONALDSON. I would much prefer, then, that you leave that to someone else representing the organization.

Senator MURRAY. I would say, Doctor, that the only purpose of the committee is to explore as fully as possible your views and criticism of the bill, and I think it is only fair that we should give every member of the committee complete opportunity to examine and cross-examine any witnesses that appear here. I am sure that we all have the utmost confidence in your willingness to do that, and if you have other witnesses now who will submit to an examination on these points, we would like to have the privilege of questioning them.

Senator ELLENDER. There is no intention on my part when I ask a question to do anything but obtain information, and I hope that the witness so understands. You have made certain statements here, for instance, Doctor, that in the bill, it is provided that there is no distinction made between the indigent and the well-off, that it is not the purpose of the bill to take care really of the poor. I would like to have you or everybody else, who appears here, to point out such language in the bill.

Dr. DONALDSON. I think that reference was to the original approval of our house of delegates last September in which we gave our full sympathy to medical care for the indigent and to the medically indigent as a tax-supported measure, but our criticism now to the Wagner bill is that it apparently sets up no method by which you are to differentiate between the medically indigent and those that are in the higher-income groups.

Senator ELLENDER. Well, from the testimony so far adduced before this committee, it was the idea of all, as I understood it, to have the bill apply only to the poor and the indigent, those who really could not provide adequate medical aid. That, as I understand it, is the purpose of this bill. If the language is not clear on that, I want to have it clarified, and if you or any other of the witnesses who will testify will point out that the well-off as well as the poor are to be treated alike, I would like to have that done.

Dr. DONALDSON. I can assure you that it will be pointed out, and I think that you will find it in the text of some of the manuscripts that have been laid on your desk.

Senator WAGNER. I have just one other question. I do not see anything in the report which suggests any amendment to the act. I understood you to say—and the reports say that you are in sympathy with the general objectives of the bill, although you disapprove of the methods. Do you know whether you or some other witness will present proposed amendments to the act?

Dr. DONALDSON. I believe no amendments will be proposed.

Senator MURRAY. Doctor, will you call the next witness?

Dr. CARY. Mr. Chairman, since the organization of the American Medical Association in 1847, the underlying motive has been the education of its membership and of doctors generally throughout this country and of the public health, and it was only in 1931 that the American Medical Association felt the need of the bureau which we call the bureau of medical economics, and I have here present a gentleman who is the head of the bureau of medical economics, which was established in 1931, and I would like to present Dr. R. G. Leland, who will be able to speak and develop for you some factual data.

#### STATEMENT OF DR. R. G. LELAND, DIRECTOR OF THE BUREAU OF MEDICAL ECONOMICS OF THE AMERICAN MEDICAL ASSOCIATION

Dr. LELAND. Mr. Chairman and members of the committee, I have prepared a statement, and I should like, if I may be granted the privilege, to make the statement, and then I will be glad to answer any questions.

Senator MURRAY. You may proceed.

Dr. LELAND. In order that there may be greater facility in understanding some of my statement, unless you already have copies of this booklet entitled "Factual Data on Medical Economics, 1939, Bureau of Medical Economics, American Medical Association of Chicago," I should like to present them to you.

Senator MURRAY. We will be glad to have the copies.

Dr. LELAND. The bill now pending before your committee is obviously based on the report of the interdepartmental committee, and that report in turn is based on the report of its technical committee. The report of the technical committee seems to be based on figures assembled by that committee that the committee itself seems to regard as supporting the thesis that death and sickness rates in the United States are excessive; that this excess depends, not on economic conditions, but on inadequate medical service, and that by expending a vast sum of money under Federal supervision, the sickness and the mortality rates can be substantially reduced. The figures relied upon by the technical committee to support its thesis are believed to be incomplete and the deductions drawn from them are believed to be unwarranted by any available evidence. The conclusion that the reduction of sickness and mortality rates awaits only large Federal and State appropriations, expended under Federal supervision and control, is believed to be without foundation.

The constant improvement in the health of the people of the United States that has been in progress many years, as shown by official vital statistics, has been made under the prevailing system of

medical and hospital care. No evidence has been advanced to show that the rate of improvement would be accelerated by the revolutionary changes proposed in the pending bill.

The death rates from some causes are approaching the vanishing point; the death rates from other causes are far more favorable than has been represented by the advocates of this legislation. More knowledge is needed before a reduction in the number of deaths from still other causes can be expected or predicted.

Statistics of the nature and amount of prevailing illnesses at any given time are not sufficiently complete or accurate to justify positive conclusions based on them, but so far as they are available in the United States, they show a trend toward a general improvement except with respect to cancer, diabetes, and diseases of the heart and blood vessels. These diseases are the accompaniments of advancing years, and their increased prevalence is associated with a greater concentration of the population in the ages above 45 years. This greater concentration above 45 years of age has occurred under the present system of medical care.

The technical committee of the interdepartmental committee seems to have drawn its conclusions largely from data assembled in connection with the activities of the committee on the costs of medical care, and the national health survey conducted by the United States Public Health Service. Data assembled by the committee on the costs of medical care, however, were not assembled in such a manner and form as to permit the conclusions of that committee in respect to the costs of medical care to be weighed in relation to the costs of the other necessities of life, nor did the conclusions of that committee point out with any degree of exactness, the elements that have entered into the increase in the costs of medical care in such a way as to suggest a method of reducing those costs. The basic data assembled by the national health survey, distinguished chiefly by its massiveness rather than by the validity of its conclusion, was necessarily collected by persons not adequately trained for the purpose, and the conclusions drawn from the data so assembled, were based on more or less arbitrarily established standards. Unless your committee bears these facts in mind, it may be misled by the recommendations of the interdepartmental committee based on the work of its technical committee.

Time will not permit a detailed explanation of all the charts that have already been placed in your hands. However, I should like to point out the general features of a few of them.

Chart I, on page 6, is a graphic presentation of the growth of the population and the medical profession in the United States. At present there is 1 physician to every 768 persons, but statistics alone will not provide the answer as to whether this is a satisfactory ratio. The distribution of physicians is governed largely by general economic conditions over which the medical profession has no control.

Chart III, on page 10, shows that the number of medical schools has decreased from 162 in 1906 to 77 at present, and the number of graduates is now slightly in excess of 5,000 each year. There are about 3,500 deaths among physicians each year. The average annual change in the number of physicians has varied from an increase of

5,485 in 1898, to a decrease of 385 in 1920-21. The present average annual net increase in the number of licensed physicians in the United States is about 1,500.

Chart VIII, on page 20, shows the number and occupancy of general hospital beds. In 1938 there was an average daily census of 132,454 empty beds in general hospitals. During the period 1928-38 there was a net increase of 61,987 beds in general hospitals. During the same period the unoccupied beds increased by 8,919.

In 1929—and this does not appear in the data in the book—the number of beds in general hospitals registered by the American Medical Association was 293,301, or 2.55 beds per 1,000 estimated population. In 1937 there were 412,091 beds in the registered general hospitals, or 3.19 beds per 1,000 estimated population. During the period 1925-37 the expansion of general hospitals amounted to 118,790 beds, a net gain of 40.5 percent. In the same period the population increased (according to population estimates) by 12.5 percent.

Chart XI, page 28, shows the percent of bed occupancy according to the number of beds per 1,000 population for each State in 1938. The curve on the chart seems to show that the maximum occupancy of general hospital beds during 1938 was at some point between 4 and 5 beds per 1,000 population—with, of course, marked differences at each end where the beds per 1,000 population were 1 or 2, or at the other end where they were between 5 and 6 or more. It is impossible to predict what the occupancy would be if the beds per 1,000 population were increased to 7 or more. There are areas where as yet hospital facilities have not been provided, largely because of sparsity of population, the lack of competent personnel to staff the hospitals, and the inability of these communities to support such hospitals. There was in 1938 a low-bed occupancy in most States which had a low number of beds per 1,000 population.

Chart XII, on page 30, shows graphically the narrow margin between the total number and the occupancy of beds for nervous and mental diseases. These data agree with other information which point to a definite need for additional beds in this field.

Chart XIII, on page 22, shows the steadily declining death rate and the expanding death registration area of the United States. The general death rate for the United States when compared with the standardized annual death rate for the industrial policyholders of the Metropolitan Life Insurance Co., meaning the persons who pay their premiums on a weekly or monthly basis (some 17,700,000 people), show that the trend of the decline of death rates among the low-income wage earners employed in a variety of occupations compares favorably with the trend for the general population.

Charts XVII and XVIII, on pages 40-42, present graphically the recorded death rates for diphtheria, and it appears to me they are so clear they do not require further explanation.

The death rate from cancer is often mentioned with great alarm. The mortality from cancer does show an increase, but it must be understood that a greater portion of the population than in previous years is now living beyond the age of 45 years, where cancer is more prevalent as a cause of death (chart XXI).

Chart XXIII, on page 52, indicates graphically the change in maternal mortality in those States that were a part of the birth-registration area continuously from 1921-35. The percentage of change varies from an increase of 1.5 percent in one State to a decline of 38 percent. The data presented in chart XXIV, on page 54, seems to indicate that the problems pertaining to maternal mortality are to be found more largely in urban areas and among other races than in rural areas and the white race.

Chart XXV, on page 56: The decline in infant mortality is shown graphically for the original registration States and the District of Columbia between the years 1915 and 1935; that this decline in infant mortality has varied from 38 percent for Maine to 62.2 percent for Connecticut. The recorded infant mortality rates for the original registration States declined 53.1 percent from 1915 to 1937. For the expanding birth registration area the decline has been 45.6 percent.

Now, I won't take more of your time with these charts.

The medical profession is aware of the significance of these and other vital statistics. It appreciates more fully than any non-professional group that the control of many diseases and consequently a reduction in the mortality rates requires further search for scientific truths. It believes, however, that the present lowering of the death rates from many causes is a primary result of the present system of medical practice.

If any group of countries having comparable racial stock has at any time been able to produce better results than those in the United States we shall be glad to receive such a list of countries in order that we may examine the evidence.

Senator MURRAY. Doctor, notwithstanding the record that you described, it is true, nevertheless, that in some sections of the country there is a possibility of making great improvements in the care of the sick and those who are unable to pay for medical attention?

Dr. LELAND. Granted.

Senator MURRAY. Have you gathered any statistics on the extent of that condition in this country? Have you made any exploration of that?

Dr. LELAND. We have, sir.

Senator MURRAY. You know that in many sections of the agricultural States, there is a serious deficiency of medical care and attention for the people who need medical care, do you not?

Dr. LELAND. I am not prepared to say exactly the extent to which the need exists.

Senator MURRAY. Did you hear the testimony or read the testimony or receive copies of the statements made by witnesses who appeared here several weeks ago representing farm organizations, who detailed the situation with reference to the farm areas of the country?

Dr. LELAND. I had no opportunity to examine those statements.

Senator ELLENDER. Doctor, I notice on page 2 of your statement this language: "In 1938 there was an average daily census of 132,454 empty beds in general hospitals."

Dr. LELAND. Yes, sir.

Senator ELLENDER. Those, of course, refer to all hospitals?

Dr. LELAND. No; general hospitals.

Senator ELLENDER. What do you mean by a general hospital?

Dr. LELAND. A hospital to which the general population goes for its ordinary illnesses, not special hospitals such as those for nervous and mental diseases or tuberculosis.

Senator ELLENDER. Those are pay hospitals, are they not?

Dr. LELAND. Most of them. There are a number of general hospitals that are now being maintained by some governmental units.

Senator ELLENDER. By that statement you do not mean that those beds could not have been filled, that there was no need for them? That there were not sick people who could have occupied them but because of their lack of money they were not able to be taken in?

Dr. LELAND. We have called attention in the past to the fact that there may be in various sections of the United States people who, because of economic barriers, are unable to obtain necessary treatment, but the extent to which that exists is still somewhat questionable in exact terms.

Senator ELLENDER. Has the association made any effort to determine to what extent it is necessary?

Dr. LELAND. The association has made a study.

Senator ELLENDER. Is that available to the committee?

Dr. LELAND. The factual data pertaining to that study are now being assembled.

Senator ELLENDER. Would you be able to make it available for the committee?

Dr. LELAND. I shall be glad to; yes, sir.

Senator WAGNER. Doctor, I want you to believe me when I say that any questions that I ask you are for the purpose of being enlightened if I can by the medical profession.

Dr. LELAND. Certainly.

Senator WAGNER. And also, I am hopeful of their cooperation rather than their resistance.

Dr. LELAND. That is right.

Senator WAGNER. On the question of the need for medical care, I read in the papers that there was a report submitted to your convention which stated that there were only 44,000 people in the United States, the survey showed, that were really in need of medical care, who did not receive such care. Do you remember that report?

Dr. LELAND. I was not in the house of delegates when that report was given. My attention has been called to the fact that that report was made, and I have read the transcript of the report that is to appear in the Journal. However, that report was not based on a complete study. We have issued only a preliminary statement of certain outstanding facts, and the report of the 40,000 stands in contrast to the 40,000,000 frequently quoted and is not intended at this time to be interpreted as an exact figure.

Senator WAGNER. What impressed me was that the investigations made under the jurisdiction of our technical committee reported that there was 40,000,000 people today that were without adequate medical care, and I thought that that was a remarkable contrast.

Dr. LELAND. It is.

Senator WAGNER. Between 44,000 and 40,000,000.

Dr. LELAND. It is.

Senator WAGNER. Are you yourself, on mere observation, satisfied that that is reasonably accurate, that only 44,000 out of one hundred and twenty-odd million people—

Dr. LELAND (interposing). I can answer that better after I have made the complete analysis of the returns.

Senator WAGNER. You would not care to make a statement?

Dr. LELAND. I do not care to make a statement on incomplete data.

Senator WAGNER. I notice here in this book that you have submitted, which is very interesting and has some very interesting charts, that on the last page you have a chart of medical service and economic status.

Dr. LELAND. Yes, sir.

Senator WAGNER. I will ask you if I can get a little more light as to the meaning of this chart. You have there "above \$3,000—self-sustaining, no special arrangements needed." Then "\$3,000 to \$1,500—for the most part self-sustaining, largely self-sustaining, but sometimes needing help." When you say "for the most part self-sustaining" I suppose that means for medical care?

Dr. LELAND. It refers as to the necessities of life.

Senator WAGNER. Including medical care?

Dr. LELAND. Yes.

Senator WAGNER. Then you have "below \$1,500—variable needs for economic and medical assistance."

Dr. LELAND. Yes, sir.

Senator WAGNER. Then there is a need that at this time you mean is not supplied?

Dr. LELAND. I think you will find, sir, in the explanation on the opposite page, that the amounts stated on the chart are not intended to be rigid and fixed amounts, because we realize, as I believe you do, that in various sections of the country, \$1,500 would mean that the man or the family would be living on the fat of the land, and therefore those parts of the country cannot be compared with other parts of the United States in which \$1,500 is inadequate.

Senator WAGNER. I understand; I do not mean to hold you down to anything but an approximation. I believe it has been shown that about one-third of our people, which would be about 40,000,000, have an income of \$750 a year or less. If there is a lack of medical care in that group comprising about 40,000,000 people, would you think that your survey was reasonable when you say that only 40,000 out of that 40,000,000 have sufficient medical care?

Dr. LELAND. I shall be glad to give you the answer to that, Senator, when I get the complete returns.

Senator WAGNER. You would not care to venture an opinion now?

Dr. LELAND. I do not care to use incomplete figures as the basis for a reply.

Senator WAGNER. Are you in sympathy with the general objectives of the legislation?

Dr. LELAND. I find no fault with the general objectives. I believe every one of us wants to help people who are in need of medical care.

Senator WAGNER. There is no doubt about that.

Dr. LELAND. That has been our object from the time that medicine was established.

Senator WAGNER. I have always said that about the medical profession, that they render a great and an unselfish service. We are all going to try with you and with your guidance and your cooperation, I hope, to bring about even a better and a more healthful life. Let me ask you this: Is your association ready to propose any amendments to this legislation that will bring it more in harmony with your views?

Dr. LELAND. It would not be proper for me to speak for the rest of those who are to make statements before you, but from my observation of the consideration that has been given this bill, I believe it is the consensus of opinion that, to improve the bill, it would require so many changes that the house of delegates took the action that Dr. Donaldson presented. I believe no amendments are to be offered. We did, however, suggest a little different approach, as was contained in the report of the house of delegates. That is the suggestion we are offering instead of amendments.

Senator WAGNER. The reason I particularly asked you, Doctor, is because we had Dr. Booth, representing the American Medical Association, before this committee.

Dr. LELAND. Yes.

Senator WAGNER. And at the very end he stated to us that the association, of course, would be willing to cooperate and said, if I recall, that undoubtedly some amendments would be proposed carrying out the views of the American Medical Association.

Dr. LELAND. That was before the annual session, was it not?

Senator WAGNER. Yes; before the meeting at St. Louis.

Dr. LELAND. The house of delegates is the legislative body of the medical profession, and that statement would need to be taken in that light.

Senator WAGNER. Are you from New York, Doctor?

Dr. LELAND. No, sir; from Chicago.

Senator WAGNER. You are generally acquainted with the workmen's compensation laws of the different States?

Dr. LELAND. Yes, sir.

Senator WAGNER. Do you know that those laws provide for cash benefit payments for injuries and also for payments for medical care?

Dr. LELAND. Yes, sir.

Senator WAGNER. The doctors are great advocates of the workmen's compensation law, first because it is a humane law, and secondly because over 90 percent of the claims are for medical care. The doctors receive compensation in that way. I wonder how you could reconcile that advocacy with your statement here that we are mixing medical payments with loss of wage payments; I just wondered why you oppose it in one instance and favor it in another?

Dr. LELAND. There is a statement pertaining to insurance against unemployment due to sickness that will be presented if the committee desires it. If the committee desired to do so, workmen's compensation offers an opportunity to enter into a very interesting discussion of the initial theory on which the workmen's compensation law was based. I might say that it began with paying very little and in some cases almost no attention to medical care, which was brought in later on because it was found necessary in order to conserve the funds.

Senator WAGNER. I do not think that you are speaking of the law in New York, because it so happens that I introduced the law in New York in 1913, and we coupled them together.

Dr. LELAND. It is my understanding of the workmen's compensation laws that the laws were intended to place the responsibility for injuries due to employment on the employer, to spread it perhaps over the general population by including the cost of the insurance in the cost of the product. It has been found necessary to add more and more medical services, but in many instances it has been done very badly and the medical profession has objected to the kind of medical care provided under workmen's compensation and has been doing as much as it could to improve those services.

Senator WAGNER. You try to repeal the New York workmen's compensation, and the doctors would be one of the groups that would oppose it, and rightly so.

Dr. LELAND. I am not suggesting that.

Senator TAFT. In this question of the fundamental difference between what these figures meant of the 40,000,000 and the 40,000 which should be at least contrasted before the comparison as to what they mean is resolved—the 40,000 would mean, I assume, only the people who are not within reach of doctors and hospitals and has no relation to their economic status. Is that correct or not?

Dr. LELAND. That is partly correct. On the other hand, the information that has been given out has left the impression, or the implication, that these 40,000,000 people that are so frequently referred to are sick all the time, 40,000,000 of them every day. I hope no one believes that, because there is only 2 percent of the population as found by the committee on costs of medical care that can be considered as ill on any given day, although the national health survey did find 4½ percent ill on the day of the survey. Of course, one needs to correct for so many of the characteristics that enter into figures. Figures are means of expressing facts, and sometimes they give impressions that are not exactly facts. The national health survey was made during the time of the year when sickness was the heaviest, between November and March, and the 4½ percent reported from the national health survey is more than twice as much as reported by the committee on costs of medical care, or that has been generally accepted as the ratio of the amount of sickness. But, now, as you have intimated, one needs to understand what these figures mean, I would prefer that the committee do not consider the 40,000 to which reference has been made, as an exact figure.

Senator TAFT. I understand that, but what I want to get is, when you get the exact figure, what does it mean? What is it supposed to mean?

Dr. LELAND. Supposedly the 40,000,000 people are people in the very low-income classes. The 40,000 to which reference was made are also in the low-income classes.

Senator TAFT. That means 40,000 people what; what category do they come into—people that cannot get medical service?

Dr. LELAND. As reported to the house of delegates, it was 40,000 who were denied medical care. There is quite a difference between the word "denied" and the inability to get medical care. Some people do not want medical care; they do not desire it.

Senator TAFT. They would rather go to chiropractors?

Dr. LELAND. Exactly. They would rather go to the drug store or treat themselves. The statement that was made was to the effect that the figure would be more likely to be 40,000 than 40,000,000 who are denied medical care, meaning the people who sought medical care and who had been turned away or refused medical services. There is quite a difference.

Senator TAFT. It is very different from the number who might have lack of means and not be in touch with a hospital.

Dr. LELAND. Very different.

Senator TAFT. So really there is no comparison whatsoever between the 40,000,000 and 40,000.

Dr. LELAND. No comparison at all.

Senator MURRAY. And there are a great many people, of course, who are unable to pay for medical care themselves, and the only way they are able to secure it is through some charitable organization or through the representatives of such agencies or the help of friends or neighbors?

Dr. LELAND. That is right.

Senator MURRAY. And that amounts to a considerable number, does it not?

Dr. LELAND. I think when the data from our study has been assembled, they will show a very large volume of illness that is cared for through those voluntary services of physicians, hospitals, nurses, health departments, official and voluntary health agencies, and many other organizations that are now carrying a tremendous load without complaint.

Senator ELLENDER. Doctor, with further regard to the report that we asked you to submit and which was agreeable to you, I notice on page 2 of your statement you have criticized the methods applied by the national health survey. How did you proceed to obtain the data upon which you expect to make this report?

Dr. LELAND. You are referring to our report?

Senator ELLENDER. Yes.

Dr. LELAND. The American Medical Association study of medical care was quite different from any other that has ever been made of which I have knowledge. I have investigated and collected information pertaining to some 4,000 surveys of various kinds. The committee on costs of medical care brought in very properly the cost of medical care, the duration of illness, and many other factors on which it based its conclusions. The national health survey undertook to find out how much chronic illness was prevalent in the country. This survey developed, however, something more than just an enumeration of chronic diseases. It was the desire of the American Medical Association to know to what extent the people of the country were actually utilizing the services and facilities that are now available. That is quite a different matter from a knowledge of the number of days a person is sick or the number of people who are sick on a given day. That study was made by the cooperative efforts, not only of physicians, but nurses, dentists, hospitals, health departments, pharmacists, the voluntary and official welfare agencies, various mutual associations, and organizations in the community such as trade unions, that have mutual benefit plans.

Senator ELLENDER. Doctor, it was not my intention to have you write into the record now the entire detail, but I wonder if you could give this to the committee—you have made just a general criticism contained in about two sentences of the work of the national health service—

Dr. LELAND (interposing). Yes.

Senator ELLENDER. I was just wondering if you could not elaborate on that when you present this report; in other words, I—

Dr. LELAND (interposing). I shall be glad to.

Senator ELLENDER. Take the conclusions reached in the national health survey and criticize them as much as you desire and show where you think they are not justified, and contrast your conclusions with them.

Dr. LELAND. You understand that this criticism is not made of the personnel of the United States Public Health Service.

Senator ELLENDER. I understand that. We are forgetting all about personalities. We want the facts, that is what we desire.

Dr. LELAND. There are certain matters that I would like to discuss in an additional report to you.

Senator ELLENDER. As I said, any criticism you have to suggest, it will be understood that in criticizing the report, that you are not criticizing the personnel.

Dr. LELAND. No; I want that understood.

Senator ELLENDER. What we want are the facts and the criticisms of the conclusions reached. In contrast present your side of the picture as you have found it under your method of gathering facts and reaching conclusions therefrom.

Dr. LELAND. I shall be glad to do that.

Senator WAGNER. Doctor, I do not want to have any misunderstanding of your survey. Did I understand you to say that 40,000—your survey showed—received no medical care, that there was no question of economics involved there, and that that was simply 40,000 who were not within reach of medical care?

Dr. LELAND. Will the Senator allow me to get the exact statement?

Senator WAGNER. I do not want to go through the details, but you must know whether—I am simply asking because in answer to Senator Taft I understood you to say that that 40,000 represents simply people who are not within reach of medical care.

Dr. LELAND. No; I did not say that.

Senator MURRAY. Denied medical care.

Dr. LELAND. I said the statement was to the effect that the number was probably more nearly 40,000 than 40,000,000 who were denied medical care.

Senator WAGNER. But in considering the 40,000, their economic status was considered, too, wasn't it? Were not some of those from the economic standpoint unable to pay for medical service?

Dr. LELAND. Perhaps so; I would not be able to say how many of them were on economic grounds and how many of them were on some other grounds. Perhaps a hospital was full at the time certain ones of them made application for care.

Senator WAGNER. One other question I would like to ask you—your association, I take it from the report, did recognize that there was

need for Federal aid or that there may be need for Federal aid based on needs, I think was the language used.

Dr. LELAND. We recognize that there is need for assistance to a great many people in time of illness. Whether that be Federal aid or local aid or State aid, we believe is largely a matter for local determination. Where the local community does not have the money with which to help these people, they need to seek help, perhaps, from the State. If the State is unable to assist the local community we conceive it to be desirable that the Federal Government listen to their needs and allow them to prove their financial ability as a State, and the health needs which actually exist, and to give them either a grant or a loan.

Senator TAFT. Let me see, Doctor, do I understand that the American Medical Association would submit an alternative plan if requested to do so?

Dr. LELAND. I think this also is something that will be discussed by some other speakers, but in answer to that question, I believe it is the disposition of the American Medical Association, if such legislation were to be drafted along lines suggested in the report which Dr. Donaldson read, that the American Medical Association would, as it always has done, offer its facilities to the Government in order to be of service in regard to principles which it believes should govern such legislation, but the American Medical Association is not in the business of drafting legislation.

Senator TAFT. I do not quite understand the distinction. Of course, we could not pass a law permitting Federal assistance to one State unless the law also permitted Federal assistance to every State. That is all that this law does. It is in the alternative, and no State has to take it unless it wishes to do so. I think it is important that the American Medical Association make clear a distinction which I do not understand. If the distinction is that this plan gives too much power to the Federal Government, that is a conceivable distinction, but I do not quite understand this idea of preferring the R. F. C. to the Social Security Board or purely on a need basis. That could be taken care of by the distribution of funds provided in the bill, and while I do not ask you to do so, I think the decision ought to try to make it clear so that I can get it in my mind what the distinction between the program is of the association and that proposed in the Wagner health bill.

Dr. LELAND. I may say that the other speakers will elaborate on that more fully.

Senator ELLENDER. Dr. Leland, you referred to the testimony of Dr. Donaldson just now. What I would like to have as a member of this committee is a specific plan of how a bill should be drafted and what should be put into it. If you have a witness who can tell us, I am sure that we would like to hear him.

Dr. LELAND. Of course, that is a difficult thing on the spur of the moment.

Senator MURRAY. Doctor, do I understand that you devote your time exclusively to medical economics?

Dr. LELAND. That is right.

Senator MURRAY. You are not a practicing physician or surgeon?

Dr. LELAND. I have not practiced since the World War.

Senator MURRAY. And you have made these studies that you have discussed here today on behalf of the American Medical Association?

Dr. LELAND. Yes, sir.

Dr. CANY. Mr. Chairman, the next speaker that I would like to introduce, we think, has had the very greatest experience and in all probability will be able to elucidate the subject as well or better than any other witness we know, and I have great pleasure in presenting to you Dr. Haven Emerson, professor of public-health practice, College of Physicians and Surgeons of Columbia University, New York City, and former health commissioner of New York City, and a present member of the Board of Health of New York City.

I take great pleasure in presenting Dr. Emerson.

**STATEMENT OF DR. HAVEN EMERSON, PROFESSOR OF PUBLIC HEALTH PRACTICE, COLLEGE OF PHYSICIANS AND SURGEONS OF COLUMBIA UNIVERSITY, NEW YORK CITY**

Dr. EMERSON. May I briefly read this statement, and then if there are questions, I should be glad to try to answer them.

Senator MURRAY. You may so proceed.

Dr. EMERSON. The record of progressively improving health in the U. S. A. for the past 50 years and particularly for the past 11 years impresses me with the trustworthiness of the official and voluntary agencies and institutions and methods of local, county, and city and State government developed by long experience and appropriate adjustment for preventing of disease and care of the sick.

No emergency of sickness or neglect faces us. No spectacular or immediate improvement in general health can be expected through extensive changes in procedures, in responsibility, or in sources of funds as proposed in the Wagner bill.

Better national health can be assured by development along well-established lines in the orderly evolution of social and professional resources made available by new medical knowledge.

Better care of the sick, and more nearly universal availability of the increasingly costly facilities for diagnosis and treatment, can be assured by extension of the various promising experiments such as voluntary prepayment and cash indemnity plans than can be expected from attempts to have the cost of sickness transferred to the Federal Government, or by relying upon State and local health officers to administer treatment facilities at public expense.

We, as physicians, whether engaged in individual practice of curative medicine, or as officers of health concerned with the administrative application of preventive medicine for local and State governments advise against disturbing a series of services which have a long history of success, by creation of another policy where local responsibility will be largely at the mercy of Federal dominance and allocation of funds.

Estimates of neglected sickness have been much exaggerated. Theoretically possible benefits from large additional expenditures are too optimistic and problematical to be convincing.

As the major cause of insufficient care for the sick and for health, where these exist, is lack of earning power and the dislocation of commerce, industry, production, and demand for goods, characteristic

of the past 11 years, so it will be the reestablishment of sound economic and employment conditions which will correct the error, rather than large spending programs by Government which do not lead to any basic improvement in the incomes of the wage earners. Neglected sickness is less often the cause of economic misfortunes than vice versa.

The best contribution that could be made by the Federal Government to general health would be by reestablishment of confidence in self-support, and encouragement of private industry, earning capacity, and productive employment.

Federal spending for the sick and for health cannot be relied upon as a panacea, for such inadequacies as can be shown to exist.

There are measures which only the Federal Government can take to advance national health.

First, the putting of its own administrative machinery in good order, by which I mean the development of a single Federal agency, whether bureau, board, or department under which all Federal health and medical functions—except those of the Army and Navy—should be served.

The chief executive office of such a Federal Health Service should of course be professionally trained and experienced, as have been a long line of Surgeons General of the Public Health Service.

Only through such a single Federal agency should State health officers have relation to the Federal Government for consultative advice, common policies, or for financial aid when emergency or persistent economic difficulties prevent a particular State, or region, or population unit from receiving protective and other medical care necessary for the people's safety and security of life.

Among the many administrative disadvantages of the Wagner bill provisions is the triple-headed character of Federal direction through which grants-in-aid of States for six separate and distinct functions would be administered.

If grants-in-aid are needed in the future, as they have often been needed and made in the past, for health and medical care, the allotting of funds should be in response to specific and proved evidence of need and request for aid by a particular State or group of States presented by the State health officer to the Federal agency authorized to extend financial aid, and preferably with confirmation of the need and the extent of it by officers of the Public Health Service.

Grants should not be offered or urged upon the States to promote some Federal theory of social improvement, nor should grants be made to any State which is able to finance its own appropriate program of health services and care of the medically needy. It seems to us unreasonable to suppose that every State in the Union needs Federal aid to carry out the functions of government long recognized as duties of the State or its political subdivisions.

It is obvious to those of us who have observed even the relatively modest extension of Federal subsidy for prevention and treatment of syphilis that often the funds were out of proportion to the supply of trained persons capable of technical competence in epidemiology, medical treatment, and administrative direction of services.

Such a program as is proposed for hospital and health-center construction, and extension of health agencies into the fields of obstet-

rics, diseases of childhood, and care of the crippled—orthopedics—would quite inevitably face at least a temporary frustration on account of unpreparedness of professional experts to make the services effective.

It is obvious that those who have shared in drafting the Wagner bill have confused in their minds the duties, or functions and capacities of the health officer, with those of physicians and surgeons concerned with care of the sick.

Health officers, except where appointed on a purely political basis, are selected because they are professionally trained and experienced in sanitation and preventive medicine, a specialty as distinct from internal medicine or surgery as plumbing is from carpentry.

In States where health officers follow each other in rapid succession with the alternation of party control of State governments, it would be a calamity if the development of the elaborate series of services for personal care of the sick, of the expectant mother, of the infant and child were left to the direction of the State health officer.

It is wholly undesirable to have any State or Federal plan for care of the sick depend upon the leadership, professional direction, or financial control of the State or local health officers. Those that are competent are more than fully occupied preventing and controlling disease and directing sanitary measures for health. Those that are not specialists in health, are even less qualified as experts in the intricacies of services for the sick.

If, as is threatened, the invaluable functions of the United States Public Health Service for industrial hygiene, which have brought such benefits to labor and industry, and such credit to the commissioned officers of the Service, are to be transferred to the Department of Labor, there will be another confusion and duplication of interest and expense similar to that so long exhibited by the medical and health functions of the Children's Bureau, which should, of course, be a division of the United States Public Health Service.

Briefly, we advise that, before attempting any such costly and considerable revolution in the source of funds, in regulation and supervision of health and medical services in the States by the scheme of Federal subsidies, in the complicated manner proposed in the Wagner bill, the intent of the President's Executive Order 7481 should be carried out, and "better coordination in Federal health work" be the first concern of the Congress.

We offer our professional support for any well-considered plan to aid backward, economically unfavored States to have health and medical care equal to that of the rest of the country, and we suggest certain principles upon which a sound Federal program of needed grants might be based.

We oppose the Wagner bill as it is at present offered for consideration, because it appears to us to be unnecessary, costly, subversive of sound relationships between Federal and State financial resources and governments, and we very much doubt whether the results hoped for by its proponents would be achieved if the present bill were to be enacted into law.

Senator WAGNER. Dr. Emerson, do you favor the provisions of the present Social Security Act which give grants based on needs to States for the care of children and for maternal care? I know that you must be familiar with it.

Dr. EMERSON. I am familiar with the original set-up under the Sheppard-Towner grants and the extension of them under the Social Security Act. I do not know of any evidence which would indicate that the progressive improvement in infant health and maternal health is in any way related to the Federal assistance that has been given to the States in that regard.

Senator WAGNER. Then you oppose it?

Dr. Emerson. No; I think if the Federal Government has spare money and wants to encourage the States to do what the States have not been ready to do, then I see no propriety in opposing such an offer, but I doubt myself whether that is an important factor in the astonishing improvement which has occurred in infant mortality where those services have not been at the Federal expense.

Senator WAGNER. Of course, there are those who disagree with you on that. Do you think it is a coincidence that with this aid, there has been an improvement?

Dr. EMERSON. Senator, at the time that I was born, the infant mortality in New York City was about 250, and there has been a steady and progressive improvement until last year when it was 38, continuous and uninterrupted improvement regardless of any Federal intervention in the local health services.

Senator WAGNER. Are there occasions where the Federal Government ought to aid in health services of the States at all?

Dr. EMERSON. Yes: I should say that the policies which have been adopted in the past of so-called grants-in-aid made available through the Public Health Service at the request and with the cooperation of the States has been a useful contribution to the extension of full-time county health services and sanitary improvements in certain of the States of the country where they were unfortunate because of climatic or geological or economic conditions. That, to my mind, if I may refer to some of the other questions that have been asked before, is an essentially different situation from the present proposal to have a large Federal fund, which the Federal Government is pushing upon all of the States to take advantage of for the sake of encouraging them to spend more than they otherwise would be willing to spend. The fact that Alabama or Georgia or Texas, because of the economic difficulty of their people, are unable to finance what we would call a minimum well-rounded public service quite justifies those States asking for an equalization of wealth, if you choose to call it that, having a grant from the Federal Government by application of the State to the Public Health Service. I think that those grants-in-aid have had an admirable effect and have been helpful, and I think that that principle is a sound one, but it seems to me totally different from the principle presented in your bill which proposes that every State, our own very wealthy State producing 65 percent of the income taxes of the United States, should have to come to the Federal Government to run its public-health service. I do not know of any women and children in New York State or City who ought to look outside of the city and State for humane and competent medical care. We have the resources, we have the personnel, we have the wealth, we have the interest in taking care of our own people.

Senator WAGNER. Of course, the United States has a concern in the health of the citizens, just as the individual States have, and New

York State has asked for aid and has accepted aid, but you think that that was entirely unnecessary?

Dr. EMERSON. Well, Senator Wagner, we are all of us human. If you have 48 health officers who are told that they can get some more personnel and more salaries by going to Washington and asking for it, they are all going to come.

Senator WAGNER. You do not think it has contributed anything to improving the health of the people at all?

Dr. EMERSON. I think that the money given for the hastening of adequate programs for the control of syphilis has probably abbreviated some of the sicknesses and the communicability of that disease. I do not know of any reason why New York City or New York State should have excused themselves out of meeting those expenses out of their own money. They have plenty of money in the State of New York to do that, but if anybody offered them \$75,000 for a lot of field services or a lot of treatment clinics, they are not going to be bashful about asking for it.

Senator WAGNER. A number of surveys have been made indicating the great need for additional medical care in New York as well as other places.

Dr. EMERSON. Well, now—

Senator WAGNER (interposing). I know your records, Commissioner. Perhaps you are a little more conservative than I am, but you are not only a very eminent doctor in our State but have been a great public official. I am prepared to say that, but I differ with you on this. You have been interested and have written a great deal on the subject of health, and you did urge some years ago—and I am wondering whether or not your views have changed—a study at least of health insurance, compulsory health insurance.

Dr. EMERSON. That was 20 or 25 years ago.

Senator WAGNER. It was 1932, was it not?

Dr. EMERSON. That I recommended State compulsory health insurance?

Senator WAGNER. I will read your statement from the report of the committee on the costs of medical care:

The committee urges the broadest sympathy toward experimentation in promising fields, together with the most searching analysis of results. We believe that experimentation along the lines of both voluntary and required health insurance, along with the other experiments in the group purchase of medicine, should be promoted and carried on. In all likelihood, in certain areas of the country, and from certain population and economic groups, required health insurance would be found to be more feasible and practicable than voluntary health insurance or vice versa.

By "required health insurance," by that you mean compulsory?

Dr. EMERSON. Yes.

Senator WAGNER. That is quoted from the report of the committee on the cost of medical care.

Dr. EMERSON. I suppose that is still true. We were thinking of the rather unusual success of the Saskatchewan experiment, where the people by the authority of Parliament at Ottawa were to bind themselves to hire a doctor to provide for the care of their municipality, or roughly a county as we should call it, and it is conceivable that there might be conditions in one or more rural areas of the United States where the only way that the people can tempt doctors into their community is to hire doctors by the municipality. It is con-

ceivable. Up to the present time, I have known of no such instances being developed. I think that is a report which conceivably can apply to a very few scattered areas in the United States as it does in Canada.

Senator WAGNER. In those cases, you see no objection to the intervention of the Government to aid, do you?

Dr. EMERSON. If the people of a community cannot tempt doctors on their own free initiative to come to their community because they cannot pay enough to draw them from elsewhere, they will want to take such resources by pooling their income that will underwrite or guarantee to the doctor a reasonable living wage. Of course, one of the ways that is being done, and the American way of settling that, has been to provide so far as possible local hospitals; in other words, a doctor nowadays needs a shop, and a group of doctors in a community needs a shop, and we have avoided hiring doctors in groups by the method of trying to provide a hospital wherever it can be afforded and where there is competent professional personnel to operate it.

Senator WAGNER. Doctor, you remember that we had a constitutional convention last year?

Dr. EMERSON. Yes, sir; a great one.

Senator WAGNER. And of which I happen to have been a member.

Dr. EMERSON. Yes, sir; a great one.

Senator WAGNER. I am glad to hear you say that. Among other things, we did provide for a constitutional amendment which would permit the enactment of a State health insurance law.

Dr. EMERSON. Yes, sir.

Senator WAGNER. In which the State itself would be permitted to lend its credit or make contributions toward those efforts, and that was submitted to the people as a separate proposition.

Dr. EMERSON. Yes, sir.

Senator WAGNER. And there were a great many of the medical profession opposed—sincerely of course—to it, and on this same theory that it is no part of the Government's business, and yet when that was submitted to a vote, as you know it received the highest vote affirmatively of any of the nine amendments proposed.

Dr. EMERSON. I remember.

Senator WAGNER. So that expresses the views in New York. I hope that you are not going to give the answer which Dr. Booth gave me, who said in effect:

Well, the people don't know what they need and we do.

Dr. EMERSON. Now, Senator Wagner, I gather that you have omitted from your bill all reference to compulsory health insurance?

Senator WAGNER. Yes; I have. Would you favor it if I included it?

Dr. EMERSON. It would add one more nail to its coffin, to my mind.

Senator WAGNER. Then you do not agree with the vote by the people of New York?

Dr. EMERSON. I voted against it when it came up for the referendum, because I believe the people do not understand what it would mean. I think there is a rational difference of opinion between physicians who have studied the effects of such policies elsewhere and what they believe would occur under our own conditions of gov-

ernment. I am not confident that we have yet achieved such independence and competence of our elective and appointive officers that we could turn over the practice of medicine to them.

Senator WAGNER. I do not know whether you appeared or not, Doctor, but we had quite a discussion at a number of hearings before the committee that had it under consideration.

Dr. EMERSON. I read those; I was not present.

Senator WAGNER. And a long discussion upon the floor and a long discussion before the people; and I take it that you agree with Dr. Booth that they just don't know what is good for them, and they did not know what they were doing?

Dr. EMERSON. No; I would not say that. But I think there are many honest people have been led in the thought to believe, largely by the tremendous prestige of influences from Washington, that the solution—

Senator WAGNER (interposing). That was a State convention.

Dr. EMERSON. The people of New York have been largely influenced, I am sure, certainly in the cities, by the belief that developed out of Washington to some extent that a compulsory system will relieve them of the financial difficulties in the care of the sick, and I believe that they are uninformed as to the truth of that, but that is their belief, and that is on our statute books. We believe that there is a proper way of doing it. I have no criticism whatsoever of the proceedings of the convention. I think it was admirable to put that before the people, and they certainly voted for it unequivocally, but the legislature, you will notice, has not taken advantage of the permission.

Senator WAGNER. There is a commission still studying it.

Dr. EMERSON. Yes; it is a fine thing to study it. I believe there are two States that recently have rejected it on practically the same basis. There are evidently in the country differences of the citizen attitude with regard to the involvement of their State government in the provision of medical care of the sick.

Senator WAGNER. Although I say that you are very eminent, I wanted to bring out that there are some in New York that differ with your point of view.

Dr. EMERSON. Yes; I know.

Senator WAGNER. I have agreed with you a lot, as you know.

Dr. EMERSON. I remember we have collaborated in the same city government at times.

Senator ELLENDER. Dr. Emerson, I notice on the last page of your statement that you state that all citizens, no matter where located, should receive the same health and medical care as those of any other citizen of any other State.

Dr. EMERSON. I don't think I say that.

Senator ELLENDER. That is just what I wanted to ask you. You say:

We offer our professional support for any well-considered plan to aid backward, economically unfavored States to have health and medical care equal to that of the rest of the country, and we suggest certain principles upon which a sound Federal program of needed grants might be based.

What do you mean by that?

Dr. EMERSON. I mean this, that if there can be shown that the reason they are not getting it is because of economically unfavorable conditions, the Government must come in and help those people in those States, but there aren't a great many States where the failure is a failure of the State government, a failure of professional organization perhaps, a failure of adequate institutions which the States can properly correct. It does not seem to me, in other words, that just because there are some people in some places that cannot get medical care, it is the function of the Federal Government to automatically come in and supply it. There are conditions, with spendable income as we were told not long ago, of about \$120 per capita in one of the States where people are not able to contribute the sum necessary to give them well developed health protection, and to assist in that case, I should say it was distinctly a function of the Federal Government to respond to an appeal for aid by those States.

Senator TAFT. Do you think that the right of self-government includes the right to govern yourself badly if you want to?

Dr. EMERSON. Yes; as long as your bad government does not hazard the health of your neighbors. If you run an incompetent health department on the border and start an epidemic of smallpox, we thank the Lord that we have a public health service that will come in and intervene on the basis of interstate commerce and help us avoid spreading it.

Senator ELLENDER. With further reference to this paragraph that I just called to your attention, would you be surprised if I told you that in some States—let us take the great State of Texas that is rich in natural resources, there was evidence produced before this committee, not pertaining to this bill, but on another bill, to the effect that five corporations control the gas and electric power of that State, and they pay taxes to that State aggregating \$100 in contrast to an income of \$8,000,000 that was distributed among New Yorkers, Pittsburghers, and Philadelphians. I contend that because of such a situation where these natural resources are being taken from certain sections of the country and are being, as it were, taken away in profits brought to other States, that that is causing a lack of proper finances for the needs of medical care in many, many States of the Union.

Dr. EMERSON. Is it true that in the State of Texas, the State and the communities pleaded poverty as the reason for their inability to get medical care?

Senator ELLENDER. Why, Doctor, many persons and high officials appeared before the State Legislature of Texas, and I know this for a fact and it is not hearsay—they have tried time and again to get the legislature to put an adequate tax on oil, gas, and other natural resources and they have never been able to do so, because somehow, through the control of big interests, they do not seem to be able to get anywhere. Our people tried that in Louisiana for many years up to 1928 when Huey Long came on the scene, and the picture was changed. Today the State of Louisiana offers to its people wonderful medical care compared to what it did prior to that time, for the simple reason that it was able to make some of the big boys pay their just proportion of taxation. If all of the States were able to properly tax the natural resources within their borders and prohibit a few from carrying all the profits to New York or Maryland or Ohio or

Indiana, the probabilities are that we would not be confronted with such legislation as is incorporated in this bill.

Dr. EMERSON. Well, after all, one State after another does correct the abuses which have been developed by monopoly, and if Louisiana did it with Huey Long, perhaps there will be somebody in Texas—

Senator ELLENDER (interposing). That is only 1 out of 48 that has succeeded, and I doubt if any others will succeed.

Dr. EMERSON. Yes; but many others were already taxing.

Senator ELLENDER. Very few and to a limited extent.

Senator WAGNER. Doctor, you were the head of the committee that conducted the survey the results of which were afterward published. I saw the publication several weeks ago in which you tried to point out, and did point out, a lack of medical care in New York, a lack of beds in hospitals. Do you remember that?

Dr. EMERSON. The hospital survey for New York I was responsible for directing, and that was like any other local community undertaking, and an attempt to discover to what extent there was a lack of proportion between facilities and needs. We found that there were some facilities in excess of the needs, chiefly in the matter of beds for maternity patients. Apparently we have enough beds until 1960 at the present birth rate. There are other kinds of beds which were insufficiently provided, and the object was not to show that New York could not afford to take care of its sick but that it must include in its city plan for the next 20 years a methodical replacement of old beds and buildings, and supply new beds, and I think that you will recall that report that we showed that while we had been spending about \$20,000,000 a year for new hospital construction and replacement, there was needed possibly \$28,000,000 in the immediate future to make sure that a balanced program of hospital facilities would be achieved.

It is quite true, probably, that in New York you will find some people that either do not ask or do not know that they want medical care. Recently we had some 11,000 calls made upon the Henry Street nurses for care, calls by the poorest people, and they analyzed each case to find out whether they had medical care and found out why not, and they found approximately 1.4 percent of that 11,000 poor people with no obvious availability of medical care which had yet been obtained. That is the kind of thing that we must expect. We were dealing with 11½ millions in the metropolitan-area population, and we found deficits here and failures of distribution there, and our report was a plan for building up to 1960 for an assumed growth of population which we can reasonably predict. It was not a disclosure that I think would be interpreted by anybody as indicating that there was a gross inadequacy in the care of the sick in New York.

Senator MURRAY. Doctor, in corroboration of the statement made by my colleague, Senator Ellender, I want to suggest that we have a situation in my State of Montana where we have a large mining camp that has produced over two billion in wealth in this country. It is a hazardous occupation—mining—and there are diseases that develop from mining known as silicosis, and yet, notwithstanding all of that tremendous production of wealth, these men were unable to secure proper care and attention. They did not have any hospitaliza-

tion facilities, and it required a desperate struggle here in Washington to get a small allocation to enable them to extend those facilities here during the last year. For a great many years they went without compensation for accidents, and, of course, there are a great many accidents occurring in mines there daily. The result is, as Senator Ellender has so well stated, they are not getting a fair deal, and we hope that something is going to be done about that situation to see that there is a better distribution.

Dr. EMERSON. I understand that you are asking us to approve of this bill as a method of adjusting social errors?

Senator MURRAY. Oh, no; I was just merely stating that fact incidental to the discussion.

Dr. EMERSON. You are referring to the copper and not to the Homestake Gold Mines, where apparently very admirable services are provided. You are referring to the Butte situation?

Senator MURRAY. Yes.

Senator ELLENDER. Doctor, I desire to ask you one more question. How would you carry on this equalization of health service to the rest of the country in order to make it equal?

Dr. EMERSON. I do not think there is any possible way of making all States equal, because some will go far ahead of others.

Senator ELLENDER. Yes; some will go farther than others. You are the third or the fourth witness who testified this morning that you are in accord with doing that, and the statements so far have been general. What we would like to have is something specific as to how that can be carried out, because, as I understand this bill, that is its purpose.

Dr. EMERSON. I believe that the mechanism that has been used in the past would be adequate if applied consistently now, the mechanism by which sums of money have been appropriated and made available for use by the public of public-health services for the grants-in-aid to the States for specific improvements in the public health. Now, the sums were relatively small, but they were extremely economically applied. They were applied in a way to encourage the maximum State collaboration, the maximum of elicitation of State initiative and support, and they were used only in those States where there was a perfectly obvious health deficit which the State from within its own resources could not make up. I do not admit that there is any condition in New York and many other States of our part of the country which cannot be better corrected within the State and within the State government and its resources than by running to Washington and asking for money to correct it. I am familiar with the serious conditions of lack of sanitation, lack of health services, and some instances where lack of medical care prevails where an appeal to the Federal Government ought to be responded to.

I believe the Public Health Service, and the Public Health Service alone, through a sufficient central body should operate any Federal grants-in-aids rather than creating three different groups with two-hundred-and-forty-odd advisory councils to deal with those complicated services offered in the bill—I believe the Public Health Service would be sufficient.

Senator ELLENDER. To what extent would you be willing, or how far would you go, toward giving aid? Would you go as far as is

intended by this bill in granting aid according to the methods that you have just suggested?

Dr. EMERSON. I should be inclined to begin by applying aid for the fundamental protective and preventive services that the people cannot do without; in other words, what I would call the establishment of full-time county health services for the prevention of disease. That seems to me the first object of the Federal expenditure, for the assistance of States that can show that they cannot afford it themselves.

Senator ELLENDER. Only preventive medicine, then?

Dr. EMERSON. I believe that to be the first object. I do not believe it is the function of the State or National Government to take care of women in confinement or to take care of babies or to take care of other things which are the functions of the practice of medicine and which can be better handled by local communities than by aid from Washington. I believe that the most intelligent expenditure of what you might call stimulating money for the health of the Nation would be in the field of prevention rather than in the field of the care of the sick. I think the ordinary humane instincts of the United States are sufficiently developed so that whenever it is called to our attention that there are neglected sick people nearby in the counties and States, you will find provision made to take care of them. But it takes a great deal of imagination and a great deal of statesmanship to spend for the preventive mechanism. The people do not see that clearly enough. I believe that it is the proper function of the Federal Government to assist the States that cannot do it themselves to have a really well-developed, a well-rounded, full-time public health service based on a county and State organization. That would seem to me to be the first object and the only really immediate object for which this expenditure might be asked.

Senator ELLENDER. If that be true, then, as I understand it, you are really against what this bill provides; for no matter if it were carried out the way you suggest—that is, through a central office in Washington—that the Government should not spend money for that purpose?

Dr. EMERSON. Perhaps we are differing merely in a matter of degree. I believe that so elaborate a plan, involving so many different things, is premature, and that until we have tried it on those bases which we know are necessary, it will be inadvisable to commit ourselves to these others, in which I believe there is no good evidence that our Federal aid is indispensable.

Senator ELLENDER. I was just wondering, Doctor, in connection with the other hearings we had here some time ago, as I recall it, the southeastern part of the United States—that is, most of the Southern States—14 percent, as I recall it, of the babies of the Nation, and that section has 2 percent of the wealth of the Nation. Now, I am just wondering how that locality can cut down the death rate that is so prevalent among the babies there so as to keep our population up?

Dr. EMERSON. I believe that you will find that the infant mortality rate in those States has been declining at very much the same rate as it has been elsewhere, and for similar reasons, the reasons being better food and milk and water and care, and that they have benefited by

the improvement of the protective services just as the State of New York and Massachusetts have.

Senator ELLENDER. We had a witness who testified 2 weeks ago, as I recall, who said that the death rate had declined, but that the birth rate—that is, the number of children born—had declined to such an extent that it has now reached the point of 2.7, and 2.6 would be on a decline, and he further stated that if we could provide for adequate measures whereby we could further cut the death rate among children, that even with the decline in the birth rate we will be able to raise a bigger crop of children. What have you got to say to that?

Dr. EMERSON. I am afraid that is a little confused. Since 1931 the married women of childbearing age in the United States have not borne enough girl babies to reproduce themselves, so that we are now potentially facing a falling population. You will see this most beautifully illustrated physically at the New York World's Fair in the Hall of Man, and you will notice that there is no conceivable way in which, by improvement of the death rate, we can catch up with the falling birth rate when the number of babies born is not sufficient to reproduce their mothers.

Senator ELLENDER. I do not expect you to catch up with it. [Laughter.] I mean us, instead of you—but the point made there was that even with the declining birth rate, that if we could better provide for those born alive, we could raise more of them and keep the population up.

Dr. EMERSON. Well, that is a practical impossibility at present.

Senator ELLENDER. I do not remember the exact date which he set, but in the next 20 years, I think he said—I may be wrong as to that—that instead of being 2.7, which is on the border line, it might soon be 2.5, and we will simply be decreasing in population.

Dr. EMERSON. There is no doubt about its decreasing. There is no doubt about it, and there is no statistical probability that we can, by further reduction of the death rate, alter that. The only way—

Senator ELLENDER (interposing). Might we not prolong the time in which it is to come.

Dr. EMERSON. Since 1931 we have been in a deficit position, and that is likely to increase. No country has found any way of bribing women to have more babies than they choose.

Senator MURRAY. I am very sorry that we cannot continue this discussion—

Senator WAGNER (interposing). May I ask the doctor one more question, because you are the first witness who has made a constructive suggestion.

Senator MURRAY. I was about to suggest that it is past our usual recess time, and that the doctor will in all probability be able to return at 2 o'clock.

Senator WAGNER. I have just one or two questions, and it may not be necessary for the doctor to return. You did state that you are in favor of some legislation, but the distribution of the funds should be based upon need?

Dr. EMERSON. I believe so.

Senator WAGNER. And that it should be limited to preventive medicine rather than to these other fields in which this bill attempts to give State aid?

Dr. EMERSON. Yes, sir.

Senator WAGNER. Would you favor it if this bill were amended—I do not agree with you—but would you favor it if that was the provision of the bill?

Dr. EMERSON. If new legislation is necessary in order to make it possible to make Federal grants to aid of States in the public health, I should believe it ought to be drafted, and I assume that it is necessary to have new legislation.

Senator WAGNER. Would you say that it ought to be on a matching basis or simply an outright grant to a State?

Dr. EMERSON. Well, I believe that a State ought to show its good faith always in asking for aid that it is willing to go a little further itself. That is the way these grants in aid have been made in the past, and I understand the principle that if the Federal Government allows something to assist them, the State should stretch itself a little more to go part of the way. I recognize that as a sound principle.

Senator WAGNER. Thank you very much.

Senator MURRAY. We will adjourn until 1:30, if you will have your witnesses back here then, Dr. Cary.

(Whereupon, at 12:15 p. m., a recess was taken until 1:30 o'clock of the same day.)

#### AFTERNOON SESSION

(Whereupon the hearing was resumed pursuant to the taking of the noon recess.)

Senator MURRAY. The hearing will come to order.

The next witness may take the stand.

Dr. CARY. Mr. Chairman, in addition to the gentlemen that I have handed in as witnesses, we are fortunate in having a witness whom we taken great privilege in presenting to you, Dr. Austin from Connecticut.

#### STATEMENT OF HON. ALBERT E. AUSTIN, MEMBER OF CONGRESS, FOURTH DISTRICT OF CONNECTICUT

Dr. AUSTIN. Mr. Chairman and gentlemen of the committee, I am in Congress representing the Fourth District of the State of Connecticut, and I would like to say, Mr. Chairman, that I appear here not in behalf of the American Medical Association, not in behalf of any group of physicians, not in behalf of any local groups, whatsoever; but I am here before this committee in the matter of this bill as a private physician and as a private citizen.

In order that you, Mr. Chairman and members of the committee, may perhaps realize that I speak with somewhat of authority in this matter, I may say that I have practiced medicine privately for nearly 35 years; I am a fellow of the American Medical Association, a fellow of the Public Health Association, a fellow of the American College of Physicians, a fellow of the Royal Society of Medicine of England. It occurs to me that by presenting these qualifications, perhaps my testimony might have some weight.

Let me say that 6 weeks ago I had more or less intimately been over this bill and all of its ramifications and its details and its possibilities. I have been very hurriedly obliged to take only the highlights of the bill in preparation for what I expect to say to your

committee in the next few minutes, and for that reason it will be necessary, more or less sketchily, to point out the things which in my opinion as a practicing physician and one more or less acquainted with such practices I look upon as the bad elements of this bill.

The first reference that I make is to what is known as title V. In that title you will find that reference is made as the court of final resort to the Chief of the Children's Bureau and the Secretary of Labor; in other words, the wording of this particular section of the bill is such that there is left to lay people, and when I say lay people I refer directly to the Secretary of Labor, reference to that particular official of matters which should be settled and decided upon and only by those who possess a professional education.

Then on page 11 of the bill, you will find—

Senator WAGNER (interposing). Are there not doctors employed in the Labor Department?

Dr. AUSTIN. I am not aware, sir, that the Secretary of Labor is a physician; I am not aware of that fact.

On page 12 you will find in lines 3, 4, and 5, this stated "and methods of establishing and maintaining standards of medical and institutional care and of remuneration for such care," et cetera; in other words, this bill directly delegates full authority and power to a lay person regarding matters which should be governed and should be controlled and should be decided upon only by those who are skilled in such professional capacities.

On page 16, under the Rules and Regulations, section 517 says:

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.

Then also on page 16, section 541, in title VI, in the matter of public-health work and investigation, if you will look through that, Mr. Chairman and gentlemen, you will find that there is brought in another lay person, to which person is delegated authority and power of decision and power of regulation, and that is the Secretary of the Treasury, in conjunction with this same Chief of the Children's Bureau, and then, not satisfied with that, the President of the United States also has a hand in making final decisions in purely professional matters.

Now, if we may pass once more to title XII, on page 25, in the matter of hospitals, you will find, under this section 608, a provision there that the President, upon the recommendation of the Secretary of the Treasury, is authorized to change the name and to 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 so on, all amounting to practically the same thing.

Now, under title XII, on page 25, we come to the matter of hospitals and health centers, and on page 28 you will find, under section 1203, page 28, lines 4, 5, and 6, that there is delegated to this particular division "methods relating to the establishment and maintenance of personnel standards on a merit basis; and methods of establishing"—in other words there is delegated to a nonprofessional body

the adjustment and the judgment of personnel standards of a physician insofar as it refers to his professional ability.

Then, in addition to that, in the matter of control of practice, on page 84 of the bill, will be found this very telling sentence in section 1209:

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

Mr. Chairman, my particular objection to that section refers to health, diagnostic, and treatment centers. According to my interpretation of this wording, it is perfectly possible for this lay committee, this regulatory and adjusting division, to decide what shall be the methods of diagnosis, what shall be the methods of treatment, and what constitutes the provision of health, private or public.

Now, in title XIII, on page 35, it brings in the Social Security Board.

Now, Mr. Chairman, we have had the Secretary of Labor, we have had the Secretary of the Treasury, we have had the President of the United States, in another section we have the Surgeon General of the Public Health Service, and now we come for final adjustment and adjudication to the Social Security Board. I am not aware that any of those authorities are so situated professionally that they may make professional judgments in matters pertaining to medicine and allied sciences.

On page 36 there is a provision here under the approval of State plans whereby it says: "Methods relating to the establishment and maintenance of personnel standards," which are left to the adjusting committee.

On page 37, the first line:

Maintaining standards of medical and institutional care.

In other words, Mr. Chairman, I fail to see how there is any possibility of not reaching the conclusion that there is left to a lay personnel and an unskilled one in so far as professional methods are concerned, the adjustment and the adjudication of matters purely and entirely professional.

Now, if we come down to a strict application of this act, should it become a law—after a great many years of experience in medicine and particularly in experience in expert work in the legal field, let me say that should any such provision as this carry as we find on page 46, section 1405, lines 10, 11, and 12, which read—

with respect to their disability not arising out of or in the course of employment.

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

It takes not always a professional man, but it simply takes on the part of anyone a little reading of the newspapers and a little actual contact in public life to see into what ramifications such a definition may lead when we list "inability to work or unfitness to work."

Senator WAGNER. What definition would you put there?

Dr. AUSTIN. I would prefer a moment or two to form and formulate a definition.

Senator WAGNER. I assumed while you were criticising the language, you must have had in mind some other language.

Dr. AUSTIN. If the gentleman will allow me, there is a difference between criticising a definition and substituting therefor an adequate provision or definition.

Senator WAGNER. The difference is that between criticising and suggesting other words which are constructive.

Dr. AUSTIN. Pardon me?

Senator WAGNER. I say that criticism is constructive where you specify something definite to take the place of that which you criticize.

Dr. AUSTIN. Criticism does not necessarily, if you will allow me, have to be instantaneous.

Senator WAGNER. Very well.

Dr. AUSTIN. The opposition to this bill, of course and naturally, comes from medical societies and medical groups. I should say that it has to do with problems with which they are most familiar. It is a part of their everyday, their professional life, and it occurs to me the criticisms coming from such a group should be criticisms to which more or less attention should be paid. In addition to that, I have selected from my correspondence a number of letters from individuals in my particular congressional district, which letters are from individuals not engaged in the practice of medicine, and with your permission I should like to have those, if possible, made a part of the record.

Senator MURRAY. They may be filed for use of the subcommittee.

Dr. AUSTIN. There are several broad grounds of opposition which I might take to this bill. From my knowledge of medicine and my rather extensive practice, I am inclined to think that there is not the necessity, the advertised necessity which we have been led to believe exists. It occurs to me that the condition is more or less exaggerated when we have spoken of the very large proportion of our population who are entirely and absolutely deprived of professional aid. It would be my experience and observation that such is not particularly the case.

There is another feature of this bill which leads me to think that it is pregnant with financial possibilities. A very large sum of money is entailed in the carrying out of the provisions of this bill, and then in many places, as the gentlemen will recall, the word "sufficient" is used—that "a sufficient sum" shall be appropriated for this particular purpose. Now the word "sufficient," to my mind is just a little bit subtle, it is a little bit elastic; in other words, there seems to be nothing definite—

Senator MURRAY (interposing). There is nothing wrong about making a provision elastic rather than rigid.

Senator WAGNER. Congressman, the medical profession recommends a word which is a little broader, although I think it is a word that can be utilized, the word "needed."

Dr. AUSTIN. Yes.

Senator WAGNER. Do you think "needed" is better?

Dr. AUSTIN. "When necessary" or "shown to be necessary," or something of the sort, I think would be preferable. I think that is better than "sufficient."

Senator WAGNER. That would be your thought?

Dr. AUSTIN. Yes.

Senator MURRAY. When you come to get the appropriation, you would have to go pretty far to show the necessity of the need for it, even though the bill did not contain the word.

Senator TAFT. Is that a new rule here? [Laughter.]

Senator MURRAY. I find that that is the rule always enforced in my section of the country against us. But in New York or Ohio, they may be able to have a different rule applied.

Senator WAGNER. I cannot get any comfort out of being amused when we try to feed hungry people on the basis of need. I believe in 95 percent of the cases or more, the one that is fed is hungry and needs to be fed, and he is hungry through no fault of his own. I just cannot be amused at that sort of thing.

Dr. AUSTIN. I am inclined to think, if I may so state, that anyone who has practiced medicine for 35 years in a country town, not within the closely inhabited centers of large cities like New York City, comes very intimately in contact with those who are at times hungry and ill-fed and ill-nourished, and I am inclined to agree with the gentleman that their need is a very crying need, and I hope that the gentleman will agree with me when I say that probably doctors are in a situation to judge of the extent of those who are hungry, and so on.

Senator WAGNER. Absolutely. I know that the doctors in my section give a great deal of free service, and very noble service.

Senator MURRAY. In some sections of the country, there are no doctors there to pass on the problem. There are sections of the country where because of economic conditions the doctors have folded up and moved out and abandoned areas where it is necessary for the people to go hundreds of miles to get medical service.

Dr. AUSTIN. That is quite true. On the other hand, doctors have to make a living the same as other people, and if doctors settle in a place and they are competent and there is no economic reason why they should stay, they leave, and the probability is that there is not any great crying need for a doctor.

If I may close in just one minute. The general objections to the bill which are quite theoretical and have nothing to do whatsoever with the pure intent of the bill are—of course we look upon it as an attempt at what might be called state or socialized medicine. With that, we quite heartily disagree. We are also a bit fearful, some of us, that it has a little something to do with the all too apparent trend, let me say, of the centralization of power in a central government. It also appeals to me as a man who has been obliged to make a living in medicine, it also appeals to me as a possibility looking toward further competition of government with private industry or private capital or private effort, and for this reason I wish, Mr. Chairman, at the same time to thank you and the gentlemen on the committee for this hearing, and to record myself as opposed to the bill.

Senator WAGNER. May I ask the doctor a few questions?

Senator MURRAY. Certainly.

Senator WAGNER. You have criticised the bill because in some respects the medical profession is not in charge of the exercising of certain functions here, and you think it requires a professional person to carry on these activities?

Dr. AUSTIN. I think, sir, that the final adjustment of a problem having to do with medicine or medical care of our population, the final adjustment should be made not by a lay person but one who is familiar and versed in the practise of medicine.

Senator WAGNER. So far as any medical services are concerned, I agree with you absolutely. Now, let me ask you, would you support the bill if that provision were met?

Dr. AUSTIN. No; I think there are too many other objections to merit support.

Senator WAGNER. I thought so. [Laughter.]

Senator MURRAY. The audience will kindly refrain from expressing approval or disapproval at anything that occurs at this hearing. You are here at the courtesy of the Senate, and we would like to conduct this meeting with some dignity.

Senator WAGNER. You spoke about fearing centralization of power and that interests me because the American Medical Association has in different pamphlets and resolutions advocated Federal aid where there is need. The authority to aid a particular State would have to be placed in some individual here in Washington and that individual would have to decide upon the evidence presented by the State whether that State really is in need of the medical services or funds for the services which it seeks. Would you regard that as centralization?

Dr. AUSTIN. I think that you and I perhaps differ in our concept there. If I catch your thought correctly, sir, your idea is that there must be an administrative office to carry out the technical provisions of the bill as to the determination where the aid is needed and how much aid should be given and the different steps to be taken by the individual State to meet the requirements of the act—I think that is your idea, isn't it?

Senator WAGNER. Is there any other way of doing it?

Mr. AUSTIN. Yes; I think there is another angle to it probably, and that is the purely professional part. I think you will agree with me, sir, that there is a professional and a technical side to the provisions of this bill. Necessarily, the technical part must be taken care of by the Bureau or something of the sort; that is quite true.

Senator WAGNER. But somebody must decide whether that State needs the aid or not. Let us assume we put it in charge of Dr. Par-ran, for instance. I cannot think of a better person, can you?

Dr. AUSTIN. I certainly cannot, sir.

Senator WAGNER. Well now, he would have to decide whether that particular State needs the assistance or not and the grant or not, would he not? Somebody has to do it.

Dr. AUSTIN. I think where you and I differ there is simply on the question of where one is technical and the other professional.

Senator WAGNER. You talk about centralization of power in the Federal Government.

Dr. AUSTIN. Yes.

Senator WAGNER. Isn't there somebody in the Federal Government that will have to decide whether the State shall secure the funds?

Dr. AUSTIN. Yes.

Senator WAGNER. Isn't that the exercise of technical power?

Dr. AUSTIN. It is but it is technical; it is not professional.

Senator WAGNER. What is that?

Dr. AUSTIN. It is technical; it is not professional. You or any of the other gentlemen who do not happen to be professionally trained certainly could take care of the technical part of the provisions of this bill. The problem that worries me is the other portions of the bill which have to do with the professional attainments, merits, things of that sort which should not be decided by a central authority. I think that is the only phase in which we differ.

Senator WAGNER. I just want to ask you one or two other questions. On the question of need, you expressed the view that the need has been quite exaggerated?

Dr. AUSTIN. I feel that it has.

Senator WAGNER. Well, the American Federation of Labor has come here. They have been interested for some years in this very question and have made, I think, as thorough surveys on this question as even the medical organizations.

Dr. AUSTIN. I am rather familiar with it, sir.

Senator WAGNER. Well, they have appeared here supporting this legislation a hundred percent. And then the C. I. O. organization, which claims a membership in the millions, appeared here as a result of surveys they have made and they support this legislation. Mr. Woll particularly, who has studied this for some time, gave us very startling figures as to the inadequacy of medical care in the country and pleaded for this legislation.

Dr. AUSTIN. Yes; I know.

Senator WAGNER. We have had practically, I think, every large farm organization of the country. Surely those organizations are not only widespread but they are acquainted with needs, social and economic needs, of their people. I have forgotten what the membership represented by all of these organizations is, but it is tremendous. It includes pretty nearly all of the farmers of the country, and they came up here with very tragic figures indicating the inadequacy of medical care and pleading for this legislation. They represent citizens in the millions. Do you think that they are all absolutely misinformed as to this whole thing?

Dr. AUSTIN. I hope the gentleman does not think that I would attempt to oppose my individual opinion against the very valuable resources of investigation had by these larger associations, that I would attempt to make anyone think that I know more about it than they do. But the gentleman will remember that I said from my observation and reading, I was led to think that such was the case. I do not know from my personal knowledge.

Senator WAGNER. I wanted you to have the benefit of the fact that these other organizations have appeared here and differed with you. I recognize that in all of these matters there is a difference of viewpoint. That is all.

Senator MURRAY. Have you prepared or do you wish to file any amendments to the carrying out of your suggestions?

Dr. AUSTIN. I have no amendment.

Senator MURRAY. Are there any other questions? [No response.] Thank you, Doctor.

Dr. CARY. Mr. Chairman, may I express our thanks for allowing Dr. Austin to appear.

I understand that the witnesses who have already appeared—is it understood that what they have said goes into the record?

Senator MURRAY. Yes, certainly.

Dr. CARP. Now, Mr. Chairman, following Dr. Emerson, who spoke very learnedly regarding public health, we think there is another angle to this question of public health, particularly public education, that is the program of health education in association with public health, and we would like to present to you Dr. Milton Robb of Detroit, Michigan, who will speak on the program of health education.

#### STATEMENT OF DR. MILTON ROBB, DETROIT, MICH.

Senator MURRAY. Doctor, you may proceed to read your statement and make any oral statement that you wish.

Dr. ROBB. A program of health education has been in progress in this country for many years, initiated chiefly by the various State medical societies of this country, and must be continued in increasing amount for undoubtedly the lack of health education is responsible for a larger proportion of insufficient medical care than the absence of availability of medical services.

What I have to say will specifically relate to the State of Michigan and her efforts in health education. However, I know that a duplication of these efforts can be found in 45 other States, depending upon their needs.

The American Medical Association, through its Bureau of Health Education, has aided in every way possible the development of these programs in the many States, as well as the development of an unusually extensive one of its own. This I shall discuss later.

In the State of Michigan in 1927 the officers of the Michigan State Medical Society at their annual meeting invited representatives from the University of Michigan Medical School and the Detroit College of Medicine (now Wayne University Medical School) to discuss postgraduate teaching. After a year's study by these agencies, it was the unanimous opinion that an effective program of continuing education in medicine should be directed by a teaching institution and that the University of Michigan should assume the responsibility.

We are now entering on the tenth year of this program, developed under this arrangement, and the association has been a happy and a successful one. Courses have been arranged to suit the convenience of practitioners in reference to costs, length of courses, type of instruction, and accessibility. Beside Ann Arbor and Detroit, nine teaching centers have been established at convenient points throughout the State, so that a minimum program of teaching designed to keep the practitioner informed in the new procedures of practice is now within easy driving distance of over 90 percent of the medical profession of the State. During this period there have been over 7,000 formal registrations in the various courses, and approximately 2,500 Michigan doctors have taken one or more courses. In addition to the Michigan profession, over 700 doctors from other States have availed themselves of these opportunities. The success of this program of postgraduate education has been due largely to the excellent co-

operation between the Michigan State Medical Society, the University of Michigan, and the Wayne University College of Medicine. This arrangement put the control of a technical problem in the hands of those that are close to it.

Similar plans for postgraduate teaching in the fields of dentistry and nursing are being promoted under similar organizations of the State.

Health education of the public has been in effect for a much longer period of time, beginning in Michigan in 1921.

The problem is not to bring to the door of everyone something they as yet do not feel they need, but the problem is to educate everyone to the need for a periodic health examination for the prevention of disease, and early medical attention when signs of disease appear.

The child with middle-ear disease which is having smoke blown in its ears by its father or hot oil put in by its grandmother for the earache, the man with an acute appendicitis who takes castor oil for his bellyache, the young woman with tuberculosis of the lungs who continues self-medication with a cough mixture, be she rich or poor—are not having adequate medical care. It is obvious that the fault lies with the individual. If there were a doctor on every street corner and a Government hospital on the next square and service could be had for the asking, there would still be many people who would not stop to get it. In other words, it is a problem for the educator.

The Michigan State Medical Society 18 years ago, through its council, asked the University of Michigan to cooperate with them in the formation of what is called the joint committee on health education. The objective, as set down at that time, was as follows:

The function of the joint committee is to present to the public the fundamental facts of modern scientific medicine for the purpose of building up sound public opinion relative to the questions of public and private health. It is concerned in bringing truth to the people, not in supporting or attacking any school, sect, or theory of practice. It will send out teachers, not advocates.

The record of these activities shows that audiences increased from a few hundred in 1922 to 240,000 in 1930; and those who served voluntarily as lecturers increased from 30 in 1922 to 576 in 1930.

In 1930, in the high schools of the State, assembly hours were granted for this purpose, and in 100 high schools 5 assembly-hours a year were devoted to this program, under the direction of the joint committee on health education. The audiences were composed of approximately 140,000 high-school students.

In addition to this, a health column was offered to the newspapers of the State which by 1930, through the medium of some sixty daily and weekly newspapers, reached an estimated number of 2,000,000 readers.

In 1931 the depression caused the withdrawal of most of the supporting contributions, and therefore the program was greatly curtailed.

In 1935 the committee decided upon a renewal of these activities and increasing the scope of the program. At this time it became evident that other professional and lay organizations would add to its effectiveness. Previously, there had been 13 health agencies of the State interested in supporting this health education plan.

At the present time practically every organization connected with education and more particularly health education is included in its membership. The following is a list of those participating:

Michigan State Medical Society.  
 Michigan Department of Health.  
 Michigan Public Health Association.  
 Michigan Hospital Association.  
 Michigan Tuberculosis Association.  
 Michigan State Nurses Association.  
 Michigan State College.  
 Michigan Division, American Red Cross.  
 Michigan Education Association.  
 Michigan State Dental Society.  
 Michigan School Health Association.  
 Michigan Association of Sanitarians.  
 Michigan Congress of Parents and Teachers.  
 Michigan State Federation of Women's Clubs.  
 Michigan Home Economics Association.  
 Michigan Physical Education Association.  
 Probate Judges Association of Michigan.  
 State Conference on Social Work.  
 State Department of Public Instruction.  
 University of Michigan.  
 Wayne County Medical Society.  
 Wayne University College of Medicine.  
 Woman's Organization for Non-partisan Reform.  
 The W. K. Kellogg Foundation.  
 Children's Fund of Michigan.

For the past 2 years the activities of the committee have centered upon two programs, one on school health and the other on adult health. The subcommittee on health education in schools is composed of leading educators in the health sciences and in the school system of the State.

Within the past few months the superintendent of public instruction has taken over the responsibility for the school health program and at present the curriculum steering committee of the department of public instruction, assisted by a selected group from the joint committee, is formulating a teaching schedule on health to be incorporated in the school system of the State. Thus the teaching schedule will include specific information on personal and community health and assume a status comparable to any of the other subjects in the school curriculum. It is felt that this is a forward going movement and repays those of us who have for almost two decades been working toward this particular end.

In Michigan the expense of the entire public health education program was borne by contributions from the various organizations comprising the committee and other Michigan philanthropies and not from the taxes of the State.

The American Medical Association has been extremely active, as I stated before, in health education, and the following summary is based on information in the files of the bureau of health education for 1938:

**Radio:** In 1938 the bureau of health education of the American Medical Association broadcast 34 dramatized radio health programs over an N. B. C. network. Six radio talks were delivered by the director and the assistant director in their travels on behalf of the bureau.

Radio scripts prepared or edited by the bureau for other health organizations or commercial programs numbered 186.

In 1938 the bureau distributed 5,540 radio talks, interviews, and dramatic scripts for use by 12 State medical societies and by 128 county medical societies. According to the records of the Bureau, at least two more State medical societies are using the radio for the health education of the public.

The Your Health program received a first award from the Institute on Radio in Education at its ninth annual meeting in Columbus, Ohio, May 1938.

**Speakers Bureau:** The director and assistant director of the bureau traveled 42,859 miles in 1938 to address 157 audiences totaling 44,786 persons in 20 States.

Our records show that at least 61 county medical societies and 11 State medical societies maintained speakers' bureaus.

A second symposium on health problems in education was arranged at the time of the annual session of the A. M. A. under the auspices of the joint committee on health problems in education of the A. M. A. and the National Education Association.

Hygeia clipping collections were loaned to 895 physicians to aid them in preparing speeches.

**Publications:** The bureau made 30 contributions on health to publications other than those of the American Medical Association.

Our records show that press releases were issued by at least 40 county medical societies and by at least 17 State medical societies throughout the country.

The association is helpful to the press in numerous ways—through the office of the editor of the Journal and through the weekly news clip sheet entitled "A. M. A. News."

An extensive catalog of publications is maintained. These publications are distributed at cost, or less. Total distribution of these pamphlets in 1938 was 120,983 copies for the publications of the bureau of health education alone.

The American Medical Association answers thousands of letters from the public through its offices, the bureau of health education (8,220 letters in 1938), the bureau of investigation, the council on foods, and, to a lesser extent, other departments.

The American Medical Association maintains cooperative relationships with the following organizations, through committees:

- National Congress of Parents and Teachers.
- General Federation of Women's Clubs.
- National Education Association.
- American Public Health Association.
- State and Territorial health authorities.
- United States Public Health Service.
- United States Children's Bureau.
- United States Department of Commerce (Accident Prevention Conference).
- National Organization for Public Health Nursing.
- National Committee on Boys and Girls Club Work (4-H Club).
- Committee on Evaluation of School Broadcasts of Federal Communications Commission.
- American Society of Mechanical Engineers.

The association cooperates upon request with any department of the Federal Government, State governments, or local governments.

Through correspondence and by personal conference it gives advice on health problems to all reputable inquirers.

Halls of health for the education of the public have been conducted in connection with the annual meetings of the State medical societies of Wisconsin, Illinois, and Kansas, and exhibits for the public under other names have been held in connection with State and county fairs by numerous State and county medical societies. Extensive contributions to these exhibits were made by the bureau of exhibit of the American Medical Association which in addition placed major exhibits at Chicago's Century of Progress, Cleveland's Great Lakes Exposition, the Dallas Centennial, the Pacific International Exposition at San Diego, the Golden Gate Exposition at San Francisco, and the New York World's Fair.

This review of the health-education activities of the American Medical Association is offered as evidence of its established policy to disseminate scientific information pertaining to health and medical services.

Thus praying for the continued extension of health education in the interest of still better national health, allow me to repeat in conclusion that the lack of health education is responsible for a larger proportion of insufficient medical care, regardless of station in life, than the absence of availability of medical service.

Senator WAGNER. That is very interesting and I agree with everything that is said there, but don't you think that there are very many people in the low-income group that you do not reach with this very worthy type of educational service.

Dr. ROBB. I presume there are some that are not interested in reading, but we do try at least in the State of Michigan to cover the entire population in every way, and in our efforts we have what we thought made a rather successful attack. It is rather peculiar—I have always felt that they may know about where to get the grocer and the butcher, but sometimes they do not seem to find out where they can get the best type of service that can be given.

Senator WAGNER. Are there not many that have not the means to pay for that service?

Dr. ROBB. Yes; but in Detroit I know and in the State of Michigan we have a number of organizations that take care of them entirely free and have always done so, so I do not believe that that is much of a factor if at least they will only know where to go.

Senator THOMAS. Doctor, I am assuming that you believe so much in health-education programs that your association is supporting fully the general education bill now pending?

Dr. ROBB. I cannot tell you that.

Senator WAGNER. You would not oppose it just because it was a Federal activity instead of a State activity?

Dr. ROBB. Not unless the people at home who I feel know all of the needs vote for it.

Senator WAGNER. Are you opposed to this bill?

Dr. ROBB. I do not know the bill, Senator.

Senator WAGNER. Your paper was very interesting.

Dr. ROBB. Thank you.

Senator MURRAY. Your theory is that the health-education program would contribute largely to overcoming the conditions that are sought to be remedied by this bill?

Dr. ROBB. I believe it will overcome a great deal of it if we can advise the people where to go for that service.

Senator TAFT. Your experience shows that a State can do it without Federal aid if they go out and do it.

Dr. ROBB. It has been done pretty generally in the State of Michigan and we have quite a big State.

Senator WAGNER. Haven't you any aid from the Federal Health Service at all?

Dr. ROBB. I believe that we have gotten some; I cannot state how much.

Senator WAGNER. How about maternity and child care?

Dr. ROBB. I am not able to answer that phase of it.

Senator MURRAY. Your knowledge of the conditions pertains particularly to the big industrial centers?

Dr. ROBB. Yes, sir.

Senator MURRAY. Not so much to the rural sections?

Dr. ROBB. I have been president of the State society and president of the local society. I have covered the State of Michigan pretty thoroughly for a period of 2 years when I was president, and I am in contact with that, so that at least at that time I was and have been to some extent and since, and I believe that Michigan has made a good stand in the handling of their problems and they have been difficult ones.

Senator THOMAS. Your program has been in existence since 1921?

Dr. ROBB. Yes, sir; 18 years.

Senator THOMAS. What States preceded you in such a program?

Dr. ROBB. I don't know of any one.

Senator THOMAS. You do not?

Dr. ROBB. There are 25 other States already or at least at the present time doing some type of health education and post graduate health education.

Senator THOMAS. You are familiar with the interdepartmental social hygiene work right after the war, are you not, Doctor?

Dr. ROBB. I know the name; I do not know its activities.

Senator THOMAS. That was a Federal-aid project. Would you favor it?

Dr. ROBB. Do you mean in Detroit?

Senator THOMAS. No; in the country.

Dr. ROBB. So far as education is concerned?

Senator THOMAS. So far as health education of a certain type is concerned.

Dr. ROBB. I cannot answer that.

Senator THOMAS. Did it ever force any of its money on a State against its will, do you know?

Dr. ROBB. Not that I know of.

Senator WAGNER. Are you familiar with the experiments going on in Detroit that I have been informed about in treating tuberculosis cases?

Dr. ROBB. I know something of their program.

Senator WAGNER. It has been successful up there, hasn't it?

Dr. ROBB. Yes; it has; and it has been a cooperation on the part of the physicians of the local community.

Senator WAGNER. Yes; we want that cooperation, too.

Senator MURRAY. Thank you, Doctor. Now, the next witness.

Dr. CARY. Mr. Chairman, the next subject which we wish to bring before you we have divided into two parts, thinking that we could cover it better that way, and I now wish to present to you Dr. Wingate M. Johnson, of Winston-Salem, N. C., a general practitioner from North Carolina. Dr. Johnson will speak on hospital facilities.

**STATEMENT OF DR. WINGATE M. JOHNSON, WINSTON-SALEM, N. C., FORMER PRESIDENT NORTH CAROLINA STATE MEDICAL SOCIETY**

Dr. JOHNSON. Mr. Chairman and members of the committee, the Wagner bill provides for the appropriation by the Federal Government, within the next 3 years, of \$158,000,000 "to construct and improve needed" general hospitals in the United States, besides an unlimited amount for hospitals for tuberculosis and mental disease. The bill also requires the States involved to spend approximately an equal amount. Before authorizing such a huge appropriation the custodians of the people's tax money will, of course, want to be sure that it is needed.

According to the latest statistics available—for 1938—there were 6,166 registered hospitals in the United States, with approximately 1,200,000 beds. Of these beds a daily average of 195,674 were empty. The number of hospital beds occupied for the United States as a whole was 68.9 percent—varying from 53.6 percent in Mississippi to 73.3 percent in Michigan. Furthermore, the proportion of empty beds for 1938 showed a definite increase over 1937.

From 1927 to 1938, while the population of the country was increasing only 8.9 percent, the number of registered hospital beds increased by 36.1 percent. The ratio of beds to population increased from 2.9 percent to 3.3 percent. During 1938 the growth in registered hospitals added 101 beds for every day in the year, including Sundays and holidays. Before spending the taxpayers' hard-earned money for the wholesale building of new hospitals, would it not be well to wait until we are utilizing those we have? In deciding the question, we should remember that the population of our country is rapidly coming to a stationary figure. From early colonial times to 1860 every decade showed an increase in population of more than 30 percent. In 1860, however, the curve of growth began steadily to flatten. For the decade ending in 1940 we may expect only 7 percent increase.

Another fact to consider before we launch upon a program for erecting additional tuberculosis hospitals is that the number of tuberculosis patients in the United States is rapidly decreasing. In 1904 there were 280 deaths from the great white plague per 100,000; in 1937 there were 56—exactly one-fifth as many.

It is true that the amount of mental illness in the United States is increasing; but, even so, hospitals for nervous and mental diseases had 29,485 empty beds in 1938, as compared with 23,710 in 1937. This increase could be explained by two principal reasons: First, these hospitals have grown in number and in capacity far more rapidly than have the general hospitals; second, the dramatic results of insulin and metrazol therapy in dementia praecox and of fever therapy for paresis have shortened the hospital stay of numerous patients.

Likewise in our general hospitals the stay of the average patient is steadily being shortened. Many prolonged diseases such as typhoid fever and dysentery have been virtually exterminated. The acute respiratory diseases which have largely replaced them are of shorter duration. Furthermore, modern medical science has found ways to shorten the duration of many diseases other than mental; for example, serum, X-ray, or sulphapyridin for pneumonia. Recent surgical advances have shortened the post-operative periods of many conditions.

The argument oftenest heard is that, while the thickly settled States have ample hospital facilities, those with a high ratio of rural or small-town population are really suffering. Last July, during the National Health Conference, a radio program entitled "The Fight Against Death" was broadcast over the N. B. C. network. According to the station announcer, it was presented by the United States Public Health Service and the Department of Interior Office of Education. In melodramatic form it told the story of a man slowly dying of cancer. He had "had every doctor in the country," but not one had diagnosed his ailment. Just before the end he was carried in a hearse to a hospital 300 miles away, where the great diagnostician who saw him there had to tell his wife that the poor fellow must die in a few hours of cancer. The play ended with a voice—presumably from the clouds—saying, "Jim need not have died had there been in his State a cancer center where he might have gone for good care."

This cruelly unjust broadcast left the impression on the public that the average doctor is not competent to recognize cancer; that there must be a specially equipped diagnostic center for this purpose; and that hospitals are widely scattered. On the contrary, a recent survey of the A. M. A. showed that less than 2 percent of the population are more than 30 miles from a registered hospital; and 30 miles on modern hard-surface roads now mean less than did a mile of dirt road in horse-and-buggy days.

The consummation so devoutly to be wished, of bringing hospital facilities within the reach of the low-income groups, will not be reached by building more hospitals than we need. Rather, to do so would make for greater hospitalization cost. To withdraw some of the patronage from hospitals now in operation would necessarily add to the administrative cost per patient. Again, the expense of building, equipping, and maintaining new hospitals would have to be borne by somebody. Instead of using tax money to build superfluous new hospitals, why not use it to pay for the necessary hospitalization of the medically indigent?

Within the past several years, millions of American people have enrolled in voluntary hospital insurance plans to assure themselves of hospital care in time of need. Have those who drafted this proposed legislation considered the effect on their voluntary hospitalization plans that would inevitably follow were this proposed bill to become a law? The Wagner health bill makes no promises for safeguarding or encouraging voluntary associations that have long been operating to the benefit of millions of workers in the United States. These voluntary organizations and mutual associations represent a commendable effort on the part of their members to make pro-

visions for assistance to their own members for the use of funds, and in many instances maintenance of their own hospitals without the use of governmental funds.

Senator WAGNER. You feel, then, that there is no need for the development of any new hospitals, that if money is to be expended it should be expended in the way of making it possible for indigent people suffering from disease to be able to avail themselves of the opportunities that are now existing?

Dr. JOHNSON. Yes.

Senator TAFT. What is the situation in North Carolina? Is there an ample supply of hospitals?

Dr. JOHNSON. Yes; we are adequately supplied with hospitals for the most part.

Senator MURRAY. Of course, you recognize that in some sections of the country, that is not always true?

Dr. JOHNSON. It is true that in some of our counties there are no hospitals, but they are within reach of hard-surface roads.

Senator MURRAY. For instance, in my city of Butte, we have hundreds of tuberculosis or sylicosis patients that were unable to have access to the only single institution in the State that undertook to care for that, and they were dying on the street as the result of not having adequate hospitalization. That probably is true in a great many sections of the country.

Senator ELLENDER. Dr. Johnson, how many hospitals have you in the State of North Carolina that are entirely maintained by the State?

Dr. JOHNSON. That are entirely maintained by the State?

Senator ELLENDER. Yes.

Dr. JOHNSON. Two for tuberculosis, two for mental diseases—

Senator ELLENDER (interposing). I meant general hospitals.

Dr. JOHNSON. We have no general hospitals maintained by the State. We have a number maintained by the towns.

Senator ELLENDER. How many have you that are maintained out of public funds by counties?

Dr. JOHNSON. We have very few, if any, general hospitals maintained by public funds.

Senator ELLENDER. You stated on page 3 of your statement that instead of using money to build hospitals, that the money ought to be used to care for the indigents. Just how would you do that, Doctor?

Dr. JOHNSON. Certainly, I think so far as it can be done, it should be done by each community as the need arises.

Senator ELLENDER. Out of funds raised how?

Dr. JOHNSON. Out of funds raised in the local communities.

Senator ELLENDER. You would not want the Government in any wise to help?

Dr. JOHNSON. I think in exceptional instances, it might be that way.

Senator TAFT. Would it be part of the general relief program?

Dr. JOHNSON. Yes, sir; it would be part of the general relief program.

Senator TAFT. And in which the States of the Nation might participate according to the size of the State?

Dr. JOHNSON. Yes.

Senator ELLENDER. Would you want the presently existing hospitals, that is the private hospitals, paid by some governmental agency whether it be local or State or national, for the expenses of the inmates who come there for attention?

Dr. JOHNSON. Yes; I think that would be far preferable to building Federal hospitals and in competition with these private institutions.

Senator ELLENDER. Would you know what the cost per person would be, about, in North Carolina?

Dr. JOHNSON. Approximately \$4 per day; \$3.50 to \$4 a day.

Senator ELLENDER. What service does that include other than the hospital room?

Dr. JOHNSON. It includes the hospital room, the general nursing care, the board, and the simple medicines.

Senator ELLENDER. It would not include medical care?

Dr. JOHNSON. It would not include medical care; no, sir.

Senator WAGNER. Doctor, I was interested in your answer that the medical cases in the State ought to be treated just as relief was treated. Is that your idea?

Dr. JOHNSON. The indigent medical cases?

Senator WAGNER. Yes.

Dr. JOHNSON. Yes.

Senator WAGNER. Just as you provide relief?

Dr. JOHNSON. Yes.

Senator WAGNER. Do you mean by the State or the Federal Government, or how?

Dr. JOHNSON. By the State, if possible. In our State I think we are capable of taking care of our own.

Senator WAGNER. Not by the Federal Government?

Dr. JOHNSON. No.

Senator THOMAS. Do you think your State is able to take care of all of the relief in North Carolina?

Dr. JOHNSON. Our State pays about five times in Federal taxes what it gets back in relief funds.

Senator MURRAY. It pays it indirectly, though, doesn't it? It is collected from the people out in Montana where I live and people all over the country—

Dr. JOHNSON (interposing). Yes; that smoke cigarettes.

Senator ELLENDER. Out of my State, too. And also in New York, isn't that so, Senator Wagner?

Senator WAGNER. Yes. Then, you do need some Federal funds for relief, don't you?

Dr. JOHNSON. In some sections of the State.

Senator THOMAS. How else would you equalize your returns from Federal taxation if you did not get something from the Federal Government?

Dr. JOHNSON. Our people are human enough to take Federal money if they can get it, of course.

Senator THOMAS. Are you in favor of cutting out all Federal relief from the people of North Carolina, who you say pay more taxes than they get from those benefits?

Dr. JOHNSON. Not so long as we have to pay those taxes.

Senator THOMAS. Then why do you say that you are in favor of everything coming right from the local community?

Dr. JOHNSON. Because the local communities feel the need most and know best how to cope with it.

Senator TAFT. You mean that the primary responsibility is that of the local community, and if they have not got enough resources they can get the money from the State or the Federal Government if necessary?

Dr. JOHNSON. That is the idea.

Senator MURRAY. What happens in your State when you have a surgical case where an injured person needs an operation and there is no State or local provision for taking care of those cases?

Dr. JOHNSON. In most parts of the State there is.

Senator MURRAY. In most parts of the State?

Dr. JOHNSON. Yes. I don't know any parts of the State where a patient could not have a necessary operation whether he is able to pay for it or not.

Senator MURRAY. Is it not true that frequently people are taken to a hospital and won't be given admission unless the costs are guaranteed in advance, friends have to hustle around the city to secure promises or pledges to take care of the case before it will be accepted?

Dr. JOHNSON. That may be true in a few strictly private hospitals.

Senator MURRAY. You know of a great many instances of that kind, do you not? You have heard of a great many instances of that kind where an operation was going to cost \$250 and the people are absolutely poverty stricken and have no means, and they have to get somebody to come in and agree to pay that money if they are going to be taken care of?

Dr. JOHNSON. In 30 years of practice I have not known of one single instance like that to happen in my observation.

Senator ELLENDER. In what part of North Carolina do you live?

Dr. JOHNSON. Winston-Salem.

Senator ELLENDER. That is a tobacco center. You have no poverty there?

Dr. JOHNSON. While it is the wealthiest town of the State, the wealth is in the hands of a comparatively few. We have more poor people and more rich people than any other town in the State, but we take care of our poor people.

Senator ELLENDER. Do you have a municipally owned hospital there?

Dr. JOHNSON. Yes.

Senator ELLENDER. Oh, that is the reason. How much does the municipality spend per year to take care of that community?

Dr. JOHNSON. I think it will average between \$15,000 and \$20,000.

Senator ELLENDER. How many other cities or counties in your State are there that do have publicly owned hospitals of that kind where they can give service to these indigent people?

Dr. JOHNSON. There are quite a number; I could not answer off-hand.

Senator ELLENDER. I asked you a while ago, and the reason I am repeating the question is because you said there were none.

Dr. JOHNSON. You asked about the State owned, did you not?

Senator ELLENDER. I also asked you about the county owned.

Dr. JOHNSON. That is a city-owned hospital.

Senator ELLENDER. Well, let us take municipal hospitals.

Dr. JOHNSON. We have some county tuberculosis hospitals in the State.

Senator ELLENDER. What I had in mind—general hospitals where operations can be performed just the same as Senator Murray was speaking of, where the necessity is there but the funds are lacking. How many municipalities have public hospitals, and when I say "public" I mean maintained entirely by money from the public treasury?

Dr. JOHNSON. I could not tell you just how many; there are a number of cities in the State that do have them.

Senator ELLENDER. But the fact remains—

Dr. JOHNSON (interposing). There are a number of communities where the hospital is not owned by the city but where there is a working agreement between the city or the county whereby the hospital will take care of indigent patients.

Senator TAFT. Is it not true that as in most States, that where there are no publicly owned hospitals, there is an appropriation to take care of indigent patients in privately owned hospitals?

Dr. JOHNSON. Yes. For instance, in our hospital we take care of a great many patients from adjoining counties which have no hospitals.

Senator ELLENDER. Do you know about how much money the State of North Carolina appropriates for that purpose?

Dr. JOHNSON. No; I do not.

Senator MURRAY. That is all, Doctor; thank you.

Dr. CARY. Mr. Chairman, I would like to present Dr. Sensenich, of South Bend, Ind.

#### STATEMENT OF DR. R. L. SENSENICH, SOUTH BEND, IND., MEMBER OF THE BOARD OF TRUSTEES OF THE AMERICAN MEDICAL ASSOCIATION

Dr. SENSENICH. Mr. Chairman and gentlemen of the committee, I should like, if I may, to submit the material for the record which I have prepared here, and to save your time, may I briefly touch the high spots, and it will be a part of your record?

Senator MURRAY. Your statement as prepared will be copied in the record.

Dr. SENSENICH. The American Medical Association in its house of delegates in session in Chicago in September 1938 took action indicating its approval of the expansion of general hospital facilities where need exists. In fact, the American Medical Association has never opposed, and has always encouraged, the establishment of hospital facilities of acceptable standards wherever such facilities were needed.

Approval could likewise be given to the purpose of the Wagner health bill to the degree that its purpose would be directed to the provisions of "needed hospital facilities," as the term hospital is defined in common usage, in areas suffering from severe economic distress, and in rural areas needing hospitals which cannot otherwise be provided. However, examination reveals that in its provisions, old terms are to be defined with newly designed meanings. The indications of "need" are to be loosely interpreted, tried practices are to be infiltrated with new agencies and undefined working agreements, and Federal

control is to be obtained through gifts of money derived from taxes. Such methods and the suggestion of undisclosed objectives make approval impossible.

It must be pointed out that "hospital facilities," as used in the action of the house of delegates, applies to hospital buildings, equipment, nursing staff, and necessary personnel, to be available for the treatment of the sick of a given community by qualified physicians, who reside and practice in that community. The action of the delegates did not endorse Federal governmental domination of local communities through subsidies obtained from taxes, as to the establishment, policy, or management of hospitals for local patients in their respective communities. It should also be clear that the action of the delegates did not approve of burdensome taxing programs for support of new undefined types of institutions and it did not approve of centralized bureaucratic control of the medical care of the people by governmental agencies.

The house of delegates of the American Medical Association on May 17, 1939, took action opposing the Wagner health bill (S. 1620) and pointed out certain principles upon which it based its opposition. The report of that action is already in your hands. Following is a more detailed discussion of specific provisions of title XII of the bill, "Grants to States for hospitals and health centers."

No formula is proposed in this bill by which needs for increase in hospital facilities shall be determined. "Where need exists" must be recognized as a proper restriction, requiring consideration of scientific and practical factors as well as theoretic and economic indications. It is self-evident that the population of a community and average occurrence of types of illness requiring hospital care determine the need for beds. However, hospitals and special equipment for diagnosis and treatment are useless tools without trained physicians. On the other hand, a physician trained in a specialty in medicine would not long retain his skill or usefulness as a specialist in major surgery, diagnostic procedures, or other special treatment, if diseases requiring such care occur only infrequently in that community. Special hospital equipment does not alter that situation.

The permanence of the hospital project from the standpoint of probable future needs and sources of income of the population in relation to existing or proposed facilities is of the greatest importance. It is self-evident that the local community for which the hospital facility is planned and which must later support it should have a major voice in determining its own need and the manner in which it shall be met. The opinions of well-informed local citizens concerning needs and maintenance should be given consideration and general hearings should be held in which citizens may be heard before hospital construction is determined upon. This bill makes no provision for such safeguards.

Turning to the report of the technical committee on medical care to the interdepartmental committee to coordinate health and welfare activities as a probable source of material from which the estimates of needs for hospital facilities used in the preparation of this bill may have been obtained, we find the statement that 1,338 counties of the United States do not contain a registered general hospital. These counties are said to contain about 17,000,000 people. Although the

report admits that many of these counties are not populous, the implication carried is that this number of people are without needed hospital facilities. Without questioning the need of hospitals in some of these 1,338 counties a closer study of the distribution of hospitals reveals that the use of the boundaries of counties as a basis of determining availability of needed hospital facilities is misleading.<sup>1</sup> For example, in the State of Illinois there are 26 counties without hospitals, but there is no part of any one of these counties which is not within easy reach of hospitals in neighboring counties. Other studies indicate that there are relatively few population groups of sufficient numbers to justify the provision of hospital facilities who do not have such facilities of acceptable standards reasonably accessible. With good roads and modern transportation the very small hospital is subject to the same influences as have largely eliminated the little red schoolhouse and the small county tuberculosis camp. With the consolidation of these facilities into larger units has come greater elasticity in meeting varying demands, better equipped institutions, better trained personnel, and better standards of medical care. Transportation distances are frequently little greater than those necessary in the larger cities and the patient can be conveyed with less disturbance than in city traffic.

For the above reasons it must be recognized that boundaries of governmental units cannot be used as a measure of hospital needs. Local conditions and distances must be studied in each instance. Likewise, the population of a community alone is not a dependable guide to needed general hospital beds and consideration must be given to varying conditions of housing and group social tendencies which are local in character.

The use of the 5.2 beds per 1,000 of population in the large city counties or 4.7 per 1,000 of population is estimated in the metropolitan and adjacent areas in 25 percent of the States, as a formula for hospital needs to be applied to the rural areas is not warranted. Not every minor illness can be hospitalized, and the average rural resident, well housed, still prefers to be treated for his less serious illness in his home; whereas, in large cities people who live in small apartments, with other members of the family employed away from home, more frequently go to the hospital for even the slightest disability. Studies by the council on medical education and hospitals of the American Medical Association show incontrovertibly that many of those areas now having the smallest number of beds in proportion to the population have the largest percentage of empty beds.

The average duration of stay in hospital per patient has declined steadily for some time. As a result existing hospitals may now care for a greater number of patients per year without increase in the number of beds. Since 1931 the average duration of a patient's stay in a general hospital has been reduced from 14.3 to 12.5 days. This represents a reduction of 12.5 percent or one-eighth in the time spent in the hospital. Such a decrease in the average stay obviously permits a larger number of patients to be cared for with the same physical facilities. If there had been no reduction in the length of stay of the average patient in general hospitals, in 1938, 60,000

<sup>1</sup> See Growth and Distribution of Hospital Facilities attached.

empty beds would have been filled. One cannot predict what further reductions may be made in the average duration of the patient's stay in the hospital, but progress in medical science continuously tends to shorten periods of hospitalization. Recent advances in the treatment of pneumonia and certain other infectious diseases should be reflected in a still further reduction in the average hospital stay.

The bill authorized the appropriation in 3 successive years of eight, fifty, and one hundred million dollars, respectively, for the purpose of constructing and improving general hospitals. Under sections 1202, 1203, 1204 financial participation by the States is required. The extent of this participation will probably vary from State to State, but assuming that on the whole the contributions of the Federal Government will be on a 50-50 basis,<sup>2</sup> there will be available for the construction and improvement of Government-owned general hospitals, in the fiscal year ending June 30, 1940, \$16,000,000; in 1941, \$100,000,000; and in 1942, \$200,000,000. Taking \$4,000<sup>3</sup> as the average cost per bed of general hospitals, it would seem that this bill makes provision for the addition of 4,000 general hospital beds in 1940; 25,000 general hospital beds in 1941; and 50,000 general hospital beds in 1942. The 79,000 beds which may be added under the provisions of this bill relate only to Government-owned hospitals and do not include such enterprises, public or private, as may be undertaken without the stimulus of a Federal subsidy. A recent study indicates that there are now 349 hospitals under construction or projected, without Federal subsidy. (See attached chart.)

From the chart it will be seen that over the 11-year period, 1928 to 1938, inclusive, the average rate of increase in the number of beds in general hospitals was 1.9 percent. The increases proposed in the Wagner bill amount to a total of 79,000 beds, 16.2 percent in 3 years, or an average rate of increase of 5.4 percent.

In 1938, the general hospitals of the country were filled to 68.9 percent of their capacity; 31.1 percent of the beds were unused.

If the addition of hospital beds alone is proposed, the wisdom of a threefold multiplication of the normal rate of hospital facilities should be seriously questioned.

Tuberculosis hospitals differ from general hospitals in that as tuberculosis is a transmissible disease, isolation and training of the patient for the safety of others is of importance. The course of the disease is chronic and periods of hospitalization are longer. However, progress in surgical treatment of tuberculosis has very greatly reduced the average period of needed hospital care. Institutions receiving only early cases have been able to reduce their average stay per patient from a year or more to a few months. Institutions for the treatment of tuberculosis are as a consequence, able to care for more patients per year in proportion to the total number of beds than ever before. The shorter periods of hospitalization depend to a great extent upon early recognition of the existence of tuberculosis, and, therefore, early treatment. This is accomplished by education of the public and not primarily by the existence of hospitals. Tuberculosis

<sup>2</sup> National Health Conference, July 18, 19, 20, 1938, p. 30, line 21.

<sup>3</sup> Ibid., line 6. The interdepartmental committee uses \$3,500 as the average cost per general hospital bed.

culosis hospitals are needed in some areas but hospitals without coordinated educational efforts are ineffective.

Small county institutions cannot readily provide facilities or medical men skilled in modern surgical treatment of tuberculosis. Later tendencies have been to the erection of larger institutions functioning as district hospitals although owned by large populous counties, or by the States. Modern roads and transportation have removed all justification for the small local boarding-house type of tuberculosis hospital. The ratio of beds needed depends upon local conditions and the educational possibilities of the community. The rapid reduction in the number of cases of tuberculosis has made any need of great hospital expansion in the major number of the States improbable. The per diem cost of maintenance is influenced by local conditions.

Hospitalization of mental patients presents requirements differing from those of the general hospital because of the factor of necessary custodial care of patients, the predominance of cases running a chronic course, and the high percentage of incurables. Admissions have increased but progress has been made in reducing the average period of hospitalization. Recent advances in treatment of some types of mental diseases may be reflected in still shorter periods of confinement to institutions.

Experimental studies are being made in caring for certain early cases of selected types of mental disorder, presumably curable, in general hospitals to avoid confinement to hospitals designated for the insane. Nothing should be done by governmental agencies to discourage these efforts.

A special survey by the American Medical Association reported in 1936 the overcrowded condition of existing institutions and stressed the need for expansion of facilities. However, there has been much building since then, and reports indicate nearly 6,000 more empty beds in mental hospitals in 1938 than in 1937. The per diem cost depends upon local conditions and kind of cases treated.

Section 1202 of title XII of the bill provides that the allotment of funds 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. Consideration of (1) the needed additional hospitals, and (2) the financial resources is required. Time will be required for investigation after such regulations have been prescribed, in the event this bill should pass.

Studies made by the American Medical Association indicate that the need for additional hospital facilities has been greatly overestimated, the lack of medical care overcolored, and the proposed expenditures extravagant. There is also much reason to doubt that reasonably proved needs could be found and any substantial portion of the proposed appropriations be wisely expended in the time proposed in this bill. A rapid, widespread construction program without sufficient study would be inexcusable. Too great dislocation of normal production of special and technical hospital equipment should be avoided. A shortage of trained hospital personnel must be considered. The effect of introduction of central Federal control of policies of purely local hospital facilities through control of sub-

sidies might readily outweigh any benefits to be derived from contributions of Federal funds.

It is not clear whether the Government under this bill proposes to assume responsibility for an indefinite period for aid in the care of all tuberculous patients and those suffering from mental disease. However, if need for Federal assistance in certain communities be established, the per diem payments should be made upon certification by properly constituted authority as to the number of patients treated who were eligible for treatment. Such reports would then be subject to examination and audit by the Federal Government. Major governmental machinery or Federal domination of local administration is not justified.

Hospitals for treatment of the tuberculous have a record of outstanding achievement in assisting in the reduction of sickness and death from tuberculosis. They have associations which provide opportunity for interchange of information developed in scientific research and experience in management and operation of these special hospitals. It is improbable that they would feel the need of Federal governmental interference in already well-functioning institutions. This interference would be especially objectionable in that the Federal agency would secure domination by acquiring control of funds now available to the institution from taxes. States financially sound and with adequate facilities would be forced to accept subsidies and Federal domination in order to secure return of any part of the pooled Federal funds to which they would be forced to contribute heavily in taxes.

Senator ELLENDER. You do not find any language in this bill that would give the Federal Government the right that you have just mentioned, do you, Doctor?

Dr. SENSENICH. It is not a right, sir; I did not say it was a right. It is what the State would have to do to get any return on its taxes. There would be stimulation to the State from the standpoint of saying that you may have a subsidy if you match it with taxes.

Will you pardon me until I finish, and then ask me that? I do not mean to be discourteous, but I am sure that you understand, and I think that what follows will answer that.

Senator ELLENDER. That is all right; I understand perfectly.

Dr. SENSENICH. Control of management and personnel and domination of policies of existing institutions in this manner would be secured by capitalizing upon the need of the few.

The required submission of plans by each local community which might seek to avail itself of the vague provisions of this bill leave much to the executive action of those who administer it. Therefore, the best interests of the public require proper qualifications by training and experience of those who would administer or advise in the provisions of this bill, having to do with the facilities for medical care.

It is not required in the bill that any executive concerned in the administration of the proposed act shall have had experience in these matters involved in the actual delivery of medical service. The Surgeon General of the Public Health Service, who is named as administrator, is primarily concerned along lines of general health service, not directed to treatment of the individual. Although that official might be specially trained, and an outstanding administrator of the

Public Health Service, he may have had little contact with hospitals and no experience in the practice of curative medicine. Interest and experience along the lines contemplated in this bill might vary greatly between different incumbents of that office.

The Surgeon General of the Public Health Service is authorized in the bill to establish an advisory council or councils. No statement is made as to the manner of selection of the members of this group. The bill likewise fails to invest this body with any authority or indicate that its recommendations need be considered by the Surgeon General in the administration of the act. Depending upon the qualifications of its members, such a group might be helpful to the Surgeon General by the contribution of information based upon experience, or it might be organized and used for the purpose of overcoming resistance to plans believed by the medical profession to be detrimental to standards of work and the best interests of the public.

State plans upon which allotments are to be made by the Surgeon General of the Public Health Service are required to provide for "State agencies" of vague description but with authority to make and publish rules and regulations, which have the effect of law. They are to be advised by advisory councils of uncertain qualifications and influence. Through working agreements with agencies concerned with welfare, assistance, social insurance, workmen's compensation, labor, industrial hygiene, education, or medical care, governmental control may extend into the most intimate personal matters of labor, welfare, and medical care of each individual.

It would seem unlikely that a Surgeon General of the Public Health Service would wish to have the responsibility for the administration of such an indefinite and all-inclusive act; at any rate, the enactment of such a law would be contrary to public policy.

The Federal Government should have no part in the program of any needed expansion of hospital facilities other than that any allotment of funds should be honestly expended in the erection of the hospital facilities according to local and State plans previously agreed upon. Federal payments in maintenance where needed should be made upon certification by a legally constituted authority that service has been provided for certain individuals eligible for such treatment. The Government should have the right to make necessary examinations and audits to determine the correctness of those accounts. However, the Federal Government should have no authority to dominate the policies or personnel of the hospitals or to make working agreements binding the community directly or indirectly in the operation of its hospitals. No extensive plan is needed.

From the definition of the term "hospital," as used in the title, "includes health, diagnostic, and treatment centers, institutions, and related facilities," it is evident that more is contemplated under the proposed legislation than is ordinarily included under the term of "hospitals." Otherwise, there would be no reason for introducing this vague and all-inclusive definition. It is noted that the technical committee, in its report, proposed the construction of 500 health and diagnostic clinics in areas in which the individual does not have convenient access to hospitals.

A plan for the establishment of clinics for the diagnosis and treatment of ambulant patients in areas already supplied with physicians should be weighed carefully from the standpoint of the ultimate best

medical service to the community as a whole. If the clinic contemplated would encourage the patient to present himself directly to the clinic for examination and treatment it would not offer anything superior to dispensary service. The latter type of service lacks needed medical history of other illnesses and treatment, and opportunity for observation. This tends to detachment of interest, and the responsibility of the medical-staff member to the patient is soon replaced by responsibility only to the system which employs him. There is reason to believe that the service would not be superior to that offered by physicians in the community.

Such a clinic is an outgrowth of the viewpoint, entertained by some, that medicine can be "depersonalized"—that the physical man can be treated without intimate knowledge as to his emotional stresses and the effects of his contact with his environment.

The establishment of clinics for treatment of ambulant patients only, assumes further that the individual may have one physician for illnesses in which he is ambulant and another when he is confined, without loss of values which are of importance in the best medical service. Obviously there are faulty assumptions.

It must be recognized that the private physician will still be necessary to attend patients who are not able to go to the clinic. The well-trained private physician, with a closer and more personalized service to the individual and his family in their home, will give good medical service to more people. He should be given every opportunity and assistance to increase his usefulness, and governmental machinery should not be permitted to impair it. The operation of large diagnostic and treatment clinics recently established in very populous centers of impoverished people cannot be fully evaluated upon so brief experience. Obviously, it cannot be translated into terms of small rural areas.

If the establishment of new types of institutions is contemplated, this should be omitted from the proposed effort to improve hospitalization facilities. Such plans should be left for consideration after time for a longer observation of existing units and for study of needs, if any remain, after needed expansion of hospital facilities has been accomplished.

The Government may enter directly into the medical care of the individual under the provision for "working agreements" between the State health agency and "any public agency" administering related services—

including welfare, assistance, social insurance, workmen's compensation, labor, industrial hygiene, education, or medical care—

as provided in paragraph 9 of section 1203. Studies and demonstrations of undefined character are provided for under section 1208 of this title. It is clear that this bill, which permits control of the medical care of the individual by undefined governmental agencies given authority to impose regulations and enforce compliance by control of tax funds, is not in the best interests of the public and should not be enacted.

The bill specifies that funds will be allotted only to provide hospital facilities to be owned by the State or its political subdivisions. This provision might destroy many existing church hospitals, com-

munity general hospitals, and other hospitals, which have given us the best hospital service in the world.

Emphasis was placed by the house of delegates in the meeting of September 1938, upon the following:

The hospital situation would indicate that there is at present greater need for the use of existing hospital facilities than for additional hospitals.

It was further suggested that—

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.

Existing hospitals, in some instances as old as the Nation, have not only provided facilities of the highest standard, but in many instances have carried on excessive load of indigent patients. This because governmental agencies have not accepted proper responsibility and have not assumed the financial support of those individuals for whom there was no other provision.

Many of these hospitals, if paid adequately for indigent care by relief authorities, could have given greater service to the community, with possible increased occupancy of now vacant beds.

No provision is made in the bill under consideration whereby any nongovernmental, charitable hospital could be given aid in making improvements or extensions of present hospital facilities.

It must be recognized that hospitals, like other institutions, can operate at a maximum effectiveness and minimum per diem costs at a certain optimum bed capacity. Many smaller hospitals could be stabilized and improved in point of service if they were assisted financially in caring for indigents. They might then apply their resources to enlargement to an optimum size, provided prospective occupancy warrants.

Duplication of existing institutions by new Government hospitals, each with its investment for heating plants and other utilities when one installation would suffice; duplication of buildings for housing personnel; for administrative offices and public space; duplication of costs throughout, when only a limited expansion of bed capacity may be required to meet community needs—is not sound economic practice. Yet, that is the situation that this bill may create.

It has not been proved that Government-owned hospitals have had better management or provided better service than other hospitals. In fact, there is much reason to believe that in the main, church-owned hospitals and community hospitals have provided better management, higher standards, and more satisfactory service than Government-owned hospitals.

Community hospitals belong to the public in point of service and in actual ownership as do Government-owned hospitals, but have the advantage of altruistic interest and direction by the best citizenship, continuity of policy, and freedom from political interference. Church-owned hospitals belong to the people in point of service if not in actual ownership. They are created and maintained on the basis of gifts from public-spirited citizens and thousands of small contributors and are the expression of the interest and support of the public. Community hospitals and church hospitals constitute the major portion of the total number of hospitals of the United States

and represent an investment of billions of dollars made before the Government became interested to any great extent in the hospital care of the sick. They should not be sacrificed to permit the disservice to the public proposed in this bill.

However, church-owned or community hospitals with long histories of medical work of high standard and recognized public service would not accept the Federal domination evidence in the provisions of the Wagner health bill. Present high standards of hospital administration and scientific care have been attained by mutual cooperation with the organized medical profession and acceptance of high ideals and not by Government assistance, regulation, or example. Acceptance of the provisions of this bill would make present high standards and grading subservient to Government regulation. A record of high-grade performance in the past is more dependable assurance of high-grade service in the future under the continued mutual efforts of religious organizations and interested unselfish local residents and the medical profession, than any pattern which the Government will provide. The lively, unselfish interest of local citizens is assurance of a better merit system than policies and management imposed by a distant Federal administration or by partisan politics.

Despite the history of outstanding public service of community and church-owned hospitals, it is indisputable that the administration of this proposed act might make it impossible for these hospitals to finance improvements or expansion because an allotment from public funds may be offered to the local community only on condition that a new Government institution be built. Government contribution toward maintenance would make such new institutions destructive competitors against older hospitals of high standards, such as have helped to make the hospital pattern of the United States the envy of the rest of the world.

It would seem to be a strange concept of the function of government to stimulate States to submit plans detrimental to community institutions of the highest standards and of the most unselfish service in order that the State might receive a partial return of heavy and burdensome Federal taxes which had been accumulated in a Federal pool. Under this bill, each State would be encouraged to prepare plans and levy additional local taxes in order that it might participate in the pool and prevent distribution to other States of funds which it is annually forced to contribute in Federal taxes. Acceptance of Federal domination accompanies acceptance of Federal subsidies. For this reason, as well as others previously stated, the Wagner health bill, S. 1620, is not in the best interests of the public and is opposed.

Senator ELLENDER. Doctor, with reference to the question that I propounded to you awhile ago, you fear that because the Federal Government will let certain communities have money under this bill, that eventually the Government might dominate them. That is the language you used?

Dr. SENSENICH. Senator, may I read to you from the bill?

Senator ELLENDER. That is what I wanted you to point out to the committee. I would like you to point out any language in this bill to show that the Federal Government would be in charge of the health service, let us say the hospital services, in the States?

Dr. SENSENICH. May I refer to section 1203-A, on page 27, beginning with—

A State plan to effectuate the purposes of this title, submitted in respect to either clause (1) or clause (2) of section 1201, 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 agency of any part of the plan administered by another State agency or by a political subdivision of the State.

And then, without taking the time to read it all aloud, on the opposite page provides such methods of administrations 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 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.

Now, this is outside of hospitals. This is the State agency. No one locally there is consulted.

Then, further on the same page it is provided:

(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 arrangements for payment for service.

Senator ELLENDER. All of that refers to what a State must do in order to obtain the funds?

Dr. SENSENICH. That is right.

Senator ELLENDER. But what I had in mind was, after the funds are given, and after the hospitals are built, show us some language there that would lead you to believe that these hospitals will be managed by the Federal Government and the States shall lose control?

Dr. SENSENICH. The Federal Government then maintains the facilities on a partial basis for 3 years; all of it the first year, two-thirds the second year, and one-third the third year. Each time these budgets have to be approved—if you will turn to the latter part of the bill you will find under, section 1205, on page 82:

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 their failure to comply substantially with any requirement of subsection 1203, 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.

Senator ELLENDER. That is correct. In other words, the bill lays down what ought to be done.

Dr. SENSENICH. What must be done.

Senator ELLENDER. What must be done, if you want to put it that way. The same principle applies to our road building; the Government furnishes a couple of hundred million dollars to the States each year; all they do is to suggest plans and specifications.

Dr. SENSENICH. That is right.

Senator ELLENDER. As to how the roads shall be built.

Dr. SENSENICH. That is right.

Senator ELLENDER. And that is all. And what the Government is interested in is that the money is spent according to the terms written in the plans and specifications.

Dr. SENSENICH. Why don't you do the same thing to the hospitals then—if they are built according to the plans and specifications, then you discontinue?

Senator ELLENDER. That is what this bill intends to do.

Dr. SENSENICH. I don't think it does.

Senator ELLENDER. I refer you to page 7 of your statement, in which you criticize the bill in this wise—you say:

The Surgeon General of the Public Health Service is authorized in the bill to establish an advisory council or councils.

No mention is made as to the manner of selection of the members of this group. The bill likewise says to—

invest this body with any authority or indicate that its recommendations need be considered by the Surgeon General in the administration of the Act.

Now, if we were to adopt your method, we might have Government control, and that is why the author of this bill has refrained from giving such authority as you propose to give.

Dr. SENSENICH. I am sorry that I did not make it clear, because I am opposed to this for the simple reason that I do not think that set-up is responsible as it is, I do not think that the Government should take part in it except to see that its money is well expended. It should not be interested in the operation.

Senator ELLENDER. That is exactly what I am sure most of the members of this committee are interested in. Under no conditions would I vote for this bill if I thought the Federal Government could go down into Louisiana, Mississippi, or New York and take charge of the hospitals of that State because, forsooth, they gave a few dollars toward their upkeep—

Dr. SENSENICH (interposing). But that is in the bill, Senator.

Senator ELLENDER. If it is, I want to strike it out, and I would like to have the American Medical Association take this bill and point out every part of it that will give such authority to the Federal Government. If it is in, we want to strike it out and amend it so as to make it doubly sure that under no conditions will the Federal Government take possession or even have anything to do with the hospital, except to see that certain plans and specifications are carried out, which were necessary in order to obtain the funds.

Dr. SENSENICH. Senator, two of the hospital associations—and I am saying this as it was given me, not in confidence but in discussion—have already reviewed the bill independently and they finally abandoned amending it, as I understand, for the reason that they each compiled a list of about 50 amendments.

Senator WAGNER. What is the name of the association?

Dr. SENSENICH. This was a matter of personal discussion.

Senator WAGNER. I understood the hospital associations were going to appear here and favor this legislation. I do not think you should say that to the committee unless you are ready to give the names.

Senator TAFT. I understand they have various amendments; that is all the doctor says.

Dr. SENSENICH. That is all they say. That was in answer to your question in an effort to know whether the bill could be amended.

Senator ELLENDER. Certainly, it is open to amendment, and that is what I suggested, as a member of this committee, to Dr. Booth when he appeared here several weeks ago. I invited him to suggest amendments and work out a plan. We want it made certain that the Federal Government will not be able to dip down into our State and take charge because, forsooth, it is putting up a little ante, as it were, to help us along. Now, let me ask you this: The Federal Government has been spending quite a lot of money through the Public Health Service?

Dr. SENSENICH. Yes.

Senator ELLENDER. Have they taken charge in the States?

Dr. SENSENICH. That has to do with education. The Public Health Service has not done any treatment.

Senator ELLENDER. But still they spend a lot of money in cooperation with all public-health servants in the States. For instance, they furnish some to Louisiana, to your State, and to other States in order to carry on this education work which you say is being carried on.

Dr. SENSENICH. I am somewhat familiar with that to the extent that I know in many instances work is composed largely of educational presentation and work which does not directly involve the individual. He may take educational work or leave it, but when you take control of the treatment, that is quite a serious matter, as I believe you will agree.

Senator ELLENDER. Do you know of any instances where the State health officer is under Federal control?

Dr. SENSENICH. I would not say that was a fair designation. I am not familiar with that because it comes down through the State health officer. Whether he is controlled or not, I do not know.

Senator TAFT. What occurs to me is that the Surgeon General has to approve the methods relating to the establishment and maintenance of personnel standards; he has to approve methods of establishing and maintaining standards for institutional management. It seems to me that those powers are so broad that they would have to be set out in rather general language, and then when he came to see whether the hospital was actually complying, he would almost have power to tell the hospital what to do in every feature of management.

Dr. SENSENICH. That is true.

Senator TAFT. It seems to me that your criticism of the language on page 28 as being too broad certainly is justified, but it could be made very very much more definite and less broad, I should think, without changing the fundamentals of the bill.

Senator ELLENDER. Those were the suggestions, Senator Taft, that I was asking for, and if there is any doubt about it, if any language can be placed into this bill to make it certain that the Federal Government will not take control of the local situation, I want it written in the bill.

Senator WAGNER. Doctor, I agree with what has been said here that nothing ought to be in this bill, and I am sure that nothing is in this bill, that in any way controls the administration of these hospitals. Let me ask you, in the first place, if the Federal Government grants money for specific purposes don't you think it ought to have

some sort of standards to make sure that the money is not diverted for some other purpose, but that it is to be used for the purposes for which it was granted?

Dr. SENSENICH. That was the point that I made, Senator Wagner, that, after all, the Government should be interested in knowing that the money that it gave was expended in the manner agreed upon and for which it was received.

Senator WAGNER. Yes.

Dr. SENSENICH. But the maintenance and the installation are two quite different things.

Senator WAGNER. Let us develop that for a moment. You do agree that there ought to be some sort of standards set by the Federal Government to see that the money is expended for the purposes for which it is given?

Dr. SENSENICH. In construction, Senator Wagner, but I would stop at that; I would trust the maintenance of the hospital to the Sisters of the Holy Cross or any one of a thousand local citizens as well as to some distant governmental director.

Senator WAGNER. Are you a believer in the civil-service system?

Dr. SENSENICH. Senator?

Senator WAGNER. You are a believer in the civil-service system, I am sure.

Dr. SENSENICH. Again I will have to define that.

Senator WAGNER. I am not talking about the appointment of a doctor, but generally speaking.

Dr. SENSENICH. You mean examination for fitness for a place?

Senator WAGNER. Yes.

Senator ELLENDER. The merit system.

Senator WAGNER. Don't you believe that if the Federal Government believes there ought to be a merit system that they should at least say that if States are going to administer our money, that those in the State should at least be appointed according to merit and not politics?

Dr. SENSENICH. Certainly according to merit, but may I finish my answer?

Senator WAGNER. Yes.

Dr. SENSENICH. But after all, I should rather depend upon the local community in establishing and in effecting a better merit system than a Federal administrator.

Senator MURRAY. Should not the local community be bound by some standards? Could we not set up standards that apply to the whole country which might be followed throughout the country?

Dr. SENSENICH. I do not believe that that would be possible, for any human agency in one central portion of the United States to lay down a pattern that would be applicable to all of the districts in the United States.

Senator MURRAY. Is that not what the hospital associations do, seek to improve the service of the hospitals and to aid them in establishing high standards of operation?

Dr. SENSENICH. Mutually, yes; but that does not mean that they say that this is a fixed pattern for every part of the country. One community has vastly different social ideas, has vastly different things that do enter into it.

Senator WAGNER. This is not socializing; it is a question of having fit persons to administer the funds. This is not new at all. And may I say to you, Doctor, that I certainly would never vote for a bill which did not provide some sort of standard that the money was not going to be squandered and that a lot of political appointees were going to administer these funds; and so we have provided in every case where we have given grants to States some standards of this kind. I recall that early in my career in the Senate, we passed an act which was known as the employment exchange bill. Every State now takes advantage of that. It is a coordinated system between the State and the Federal Government in which the State operates exclusively its employment exchanges and the Federal Government matches up to a certain sum depending upon the generosity of Congress, the funds of the State for the administration of that State; and, in return for that, certain services are rendered to the Federal Government. In that law is a provision that the appointments are to be made according to the civil-service standards, because what we wanted to be sure of was that in these localities, some political fellows who had no test of competency are not placed in charge and the money wasted. It is perfectly proper, and Congress would not have passed that bill without those standards. They were developed in the committee hearings. You take the United States Housing Administration that only provides for loans. That was originated in this committee itself. We wanted to be sure that there would be no labor exploitation, and in that bill there were standards set up—and that was only a loan. The law says, "You cannot get this loan if you do not pay the prevailing rate of wage." Under your theory you would say that is an interference with local administration, but we are simply setting standards that the Federal money is not to be used for the exploitation of people. You will find in every statute where there is this grant-in-aid, there are certain standards. Beyond that, I challenge you to find a single case where the Federal Government interferes with the administration by the State. That is all that we want to do here, and, beyond that, there certainly is no intent here to give any control in the administration of the hospitals to the Federal Government. If there is, I agree with the members of the committee who have expressed themselves on that subject.

Senator ELLENDER. Senator Wagner, in connection with that statement, I suppose you will welcome amendments to clarify the language if clarification be needed in that regard?

Senator WAGNER. Absolutely. I have been saying right along, and I am surprised that there has not been more constructive criticism, because at the last hearing Dr. Booth said to Senator Ellender that undoubtedly the Medical Association would be glad to cooperate and undoubtedly would have some amendments to propose. And now we hear criticism but not suggestions. I, like any other member of the committee, would like to have suggestions of those who ought to guide us in this thing, and that is the medical profession.

Dr. SENSENICH. I am sure that we have the same thing in mind when we are talking about fitness and proper operation, but you are dealing with a little different situation when you are dealing with a medical matter than you are with most others. If you were to apply

the same civil-service examination for positions as managers of these hospitals, or if the bill went further into the development of diagnostic clinics—I know in a general way what that pattern is—I don't know what the institutions are that are spoken of which might fall within the definitions of this bill, but it is perfectly possible for the man who writes the best examination paper in the world to be the poorest doctor, one whom you or I or anyone else wouldn't want to trust with his life.

Senator WAGNER. This does not mean that the Federal authorities make up the examination lists.

Dr. SENSENICH. I understand, but it is the method I am talking about.

Senator WAGNER. A moment ago one of the other witnesses complained, because it was not a man familiar with the medical profession that was doing this prescribing. Now, we have the Surgeon General of the Public Health Service—Dr. Parran. I don't know anybody more competent. Do you?

Dr. SENSENICH. I know Dr. Parran very well, and I have the greatest respect for him—

Senator WAGNER (interposing). Do you trust him on that?

Dr. SENSENICH. May I finish?

Senator WAGNER. Yes.

Dr. SENSENICH. I don't know anyone I have more respect for as a public officer—and I am discussing Dr. Parran in connection with this bill—but experience with hospitals or the care of the sick is not necessarily considered in the assignment of the Surgeon General. Furthermore, you are speaking of a bill which is going to operate for some time.

Senator WAGNER. Have you a suggestion which will make it more practical?

Dr. SENSENICH. I have no experience in drafting bills.

Senator WAGNER. What is your idea?

Dr. SENSENICH. I would say that the American Medical Association made its suggestions which it presented this morning in the action taken by the house of delegates at the St. Louis meeting that this elaborate machinery not be set up, that there is no need for it, that it be established on a need basis.

Senator WAGNER. How?

Dr. SENSENICH. Have some existing agency or create an agency or board of some kind or character to pass on the need and see that your money is well spent on the supplying of facilities where they are needed, and then let the local community take care of it, because it will do a better job than you or I at some distance from it.

Senator ELLENDER. What are you going to do, Doctor, where the local community has not got the money?

Dr. SENSENICH. I said if the need exists, to build it, but to be satisfied to step out, and if the local community cannot maintain it and the State cannot maintain it, I don't know any other way that you can do it except with Federal funds. We are in sympathy with the objectives; we have not opposed that at all, but we do object to the method because we think that it is not right.

Senator ELLENDER. Would it improve the bill if we should write into it, let us say, that on this Professional Advisory Committee, that

the medical profession of the various States shall have the right or have some say-so about the appointment of this board?

Dr. SENSENICH. There are still these broad constructions in the bill which—it would not be safe.

Senator ELLENDER. I am talking about that particularly. I am talking about that particular phase of it. Let us see if we cannot get on some common ground as to that phase of the bill.

Dr. SENSENICH. I am sorry, but what particular phase do you mean?

Senator ELLENDER. In preparing plans and specifications and things like that that you mentioned in this discussion.

Dr. SENSENICH. The need is the serious matter.

Senator ELLENDER. The what?

Dr. SENSENICH. The determination of the need is the serious matter.

Senator ELLENDER. Who is going to determine that? Who should have that authority, in the bill? Whom should you suggest as authority on that, let us say, in the State of Mississippi?

Dr. SENSENICH. The suggestion was that if you have no existing agency here, that you create an agency which would pass upon the need, and that appropriation be made the same as it be made in any other State in the event of need?

Senator ELLENDER. If you do not want to deal with Mississippi, let us deal with your State. What kind of agency would you suggest in your State that should do the work?

Dr. SENSENICH. In the first place, there would be no need for an agency in my State unless it had need for assistance. That is the point.

Senator ELLENDER. Let us assume that you have in a rich State that gets a lot of its funds from poor Louisiana, poor Mississippi, and poor Montana, and you are getting oil and sulphur and salt and everything that we have got down there. Under such a set-up you may have enough funds. Let us just forget that you are from Indiana—that is your State?

Dr. SENSENICH. Yes; Indiana.

Senator ELLENDER. And that you are living in Louisiana, a rich State, wherein we have a lot of oil and we have a lot of salt, we have a lot of natural resources, but unfortunately the profits that are derived from those natural resources are not available to the people of the State. They were too poor years ago to develop them. Capitalists from the northeast came down there and took possession. They are getting millions of dollars from our State today, they are getting millions of dollars from the State of Texas, and because of that, those States are now unable to provide adequately for the indigent. Now, assume you are living down there and you are a doctor; what board would you suggest or what kind of a board would you suggest would be competent to pass upon the needs of a community of that kind?

Dr. SENSENICH. I should be in favor of permitting the State to set up a board to represent it, but—

Senator ELLENDER (interposing). This bill provides that.

Dr. SENSENICH. All right, but it gives the board, that committee, that State agency, much too much power because it sets up vast machinery.

Senator ELLENDER. How would you limit it?

Dr. SENSENICH. The only purpose of that board would be the determination of the need, the same as the central board determines need, and if this community needs the hospital, and I understand that that was the suggestion made, and it is determined jointly by the Federal Government and the local State agency that the need exists here, and the Government says "It will take \$100,000; we will give that \$100,000, the Government will advance that money if it is not locally available"—we are saying now it is the need—"and that building is constructed"—now, then, for that purpose the Government has no real reason to enter into this indefinite control any more than when it aids another State in the case of a hurricane, it doesn't go down and say, "Plant so many trees," or "Do this" or "Do that in connection with rehabilitation." We will assume that in the average community they will do quite a good job of managing their own institution if you help them to obtain it. I am trying to make myself clear without telling you what kind of legislation because, after all, that is out of my province.

Senator ELLENDER. From what you have just said, we are not far apart.

Dr. SENSENICH. I think that is right.

Senator ELLENDER. We are not far apart because, as I interpret the bill, aid is to be given to those communities that are actually in need, and that is determined how? By equalizing things. The needs may be such that some State may get but one-third of whatever it may ask for, whereas others may get two-thirds from the Government—don't you see?

Dr. SENSENICH. Yes.

Senator ELLENDER. What will determine the proportion that will be the need of the community?

Dr. SENSENICH. But do not set up big machinery which induces New York and Indiana and some other States to ask—

Senator ELLENDER (interposing). You could not draft an act that would eliminate any community.

Dr. SENSENICH. It is not necessary.

Senator ELLENDER. We have to write a formula.

Dr. SENSENICH. That is right.

Senator ELLENDER. And if the States come within it or if they show that they come within that formula or within the yardstick written into this bill, of course they get a share of the money, but otherwise they do not.

Dr. SENSENICH. Then let us eliminate all of the massive machinery—

Senator ELLENDER (interposing). Which massive machinery?

Dr. SENSENICH. I mean that set-up here of institutions and hospitals and diagnostic and treatment clinics and a lot of things that I don't know what they mean, nor does anybody else, and say to any State—you can go to New York and say, "You need diagnostic clinics or you need something else." It does not necessarily have to be the need of the little rural hospital that you and I are talking about at the moment, but it can be something else, some new step or some new suggestion or some new ideology as to how the thing should be taken care of.

Senator WAGNER. The Federal Government does not go to the State and say, "You need that." The State comes to Washington.

Dr. SENSENICH. They have a way of suggesting it—not the Government itself but the officials.

Senator WAGNER. There is a need test right in the bill.

Dr. SENSENICH. Yes, but turn to the definition of hospitals, Senator Wagner.

Senator WAGNER. To get the Federal money, you have to show the need.

Dr. SENSENICH. Yes, but look at "hospitals." You and I are thinking about the ordinary hospitals.

Senator ELLENDER. What page is that?

Dr. SENSENICH. Page 34; the definition of hospitals according to the bill is as follows: "The term 'hospital,' when used in this title, includes health, diagnostic, and treatment centers, institutions, and related facilities." I don't know what they are, but I suspect.

Senator ELLENDER. How would you define that?

Dr. SENSENICH. I think that the term "hospital" is quite clearly understood throughout a great many, perhaps thousands, of years, and I think that is sufficient. Let us call it a hospital, as it is, and not define it in some new terms.

Senator MURRAY. What is a hospital?

Dr. SENSENICH. A diagnostic clinic is a place in which a patient does not reside during examination. An institution may cover anything—I don't know what.

Senator MURRAY. You would relate it strictly to an institution then where people are taken for treatment during a period of their illness?

Dr. SENSENICH. In the generally accepted manner in which the term "hospital" is applied.

Senator ELLENDER. Would you furnish us the definition of a hospital that you want to cover by this bill?

Dr. SENSENICH. I would have to get it out of the dictionary; I don't know any other place for the definition of the word "hospital."

Senator MURRAY. But people are taken to hospitals for the purpose of having their conditions diagnosed?

Dr. SENSENICH. That is right,

Senator MURRAY. So it is a diagnostic place?

Dr. SENSENICH. May I interrupt. A diagnostic clinic, I think comes from the report of the National Health Conference in which they suggest the creation of 500 diagnostic and treatment clinics which are quite outside the ordinary definition, so there are things in here that I think have been prompted by that study.

Senator WAGNER. If the criticism that you made would be met, would you favor the bill?

Dr. SENSENICH. Senator Wagner, there is nothing personal in this, but I think that you could have done a better job.

Senator WAGNER. What is that?

Dr. SENSENICH. There is nothing personal in this, but I think that you could have done a better job.

Senator WAGNER. I am not saying that; you do not offend me. I think I understand some of the opposition, but I asked you this—supposing these corrections were made that you talking about, would you favor the bill?

Dr. SENSENICH. I could not limit it to those corrections, because I think there are other things that are objectionable.

Senator WAGNER. No matter what we did, you would not favor this legislation, isn't that the fact?

Dr. SENSENICH. No, that is not true.

Senator WAGNER. All right, then.

Dr. SENSENICH. But the type of legislation need not necessarily follow this type. I have been trying to tell you what I had in mind.

Senator WAGNER. What do you mean by the type? Your criticism has been as to details so far.

Dr. SENSENICH. They are quite important details.

Senator WAGNER. All right. You quarrel about the formula to determine need.

Dr. SENSENICH. That is right; yes, sir.

Senator WAGNER. Have you got a better formula to suggest?

Dr. SENSENICH. We have just developed that, I think.

Senator WAGNER. You have talked about it. You said you wanted to use the word "hospital" without any further specification.

Dr. SENSENICH. Prior to that, I suggested that an agency be set up and determine the need the same as for any other help to be given to a local community.

Senator WAGNER. Before that, I thought you said there was too much help.

Dr. SENSENICH. No, I beg your pardon.

Senator WAGNER. Do you think that there should be a larger set-up than here provided to determine the need?

Dr. SENSENICH. No, sir; much simpler.

Senator WAGNER. How much simpler would you say?

Dr. SENSENICH. I would say a central agency, as I have already stated, a central agency to whom requests should be made if need can be demonstrated.

Senator WAGNER. Now, do you mind following that up a little? Now, what is the agency; how would you set it up? We have got the Surgeon General—now, what would you set up?

Dr. SENSENICH. You also have other agencies.

Senator WAGNER. I am speaking about this particular service.

Dr. SENSENICH. I have no objection to the Surgeon General, but with that, I think that he should have advice from others, and I mean not only active, but more, judgment and decision by those who have medical experience, especially in the hospitals.

Senator WAGNER. All right. Then you would include with him a committee of doctors?

Dr. SENSENICH. Some appointments, certainly. I might say that I am not digressing here as to the suggestion—

Senator WAGNER (interposing). I want to meet your suggestion if it can be met.

Dr. SENSENICH. The suggestion of the American Medical Association for some existing agency or some one to be created.

Senator WAGNER. Now we are getting down to what you want, and as I understand it, it is someone appointed by the American Medical Association?

Dr. SENSENICH. No, sir; not necessarily.

Senator WAGNER. I would not even object to your recommending it, although I do not think that you should have the final say. Now, what further?

Dr. SENSENICH. I could not go into detail.

Senator WAGNER. You are criticizing this legislation.

Dr. SENSENICH. I have already made the suggestion, but I cannot tell you just how many changes there should be, in this few moments' notice. I am quite sure that considerable time was spent preparing this bill.

Senator WAGNER. Now, we have the Surgeon General plus some professional men, doctors as a part of a board to determine the question of need. Now, we have that. What next would you propose?

Dr. SENSENICH. Well, sir, I cannot give you anything more than I have in general. You cannot expect me to stand here and tell you how the bill should be drawn.

Senator WAGNER. But I want to get your idea. You say this is not workable or it is not sensible, therefore you must have something in mind that is sensible or otherwise you would not be in a position to criticize.

Dr. SENSENICH. I have already made that suggestion. I will make it again—some agency—

Senator WAGNER (interposing). All right; we will take that board. As the other Senators said, whatever rule we have must be applicable to all of the States; that is, it must be a rule which applies universally. Then you would say that you would have a test as to whether the hospitals are needed according to some test of need; is that right?

Dr. SENSENICH. Investigation of the local situation in which local authorities participate.

Senator WAGNER. That is provided here.

Dr. SENSENICH. It is not required.

Senator WAGNER. What is that?

Dr. SENSENICH. It is not required.

Senator WAGNER. You would require an investigation of the situation?

Dr. SENSENICH. In which local people be given an opportunity to be heard, because they are the people who have to support it.

Senator WAGNER. Then we have that. Would that satisfy you then?

Dr. SENSENICH. And then that it be established on a need basis.

Senator WAGNER. We have that on a need basis.

Dr. SENSENICH. And define the hospital as it is defined—

Senator WAGNER (interposing). It ought not to be given unless it is needed?

Dr. SENSENICH. That is right.

Senator WAGNER. Would that satisfy you then? Would you favor it then?

Dr. SENSENICH. I would have no opposition to this bill if—

Dr. CARY (interposing). Doctor, let me say this—

Senator ELLENDER (interposing). Dr. Sensenich, forget that you are a member of the American Medical Association.

Dr. SENSENICH. I am not taking dictation as to my testimony.

Senator ELLENDER. Maybe Dr. Cary does not like you to go so far, but forget that you are a member of the American Medical Association, you are just a plain doctor from Indiana.

Dr. SENSENICH. That is what I am, sir. With that in mind, let me restate my position as I have stated it, and I think it is understood by all of you, and that is that an agency be created and the assistance be established on the basis of need, and that the local community participate in determining the need and determining the remedy to be applied. Now, then, I cannot tell you of the mechanism how that bill should be drawn up, but that is the formula.

Senator WAGNER. If that were provided that way, you would be for it?

Dr. SENSENICH. Pardon me?

Senator WAGNER. Would you favor the legislation?

Dr. SENSENICH. I would favor that legislation; but you formerly asked me whether I favored this bill.

Senator WAGNER. All right; that is very far.

Senator MURRAY. Doctor, we thank you for your statement; you have been very helpful. You did a very fine job, and we appreciate your candor and your assistance.

Dr. CARY. May I ask how much further time we have?

Senator MURRAY. We will keep right on until we get tired. It is very interesting.

Dr. CARY. Mr. Chairman, I wish to state at this moment that I think we have just three more witnesses, and it might be possible that we get through this afternoon.

Senator MURRAY. That will be fine.

Dr. CARY. The next one to speak will speak on the subject of the care of the indigent, and I take pleasure in presenting to you Dr. Robert L. Benson, of Portland, Oreg., a member of the Oregon State Welfare Commission and also a member of the Oregon State Board of Health.

**STATEMENT OF DR. ROBERT L. BENSON, PORTLAND, OREG., MEMBER OF THE OREGON STATE PUBLIC WELFARE COMMISSION AND MEMBER OF THE OREGON STATE BOARD OF HEALTH**

Dr. BENSON. What I have to say is very brief. Some of the substance of what I would have to say is already covered by other speakers.

For years I have been a member of the State relief and welfare agency of Oregon under three State administrations of three different political parties. Anything that I can say here is nonpartisan.

Senator WAGNER. May I interrupt you? I am a little curious, and I am sure the chairman won't mind. You said that you worked under three political parties. What is the third one?

Dr. BENSON. Independent.

I believe I am familiar with the needs. In Oregon Federal participation in general assistance was withdrawn in 1935. Since that time Oregon has borne the burden of indigent care and has ministered generously to the relief of want. Road funds, liquor revenues, and all possible sources of income have been diverted to meeting this

demand. They have been difficult years, but in spite of this we feel that we have been successful. The Oregon State budget is still balanced, and we are solvent.

The Pacific coast section has recognized, like most parts of the country, that the millions of destitute people of the Nation require material aid. Most urgent of these demands concern adequate shelter, necessary food, essential clothing, and fuel. Secondary only to these is the need for medical care.

The following briefly describes Oregon's effective set-up for handling the problems of the medically needy. The State relief agency always refers medical problems to its medical member for study and recommendations. He, in turn, has a full-time medical advisor whose duty it is to visit all parts of the State to study their respective needs. We also employ a chief medical social worker under medical supervision to direct the activities of the various case workers as they are confronted with persons needing medical attention.

The Oregon State Medical Society is consulted on all important affairs relating to practice among the needy of the State. The society has a special standing committee which meets several times each month with the committee from the State relief agency to decide on policies to be adopted. The two, after collaboration, have a definite detailed plan for handling all questions relating to medical care of the indigent throughout the State.

The results have been gratifying. There has never been a situation that has not been ironed out. Diagnosis and treatment have been made available to the medically needy. Nursing care and hospitalization have been provided wherever needed. As far as possible the time-honored relationship of patient and doctor has been maintained, an exception being in the metropolitan Portland district, where the medical profession cooperates with the medical school clinic. Difficult cases are brought to the metropolitan center for study by a specialist in private practice, in a large number of cases. Autonomy in method of handling is left to the county unit and its medical advisor, subject to approval of the State relief agency.

The financial burden has been borne jointly by the State and the counties without aid from the Federal Government—usually on the basis of 60-40 or 50-50. Oregon is at present spending for medical care an average of about \$1.07 per month for each person on relief, two-thirds of which goes for hospitalization. This means an outlay of \$4.28 a month per indigent family of four persons. Physicians have in general offered their services freely with the result that their fees outside of Multnomah County, the metropolitan area, have absorbed about 12 percent of the total medical cost. The expense to the State amounts at present to about \$65,000 per month, or a total for 1938 of \$795,752.77. It is a small State in population, something over 1,000,000.

In the more thickly settled States of California and Washington the situation has been generally similar, but their accounting system is different and does not admit of ready comparison. Their needs are, however, identical with ours and their response to the need equally generous. The medical profession of the Pacific coast States agrees fully with the profession of the whole country that the millions of people on public assistance through the United States must be furnished with adequate medical care. Our chief concern is that

such aid shall be in a form that will uphold and improve the high standards of service previously achieved in medical practice.

The National Health Conference, held in Washington July 18, 19, 20, 1938, and which I attended, received five separate recommendations of the interdepartmental committee. No. III concerns medical care for the medically needy, and IV, a general program of medical care with its implication of compulsory sickness insurance. In the Wagner health bill we find these two grouped under one heading: "Grants to States for medical care." Are we to infer that the proponent of this act undertakes to group indigent medical care and the care of the self-supporting brackets under one category? Again, must the State, to qualify for a grant, obligate itself to accept, besides the universally recognized need for indigent medical care, a program for medical care to income groups which may be incompatible with its local needs? We find such a plan highly objectionable and entirely unnecessary. Those who have had years of experience in relief agencies realize that indigent medical care requires one set-up, and that the self-supporting group must be handled in an entirely different way. It is essential that they be kept separate.

In conclusion, we are entirely in sympathy with the humanitarian principle of ministering in a generous measure to the medical needs of the indigent. Such care should be in the hands of the medical profession. Medical care of the lower self-sustaining brackets is a separate problem, and should be met by a voluntary prepaid plan within the option of the State in which it is to operate. For the higher paid brackets of the population, there is no need for any provision which will undermine self-determination and independence. The advanced achievements and high standards of medical practice should be maintained at their present level and encouraged to further strides.

We shall be glad to further scientific medical progress in every possible way, but we cannot fail to oppose a proposal such as S. 1620, which will supplant these high standards by a system which is vague, visionary, inordinately extravagant and subversive of the best interests of an independent and self-reliant people.

Expenditures for medical care as proposed by the Wagner bill involving matched funds have been anticipated in Oregon by the County Judges' Association, which has expressed its inability to admit further large matching programs. The State legislature has expressed itself similarly. In conclusion, let me introduce a letter addressed to me this month by the Governor of Oregon, Hon. Charles A. Sprague, as follows:

In reply to your letter of May 1 with respect to the Wagner bill providing funds for public health administration, I wish to say that in my judgment the State of Oregon is not in position to increase its contribution in the direction of social security.

Last year about one-third of its expenses for general assistance went for medical aid and hospital care. If these funds could be regarded as the State's contribution on a matching basis we would receive additional sums from the Federal Government for use in the State.

We are not unmindful of the need of proper care of the poor but the tax burden which has been assumed for general social welfare purposes is as heavy as can well be sustained by our people.

CHARLES A. SPRAGUE, Governor.

I close by stating that while we have due regard for the need of adequate care for the needy, the feeling in Oregon in general is not in favor of greatly increased cost, and as we are all aware, confining myself to the care of the indigent, there is proposed here for the first year \$35,000,000 for medical care, and unlimited amounts thereafter, and there is no provision as to whether that will all go to the care of the indigent. Our concern is that these needy people, the really indigent, shall have whatever care is offered.

I thank you.

Senator ELLENDER. Doctor, I am very much interested in the Oregon plan that you have outlined. You say that the State contributed to the extent of about \$100,000 per year?

Dr. BENSON. To what?

Senator ELLENDER. Medical care.

Dr. BENSON. No; it is about \$800,000.

Senator ELLENDER. How is that money distributed as among the counties of your State. What is the yardstick?

Dr. BENSON. The county puts in a budget, and that budget is gone over and audited and passed upon by the State relief agency. There is not a great deal of trouble in doing that.

Senator ELLENDER. All of the counties of course do not get the same amount?

Dr. BENSON. No.

Senator ELLENDER. It depends on their needs?

Dr. BENSON. It depends on their needs; yes, sir.

Senator ELLENDER. What kind of service is furnished to these people?

Dr. BENSON. That is left to the local option, but in general we have a system under which the physicians have agreed locally to a fee schedule that will make possible care for all of these people under the budget at hand.

Senator ELLENDER. Do you fix the fees?

Dr. BENSON. Yes, sir; we have a schedule of fees.

Senator ELLENDER. In other words, those doctors take care of these indigents, the fee is fixed by the State?

Dr. BENSON. No, sir.

Senator ELLENDER. How it is fixed?

Dr. BENSON. This fee has been fixed by the local medical society, the State medical society.

Senator ELLENDER. Are the doctors paid out of this \$800,000 that is raised by the State, and also from what the counties contribute?

Dr. BENSON. That is right.

Senator ELLENDER. Does the same go for hospitalization?

Dr. BENSON. Yes, sir.

Senator ELLENDER. Is that plan working very well in Oregon?

Dr. BENSON. I think it is working very well. Of course, it is not giving all of the aid that we would like to give, but I think we can say that the percentage who go without needed medical care is extremely low.

Senator ELLENDER. But you could give better service and have better results if you had more money?

Dr. BENSON. Yes, sir.

Senator ELLENDER. To what extent have the State agencies taken advantage of the social-security money that is now being furnished to the State?

Dr. BENSON. We are using it.

Senator ELLENDER. Is there any evidence of Federal control in the State of Oregon by virtue of the use of this Federal money?

Dr. BENSON. Yes; quite a bit.

Senator ELLENDER. What is that?

Dr. BENSON. Quite a bit.

Senator ELLENDER. Very well. Will you tell us to what extent there is?

Dr. BENSON. I probably could not tell you to the entire extent which it has been done.

Senator ELLENDER. No; but you have been in the State Department for three administrations.

Dr. BENSON. I have not been in charge; I have been a member.

Senator ELLENDER. You have been connected with it?

Dr. BENSON. Yes, sir.

Senator ELLENDER. Tell us to what extent has the Federal Government shown control over the State agency by virtue of furnishing this money that your State does get under the social security law?

Dr. BENSON. The Federal Government is not participating except in certain programs.

Senator ELLENDER. What programs?

Dr. BENSON. Old age and—

Senator ELLENDER (interposing). I am talking about the maternal and child care. I think, under the bill, social security is getting \$3,800,000 for those services. Is the State participating to any extent in that fund?

Dr. BENSON. Yes.

Senator ELLENDER. Will you tell the committee to what extent has the Federal Government tried to take advantage of that and control the State agency?

Dr. BENSON. Not very much.

Senator ELLENDER. Can you qualify that? "Not very much" means some to me. But to what extent has it taken advantage or has it taken control of it or had its hand in the pie, as it were?

Dr. BENSON. I might inform you there that that is not under our agency in Oregon. That is under the State board of health.

Senator ELLENDER. Would you know of your own personal knowledge if any influence has been used?

Dr. BENSON. I don't know of any at all, Senator.

Senator MURRAY. Has there been any criticism by the medical profession that the Federal Government has interfered in that program?

Dr. BENSON. I imagine there has, Senator. If you think there is any Federal or State agency that does not get criticism—you can be sure that there is criticism.

Senator MURRAY. But you do not consider it justified?

Dr. BENSON. Well, I have no knowledge of any justified criticism of that control; no. Of course, it is not under our agency; we are not being concerned with it directly.

Senator ELLENDER. Doctor, how would you look upon a Federal statute, let us say, drafted by this committee carrying out the same

principles and the same medical aid that is being afforded now to the people of Oregon under the Oregon plan?

Dr. BENSON. I think that if it were confined to administering to the needy, to the indigent, I think that Oregon would yield to the same temptation that pretty nearly any State would of accepting a gift.

Senator ELLENDER. How would you feel about it?

Dr. BENSON. I would be for accepting it.

Senator ELLENDER. For accepting it?

Dr. BENSON. Yes.

Senator ELLENDER. Your main reason, as I understand you emphasized in your answer to me was with respect to the need for it, in other words, give it to those communities that want it and can show need for it?

Dr. BENSON. That is right. I want to qualify it further, however, that I would want to be absolutely certain, Senator, that the statement of that need came from Oregon, if we are speaking of Oregon, or from any other State—

Senator ELLENDER (interposing). Yes, but Doctor—

Dr. BENSON (interposing). Just a minute. I want to finish this answer because this is important to me.

Senator ELLENDER. I do not want to cut you off.

Dr. BENSON. I do not believe in the promulgation of any big program that through propagation thrusts itself upon States, and I fear that that is the trend in this bill. I think all the aid that the States need, and I know a State that is as honest in its administration as ours has been, can be trusted with it, all the aid that would be acceptable to us is an aid that comes through our own application on the basis of a known need that is local, and we do not want any matching funds poured in our direction which would tempt our State and other States to just create a need. That is a temptation.

Senator ELLENDER. Under this bill, as I understand it, you would not have any funds poured into Oregon unless Oregon could show a need for it. The bill provides for certain yardsticks, and unless the States applying can measure up to those yardsticks, they are going to get nothing, and it is up to you to show a need for it under the specifications as contained in the bill. Now, if you or anybody else or any other witnesses can propose any other yardstick that would carry out what I conceive to be the purpose of the bill, let us have it. I would like to have it made certain that no State or no community shall have any of these funds unless there is need for it. Certainly I would not want to advocate that the Government collect taxes here and there and just simply pour forth just because the State asked for it; I don't want that.

Dr. BENSON. But here is the thing that you probably do not get here in the Capital of the Nation, but certainly we get it at home, and it is not only in our State but in all States, whenever it comes to the matching of funds, and we hear this stated time after time, not that we must have that, but that we can get that. I am talking of, as I said before, a temptation which they will yield to.

Senator ELLENDER. You have cited Oregon as a model State?

Dr. BENSON. One of the model States.

Senator ELLENDER. Has Oregon obtained any money from the Government that it was not entitled to under the social security laws?

Or in fact any similar laws where funds were made available for various purposes?

Dr. BENSON. Now, I would have to answer that by saying that all things are relative. Needs are relative, and it is so easy for a State to show a need when it comes to a dollar for their 50 cents spent, and when their 50 cents spent suddenly grows into a dollar, there is certainly a temptation to feel a need that they did not feel before. I know that is true in Oregon and in other States; it is human nature.

Senator ELLENDER. Notwithstanding the fine reputation that you have given to Oregon, still you think that if the opportunity is afforded that it would probably ask for it?

Dr. BENSON. Yes, I do; we are human.

Senator ELLENDER. That is your view?

Dr. BENSON. Yes, sir.

Senator ELLENDER. Well, there are quite a few who take that view.

Senator WAGNER. You read a letter from your distinguished Governor, and I want to read another letter that came out of the West. I will just read portions of it:

Our experience in dealing with problems of dependency during these past years has impressed upon the health and welfare administrators of this State the significant part that ill health and inadequate health facilities play in the lives of people who are recipients of public assistance. Consequently, in the development of our social-security program, we have seen a close-working relationship between these two branches of public service. Out of this experience has come the realization that an expansion of public-health facilities will play a large part in our future attempts to lessen the economic and social dependency of our citizens.

Further on in this same letter it is stated:

We have read the material that has been gathered over the past several years by the Interdepartmental Committee on Health and Welfare, and we realize that these exhaustive surveys undoubtedly have brought to the attention of the committee the facts underlying the whole problem and the plans outlined to meet the problem. However, if there is any further information that you believe we might supply, please feel free to call upon us. We shall continue to watch with interest the progress of this constructive legislation.

Sincerely yours,

CLARENCE D. MARTIN,  
*Governor of the State of Washington.*

He takes, apparently, a different view, doesn't he?

Dr. BENSON. No; I do not think so, Senator. That was largely public health, you see. I am like most members of the medical profession, I am in favor of enlargement of public-health activities. For instance, just to make my point clear, if we were to spend a sum of money to go down in Florida, or any other State—I used to live in Florida and I think of the way the mosquitoes used to bite there and I had malaria there, and I had dengue fever too, both from mosquitoes—if those swamps are to be drained and we can rid them of those diseases, and also of the yellow fever that Florida had that swept away a large percentage of their people, I am for that too, more and more development in a reasonable way of public health.

Senator WAGNER. In anything that I say I do not want you to understand that I question your desire to improve the public health. We are all for that, but we are trying to find a method.

Dr. BENSON. That is what Governor Martin is speaking of there.

Senator WAGNER. He is speaking of the whole program—I did not read the whole letter, but I will read the portions that I did not read previously:

As a recognition of this need, the 1939 State legislature made provision for making moneys available in the event that the Federal Government inaugurates a national health program through which matching funds will be made available to the respective States. This is an indication that the State of Washington recognizes the principles of such a program and is ready to accept them should congressional action put them into effect. It is my understanding that a national health program, such as the one outlined in the bill which you have introduced, would fit it with existing health and welfare programs, and would, therefore, augment the services now available. It would give Federal financial assistance to many of the phases of the program which the States and counties are operating on a small scale now. Where deficiencies in the service are already recognized, such assistance would prove of great value to the respective States as they carry out their programs of social security and public health. It is my further understanding that the legislation which Congress has before it aims to assist States along the lines of the health and welfare programs which the States themselves have initiated.

In talking about health, one of the doctors this morning I think minimized a little bit the extent of need of more adequate health service. Here is a statement from the head of the Welfare Department of New York:

A recent study made by the Department of Welfare of New York City indicates that in New York State, sickness of the breadwinner alone is responsible for approximately 15 percent of the cases on home relief—and this is merely one type of public aid. In other words, in any 1 month in this State, over 130,000 men, women, and children and more than 47,000 cases are dependent upon home relief because the wage earners have lost their jobs through illness. The approximate cost of this burden is over \$22,000,000 annually. And remember, we are excluding institutional care, those persons served by the hospital and health departments, and all other forms of public aid.

You see what a great economy we could in the long run provide by making our citizens healthful. I am sure you agree with every word of that.

Dr. BENSON. Senator, in comment on that, that whole matter relating to prepaid care of industrial groups is an interesting topic and we could drag on here for days, and, if I could make my position clear, I am sure that you won't find it so unreasonable—

Senator WAGNER (interposing). I do not think you are unreasonable.

Dr. BENSON (continuing). As regards my ideas on indigent care, but I believe that the State and the counties—the political subdivisions—should furnish adequate medical care for the indigent, and I go further and I believe that, if they are unable to furnish all that, they should go to the Federal Government and ask for a grant as a gift or on a matching basis, a grant-in-aid. My whole point is that I feel that the matter should be simplified. We should be kept within bounds so that the Federal Government is on a balanced budget the way my State is. Mine is a poor State, but we are on a balanced budget, and I believe the Federal Government ought to be. I am going out of my subject, I know.

Senator MURRAY. Doctor, I think we have come to the point where we will have to suspend for the day. How many other witnesses have you?

Dr. CARY. Mr. Chairman, I have two; and after speaking to Senator Ellender, I am quite prepared to say that it will suit us to have this suspended and come back at 10 o'clock tomorrow.

Senator MURRAY. Will you be able to finish tomorrow morning?

Dr. CARY. Yes.

Senator MURRAY. We will stand in recess then until tomorrow morning at 10 o'clock.

(Whereupon, at 4:20 p. m., a recess was taken until Friday, May 26, 1939, at 10 a. m.)

# TO ESTABLISH A NATIONAL HEALTH PROGRAM

FRIDAY, MAY 26, 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, Thomas, and Davis.

Also present: Senator Robert F. Wagner.

Senator MURRAY. The hearing will come to order.

Before calling any witnesses, I wish to introduce into the record some statements of witnesses who are not going to be present.

I submit this one from Mr. H. B. Anderson, secretary of the Citizens' Medical Reference Bureau, Inc., with headquarters at 1860 Broadway, New York City.

Also a resolution passed at the national convention of the National Lawyers Guild, held at Chicago, Ill., on February 12, 1939, pertaining to a national health program.

Also a statement of the United Rubber Workers of America, to the Senate Committee on Education and Labor, on the national health program.

Also a statement on the national health bill, by the Amalgamated Clothing Workers of America.

These statements may be filed with the committee.

(The statements referred to above were filed with the committee.)

Senator MURRAY. I ask to have incorporated in the record a statement of Dr. Walter E. Vest, of Huntington, W. Va. This will be printed in the record in connection with the testimony now being given.

(The statement of Dr. Vest is as follows:)

STATEMENT OF DR. WALTER E. VEST, PRESIDENT, PUBLIC HEALTH COUNCIL OF WEST VIRGINIA, HUNTINGTON, W. VA.; EDITOR, WEST VIRGINIA MEDICAL JOURNAL; PAST PRESIDENT, WEST VIRGINIA STATE MEDICAL ASSOCIATION

## INSURANCE AGAINST UNEMPLOYMENT DUE TO SICKNESS

The disability-compensation program dealt with in title XIV of the Wagner health bill is collaterally allied to, rather than an integral part of, a medical-care program. Essential medical care will materially reduce the cost of disability insurance, and appropriate hospitalization and scientific rehabilitation, however provided, are necessary to keep the actual expenditure incident to such a program within reasonable bounds.

Compensation for loss of wages during illness may, when a part of a mutual voluntary indemnity insurance plan, have a favorable influence on the duration of disability and early return to employment. Self-interest and self-respect tend to prevent abuse of mutual-indemnity plans.

Where the workman's financial responsibility is small in proportion to the benefit expected during disability, there is a tendency to assume and take advantage of a state of invalidity. In other words, the workman has a financial interest in assuming and continuing a state of apparent invalidism.

Properly safeguarded, payments for wage loss due to sickness, administered in like manner as payments compensating for unemployment due to other causes, would relieve much of the economic burden of illness in the low-income segment of the population.

The American Medical Association endorses the principle of insurance against loss of wages during sickness. It is indispensable, however, that the physician's function in caring for the sick workman should be completely separated from medical certification of compensable disability. This should be the function of a qualified medical employee of the disbursing agency.

The Wagner health bill, however, is not satisfactory for the following reasons:

1. It requires the furnishing of medical services in addition to cash indemnity;
2. It furnishes a stepping stone toward universal compulsory sickness insurance; and
3. It provides for Federal control of what should be essentially a State function.

Senator MURRAY. Is Homer Folks here?

Mr. FOLKS. Yes.

Senator MURRAY. Will you come forward, please?

Mr. Folks, I understand that you are anxious to get away and desire to make a statement at this time?

Mr. FOLKS. That is right, sir; both.

Senator MURRAY. Will you state your full name, whom you represent, and what your profession is?

#### STATEMENT OF HOMER FOLKS, SECRETARY OF THE STATE CHARITIES AID ASSOCIATION OF NEW YORK

Mr. FOLKS. My name is Homer Folks, secretary of the State Charity Aid Association of New York, and here I represent two organizations on certain parts of the bill; the National Tuberculosis Association, of which I am the chairman of a special committee on Federal participation in tuberculosis control; and I represent also the State Charities Aid Association, which has long experience and which is the tuberculosis voluntary organization in New York State, and is in favor of the tuberculosis provisions, practically as they are, in the Wagner bill.

Now, I want to emphasize, in behalf of those two bodies, and the National Association represents State bodies in every State in the Union, that to our mind an exceedingly important part of the Wagner bill is the provision which it makes for more immediate and early control of tuberculosis, which, it would seem to us, is the outstanding health problem, public health problem, before the country today.

And there are three reasons, as it seems to us, for Federal participation in a more regular, and in a larger, degree than before, because there has been some help through P. W. A.—there are three reasons for greater Federal participation in the tuberculosis-control movement, which up to now is mainly a matter of the States and the local authorities, cities, and counties.

The first of those is that notwithstanding all that has been done, in the year 1938, 69,324 persons died of tuberculosis in the United States of America, which approaches toward 200 persons a day.

Now, there are a few causes, six to be exact, which cause a larger number of deaths, but as to those, we either do not know what to do about them, as yet, or there are practical reasons why we cannot, at the moment, proceed to deal effectively with them.

We can proceed effectively to deal with tuberculosis—and 69,324 persons died in the fruitful years of life, in the early middle-aged period, when they are carrying the major responsibilities of life to their families and their communities, from a cause which we do understand, from a cause which we can control, which we are very slowly approaching a control of, but which, if we only applied more fully what we now know, could be eliminated as any substantial cause of death in a very much shorter time than it otherwise will be.

It is a national problem because these deaths are distributed over the entire country.

Now, a second reason for Federal participation is that no one State can do it alone, and New York is a very good instance of that. We have half a million colored people in New York; most of them came there within a few years. Five times as many of them die of tuberculosis as among the white people of New York. That is an enormous problem.

Besides, we are the most moving people, apparently, in the world, interstate migration is extraordinary. People are moving around for better employment, or for health, or for a wide variety of reasons, and the figures on that are perfectly astounding as I have seen them recently.

Less than half of the people now in New York State were born there. The amount of change and mixing up and the exposure to tuberculosis cannot be controlled in one State by itself, and we have reached the stage now in up-State New York where a surprising percentage of the deaths from tuberculosis are from people who have only recently come there, whether it is from across the border in Pennsylvania or wherever it may be.

And the third reason is that while the cities and counties and the States have heretofore done quite a bit, have done in the main what has been done about tuberculosis, they cannot now provide the sums required for hospital care. They cannot put up the money—they haven't got it; they are approaching their debt limit and they are finding it extremely difficult to meet their current budgets; and I know that we couldn't go now to the city of New York or to the up-State localities and get substantially any funds for new hospital construction on their own alone.

Now, fortunately—I represent up-State New York in a special sense—we have the number of beds we need for tuberculosis, we have three beds per death per year—three hospital beds. Now, the whole business of controlling tuberculosis substantially is on the old idea that we knew the moment the germ was discovered, that it is a communicable disease and you have to segregate those who have got it and can expose others, from those who are well, and we have learned that the only way we can do that is in a hospital.

Now, the national association has just three points in its plan, which I say in substance is in the Wagner bill.

The first of those is that we plan over a period of 6 years to bring the number of tuberculosis hospital beds up to a minimum of two per annual death in each State in the Union. That is a very modest amount. Massachusetts and Detroit and up-State New York and several other States have gone quite beyond that.

But I think that no one would question that we need at least two beds per annual death to segregate, as we say, the open cases who can expose others, whose sputum carries the germs of tuberculosis.

Then I think it is quite true to anyone who has got to do with local finance, that the localities cannot at once take on the full cost of maintenance, and so we suggest in our plan that the Federal authorities aid for a period of 6 years in the maintenance of the additional hospital beds, not the existing ones.

And, thirdly, that the Federal Government assist the States in finding the cases of tuberculosis which most need to be hospitalized.

There are new methods of doing that, developed within the last few years, the significance of which is as yet only relatively understood, namely—I am speaking now for the national association, not of my personal knowledge professionally because I am not a doctor, but I know their views—that tuberculosis, early tuberculosis, can only be discovered definitely by an X-ray of the chest, and in no other way; that no practitioner without an X-ray machine can discover early tuberculosis.

Senator MURRAY. Is that proposition recognized by the medical profession generally?

Mr. FOLKS. I don't know, I guess so, I hope so, I think so. It is recognized by the National Association for Tuberculosis where the experts are—at least. They certainly must know it.

But it is a question of whether you simply recognize a man or whether you shake him by the hand and really know him. You may notice him, but you may not know him really well.

If you are really going to find the people who are in a stage when they can be cured readily, you have got to go at it with the X-ray examination of the chest.

And so we propose here that the Federal Government assist in that particular matter up to 50 percent.

We had this plan worked out before there was a health conference last summer, and it is embodied in a little leaflet which I am going to ask be incorporated in the record in the hope that each of you will read it. It is very short, and right to the point. It covers just those three things.

Senator MURRAY. That may be filed with the committee.

(The pamphlet referred to was filed with the committee.)

Mr. FOLKS. I think that covers perhaps most of what I had to say about tuberculosis, except I do want to say just one more thing.

One of my old friends, speaking here yesterday, said there was no emergency calling for particular action at the moment, as I read it in the papers. I don't know whether you would call close to 200 deaths a day an emergency or not, it depends, I guess, on how used you are to it, but I should think that 200 persons a day, more or less, every day in the year, dying from a cause which we know we

can control, and which we know how to control, and which we have known how to control for 57 years, calls for emergency action anyhow. We may be used to the fact that that is it, but it is an emergency, the opportunity to prevent that calls for early and adequate and emergency action.

I do want to take just 2 minutes to speak one word of a bit of history of New York State, which I think is quite pertinent on this occasion.

In 1913 the Governor of New York State appointed a little group of citizens to take a look at the health law of the State, and the administration of it. It was pretty thin, and the State department of health up to that time had no funds to speak of, and no leadership and no relation to the cities and counties and towns; it had a little bit of a laboratory in a corner of a horse stable, and it was practically of little moment except to keep the statistics right.

Now, that little commission recommended to the governor and to the legislature a complete overhauling of the public-health law of New York State, qualifications for the commissioner suitable to his responsibilities, the creation of a public-health council to pass regulations about health matters, having the effect of law, a district office of the health department in each part of the State, with a qualified person in charge, a full-time man.

That law was passed; it has not been amended in any important particular since that time; amended every year in minor respects, but never to repeal any of its major features or fundamentally change them.

We have made a very good record under that law in up-State New York. We have got our tuberculosis down to where we can begin to see toward the end. We don't want any more beds; we have got rid of diphtheria; it is practically gone. We are one of the leaders in the syphilis-control movement; we have had only four State health commissioners since 1913, and every one has been a fully qualified career man on full time, serving until he died or was promoted to something else.

That law has been adopted in substance by some 20 other States.

Now, the man whose name that bill carried in the senate was the leader of the senate of that day, one Robert F. Wagner; and the people of New York State, at least, are inclined to think that any health bill that carries the name of Robert F. Wagner is likely to be very good stuff.

As an individual I did my home work on the Wagner bill last night, a second time. I read it through from the first word to the last one and gave the whole evening to understanding it. I have been a little critical of it at times, as it seemed to be pretty complicated and pretty hard to understand. I finished up last evening with an entirely different feeling about the bill as a piece of workmanship. To my mind it is a splendidly written piece of legislation. It wasn't just written, it grew, it is coherent, it is consistent, it is in harmony all the way through; and to my mind it is an excellent piece of bill drafting, and I hope it will get your most serious and favorable attention.

Senator MURRAY. Thank you, Doctor; we will hear from Dr. Gordon Heyd, of New York City.

Dr. CARY. I just want to make this comment before Dr. Heyd is presented, that we are always delighted to hear from Mr. Folks, but I would like to call attention to the fact that the history of medicine shows a marvelous contribution on behalf of the hard-hearted and calloused doctors in regard to tuberculosis.

Senator MURRAY. Dr. Heyd, you may state your full name and your profession and where you reside and whom you represent.

**STATEMENT OF DR. CHARLES GORDON HEYD, PROFESSOR OF SURGERY, NEW YORK POSTGRADUATE MEDICAL SCHOOL, COLUMBIA UNIVERSITY, NEW YORK CITY**

Dr. HEYD. Mr. Chairman and Senators, Charles Gordon Heyd, professor of surgery, New York Postgraduate Medical School, Columbia University.

Mr. Chairman, I should like to draw your attention to a paragraph from the proposed national health act of 1939, page 5, paragraph 7, line 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.

This paragraph appears twice in title V, once in title VL, once in title XII, and once in title XIII.

This bill, therefore, expressly provides for working agreements, "including social insurance." Furthermore, two individuals and one executive control, administer, this bill. First, the Chief of the Children's Bureau; second, the Surgeon General of the Public Health Service; and third, the Social Security Board.

These three individuals, with the consent or approval of the Secretary of Labor and the Secretary of the Treasury—

shall allot to the States the sums appropriated in accordance with rules and regulations which they shall make and prescribe.

It has been said that the power to tax is the power to destroy, and the power to give and withhold money is the power to coerce and control. There is, inherent in this bill, the power to dominate the entire field of medicine and to induce States to submit plans to certain three individuals in Washington, or bureaucrats, and—

Failure to comply substantially with any requirement \* \* \* further payments will not be made to the State (p. 22, sec. 605, line 12).

Senator MURRAY. Wouldn't it be necessary, Doctor, to have any law that way, that they would set up a formula or a basis for the granting of the assistance, and if they didn't comply, then they wouldn't be entitled to receive the assistance?

Dr. HEYD. That is true; the Comptroller General has to see that the funds are distributed within the law.

Senator MURRAY. That is the only way, anyhow—

Dr. HEYD (interposing). But the prescribing of the rules, Mr. Chairman, is by these three individuals.

Senator THOMAS. Whom would you have them by?

Dr. HEYD. Whom would I have them by? May I, Mr. Chairman, finish my remarks, and then I shall be perfectly willing to answer any questions.

Senator THOMAS. Excuse me, Doctor, but I have to run, and that is why I asked the question here.

Dr. HEYD. Senator, I am trying to present an argument, and if I stop I really believe that it will invalidate the continuity of that argument.

This bill would create a vast, complicated system of sickness insurance, with a centralized control by the Federal Government of every phase of medical service. It would control the education of doctors, hospitals, the distribution of medical services, pharmaceutical houses, instrument makers, and all of the allied industries that go to the field of medicine.

It would provide a vast bureaucracy for the distribution of medical services, and in essence would be a form of national sickness taxation. The Government would have to collect the money, approve of it, distribute it, employ trained laymen and professional personnel for its distribution. It has all the defects that are inherent in the compulsory health system in any of the totalitarian states.

Furthermore, the bill will not provide good medical service. It deals with quantity rather than quality, and it provides a means for distributing minimum medical service.

There is not in the bill any provision for periodic health examinations, immunization, for any discoveries in the field of medicine. It freezes medical science and makes it static instead of allowing the onward procession with scientific progress.

Furthermore, the bill will increase illness, because it gives an alleged "free medical service." Paradoxical as that may seem, the history of sickness insurance is an increase in illness. In Germany, in 1888, 33 individuals out of 100 insured, availed themselves of sickness insurance; in 1925, 52 percent, or more than half of the people insured.

Again, in the number of days of sickness, there was an increase. The number of days of sickness per 100 insured increased in the same period of time from 547 days to 1,250 days.

This bill, with its implicit instructions for sickness insurance, social insurance, will sterilize medical discovery. There isn't an American, be he layman or doctor, that is not proud of the contributions of American medicine during the last 25 years—insulin, vitamin therapy, liver therapy for anemia, high voltage X-ray, increase in the knowledge and advancement in the treatment of cancers are all due to the free enterprise of science and the medical world in this country because it is not shackled by Government control.

The bill will prolong illness. In the United States a workman will lose 6 or 7 days a year. In England, under the panel system, 9 or 10; and in Germany, 14. When an individual is given alleged "free medical service," there is no particular urge for him to get well quickly.

Senator WAGNER. Would you mind repeating that again?

Dr. HEYD. When an individual is given alleged "free medical service," there is no particular urge for him to get well quickly.

Senator MURRAY. What do you mean by that, Doctor?

Dr. HEYD. Let me make a note of that, and I will come back to that when I am through.

Senator MURRAY. All right.

Dr. HEYD. Now the second phase of my argument.

The phrase "including the training of personnel," page 8, section 5, line 22, occurs six times in titles V, VI, and XIII, and actually compels the various States to pass enabling acts. There are at least seven of the States of this country in which enabling acts have been passed, or have been introduced. I need only refer to the Goldstein bill in New York, which was introduced in the Assembly of New York State, which provides for the complete regimentation of the medical profession. I beg to submit here a copy of the Goldstein bill.

Senator MURRAY. That may be filed with the committee.

(The document referred to was filed with the committee.)

Dr. HEYD. I would like to quote one portion from that proposed legislation:

In the event an insufficient number of persons elect to become members of the staff pursuant to this section within one year after this section as hereby amended takes effect, any additional number of staff members shall be procured by aiding students and prospective students to obtain the necessary training, experience, and qualifications at professional schools and colleges with a financial subsidy of not to exceed one thousand dollars per annum to each such student who will agree, upon graduation from such school or college, to elect to become a member of the staff subject to the terms and provisions of this chapter and the rules and regulations of the department for a period of at least three years.

In 1933, while in Moscow, I heard those identical words of that paragraph from the Assistant Commissar of Health.

Now the training of personnel by Government subsidy will entirely change the basis of our education. It will lower the quality, remove the basic qualifications, and make entrance into a medical school dependent upon favor, recommendation.

Furthermore, this bill jeopardizes the voluntary hospitals. This American hospital system is a peculiar product of our civilization and culture—the integration of voluntary effort into Government effort. It works well, and yet there is not one word in this projected bill that will maintain this marvelous structure of the voluntary hospitals.

Furthermore, the bill does not solve medical indigency. It does not supply an adequate, efficient medical or dental service. A huge bureaucracy is created. Fifty percent of the personnel will be non-professional people, and the amount of money that is spent for medical care will be that sum of money less the cost of the administration of this huge lay personnel.

Psychologically and fundamentally, it destroys character, because the giving of something for nothing undermines character, and the idea that the Government can pay for everything brings about a slow deterioration of the race.

Furthermore, this bill will dominate all citizens because a complete control of the medical service, such as is envisaged in this bill, will mean that every citizen is under the control, in one way or another, of the influence of this bureaucratic medical system.

Senator Wagner, I think this will explain in a measure the little doubt that I didn't make myself clear.

Under this bill cash benefits for wage loss, while sick, impairs the physician's usefulness and in turn blackmails the doctor. The effect of making the doctor certify to cash benefits for sickness places the physician under the economic necessity of certifying illness for fear of losing his patients, and if an individual is treated in a hospital, receiving compensation while he is sick, and he is maintained in that hospital at Government expense, he has very little incentive to get well.

Understand me, I am for paying the workman, when he is sick, his wages, but he should be paid from the organizations that deal with unemployment. It is not part of the distribution of medical services.

This bill is financially wasteful and extravagant. The form of poor relief or medical dole is incorporated therein.

Since taxes are spread generally, they must be paid in the long run by the great mass of the people.

Now you have distributed funds through the Public Health Bureau and the Child Welfare Bureau without any difficulty, and you have given to the State of Nevada, under the Children's Bureau, for 1938, \$1.61. The Public Health Bureau in the same time gave, in the State of Nevada, 41 cents. The total of those two amounts is \$2.02.

Now the basic cost of distributing all of the public health services in any State, be it a low-expense State or a high-expense State, is \$1.31, and that is the figure that the populace in the rich State of New York spends. Yet the State of Nevada received \$2.02.

So I bring that as an example of financial waste and extravagance.

Senator MURRAY. Doctor, in the State of Nevada you have tremendously wide stretches of territory; you couldn't expect a State like that to maintain the low cost of service that you would in a big State like New York or in any part of the State of New York; isn't that true?

Dr. HEYD. I will grant you, Mr. Chairman, that that is an offset.

Mr. Chairman, there is no magic in Government spending. Government does not create money or values. This national health bill will, it is true, spread the cost of medical service. It must be paid for in taxes, there is no such thing as free medicine, but it will buy less medical service than the same amount of money spent as under the present set-up.

This bill, with its centralized control, is an implement of the totalitarian state.

Senator WAGNER. What is that?

Dr. HEYD. This projected bill, that bears your name, is an implement of the totalitarian state, with its centralized federalized control.

Senator WAGNER. You see coming out of this a totalitarian state?

Dr. HEYD. No, no; I said it is one of the implements.

Senator WAGNER. I see.

Dr. HEYD. Gentlemen, it is easier for anyone here, or you, to walk out of this building and get medical service than it is to get food or shelter or clothing; and aside from certain areas in the United States, which organized medicine freely admits need care and want care and are perfectly willing that Mr. Wagner shall give them care under certain institutions and organizations—but it is easier to get medical care in the five or six thousand towns, of over ten or fifteen thousand population—a stranger—than it is to go out and get shelter or food or clothing.

Thank you very much.

Senator MURRAY. Doctor, your statement is a very severe indictment of the bill, but I am sure that we all welcome it and it will stimulate our study and close analysis of the bill, and we want the medical profession to come here and attack the bill with all the force they possess, because if there is anything wrong in it, I am sure that Senator Wagner and every member of this committee wants to correct it, and I think that the medical profession is best fitted to come here and do that job of analyzing this measure, and I want to thank you for your very strong statement.

Of course, we may not thoroughly agree with you on everything, but it is going to stimulate our very close study of the bill.

Dr. HEYD. Thank you so much for your courteous treatment.

Senator ELLENDER. Doctor, if I am to understand your argument, you don't believe that the Federal Government should spend any money for such purposes?

Dr. HEYD. I didn't say that, Senator.

Senator ELLENDER. Well—under what circumstances, then, would you permit the Federal Government to aid the States?

Dr. HEYD. Whenever the need is demonstrated.

Senator ELLENDER. Very well. That statement has been made by every physician who has so far appeared for the American Medical Association, and what I am very anxious to have written into the record are your views as to how that can be accomplished.

Now you needn't have in mind that we want you to dictate in the record a bill to that effect, simply give us the ideas and we are going to get the lawyers who draft our bills to write your views into law.

Dr. HEYD. I am very happy to comply with that, and welcome the opportunity.

My first point in my argument is to present what I believe are the dangers here.

Senator ELLENDER. Let's forget the pending bill, and you say you are in favor of having the Federal Government aid the States?

Dr. HEYD. Yes, sir.

Senator ELLENDER. To help the sick?

Dr. HEYD. Yes, have the Federal Government create a Department of Health, to coordinate all health activities.

Senator ELLENDER. Would you say that the present Health Department is inadequate?

Dr. HEYD. I am not here, and I have no competency to criticize the present Health Department.

Senator ELLENDER. I am not talking about the personnel; forget the personnel; I am talking about the law establishing it.

Dr. HEYD. Senator, you asked me for my views as to how I would get Federal money to these deserving areas.

Senator ELLENDER. Yes, sir; and you said the creation of a Federal Department—

Dr. HEYD (interposing). A Federal Department of Health.

Senator ELLENDER. We have that now under the Federal Government. Would you improve on the existing one or would you suggest any changes, or would you create an entirely new and separate department?

Dr. HEYD. The creation of a Federal Department of Health; two, a Secretary of Health; three, the coordination of all health activities in that department; four, the creation of a sufficient sum of money under proper legislative and congressional controls in that department; and five, the allocation of funds from that amount upon due presentation and demonstration of the need, wherever that need may be.

Senator ELLENDER. Now, let's go to your first suggestion. Would you improve the law that is now on the statute books with reference to the creation of a Health Department?

Dr. HEYD. I am not competent, Senator, to offer any criticism as to the law. I have never been trained in it.

Senator ELLENDER. Now, why do you mention a Secretary?

Dr. HEYD. Because if medicine is one of the three great industries of this country, and the whole ideology of the Wagner bill is to save sick people, I think it needs a full-time man, trained to do nothing else but that.

Senator ELLENDER. You mean to take care of—

Dr. HEYD (interposing). All the health activities of the Federal Government.

Senator ELLENDER. One Secretary?

Dr. HEYD. Yes.

Senator ELLENDER. Would you suggest that the Secretary be a member of the President's Cabinet, or how would you handle that?

Dr. HEYD. I think if I were handling one of the two or three biggest industries in the country, as big as most of the other departments, that that should be a Cabinet officer.

Senator ELLENDER. As you know the Government must appropriate funds each year before they can be distributed among the States. Now, what would you start that fund at, have you any views in that regard?

Dr. HEYD. Senator, I know less about that than you do; I am not competent to tell you how much money would be required. I know that this bill projects nearly \$454,000,000 in 3 years, and there is no limit.

Senator ELLENDER. How much?

Dr. HEYD. Nine hundred million, doesn't it, within the 10 years that it is supposed to run—well, it doesn't matter, the figures are there.

Senator ELLENDER. I don't think your figures are correct.

Dr. HEYD. They may not be.

Senator ELLENDER. How would you define "need"? Who would determine that?

Dr. HEYD. I would have a man like Homer Folks, to tell me what the needs were.

Senator ELLENDER. How would you organize that division, who would have the power to organize and appoint Homer Folks?

Dr. HEYD. The Federal Government.

Senator ELLENDER. What rights would you give the States in supervising this work, if any?

Dr. HEYD. I am not prepared to answer that, I am not a constitutional lawyer.

Senator ELLENDER. Never mind the constitutional aspect, that will be determined later. I am simply asking you, under your plan would

you have the State cooperate with the Federal Government or vice versa, or who would you suggest have the last word?

Dr. HEYD. The last say, as it is now, is with the Federal Government.

Senator ELLENDER. In other words, any plans that would be worked out, and in which the Federal Government would furnish money, you would expect the Federal Government to maintain authority?

Dr. HEYD. Yes.

Senator ELLENDER. And what authority would you vest in the States?

Dr. HEYD. That I am not prepared to answer, I can't frame a bill on my feet, I am only anxious to prevent this train coming into a washout by holding a red signal.

Senator ELLENDER. You know, of course, that I and, in fact, nobody on this committee, would vote to surrender the rights that belong to the States to the Federal Government. So on that particular issue we are apart.

Dr. HEYD. We are both agreed on that.

Senator ELLENDER. But under your plan that is what would happen; you would direct it all from Washington, as you say, and the entire matter would be left to the Secretary and the Public Health, and the States would have nothing to do with it?

Dr. HEYD. Oh, no; after the need had been passed upon and the money had been given to the States, a State, local organization, State or county, or municipality, would distribute that money for the purposes that were written into that grant.

Senator ELLENDER. Well, the need, then, would be determined by the Federal Government through a person appointed by the Federal Government, and after that need is made certain, then the Federal Government would turn over to some State health service, or whatever might be established, funds to supply the need.

Now to what extent would you permit the Federal Government to oversee, as it were, these funds after they get into the hands of the State department of health.

Dr. HEYD. That is already, I think, in the law, that the Comptroller General must see that the funds expended are within the terms of the enactment, or whatever it is.

Senator ELLENDER. And you wouldn't consider that Federal control, that is, the taking away of State rights, would you?

Dr. HEYD. I think that we differ in our viewpoint. The Federal Government, if it puts up money, obviously must have control over the money. I am talking about the Federal control of medical service.

Senator ELLENDER. Well, what I was trying to get from you was some plan which would not incorporate all of these various phases of this bill that you are not in agreement with.

Now, just what authority would you give the Federal Government after the funds reached the State?

Dr. HEYD. I am not prepared to answer that; that requires thought and consideration. I am not competent to do that.

Senator MURRAY. Doctor, could you study out this matter and submit a plan that you think might be feasible?

Dr. HEYD. I am quite sure the American Medical Association, with its personnel, could work out that detail if there was a failure to accomplish it in Washington.

Senator MURRAY. In other words, you feel that a national health program would be proper, but you—

Dr. HEYD (interposing). I did not say that, Mr. Chairman. I did not say that. Senator Ellender asked me what I would suggest to meet conditions of local need or medical need and I submitted what I thought was a competent and effective plan, the Department of Health, the Secretary, all medical activities in that department—

Senator ELLENDER (interrupting). Am I to understand that although you suggest that plan you would be against it?

Dr. HEYD. Against the Wagner bill 100 percent.

Senator ELLENDER. Against the plan you suggest?

Dr. HEYD. No.

Senator MURRAY. In other words, you think that there would be a justification on the part of the National Government in establishing a system whereby assistance could be given—

Dr. HEYD (interposing). No; not a system, Mr. Chairman, a Department of Health. That is the keystone of all I have said, a Department of Health and a Secretary of Health, not a system of medical service.

Senator MURRAY. I didn't say a system, I said "assistance." I failed to speak as distinctly as I should, possibly, but I understand you now and you understand me.

Senator ELLENDER. Would you leave this question of the determination of need solely in the hands of the party appointed by the Government, or would you have this party cooperate with the State agency which is to spend the money?

Dr. HEYD. Either way it could be worked out amicably. When minds are for the same objective, they can usually meet if the fundamental principle is sound.

Senator ELLENDER. Now, Doctor, you have stated—I may have misunderstood you—that a person who receives free treatment is not as likely to get well as one who must pay for it, am I right in that?

Dr. HEYD. I will accept your version of it; yes.

Senator ELLENDER. You don't believe in Christian Science?

Dr. HEYD. Do I believe in Christian Science?

Senator ELLENDER. Yes.

Dr. HEYD. You mean as therapy or medical treatment?

Senator ELLENDER. I don't know, but I would judge from the question that I have just asked and your answer thereto, that is on the borderline of Christian Science, as I, as a layman, understand it? The fact that I go to a hospital and I mustn't pay, I will just stay in bed and accept the hospitalization and I will not get well as quickly as though I paid for medical care.

Dr. HEYD. I think that is true in about 95 out of 100 cases.

Senator ELLENDER. Do you like to stay in a hospital bed?

Dr. HEYD. Yes; sure.

Senator MURRAY. Doctor, after hearing all this conflicting testimony, I would like to go to a hospital and stay there a week now and get a good rest. [Laughter.]

Senator ELLENDER. Would you expand on that for us?

Dr. HEYD. Yes; and I will give you a direct answer to it.

Senator ELLENDER. I don't mean these chronic cases; I mean generally speaking?

Dr. HEYD. You mean, as you might be sick after this session?

Senator ELLENDER. Yes; but I have, seriously, been sick just a few times and I was glad to get out of the hospital, not because it cost money, but because I was anxious to get out of that environment.

Dr. HEYD. Let me explain that to you.

Here is an individual. I want time to make two examples. Here is an individual who doesn't like his job particularly and he develops a nice big boil on the back of his neck and he goes to a hospital and he is fed well and he has a lot of pretty nurses wait on him and he has dressings. Do you suppose that fellow is in a hurry to get out and go back to work?

That is one example.

Senator ELLENDER. I don't think a man who has a boil would be admitted to any of these hospitals. It would simply be opened and out he would go. [Laughter.]

Dr. HEYD. Did you ever have one?

Senator ELLENDER. Yes.

Dr. HEYD. With a temperature of 104 and the possibility of meningitis and dying?

Senator ELLENDER. That is a different proposition; if those conditions exist I would then say he ought to stay in. It is seldom, however, that a mere boil will cause such a condition.

And another thing, Doctor, it strikes me that any plan that would be worked out by the Federal Government through the States, the tendency would be to leave it to the doctors to determine whether or not the patient should remain in the hospital, as is done now in charitable institutions that I know of in my own State. They usually give them a card and say, "You are well," or "You have got to be transferred," or something of that kind. Isn't that usually true?

Dr. HEYD. Right.

Example No. 2: The Associated Hospitals in New York City have over 1,000,000 subscribers. You are familiar with that. That is the 3-cents-a-day plan. Under their plan, by paying \$10 a year, any individual, a policyholder, can, upon the advice of a doctor, go to a hospital. Under that plan all the hospital charges are paid up to 30 days.

In 1938 the admission of people to hospitals with colds, with trivial cuts, was so great as to practically make severe inroads into the reserves of that organization, showing you that when people do not pay for their per diem maintenance, in hospitals, they tend to prolongation.

Example No. 3: In the veterans' hospitals I have heard that it takes 29 days to take out tonsils and discharge the patient. In civilian hospitals it takes 3 to 4 days.

Senator ELLENDER. And you attribute that condition to the fact that in one instance they must pay and in the other they musn't?

Dr. HEYD. The psychology of getting something for nothing.

Senator ELLENDER. I know, but isn't the medical profession, that is, the doctor who permits patients to do that largely to blame?

Dr. HEYD. They are particeps criminis, I believe.

Senator ELLENDER. Don't you think they are 99 percent criminis?

Dr. HEYD. Oh, no.

Senator ELLENDER. I don't know, but it strikes me that the—

Dr. HEYD (interposing). Don't forget the doctors in the veterans' hospitals are Government employees.

Senator ELLENDER. Civil service—the merit system. [Laughter.]

One more question I would like to ask you, if you don't mind answering it?

Dr. HEYD. Not at all, I love it.

Senator ELLENDER. On page 5 of the bill you cited section 7?

Dr. HEYD. Yes, sir.

Senator ELLENDER. And I understand your conclusion, that is, what you derive from that section, is that it may lead to socialized medicine; am I right?

Dr. HEYD. It is inevitable in the terms of the bond.

Senator ELLENDER. Personally, I do not favor socialized medicine. Would you suggest any language to a negative situation?

Dr. HEYD. I cannot suggest language on my feet to cover such an important matter.

Senator ELLENDER. These hearings are not going to close today, and we expect to continue them later, but would you have someone to suggest suitable language?

Dr. HEYD. No, sir; you can't patch this house up.

Senator ELLENDER. Wait a minute, Doctor, I am not suggesting the entire bill; I am talking about that portion of it dealing with socialized or social medicine, and you cited this paragraph on page 5 and several others that lead you to believe that that is inevitable if that language, as I understand it, is retained in the bill. Now what I would like to have is a suggestion from you or any member of the association, in fact anybody against the bill, who thinks that this would lead to socialized medicine, of suitable language to negate your assumption.

Dr. HEYD. Senator, it is my considered opinion that you cannot amend this bill and make it workable.

Senator ELLENDER. That is all. I predicted that if the bill is passed the association will be suggesting amendments after it is too late.

Senator WAGNER. Doctor, you just said that when people get something for nothing, that there is the psychology which keeps a man in a hospital longer than he should?

Dr. HEYD. Yes, sir.

Senator WAGNER. Do I understand you to mean by that that people who are poor and helpless and sick and want to get well, ought not to receive any care because they can't afford to pay for it?

Dr. HEYD. No, sir; they should receive all the care they need.

Senator WAGNER. What do you mean, then, by this thing you just said a moment ago, that getting something for nothing just prolongs illness, rather than curing it?

Dr. HEYD. There comes a time, Senator, when a person, after an illness or an operation, a certain given number of days, when he is considered well enough to go home.

Senator WAGNER. I am not talking about that—I have heard about that—I don't agree with you at all, but that isn't what I am talking about. I am talking about the person that hasn't got the money to pay for an operation and he is sick and he is helpless; what about that person?

Dr. HEYD. Senator, won't you be fair and let me finish my argument on that?

Senator WAGNER. You started it; you said after an operation—I am talking about something before an operation, I am talking about the person that hasn't the money with which to pay for an operation, and yet he needs it and he is very ill and he is poor; he hasn't the money; he is in that lower-income group. What about that person?

Dr. HEYD. He should receive medical attention without any question.

Senator WAGNER. Aren't you afraid of ruining that person by giving him medical attention because he is getting it free?

Dr. HEYD. On the contrary, we are making him well.

Senator WAGNER. You said a moment ago that getting something for nothing makes persons ill rather than well.

Dr. HEYD. No; it tends to prolong illness and convalescence; they are totally different, Senator.

Senator WAGNER. Tends to prolong illness?

Dr. HEYD. Yes, sir.

Senator WAGNER. Well, we don't want to prolong illness, and how are we going to stop it?

Dr. HEYD. I don't think you will stop it under your bill.

Senator WAGNER. How would you stop it?

Dr. HEYD. I would carry on the present medical system that has been so successful.

Senator WAGNER. Has it been?

Dr. HEYD. Has it been successful?

Senator WAGNER. Yes.

Dr. HEYD. I am going to give you the answer, that it has been.

Senator WAGNER. Aren't you relating what you are saying as the result of your experience?

Dr. HEYD. Yes, sir.

Senator WAGNER. That helping these people that are getting it for nothing prolongs their illness?

Dr. HEYD. Yes.

Senator WAGNER. Don't we want to cure them?

Dr. HEYD. Certainly.

Senator WAGNER. How are we going to do that?

Dr. HEYD. Under the scheme that I outlined to the Senator, centralized department of health, and—

Senator WAGNER (interposing). Is that the way you are going to do it?

Dr. HEYD. Carry on the present medical set-up that has been so effective and aid areas that need help by Federal funds.

Senator WAGNER. Aren't you going to set up—I understood you to say that you wanted to substitute another set-up?

Dr. HEYD. Not to destroy the present medical distribution; no, sir.

Senator WAGNER. Well, does this bill destroy the present method of distribution?

Dr. HEYD. In my opinion, it does.

Senator WAGNER. Well, what is it that does?

Dr. HEYD. Well, if this bill were enacted, you would have 48 commissioners of health coming to Washington, to interview three indi-

viduals and making requests for allotments, and they would or would not get those allotments, and when you have the power to give or withhold money, you can coerce or control that medical service.

Senator WAGNER. Now, let's get right down on that point.

What did you suggest in place of that; didn't you suggest a moment ago a department of health?

Dr. HEYD. Yes.

Senator WAGNER. To which the 48 States would come?

Dr. HEYD. No, sir.

Senator WAGNER. Who would come?

Dr. HEYD. Any subdivision of the States that had a local need could come and petition that department and have the merits of their request passed upon.

Senator WAGNER. Well, what is the difference between the State coming and any subdivision of the State coming?

Dr. HEYD. Because in this bill you make the deficiencies of one State a pattern for spreading all of this allotment over the whole 48 States and dependencies. My fundamental proposition is where the need is demonstrated.

Senator WAGNER. Very well; then if this bill—I think it is based on need, but I am not going to argue that with you—suppose the bill is changed according to your suggestion now, and instead of only the head of the State coming, any subdivision of the State may come, isn't that what you suggested a moment ago?

Dr. HEYD. No, sir; I would have nothing to do with this bill.

Senator WAGNER. Well, under any bill?

Dr. HEYD. I didn't say that, and you can't read into my language anything like that. I said—

Senator WAGNER (interposing). I am asking you, suppose a bill is introduced which will provide for the central bureau here in Washington with a health commissioner at the head, with funds supplied by Congress, and with an authorization to give to States or political subdivisions according to the needs of those communities for medical aid. Would you then favor such a bill, Doctor?

Dr. HEYD. When such a bill is introduced I should like to study it and discuss it with you; I will not sign a blank check.

Senator WAGNER. Well, of course, that isn't centralization of power, is it, having a central bureau such as you recommend where the commissioner at the head has the right to determine whether a State should receive money or not?

Dr. HEYD. It may have something of centralization in it.

Senator WAGNER. Well, isn't that bureaucratic?

Dr. HEYD. No; the Post Office Department in Washington, that is centralization.

Senator WAGNER. I understood you to say that you were opposed to centralization.

Dr. HEYD. I am opposed to the centralization that flows from this bill.

Senator WAGNER. Well, with all due respect to you, what you are suggesting is much greater centralization than the provisions of this bill suggests.

Dr. HEYD. I don't believe so, Senator.

Senator MURRAY. May I call his attention to this provision in here, on page 4, at the bottom of page 4, in connection with the grants to States:

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 the child-health services.

Under that section it depends upon the profession, as a medical profession, and other public agencies, to determine the need for the assistance that is to go to the State. Wouldn't you favor that?

Dr. HEYD. With all due deference to you, Mr. Chairman, those advisory councils have no power; it says "members of the profession." They might be a minority, and in substance that section means that the advisory councils would be rubber stamps.

Senator MURRAY. Could that be corrected, then, if that is not satisfactory as it stands; could it be amended so as to make it feasible?

Dr. HEYD. I don't believe you can amend this bill and make it workable.

Senator WAGNER. A moment ago you said something about the distribution of moneys to Nevada?

Dr. HEYD. Yes, sir.

Senator WAGNER. Well, what was the purpose of that—to show they were getting more money than they should get?

Dr. HEYD. No; the purpose of that was to show that the ordinary per capita expense of a well-rounded health service is \$1.32, and the money received for those two items from the Children's Bureau, and the Public Health Service, was \$2.02, indicating in a relative way the element of the increased cost that grows from the filtering down of funds.

Senator WAGNER. Well, if that was so, you shouldn't be for any Federal aid; if giving Federal aid increases the expense of medical service, how do you justify your being for any Federal aid?

Dr. HEYD. Well, certain functions in medicine must be provided by the Federal Government.

Senator WAGNER. How do you know that that is not a case where medical care was needed and an increased sum was needed to take care of the individuals in that State?

Dr. HEYD. I am prepared to admit that it was needed or it probably wouldn't have reached there.

Senator WAGNER. If you are prepared to admit that, then what was your point in citing it to us?

Dr. HEYD. Because it heads the list of States that received this aid, in amount of money, and I can't imagine that the wants in child welfare and in maternal welfare can be greater in Nevada than in Oklahoma or in New York City, because Nevada has less population; less babies born; and must have less crippled children and yet they got more money.

Senator WAGNER. Did you examine these facts?

Dr. HEYD. These are facts that have been supplied by these bureaus, sir.

Senator WARNER. I mean, did you inquire as to what the need was in those particular instances?

Dr. HEYD. No, sir.

Senator WAGNER. Well don't you think if you wanted to make a fair statement that you ought to have inquired whether that much money was needed to give proper medical care?

Dr. HEYD. No; I see no reason to believe that those bureaus didn't give the required amount of money.

Senator WAGNER. Well, if they did, then it was a very desirable aid, wasn't it?

Dr. HEYD. I presume it was.

Senator WAGNER. Well, you quoted it in criticism.

Dr. HEYD. Yes, sir.

Senator WAGNER. And yet now you say it might very well have been needed.

Dr. HEYD. Yes.

Senator WAGNER. Doctor, do you know the organization known as the National Committee to Uphold Constitutional Government?

Dr. HEYD. Yes, sir.

Senator WAGNER. Have you anything to do with that organization?

Dr. HEYD. No, sir. What do you mean by "anything to do" with it?

Senator WAGNER. I will put it another way. I have a telegram, a copy of a telegram, that you sent. I take it that you sent it to more than one individual?

Dr. HEYD. Certainly.

Senator WAGNER. And in this telegram you say:

Today's mail brings you from Sumner Gerard booklet, Political Medicine and You. Leaders of medicine convinced pending Wagner national health bill and supplementary bills being pressed various State legislatures harbor grave dangers, impairing standard of medical profession, crippling research, and threatening church and volunteer hospitals. Since this issue is being carried to every State, we are convinced necessity Nation-wide educational campaign proposed booklet, page 22. Will you read and give support measured by importance of issue, or if already supporting, interest others?

CHARLES GORDON HEYD,

*Past President, American Medical Association.*

JOHN A. HARTWELL,

*Past President, Academy of Medicine, New York.*

That is signed by you?

Dr. HEYD. Yes.

Senator WAGNER. To how many people did you send such a telegram; do you know?

Dr. HEYD. I haven't the remotest idea.

Senator WAGNER. Well, you must have some idea; I can't accept your answer that you haven't the remotest idea.

Dr. HEYD. I signed the master telegram that was sent out as a sampling, I think, to 50 individuals in New York, and then it was probably extended, I don't know to how many, sir.

Senator WAGNER. It would be extended by whom?

Dr. HEYD. By the Gannett organization.

Senator WAGNER. That is what I want to know. The Gannett organization sent these telegrams ostensibly signed by you?

Dr. HEYD. Yes, sir.

Senator WAGNER. To all of the doctors alone or others, too?

Dr. HEYD. That I don't know; probably all types of people.

Senator WAGNER. This was sent to a bank.

Dr. HEYD. It was sent to all the citizens.

Senator WAGNER. Did you supply that list?

Dr. HEYD. No, sir.

Senator WAGNER. Did the Gannett organization supply the list?

Dr. HEYD. If they had a list they certainly got it, because we did not supply it.

Senator WAGNER. Well, you said you originally sent out 50, and then there were any number more sent out after that?

Dr. HEYD. I believe so.

Senator WAGNER. Well, aren't you a little more particular about the use of your name than not inquiring even as to who these telegrams were sent to?

Dr. HEYD. No; I was quite prepared that that telegram go to every citizen in the United States.

Senator WAGNER. I see; to support the Gannett organization?

Dr. HEYD. I have contributed to it.

Senator WAGNER. And you asked these people to contribute to it?

Dr. HEYD. Yes, sir.

Senator WAGNER. Do you know what their activities have been?

Dr. HEYD. Only in a general way. I know the phase of the medical activities.

Senator WAGNER. You think it was all right for you as a doctor to associate yourself with propaganda of that character?

Dr. HEYD. As a citizen; yes.

Senator WAGNER. Well, as a doctor?

Dr. HEYD. As a doctor.

Senator WAGNER. Doctor, a moment ago—I just wanted to get some views of what is in your mind—you spoke of disability, temporary disability—

Dr. HEYD (interposing). I didn't understand you.

Senator WAGNER. You were talking some little while ago about the provisions in this bill which provide for payments for temporary disability and you said, as I understood you—and if I am wrong will you please correct me—that one of the reasons you opposed that is that one receiving some cash benefits because of loss of wages, would continue his unemployment and illness in order to receive the compensation, although the illness had disappeared. In effect, was that what you said?

Dr. HEYD. Experience demonstrates that that is correct, both in England and in Germany.

Senator WAGNER. Well, is it so with reference to workmen's compensation?

Dr. HEYD. I think it is true of workmen's compensation.

Senator WAGNER. Well, do you know anything about the studies that have been made in New York State and other States?

Dr. HEYD. Yes, sir; I went to Governor Lehman, and had the doctors' committee appointed that framed the amendment to the Workmen's Compensation Act of New York State.

Senator WAGNER. When was that?

Dr. HEYD. In the previous term of Governor Lehman, when the amendment to the present Workmen's Compensation Act was enacted. That is, I should say, about 3 or 4 years ago.

Senator WAGNER. Are you acquainted with any investigations that have been held in New York on that very subject?

Dr. HEYD. Yes, sir.

Senator WAGNER. Don't you know that they show that there hasn't been any such experience in New York?

Dr. HEYD. Since the enactment of the amendment it has been clear and clean, Senator, because the policing of the profession is stated in the amendment to the workmen's compensation as being the responsibility of the medical society of the State, but previous to the amendment, the workmen's compensation was scandalous.

Senator WAGNER. Will you point out to me any investigation that shows that—do you mean the conduct of the doctors?

Dr. HEYD. The conduct of the doctors, the conduct of the insurance chasers, the conduct of the auditors, of the insurance companies, and Governor Lehman appointed this commission to study it, composed of five members of the New York Academy of Medicine and five from the medical society of the State of New York, and upon the recommendations of that committee, the Workmen's Compensation Act was amended, and since that amendment it has been cleaner.

Senator WAGNER. What is the nature of the amendment?

Dr. HEYD. That is one of your bills—the original bill, I know.

First, the medical society was ordered to prepare a detailed fee schedule and they worked with the insurance companies and devised a schedule which was fair and reasonable and within the compensation of the workman.

Second, on disputed bills the bill must be passed by a tribunal of a county medical society.

Third, there were double penalties if the insurance company stole a case—that is, if I saw a case and the insurance doctor came in and took the case away.

And a lot of things that tended to purify the atmosphere surrounding the injuries to workmen.

Senator WAGNER. Well, are cash benefits now paid under workmen's compensation?

Dr. HEYD. Yes, sir.

Senator WAGNER. And is medical service paid under workmen's compensation?

Dr. HEYD. Yes, sir.

Senator WAGNER. And what portion of compensation is for medical service and what for cash payments?

Dr. HEYD. I can't tell you that.

Senator WAGNER. Would you be surprised if I told you that over 90 percent of compensation claims are for medical services and 10 percent for cash payments?

Dr. HEYD. No; I would not be surprised, I would expect you to know.

Senator WAGNER. So that the medical profession is getting a real benefit out of the workmen's compensation?

Dr. HEYD. The medical profession of the State of New York are eminently satisfied with the workmen's compensation in the State of New York.

Senator WAGNER. Well now, if that is so, I don't understand why disability insurance, which involves the same theory except it is for an illness which was not acquired in the scope of employment, would

not work just the same as it does with the workmen's compensation law?

Dr. HEYD. Well, there are a lot of reasons, Senator, why it wouldn't work as well.

First, you have the control of the injured workman, he is working for a company, they know where he is, they know the manner of the injury, he selects his own doctor and he goes there, and all during that time there is the supervision by the company's doctor to prevent prolongation.

Now, in contrast to that, in England and in Germany the prolongation of sickness beyond any reasonable time was so great that many times special agencies of the Government had to be appointed to investigate this and to get rid of the malingering. There are a lot of very obvious psychological factors in the two pictures.

Senator WAGNER. And you think we are not competent to prevent these prolongations?

Dr. HEYD. Oh, no; I am quite sure that the Federal Government can devise a means that is comparable to the workmen's compensation, but it is not in your bill.

Senator WAGNER. All right, will you suggest some provision that will strengthen that particular section of the bill?

Dr. HEYD. I don't think you can amend the bill, Senator.

Senator WAGNER. Well, forget this particular bill.

Dr. HEYD. I am not called upon to write a bill, Senator.

Senator WARNER. I see, that is your idea of public spirit?

Dr. HEYD. I came down here in the spirit of public spirit.

Senator WAGNER. Simply to oppose?

Dr. HEYD. Yes.

Senator WAGNER. Not to suggest, make any constructive suggestions?

Dr. HEYD. May I put a question to you, Senator? Suppose I see a railroad train coming, where there is no bridge and a washout, am I going to start building a bridge or am I going to get a red flag and stop that train?

Senator WAGNER. That is not at all analogous.

Dr. Heyd, do you know whether the medical journals contain any letters which criticize your action in sending this telegram, or your association with the so-called Gannett movement?

Dr. HEYD. Yes; I know of half a dozen.

Senator WAGNER. May I read one of these letters?

Dr. HEYD. By all means.

Senator WAGNER. That is to the editor of the Medical Week, organ of the New York County Medical Society:

In order to combat the Wagner health bill some of our physicians have formed the Physicians Committee for Free Enterprise in Medicine, a committee working with Gannett's National Committee to Uphold Constitutional Government.

There may be some physicians in Manhattan, as there were in Brooklyn, who did not quite understand the function of the group they were joining.

Therefore it is pertinent to point out some facts about the Gannett committee.

The activities of this committee are such that the Senate was impelled to question Gannett as to who the backers were. But this Gannett refused to divulge.

The most interesting aspect of the committee is the fact that Gannett chose Dr. Edward A. Rumely to be its manager. This Rumely is none other than the "war-time pro-German propagandist who, with the aid of pro-Germans bought

the New York Evening Mail for the purpose of presenting the Kaiser's cause \* \* \* He was convicted of trading with the enemy and sentenced to serve a year and a day in the Federal penitentiary in Atlanta" (George Seldes, *Lords of the Press*, p. 211).

Does any group in America which really wishes to maintain our constitutional democracy need the services of a man who was convicted as a spy? Are there no others whose motives are above suspicion? And it would be interesting to inquire whether Rumely's sympathies for the Kaiser's military machine have not grown apace with the development of Hitler's supermilitarism. One cannot escape the suspicion that a committee to uphold the Constitution which needs the services of a former spy smacks of that patriotism which is the last refuge of a scoundrel.

The fact that outstanding men in the profession have joined the Gannett committee puts the whole profession in a very questionable light before the lay public. The opinions of these men are not representative of the profession as a whole, as was shown at the meeting of the Kings County Medical Society (reported in the New York Times, April 23, 1939), where a resolution condemning the Free Enterprise group was passed by a vote of 10 to 1. The fact that some of these men are officers of the New York County Medical Society puts the problem directly before the membership of that society.

I have mentioned the above facts about the Gannett committee on the chance that these officers were not acquainted with them. If, knowing them, the president, the president-elect, the secretary, and the editor of Medical Week, among others, are still content to lend their support to a spy-run organization which refuses to divulge its financial backing, then it becomes incumbent on the membership to question whether these men are qualified to act as the official spokesmen for organized medicine. The choice is clear-cut and should be an easy one for men of integrity to make.

MARTHA MENDELL, M. D.

There are a number of others along the same lines, but I don't propose to read them. Do you remember reading that letter?

Dr. HEYD. Yes; I know Dr. Mendell.

Senator WAGNER. Is it true that the medical society in Brooklyn took a vote on this proposition?

Dr. HEYD. I think that is true.

Senator WAGNER. In favor of this legislation?

Dr. HEYD. That I don't know.

Senator WAGNER. Was this vote 10 to 1 as reported?

Dr. HEYD. That I don't know.

Senator WAGNER. I do not, of course, question your constitutional right to engage in these activities.

I don't want to pursue this indefinitely. You said something about research, of the bill possibly interfering with research.

Of course I don't understand how it possibly can interfere with research, and in my opinion it encourages it, but one of the eminent doctors in New York came before this committee and stated that the National Health Service has done research work which is equal to the work of any private research laboratory. He was a professor up at Columbia.

Dr. HEYD. That is the National—

Senator WAGNER (interposing). The National Health Service, which is conducting research work constantly.

Dr. HEYD. Has done research comparable to—

Senator WAGNER (interposing). To that of private institutions that conduct research.

Dr. HEYD. I don't believe the body of facts would sustain that statement.

Senator WAGNER. Well, you differ with him?

Dr. HEYD. Yes, sir.

Senator WAGNER. You did say something about the danger of the subsidizing of medicine?

Dr. HEYD. Medical students.

Senator WAGNER. Medical care?

Dr. HEYD. Training of personnel—I spoke of the subsidy for training of personnel, is that what you refer to?

Senator WAGNER. Was it that? I thought you made a general statement about subsidizing medical care?

Dr. HEYD. I think, sir—

Senator WAGNER (interposing). Medical schools, that was it?

Dr. HEYD. Yes; I think that is the only time I used that word. The training of personnel by Government subsidy would change the entire basis of medical education.

Senator WAGNER. Well, do you believe in our free school system?

Dr. HEYD. Certainly.

Senator WAGNER. Isn't that subsidized by the Government?

Dr. HEYD. Yes, sir.

Senator WAGNER. It has worked very well, hasn't it?

Dr. HEYD. Yes.

Senator WAGNER. A great deal more people get education than before we had such a system?

Dr. HEYD. Yes, sir.

Senator WAGNER. Don't you think that it would rather help the medical education in the medical field if the Government did aid in subsidizing schools?

Dr. HEYD. Medical schools—you ask me if I think that subsidizing the medical schools will help medical education, is that the question?

Senator WAGNER. Yes.

Dr. HEYD. I say emphatically it will not. Temporarily it will bail some of them out of their insolvency, but in the long run it means depreciated and deteriorated medical service, and the reason is that you send a child to school, and you give him a broad, basic education, but what medicine has done in the last 25 years is to select young men who will be competent to be doctors, and that competency is judged by their scholarship record.

You are not giving them just an X degree of education. You are selecting men to take a particular job, giving them a particular education. Now when you subsidize a medical school, any citizen may claim the right of his son to enter a medical school.

Senator WAGNER. In New York City, you know, my alma mater as a matter of fact, is the College of the City of New York. Do you think that has destroyed our young men in the City of New York by giving them that free education?

Dr. HEYD. No; obviously not. [Laughter.]

Senator WAGNER. I am sure you must have referred to Judge Felix Frankfurter, who is a graduate of the College of the City of New York?

Dr. HEYD. No less than you, Senator.

Senator WAGNER. But I am trying to get what is in your mind.

As to whether it was a good thing for me to get that education or not I am afraid to ask you [laughter], but that is available to the

poorest in New York, and I know I was one of those. I couldn't possibly have gotten an education without that free College of the City of New York, which the taxpayers of New York support and very willingly, I think.

Now do you believe in that institution?

Dr. HEYD. Your alma mater; yes.

Senator WAGNER. You, by chance, are not a graduate of that college?

Dr. HEYD. No; I am not, unhappily.

Senator WAGNER. One of my classmates was a very eminent professor in Columbia, Dr. Spitzer. He was a very eminent doctor, too, wasn't he?

Dr. HEYD. He was.

Senator WAGNER. Well, what is the difference between that sort of an education and a medical education? I don't know how I got by, and I happened to get by very well, just by luck, pure luck, but you know we have to keep up a certain standard there or out we go. So the subsidizing of that institution didn't affect our character or reduce the scholarly standing of that institution. As you know, it stands well among the colleges of this country from the standpoint of scholarship. Now subsidizing that institution hasn't affected that standard of scholarship, has it?

Dr. HEYD. No.

Senator WAGNER. Well, then, why would it—if a boy whose people haven't the means and yet he has the ambition and the capacity and the ability—why would that individual be affected because the particular institution is subsidized?

Dr. HEYD. Well, Senator—

Senator WAGNER (interposing). Or is it your idea to keep it among those who can afford to pay the tuition?

Dr. HEYD. Oh, no.

Senator WAGNER. I didn't think it was.

Dr. HEYD. If I may digress from the purpose for which I am here, it has always been a matter of great regret to me that the cost of a medical education was so great, I grant that. However, if the Government is going to subsidize young men to enter medicine, then you are going to have anybody or everybody apply for that subsidy, and we will not continue the development of medical education if we have a large number of young men coming to medical schools who must perforce be admitted because the Government is subsidizing them.

Senator WAGNER. Now I am getting to your point, I think. You want to limit those who go, who seek to qualify in your profession, to those who can afford to pay the tuition, and the cost of the education, because you are fearful that if the Government aids them that there will be too many of them; that is your idea?

Dr. HEYD. The chances are, I think, in the long run, that there will be about as many doctors as the community can stand. The past 25 years has demonstrated that.

You see, Senator, there are about fourteen or fifteen thousand young men apply in medical schools to be doctors, and the total number that can be accepted is about 5,000, you see. Now, therefore,

the requirements for admission to medical schools are very severe, scholarship, age, background, and so on, and recommendations and academic scholarships, and a certain number are selected.

Now then, if Government money is used to subsidize the medical school, the freedom of action of the medical school is very seriously imperiled, and over a period of years you will have, in my opinion, a lessening of standards.

Senator WAGNER. I see. You don't think subsidies for private institutions have ever affected the curriculum of colleges and medical schools, do you?

Dr. HEYD. I can't answer that, I don't know.

Senator WAGNER. Well, you remember the cases where very large corporations were the supporters of educational institutions and it was openly charged that their curricula were more or less chosen according to the views of the large contributors—you wouldn't regard that as a menace, would you?

Dr. HEYD. Yes; I believe anything that interferes with the free expression of thought in universities is prejudicial.

Senator WAGNER. As a matter of fact, you are at Columbia, aren't you?

Dr. HEYD. Yes.

Senator WAGNER. Are you connected with the College of Physicians and Surgeons?

Dr. HEYD. Yes, sir.

Senator WAGNER. You receive subsidies, of course; you couldn't exist without them?

Dr. HEYD. Yes, sir.

Senator WAGNER. They are subsidies properly given, and I am sure they don't influence your educational standards, but you do receive donations from private individuals?

Dr. HEYD. Yes, sir.

Senator WAGNER. That is a subsidy?

Dr. HEYD. Yes.

Senator WAGNER. You don't see any objection to that?

Dr. HEYD. No.

Senator WAGNER. But you don't want any public subsidy?

Dr. HEYD. Under certain circumstances; yes, there must be public subsidy, of course.

Senator WAGNER. Well, what?

Dr. HEYD. That I can't answer offhand.

Senator WAGNER. Then why did you make the statement that the giving of a subsidy is going to deteriorate the educational standards of the medical profession?

Dr. HEYD. May I read this?

Senator WAGNER. No; I don't want you to read it, I am asking you something regarding a statement you made, and I am trying to find out what is in your mind that could persuade you that the aiding by the Government of educational institutions is going to deteriorate the standards of the medical profession?

Dr. HEYD. For the training of personnel, as outlined in this bill, it requires the enabling acts in the State legislatures, and it requires that the individual who is going to serve under any one of these titles shall receive a subsidy to go through a medical school

and in return he pledges himself to remain for 3 years in the service.

Now, I believe that that mechanism of subsidizing a student, any student, to go through a medical school, will inevitably force that medical school to lower its standards.

Senator WAGNER. You believe that, do you?

Dr. HEYD. Yes, sir.

Senator WAGNER. I see. Do you know Cornell University?

Dr. HEYD. Yes, sir.

Senator WAGNER. Do you know whether that receives any public support?

Dr. HEYD. I do not.

Senator WAGNER. You don't know?

Dr. HEYD. No.

Senator WAGNER. Well, if you look at the budget, the State budget for New York, you will find a very large appropriation this year for Cornell University. That has a medical school. Do you regard that as a school of high standards?

Dr. HEYD. Yes, sir.

Senator WAGNER. Well, that is subsidized by the Government?

Dr. HEYD. The university receives the money.

Senator WAGNER. Well, it is all part of the same, it is all part of Cornell University.

Dr. HEYD. No; they are subsidizing the individuals here that go into a medical school.

Senator WAGNER. That is the portion you object to, you don't want him or her helped?

Dr. HEYD. I don't want that mechanism because I think it deteriorates, brings about deterioration.

Senator WAGNER. In other words, you don't want these individuals helped by the Government to secure the education; is that it?

Dr. HEYD. No; I can't give you an unqualified expression that I don't want that.

Senator WAGNER. Well, I don't want to pursue this forever, but I am trying to get what is in your mind. At one time, Doctor, if I may say so, there was opposition to the appropriation for the College of the City of New York by those who said that education ought to be confined to those who are able to afford the tuition fees. As a result, I helped enact in Albany legislation which gives to the College of the City of New York a certain portion of the tax each year.

Now, you wouldn't have favored the reduction in the support of the College of the City of New York, would you favor that today, Doctor?

Dr. HEYD. Favor a reduction?

Senator WAGNER. Yes.

Dr. HEYD. No.

Senator ELLENDER. Doctor, before a boy qualifies to study medicine at Columbia, he must have certain qualifications?

Dr. HEYD. Yes.

Senator ELLENDER. Is not the number of students limited also?

Dr. HEYD. The number of students limited?

Senator ELLENDER. Yes.

Dr. HEYD. Yes.

Senator ELLENDER. Is that not the case in every medical school, practically every medical school in the Nation?

Dr. HEYD. Yes, sir.

Senator ELLENDER. Well, now, if a boy receives a subsidy from the Government, what is there in the law to force the college to accept the boy who receives this subsidy? Unless he meets the qualifications of the college, will he not be placed in the same category as any other student who applies for admission?

Dr. HEYD. I don't know of anything in the law.

Senator ELLENDER. Very well.

Senator MURRAY. Thank you, Dr. Heyd.

Dr. CARY. Mr. Chairman, at this time may I enter in the record some information which I think the committee should have.

(Magazine entitled "Hospital Service in the United States, 1939," was filed with the committee.)

Dr. CARY. At this time, I have the pleasure of presenting the editor of the American Medical Association Journal, Dr. Morris Fishbein, who will continue the discussion.

Senator MURRAY. Dr. Fishbein.

#### STATEMENT OF DR. MORRIS FISHBEIN, EDITOR OF THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.

Dr. FISHBEIN. The name is Dr. Morris Fishbein, editor of the Journal of the American Medical Association, Chicago.

We have been presenting here, during the past 2 days, and on some previous occasions, the statements of men who have developed information concerning the medical point of view regarding the Wagner Act, and I do not wish to take the time of the committee to repeat either the arguments or the general statements that have already been made. I hope, rather, to cover the ground that has not yet been covered or perhaps to correct some of the misstatements and misimpressions that have been made by some of those who have appeared previously.

I would call attention first of all to the fact that I have had opportunity in the past week and previously to read some of the recorded hearings that have already taken place, and I believe it will be in the interest of bringing out the facts to mention some of the things that have been said and to call attention to the differing points of view held by the representatives of the medical profession in this regard.

I would like, first of all, to point out that perhaps in a malicious, perhaps in a wholly humorous manner, the representatives of the medical profession who are sent by the American Medical Association are commonly referred to as a hierarchy, and it has been said by a previous witness at the hearings that the views represented by these men are just the views of this inner group, and do not in any way represent the views of the vast majority of the doctors in the United States.

Senator MURRAY. No one on this committee has referred to them as a hierarchy, or made any slurring remarks toward any member of the American Medical Association.

Dr. FISHBEIN. With that statement, I will omit any further discussion of that point.

Senator MURRAY. If a statement of that kind appears in the public press, we couldn't be held accountable.

Dr. FISHBEIN. It appears in the record of the hearings.

Senator ELLENDER. A witness so testified?

Dr. FISHBEIN. Yes; Mr. Lee Pressman of the C. I. O.

Senator MURRAY. Of course, we couldn't be held responsible for statements made by a witness.

Dr. FISHBEIN. No, I merely wished to correct the general point of view that what we have had presented here is not alone the view of the officers who are here, but the views which we have presented were adopted by the house of delegates of the American Medical Association after a considerable number of hearings held by a reference committee before which there appeared scores of men.

Senator ELLENDER. Doctor, I think some member of the association testified yesterday that there were one hundred thirty and some-odd members—

Dr. FISHBEIN (interposing). One hundred and fifty-four delegates in attendance.

Senator ELLENDER. I mean doctors.

Dr. FISHBEIN. One hundred and thirteen thousand physicians as of May 1, 1939, out of a total licensed to practice of approximately 170,000, of whom approximately 14,000 are over 65, and 145,000 actually in practice.

Senator ELLENDER. The delegates met in St. Louis?

Dr. FISHBEIN. Yes, sir.

Senator ELLENDER. How are they selected?

Dr. FISHBEIN. They are selected by the houses of delegates, the representative bodies of the individual State medical societies. These houses of delegates are in turn selected by the county medical societies which compose the individual State medical societies.

Senator ELLENDER. How are the selections made from the States?

Dr. FISHBEIN. They are made by nomination and election from the State medical society house of delegates.

Senator ELLENDER. In what proportion to each State?

Dr. FISHBEIN. The proportion is 168 delegates for 113,000 physicians.

Senator ELLENDER. When you say that the Medical Association met in St. Louis, this meeting was composed of 154 delegates?

Dr. FISHBEIN. One hundred and sixty-eight delegates, and there were approximately 7,500 physicians in attendance.

Senator ELLENDER. And the power to act, though, on any proposition that came before the association, was in the hands of these delegates?

Dr. FISHBEIN. Entirely in the hands of the house of delegates which determines policies and is the only body which can determine policy for the American Medical Association.

Senator ELLENDER. A witness testified yesterday that hearings were held?

Dr. FISHBEIN. Yes.

Senator ELLENDER. Witnesses were produced before the house of delegates?

Dr. FISHBEIN. Yes.

Senator ELLENDER. How many persons or doctors appeared in favor of the Wagner bill before your house of delegates?

Dr. FISHBEIN. Before the reference committee of the house of delegates I would say that there were possibly five or six men who thought that, with suitable amendments, something might be done with the Wagner Act.

Senator ELLENDER. Who were those men, members, delegates, or were they members of the association?

Dr. FISHBEIN. Some of them were delegates, some were members of the association and some were representatives of the hospital associations.

Senator ELLENDER. How many were delegates?

Dr. FISHBEIN. I would say approximately—of those who favored the Wagner Act with amendments?

Senator ELLENDER. Yes.

Dr. FISHBEIN. Not more than five.

Senator ELLENDER. Out of how many witnesses?

Dr. FISHBEIN. Out of a score or more witnesses.

Senator ELLENDER. Well, could you be a little more specific?

Dr. FISHBEIN. I would be glad to send you a record of the hearings with the exact number of men who made the statements and approximately what they said.

Senator ELLENDER. I appreciate your offer, but we have so much to read now.

Dr. FISHBEIN. I would say that my personal impression of the hearings which I attended, and at which I myself did not speak, my personal impression of the hearings was that those who were inclined to favor the Wagner Act with amendments, were the men in the house of delegates who represented what I would call the State health officer group, that the representatives of hospital groups and individual delegates who were not associated with State health departments were not inclined, in general, to favor the Wagner Act with or without amendments.

Senator ELLENDER. How did you come to classify them—

Dr. FISHBEIN (interposing). They are known, of course, the members of the house of delegates who happen to be State health officers are, of course, generally known.

Senator ELLENDER. The selection, however, is made from back home?

Dr. FISHBEIN. Yes.

Senator ELLENDER. What proportion of the doctors do you think these five delegates represented throughout the entire membership?

Dr. FISHBEIN. The five delegates who inclined to favor the bill with amendments?

Senator ELLENDER. Yes.

Dr. FISHBEIN. What proportion of the membership of the association did they represent.

Senator ELLENDER. Yes; about?

Dr. FISHBEIN. I would say somewhere between five and ten thousand.

Senator ELLENDER. What efforts were made by the house of delegates to invite other witnesses to come in and testify?

Dr. FISHBEIN. It is a rule that anyone who has interesting material or evidence to present may appear and men did appear who were not even members of the association.

Senator ELLENDER. Was that widely advertised?

Dr. FISHBEIN. It was announced in most of the newspapers of the United States, and certainly in the headlines of the newspapers in the city where the convention was being held.

Senator ELLENDER. Although five delegates were in favor of the bill if amended, is the committee to understand that the delegates were unanimous in opposing the Wagner bill?

Dr. FISHBEIN. When the vote was called for, the action of the reference committee as brought in to the House was adopted without a single dissenting vote.

Senator ELLENDER. Was the vote tabulated or a viva voce vote?

Dr. FISHBEIN. It was a viva voce vote, and no one said no.

I will proceed, then, now to a brief discussion of the possibility of amending the act.

At the reference committee the question was raised of the possible amending of the act or certain portions of the act in order to make it meet certain needs which I believe all of us recognize actually do exist. I will say that on that occasion representatives of the three hospital associations which lead in the United States, namely, the Protestant Hospital Association, the Catholic Hospital Association, and the American Hospital Association, spoke to the committee and the statement was made that each of these men had worked out 50 different amendments to the section dealing with hospitals alone, which might possibly make that begin to meet the needs that it was proposed to meet.

Now, then, as we have considered the development of the Wagner Act, it has appeared to us that there has been a relentless, persistent, almost a ruthless, drive for the development of this legislation over a certain period of time, and we trace this development from the beginning of the national health survey which, as you know, was a house-to-house canvass of 750,000 urban and 50,000 rural families, made by 4,500 W. P. A. workers under the direction of the United States Public Health Service.

Senator WAGNER. Doctor, you use a rather strong term, and I don't know that I was guilty of any such offense. I never intended to indulge in ruthlessness.

Dr. FISHBEIN. I will endeavor to explain the term as I go along.

Senator WAGNER. I would like to have it explained now.

Dr. FISHBEIN. What I would point out is that we see a definite development of this legislation without any opportunity being given, although frequently offered, to the medical profession, to consult with those who were developing the national health program, the national health conference, and the development of the bill itself, which grew out of the national health program.

Senator WAGNER. Well, Doctor, of course I am not acquainted with all of these activities you talk about, but a Dr. Booth from my own State appeared before this committee early and I think it was Senator Ellender that asked him if he wouldn't cooperate with the committee by suggesting amendments.

Dr. FISHBEIN. We are now up to the committee. I referred to the time of the drafting of the bill.

Senator WAGNER. Yes; I know.

Dr. FISHBEIN. The committee has been more than kind in giving us full opportunity to present the point of view of the medical profession. This is the first occasion on which such an opportunity has actually been given.

Senator WAGNER. Well, of course, this is the first occasion that we have had hearings on the bill.

This is the time to cooperate.

Dr. FISHBEIN. I refer largely to those who are concerned with the development of the national health program, the national health conference, the hearings on the national health program, after it was developed, and the time of the drafting of the bill. I have no objection whatever to saying again that I believe the fullest opportunity is now being given here to the medical profession as represented by the American Medical Association for the first time to express its point of view.

Senator ELLENDER. Doctor, in that connection, are you aware of the fact that many of the bills that are introduced in the Senate, and upon which hearings are held, you wouldn't recognize them after they are reported back to the Senate by a committee?

Dr. FISHBEIN. I am quite sure of that.

Senator ELLENDER. Well, that, in a measure, is what may happen to the pending bill and it is our purpose to obtain your ideas and if we can write them into this bill, that is what we desire to do. I emphasized to Dr. Booth, after he testified, and as a matter of fact, I begged him to go to St. Louis and try to get the Medical Association to work with us, to try and offer some suggestions.

Dr. FISHBEIN. That point of view was given the most serious consideration.

Senator ELLENDER. The suggestion made to Dr. Booth was made to the association—

Dr. FISHBEIN (interposing). The possibility of amending the act was considered but the house of delegates did not choose to believe that it was possible to amend this act to make it meet the needs that it is proposed to meet, and the general objectives which we all agree are desirable.

Senator WAGNER. By amending an act you can offer a completely new act, if you really desire legislation.

Dr. FISHBEIN. It is quite possible that I shall recommend later the possibility of striking out all of the act except the enacting clause and introduce certain other possibilities for meeting the needs.

Senator ELLENDER. If you could do that, that is exactly what the committee would like to have you do; and will that have the O. K. of the association?

Dr. FISHBEIN. I will give you the action taken in regard to that when I come to it.

Senator WAGNER. I am not saying that I am going to support it, but I certainly will welcome the suggestions. And I may say this, this is not any breach of confidence. I spoke to Dr. Booth after the hearing and I asked him if he wouldn't impress upon the American Medical Association—I know something about your activities and I suppose you are harder to convert than some others, but I am never hopeless about those things—and I asked him if he wouldn't say to the members of the association that I am anxious to receive their cooperation and their advice and guidance in this matter. He asked

me whether he was authorized to say that, and I said absolutely. Whether he did or not, I don't know.

Dr. FISHBEIN. May I say, Senator, we would have felt better if we had had opportunity at the time the bill was drafted to present some of these points.

Senator WAGNER. Well, the opportunity is here now.

Dr. FISHBEIN. Yes; we are proceeding here now from that.

Senator MURRAY. Senator Wagner is not a member of our committee so we have got an advantage over him here, that we are going to handle this bill.

Dr. FISHBEIN. That is very good.

Senator MURRAY. I think we are getting to develop into a sort of a mutual-admiration society here this morning.

Dr. FISHBEIN. It is very simple to be pleasant.

Senator MURRAY. I think we are getting along very nicely.

Dr. FISHBEIN. I think so, too.

Now one of the main objectives to which the American Medical Association representatives have referred in connection with the drafting of suitable legislation to meet the general objectives upon which we are all agreed, is the possibility of an attempt of a unified organization under the Federal Government, for the handling of medical affairs and integrating properly the care of the sick, preventive medicine, child-welfare activities, industrial medicine, and many of the other similar aspects of medical care, into a suitable arrangement.

I may say that when I first heard the words "Interdepartmental Committee to Coordinate Health and Welfare Activities of the United States Government," I was under the strange impression that it proposed to do what the title indicated, namely, to draw together all of those activities of the Government which were concerned primarily with the problems of medical care and of welfare as associated with medical care.

However, as we went along we discovered that that has not apparently been the intention and is apparently not the expressed intention at the present time.

I would, of course, point out that the Federal Government now, in addition to the Army and Navy medical department, has innumerable departments which are greatly concerned with the problem of medical care, which by this act are still left to operate independently, to duplicate certain activities, to spend a good deal of unnecessary time and money and personnel.

Now I will refer specifically to those departments. I would point out, for example, that the Children's Bureau, which is located in the Department of Labor, has both medical functions and other functions which are not strictly medical. Many of the functions thus concerned are also acted on to some extent by the United States Public Health Service and perhaps to some extent by other agencies which I will mention as I go along.

In the Department of Agriculture we have the Food and Drug Administration, as you know, whose problems are largely medical in character.

In the Federal Trade Commission we have supervision over the claims made for various foods, drugs, and similar products used in relationship to medical service.

It is also the case that in the Department of Commerce there is a Bureau of Mines which is concerned with a certain number of medical functions.

In the Department of the Interior there is the care of the Indians, the control of two medical schools, the care of several institutions for the mentally defective.

In the Department of the Interior also there are certain educational functions which are to some extent medical in character.

In the United States Public Health Service, which is associated with the Department of the Treasury, there are certain functions which are wholly in the field of preventive medicine; other functions which are in the field of medical care, and then there is the control of narcotics, narcotic addiction, and the administration of two hospitals for that purpose, one of which is now located in Texas, and the other in Kentucky.

In fact, there is no division of the Government which does not now have certain medical functions widely separated. I believe the total expenditure on all of these functions, aside from the Army and Navy medical departments, amount approximately to between \$125,000,000 and \$150,000,000 per year.

It occurred to us that an interdepartmental medical committee to coordinate these different departments under a single head, whether or not he be a member of the Cabinet or one of the new types of secretaries to be created, is, after all, a question for the Government to determine, but certainly unification of these functions might be of importance.

Now, in addition to that, as you know, there have been created in recent years a considerable number of Federal functions which are outside Cabinet control, created as new divisions of the Government, and therefore we have in the C. C. C. a medical department, we have in the W. P. A. a considerable amount of medical activities, we have the P. W. A. concerned with the building of hospitals, and hospital construction with Government aid has been frequent during the last few years.

I receive regularly from the P. W. A. and the W. P. A. and these other departments significant items of publicity having to do with the considerable amount of hospital building which they have aided in recent years, and the number of additional beds supplied through such agencies.

Senator WAGNER. You favor that?

Dr. FISHBEIN. Yes; I think it is excellent. I propose later to refer to certain wastages of which I have personal knowledge, which, as far as I am concerned, as a citizen, I think should have a little governmental investigation.

Now, we move on, then, to the fact that under a certain branch of the Government which has to do with the aiding of the rural areas there are now in existence in some 25 to 29 States, plans for aiding people in rural districts to get complete medical care, and obviously that sort of a function should be intimately associated with any Government attempt to handle the problem of medical care. If I may, I will refer to an article in the Saturday Evening Post entitled "Rehearsal for State Medicine."

And I could go on with other Government functions, but I believe I have indicated the widespread—

Senator ELLENDER (interposing). I wish you would go on with more of them, if you know of any. That is very interesting, and I would like to probably "jine" some of them, as the darkies say.

Dr. FISHBEIN. That, I think, is a highly desirable thing, and I could refer to the Coast Guard Service, which carries on a certain amount of first-aid relief; that is in another department of the Government.

Now then, I conceive that it would be the service of the interdepartmental committee to coordinate the health and welfare activities of the United States Government to bring this matter before the Congress of the United States as probably its first function, because obviously the creation of a suitable mechanism to handle medical care in the United States should depend on setting up an agency in which there would be an avoidance of duplication of effort, proper integration of each phase of the service under a single head, and that would produce both economy and efficiency and absence of the difficulty which is now involved in having to meet numbers of different governmental agencies in order to accomplish a single purpose.

Senator ELLENDER. Would you be able to outline these various agencies that are now engaged in this work? You evidently have this worked out?

Dr. FISHBEIN. We have a complete analysis for all the agencies of the Government, and the appropriations made for each of them in different years.

Senator ELLENDER. Can you furnish that to the committee?

Dr. FISHBEIN. Yes; I would be glad to do that right away.

Senator ELLENDER. And it will indicate the departments?

Dr. FISHBEIN. The department, the amount of money spent, the nature of the medical service, and many other facts that would be of great importance to this committee.

Senator WAGNER. Are you for putting them all together under one head?

Dr. FISHBEIN. I believe it would be desirable to integrate the various medical functions of the Government in a unified set-up which would prevent duplication of effort, loss of efficiency and wastefulness.

Senator WAGNER. In other words, to sum up what you have just said, you do favor putting them all under one head, all that you have enumerated?

Dr. FISHBEIN. Yes; within the possibilities of government, because I will now point out, and I hope to emphasize, the point that I am not a lawyer, primarily, and that while—

Senator WAGNER (interposing). Or a politician, are you?

Dr. FISHBEIN. I hope not. I have never been accused of that.

Now, so far as concerns the Constitution, again I will say that the mechanism of fitting present activities of the Government into the Constitution or future activities, is again, I do not believe, my function.

Now, the interdepartmental committee, on the basis of the national health survey, brought out what was called a national health program which was a long-range program planned for the development of the medical activities of the United States over the next 10 years. At the time of the national health conference, I expressed the opinion that I did not consider it would be the efficient path to plan a program

of medical care for the United States for the next 10 years on the basis of conditions as they existed today, because with the amount of unemployment that exists today, with the amount of need that exists today, we have one concern; with the amount of employment and the amount of need that might exist 10 years from today, we have another concern.

As all of you know, it is, however, desirable to plan ahead, but frequently such planning turns out to be of rather unfortunate effect. I remember attempting in 1918 to aid a distinguished committee to try to estimate the number of soldiers with nervous and mental disease, with cancer, with degenerative disease, and other conditions that would require care in all of the years from 1930 up to 1950, and obviously that was necessary in order to prospect a hospital building campaign for the future.

Now, I believe if we will look back on the plans then projected, in the light of conditions then existing, and with our knowledge of medicine as it then existed, many of our estimates will have been found wholly away from the actual needs at the present time. I may refer, for example, to the changes that may be brought about by the development of a new discovery, for example, that would relieve us of the care of considerable number of persons with general paresis, or the development of insulin, or the development of liver extract for pernicious anemia, or various new methods for the handling of cancer, or tuberculosis, which gives us an entirely new picture, after 20 years.

In this connection, also, I would like to refer very briefly to the difference of scientific opinion that may exist in estimating a so-called need. At the present moment, for example, a distinguished officer of the United States Public Health Service has made addresses in various portions of the United States, condemning to some extent the use of the tuberculin test as a means for determining whether or not a child has tuberculosis, or its relationship to tuberculosis. In the statement made by Mr. Homer Folks—

Senator WAGNER (interposing). You mean the X-ray test?

Dr. FISHBEIN. Tuberculin test. In the statement made by Homer Folks, he was quite content to rely on the X-ray, apparently, alone. I know of no doctor in the United States who would rely on the X-ray alone in making a diagnosis for tuberculosis. I know of no authority in the United States at the present time, except perhaps this one authority in the United States Public Health Service, who is convinced that the tuberculin test might as well be discarded, and that is a debatable point in medicine. And yet, presuming that this particular officer were to be put in charge of setting up the standard for determining needs in relationship to tuberculosis and the sole authority placed upon him, he would find himself in a considerable disagreement with members of the medical profession who are generally recognized throughout the United States to be leaders in their field.

Senator MURRAY. Doctor, it is very apparent that you won't conclude your testimony for some time.

Dr. FISHBEIN. Well, if you are interested in it, I can go on quite a while.

Senator MURRAY. We are very much interested, but we want to give you a full opportunity to tell us everything that you want to.

Dr. FISHBEIN. I will be glad to come back after lunch.

Senator MURRAY. We will recess now, then, until 1:30, and you can proceed at that time.

(Whereupon, at 12:10 p. m., a recess was taken until 1.30 p. m. of the same day.)

#### AFTERNOON SESSION

Senator MURRAY. We will proceed with the hearing. You may resume, Doctor.

Dr. FISHBEIN. Mr. Chairman, at the time of the adjournment this morning I had reached a point in the development of the interdepartmental committee which led toward the national health program of the National Health Conference, and that in turn toward the development of the Wagner health bill. Now, at the time of the National Health Conference I want to make clear for the purpose of the record that a number of the representatives of the medical profession were present and had opportunity to speak, but that at the time of that conference the very first opportunity that was available to the representatives of the medical profession to see the national health program was at the time of its presentation at the conference, and obviously the time was hardly sufficient to examine very carefully into the proposals that were made or the evidence or data on which the proposals were based. Just as soon, however, as the National Health Conference adjourned the American Medical Association called a special session of its house of delegates, the third such special session in the history of the organization, for the purpose of examining the national health program and adopting the point of view of the medical profession toward the national health program.

At the special session of the house of delegates a considerable amount of evidence was presented, differing, to some extent, with the data that had been developed and offered by the Public Health Service, in relationship to the national health program. In addition to that, a special committee was appointed by the house of delegates to confer with the interdepartmental committee and with its technical advisory committee relative to the proposals of the national health program; that committee met on two occasions, I believe, with the interdepartmental committee and had opportunity there to present some of its objections to certain portions of the program, and some objections with respect to some of the basic data and other considerations that were considered fundamental by the medical profession.

Now I mention that merely because in the previous testimony presented here by Miss Josephine Roche that point is made, that 19 such conferences were held by the interdepartmental committee between the time of the National Health Conferences and the sending of the national health program by the President of the United States to the Congress in January. With a considerable amount of study and very careful analysis of the national health program, as sent in January and as presented in July, no significant change or modification apparently resulted from the 19 conferences. I know that cer-

tainly none of the basic points brought out by the medical profession were introduced into the national health program as sent to the Congress by the President.

I would like at this point to mention the fact that the President of the United States himself did not urge immediate enactment of the national health program; that he recognized the report of the United States Public Health Service on the excellent health conditions in the United States during 1938, and that the President of the United States sent the national health program to the Congress with a recommendation for careful study, and that it is now with the Ways and Means Committee of the House of Representatives.

Also, I would like to point out in this connection that obviously if an emergency existed the President might very well have recommended, let us say, immediate enactment of some portions of the national health program; nevertheless, no such recommendation was made, and we had but a recommendation for careful study.

Another consideration which came before this committee concerned the proportion of the medical profession who are said to advocate the passage of the Wagner health bill. The statement was made that 1,500 pediatricians of the United States are behind the Wagner Act. Now, I know of no evidence, no data, which would warrant such a statement in relationship to that special branch of medical practice. In fact, I made particular inquiry of the legislative committee of the American Academy of Pediatricians, and of a considerable number of its members, relative to the question as to what extent an effort had been made to find out exactly what the pediatricians thought of the Wagner Health Act, and what number of pediatricians were behind the Wagner Health Act, using the exact words which appear in the record, and I am unable to find any evidence to substantiate that, and I am able to find a considerable amount of evidence differing from that particular point of view. That does not mean to say, however, that I am not of the opinion that many of the pediatricians of the medical profession would welcome certain types of aid to the development of a further preventive-medicine program in relationship to child care, or in relationship to extending the ability to feed infants properly in certain portions of the large cities, or, in fact, in many other ways. However, there is nothing specific to be offered in that connection.

Another appearance before this committee had to do particularly with the problems of maternal mortality, and I believe it will be important to the committee to have a little consideration, very brief I hope to make it, having to do with the exact figures relating to maternal mortality in the United States, as they are so frequently compared to the disadvantage of the United States in all sorts of promotions that are planned to secure vastly increased funds in relationship to maternal mortality. Quite commonly the comparison is made with England, Ireland, Scotland, and Wales, pointing out that the maternal mortality rates in the United States are worse than in England, Ireland, Scotland, and Wales, or that the maternal mortality rates are worse than those of Sweden or of the Scandinavian countries. I would like to point out, of course, in this connection that that comparison is quite unfair, that if you will take the rates in some of our better favored States, as, for example, New York, Massachusetts,

Michigan, and Illinois, and compare them with England, Ireland, Scotland, and Wales, we appear to have a considerable advantage in relationship to such comparison. A more interesting comparison, one better warranted, would be one which would take into account the fact that in the United States we have our frontiers within the country and therefore a more reasonable comparison would be the United States as a whole with England, Ireland, Scotland, Wales, and portions of South Africa and the Balkans. Such a comparison would give us a comparable situation and perhaps a more reasonable comparison as to maternal mortality rates.

Furthermore, I would like to point out that most of those who have appeared here before your committee in relationship to the question of the extent of maternal mortality work and the care of mothers in childbirth have been the obstetricians, representatives of the obstetrics profession, who have been largely raised up with and who have given their full time to obstetrics while located in hospitals, and often particularly in maternity hospitals, and while I am aware of the fact that there are conditions in our frontier areas in which maternal aid can be improved and much can be done for mothers in childbirth, it is not quite correct to go at that particular point of view from the point of view of the obstetrician who has developed his entire technical knowledge in the hospital. But even if we were to do that I would like to point out the comparison I have just stated here given to me by Dr. Joseph B. De Lee of the Lying In Hospital whose records in this matter are well recognized and therefore may be taken as authentic.

In other testimony which was offered here, I believe in Senator Wagner's personal appearance before the committee, particular emphasis was placed on certain facts in relationship to two diseases, diphtheria and infantile paralysis. There was no tuberculosis in Detroit, the gentleman said, of any account, and Senator Wagner pointed out he would produce later the authority whom he had consulted in regard to this matter.

Now it is generally well recognized in medical practice that the maintenance of a drive on a single disease is likely to result in almost any part of the country in a temporary lowering of the rates in relationship to that disease. However, it is not possible to maintain such a drive on a single disease as a permanent effort. At such moments we put our entire effort behind a single disease. I could point to the drive against diphtheria which took place in Chicago, or I could point to this drive against tuberculosis in Detroit, and recognize that the chief value of such a drive is its educational effect upon the community, calling the attention of the community for the time being particularly to that disease, but it is not possible to maintain such a drive and very frequently there is a reaction after the drive that takes you in to a condition in which perhaps you are worse off than you were before the drive started. So I think if anyone will look at the tuberculosis work in Detroit since the drive has stopped it will be discovered that even now it is not maintained at the level it was maintained during the time of the drive, and with no amount of money would it be possible to maintain that particular kind of a drive permanently in any community. One of the chief reasons would be that such a drive would dislocate entirely your preventive-medicine effort, and by the extra effort you put on a single disease

you diminish equally your effort on a considerable number of other diseases.

How do the figures compare before the drive and since the drive? I would say with a condition like tuberculosis it is not safe to base figures on a matter of a year or two, but comparing the rates of the entire area over a long period of time with the rates of cities of comparable population it will not be found that such a drive will have a permanent effect. It does have some value in educating the public, but such figures are susceptible to all sorts of analyses, as I believe Prof. Haven Emerson pointed out yesterday, and certainly that fact must be taken into account in relationship to the general trend downward of a considerable number of diseases at certain periods and a trend upward at other periods.

Now, again, it has been said that a vast fund is of the greatest importance in attacking many of our disease problems. In relation to one of the disease problems I had sort of made a personal study of late, let us say within the last 5 or 10 years. In the report on the national health program, in their discussions of that matter, much is made of the possibility of control of crippling diseases, and particularly infantile paralysis. I happen to be associated very closely with the handling of more than a million dollars which has been collected in connection with the National Foundation for Infantile Paralysis. In recent meetings of the body of the organization charged with the dispensing of the funds, having a million dollars available to be disposed of in any manner that this committee might wish, the committee having practically supreme authority over the disposition of this \$1,000,000, it was exceedingly difficult to find a way to spend efficiently and successfully \$100,000 in encouraging research in infantile paralysis, and so having a million dollars it was difficult to find a legitimate number of research projects warranting the prompt expenditure of \$100,000 by men capable of doing good research work. So making an allotment is not of primary consideration in the development of an attack upon the disease. Knowledge is the first consideration, and knowledge can be accumulated only in relationship to the possibility of having men capable of doing research under conditions where good research work can be done, and in addition to that having material upon which to work. For example, if we had an infantile paralysis epidemic extending over large areas of the United States, we could do a lot more research on infantile paralysis than we are able to do, simply because it is the tendency of the disease to disappear during the cold-weather season and then breaking out anew during warm weather, and unless we have cases upon which to make tests and studies it is extremely difficult to make studies.

Let us go on from that into the question of the provision of hospitals. As I mentioned this morning, there has been no lack of hospital construction, no lack of the additional building and provision of new beds in recent years. In the main we have seen a considerable number of hospital projects being carried out, on a scale much beyond, perhaps, and at a rate much beyond what we have had 5 or 10 years ago. I believe the Senator from Louisiana is acquainted with the great hospital which is now being constructed in New Orleans, providing a great number of new beds, and I am myself acquainted with

a project which I recently visited in Richmond, Va., where a 18-story hospital is now being built, largely with public funds, and where I was informed three other additional hospitals are contemplated, and the funds are apparently being sought. I have myself seen one particular hospital, which I wish to refer to in this connection, namely the hospital which was built in Hot Springs, N. Mex., costing \$2,000,000, with the provision of 90 beds for crippled children. At the time I visited the hospital the beds were inhabited by 30 New Mexican children. The town has 800 people, approximately 185 miles from any place.

Senator WAGNER. You did not mention these hospitals, of course, in criticism of their construction?

Dr. FISHBEIN. I am about to criticize the one in New Mexico, not the other two, the new one in Richmond or the new one in New Orleans. I am criticizing the one in New Mexico as an example of the fact that abuses may arise in relation to the building of certain of these hospitals. Obviously, the one in New Orleans was a necessity. In fact, if I may digress at this point, I think I may have had something to do with aiding and encouraging the building of the hospital in New Orleans, because I came to New Orleans sometime ago and discovered four Negroes using one bed in a city-managed institution, one of them moribund at the time, and I saw to it that it got proper publicity in the press, and that intensified, to some extent, the drive for sufficient hospital facilities.

Now, then, the hospital in New Mexico to which I referred has 90 beds for crippled children, but when the time came to man the hospital it was discovered that no orthopedic surgeon was available in New Mexico. Therefore, by special action of the legislature, an orthopedic surgeon was employed from El Paso, Tex., at a pay of \$7,200 a year to ride 185 miles into New Mexico once or twice a week to do the necessary surgery; the rest of the time the hospital was under the management of a young resident who was developing himself as a specialist in the field of orthopedics.

I pointed out the fact that a population of a certain size can develop only a certain number of cripples. That fact must be taken into account, that with a population of a certain size you develop a certain number of cripples; that is, unless an epidemic of crippling disease breaks out, and unless there is an epidemic, or unless for other reasons the hospital is employed, it will surely be short of patients, or unless the population increases very rapidly. Now, after its establishment, a matter of a year and a half, the hospital is actually short of cripples, it does not have a sufficient number of cripples to use the facilities. It was built particularly for that purpose, and already it is a matter of concern, both to the people of New Mexico and the country generally, and of all physicians interested in these matters, as to what is to be done with this hospital, situated in a town of 300 people in the State of New Mexico, built for a specific purpose at considerable cost. If you will ask as to the cost you will discover that it cost \$22,250 a bed for building and equipping, whereas it is possible to build a good hospital today at a cost of \$5,000 a bed.

Senator MURRAY. Who built it?

Dr. FISHBEIN. It was built partially on Federal funds and partially on State funds.

Senator MURRAY. At what cost?

Dr. FISHBEIN. \$2,000,000.

Senator MURRAY. Could not it be converted into a general hospital, used for other purposes?

Dr. FISHBEIN. I will say, from correspondence that I have available, there is evidence that that is a matter which is worrying particularly the Senators from New Mexico.

Senator WAGNER. Doctor, how were the funds obtained? Was not there a proper showing made in order to be able to make the money available?

Dr. FISHBEIN. I believe that that would be a matter of suitable inquiry. I believe that there is a custom that those who obtain money are supposed to show a need, and that having shown this need certain money-dispensing agencies are authorized to grant the funds for that purpose. I know of no other method of obtaining money in Washington except through that technique.

Senator WAGNER. Was that money obtained from the W. P. A. or the P. W. A.?

Dr. FISHBEIN. I have not checked into that particularly. I merely know the hospital is a crippled children's hospital built with State and Federal funds.

Senator WAGNER. At a cost of \$2,000,000?

Dr. FISHBEIN. At a cost of \$2,000,000 for building and equipment.

Senator WAGNER. Do you know what proportion was contributed by the Government?

Dr. FISHBEIN. I can investigate and supply that, if you wish to have the figures.

Senator MURRAY. Go ahead, Doctor.

Dr. FISHBEIN. Now, the suggestion was made, incidentally, from two different sources: One, that this be developed as an institution for the tuberculous, the other that it be developed for the care of children convalescent from rheumatic fever. The latter suggestion would be obviously impossible, because it would not be considered a good atmosphere, or a good temperature to ship children to.

A criticism which was established by the professor of public health in the University of Michigan pointed out that at one point the recommendation was meant for additional funds in relationship to rheumatic fever on the basis of the removal of a considerable number of tonsils and adenoids.

Senator WAGNER. What would be the greatest benefit in counteracting the disease?

Dr. FISHBEIN. It would be in restoring the patients to working conditions. Here again is a case in which the medical profession, speaking as experts in relationship to the condition called "rheumatic fever," would be inclined to express a considerable amount of doubt. So many of the points have to do with the need and the manner in which the need is to be determined that we must recognize the fact that there can be differences of opinion among physicians, and well-qualified physicians, as to these matters of need, but if any simple mechanism, in the hands of one or two persons, is therefore a matter for special consideration. I am not prepared to say exactly what kind of committee I would expect here, but I am inclined to believe that there ought to be enough people and enough of a cooperative effort be-

tween the State and Federal agency concerned so that there would be no question as to an actual scientific determination of a basis for a need that is equitable to the Federal Government in relationship to the medical profession. I do not believe the Wagner Act suitably protects the people or the money of the United States in relationship to that particular determination.

Senator WAGNER. Have you any suggestions as to how to make that effective?

Dr. FISHBEIN. I have, Senator, and I have said, in relationship to that, that I believe it must be much more regulated than the plan set up in your particular measure, and that it would certainly involve the development of competent scientific evidence in the determination of need, based on the experience of recognized experts whose opinions would be given weight and value, and which might be discarded at the behest of a single individual.

Senator WAGNER. Doctor, I take it you are acquainted with title VI of the Social Security Act?

Dr. FISHBEIN. I believe that much good has been done in relationship to some of the use of money that is given to the United States Public Health Service to meet certain needs; yes, sir.

Senator WAGNER. That is similar to the provisions of this act?

Dr. FISHBEIN. Yes. I believe, also, that a careful scrutiny in relationship to the practicability of those projects should be made by the scientific investigators, who would study and make a careful resurvey of the exact manner of use, in order to reveal, in certain instances, something beyond the ordinary scope.

Senator WAGNER. Is that surmise, or do you know that that is so?

Dr. FISHBEIN. Well, that is based largely on the statements that are sent to a periodical of the type of the Journal of the American Medical Association by physicians in various parts of the country who venture their criticism. I am not willing to accept such criticism on the say-so of one physician who writes, but I believe if the Federal Government were interested in resurveying directly the manner of disposition of money and meeting certain needs in relationship to preventive medicine, that occasionally it could be found that the money was not employed with the greatest of efficiency.

Senator WAGNER. That is a matter of examination?

Dr. FISHBEIN. Yes.

Senator WAGNER. As to the general method involved, as to the aim in making grants-in-aid?

Dr. FISHBEIN. I propose to discuss the question of grants in aid, and offering my own concept of perhaps some different method of meeting the needs, because I think there are needs that are required to be met. In fact, in my opening statement I said no one can disagree with the general objectives that have been stated for the Wagner Act.

Senator WAGNER. That is a good beginning.

Dr. FISHBEIN. Thank you, sir. I think you and I could get along very well.

Senator WAGNER. I think so, too. My son told me that.

Dr. FISHBEIN. Yes; he told me he was going to tell you.

Senator WAGNER. Listening to you, I think he had tremendous courage in trying to debate the matter with you. I suppose you were generous with him.

Dr. FISHBEIN. You are not going to embarrass me, I hope.

Senator WAGNER. No.

Dr. FISHBEIN. Now, when we come to consider the needs expressed as the result of the national health survey we discover that, according to the figures which are offered, approximately 17 percent of the people with incomes of \$3,000 per year or over, families with incomes of \$3,000 per year or over failed to receive or obtain medical care for chronic disabling illness. According to the same survey, 30 percent of people with incomes per family per year of \$2,000 or less failed to receive medical care for chronic disability, chronic disabling illness, and 28 percent of people on relief failed to receive medical care for chronic disabling illness. Those are figures which you will find in the national health survey.

Senator WAGNER. You do not mind these interruptions?

Dr. FISHBEIN. No, sir; I enjoy these interruptions.

Senator WAGNER. Yesterday we had a report from one of the welfare commissioners of New York.

Dr. FISHBEIN. Yes.

Senator WAGNER. He said that on the present relief roll, of those receiving relief, 15 percent were due to illness.

Dr. FISHBEIN. I wouldn't doubt that at all. That would coincide rather well with these figures, particularly as New York, as we all recognize, in medical affairs is far beyond the rest of the country; in fact, it is stated in New York today 50 percent of the people of the State receive free medical care. I am not sure of that figure but I think they sent me that statement from Brooklyn on Tuesday night. I have not yet verified it; I expect to verify it, however.

There is nothing in the national health survey which establishes any reason why 17 percent of the people living in families with incomes of \$3,000 per year or over fail to receive medical care. Obviously, unless all of the family's money was utilized for various purposes, something would have been available for medical care, and perhaps the reason then was not a lack of funds. So that the correction of that condition would not lie primarily in the lack of funds. I might say that I have my own concept as to why 17 percent of people in families with incomes of \$3,000 per year or over failed to receive or generally use medical care for chronic disabling illness. I am of the definite belief that about 10 percent of the people of the United States do not want medical care under any circumstances. I mean, even if it were put in their hands for nothing they would not take it. That is based on a survey made by the American Psychological Association, which discovered in the United States approximately 27 groups who do not believe in medicine in any way, shape, or form, and who oppose its use whenever they can. Now, obviously that would be deducted from the 17 percent, which would leave you 7 percent.

In the State of Massachusetts a survey made under the supervision of the health department, using five trained medical investigators, with house-to-house contacts, involving 30,000 families, indicated that only 3 percent of the people of Massachusetts failed to receive medical

care, who failed to receive it because of lack of funds, and 71 percent of those who failed to receive medical care failed to receive it because of some break-down in the line of communications, that ought to bring those needing medical care to the places where medical care was available for them.

Now, obviously the question might well be argued from a philosophical point of view, and was perfectly well discussed by Dr. Robb in his discussion yesterday, that obviously there we do not have enough provision for the education of the public and there is a failure of the profession commonly known as social service, or a failure to achieve its object of acting as a liaison between the medical profession and medical service. I feel that in many instances they have been content to make a diagnosis of the condition and then not do what could be done in relationship to the correction of the condition. I think that is clear.

Now, we go on then to the 30 percent of families with incomes of \$2,000 per year or less who failed to receive medical care because of chronic illnesses. It is my belief we must deduct from that figure the 17 percent I have already mentioned in relationship with those families with incomes of \$3,000 per year or over. I take it the people with families with an income of \$2,000 a year or under are no more intelligent, better educated, of finer type of intellect, that would cause them to do something that people with \$3,000 a year or over would not do, leaving you a differential for that group of 13 percent.

Now, again we must recognize the fact that of the people in the United States with incomes of \$2,000 a year or under we have a vast preponderance of certain poorer family groups in the population, particularly the Negro group, that there are perhaps 90 to 95 percent in the Negro group with families with incomes of \$2,000 a year or under, whereas from 45 to 55 percent of whites, roughly, would be in families with incomes of \$2,000 a year or under. Then we come to a localization of this problem, particularly in those States which the President himself has characterized as public problem No. 1, and in those States the question of medical care is intimately bound with the economic situation of the State. So I would say that the State of Senator Ellender is to be particularly congratulated on having made a considerable amount of progress in solving this problem by a technique developed in that State. Although I am not in a position to consider the technique one way or the other, in any event they have answered the problem to a more considerable extent than that same problem has been answered in other States with a similar population and a similar character of medical problem.

Senator WAGNER. Is not that also a question of providing for technical hospital service?

Dr. FISHBEIN. I believe the provision for technical hospital service is a great help. I may point out in the State of Mississippi, for example, they have 0.7 beds per 1,000 for the Negroes as contrasted with something like 2.3 or 2.4 for the whites, and as contrasted with 3.5 for the population generally, so the State of Mississippi certainly has not come as far as the State of Louisiana in this regard. Whether or not Mississippi can do so is a question that is to be determined.

Senator WAGNER. Doctor, right there, may I ask you if the State of Mississippi does not have the resources to take care of its quota of medical services and hospitalization, whether the Federal Government should not step in to provide those resources?

Dr. FISHBEIN. I believe that no citizen of the United States for whom a demonstrated need for medical service which he is unable to supply exists, should do without medical service.

Senator WAGNER. Even though it may be apparent that the Federal Government has to help?

Dr. FISHBEIN. Yes. I believe what we are confronted here with is a humanitarian problem that is outside of the range of the other problem.

As to the technique, again I make the reservation I would not like to see a technique set up which would destroy economic standards.

Senator WAGNER. Do you think we have intelligence enough to formulate methods to obtain these objects?

Dr. FISHBEIN. I think we have, but sometimes we do not use it.

Now, moving on from that to the 28 percent of persons on relief who failed to receive medical care, in many States people on relief are entitled to medical care merely by applying for it. For example, in the city of Chicago, through the State relief agency and with the aid of local funds, a system has been set up whereby any person in the community requiring medical services may apply at the relief agency and receive medical services from a physician of his choice, 2,800 physicians having registered their names as willing to give medical service on call to any person requiring medical aid, the fees entirely to be adjusted through the relief agency by cooperative agreement between the relief agency and the medical society. The need is determined by special social-service investigation under the direction of the cooperative group which has the medical care in charge. A system similar to that of course is the one referred to by Dr. Benson yesterday affecting the State of Oregon; again suitable relief being developed under local control, utilized by medical agencies with the assistance of State funds and without asking the Federal Government for a contribution, indicating that in some places very acceptable measures may be set up to solve the problem quite satisfactorily, whereas in other places the problems cannot be solved with the means or the facilities that are available.

Now, then, we come to my particular answer to the problem as to what is to be done under these circumstances, and, as I have said, I am not a constitutional lawyer, I am not prepared to write an amendment, I do not believe I ought to be asked, and I do not believe the medical profession ought to be asked to amend the Wagner Act. As I have said, my consultation being with various hospital officials as to just that phase of the bill, that it was pointed out that experts in the field of hospital administration would require more than 100 amendments just to fix that one portion, to coordinate it with the hospital conditions that we have in the United States today.

Again the Wagner bill, as I have already pointed out, would perpetuate a system of administration, through diverse agencies, which must inevitably result in duplication of effort.

Now, I believe, being practical minded people and with some knowledge of human psychology, we recognize the desire of an agency, once established, to continue; but, of course, that is not our particular concern under these circumstances. We recognize also the desire of various groups of people with special interests to have such agencies placed under a control where they may perhaps have a more immediate connection than under another control. For example, I notice it was the desire of two of the representatives of labor who have appeared before this committee that all functions having to do with industrial hygiene and preventive medicine in relationship to workers in industry ought not to be assigned to any of the agencies under the Wagner Act. Mr. Pressman and Mr. Woll both said they would prefer to amend the act by moving those over to the Labor Department. You have that in the record of the hearings.

Senator WAGNER. I remember that very well. New York State would do it very well.

Dr. FISHBEIN. That might very well be. I am not prepared to say. I would be willing to accept your statement, but, as I said, under this law it cannot be done successfully.

Senator WAGNER. Why?

Dr. FISHBEIN. New York, of course, is a rich State. It has a vast taxing power, it has considerable funds.

Senator WAGNER. What I would like to do now under this bill—

Dr. FISHBEIN (interposing). Is to equalize.

Senator ELLENDER. You mentioned the rich State of New York. It gets some of its money from Louisiana, from Texas, and from the natural resources throughout the country.

Dr. FISHBEIN. I recognize that.

Senator ELLENDER. What we want, what we desire is that the States that get the money from us give a little back to us.

Dr. FISHBEIN. It is my belief that the task of attempting to equalize these matters for the 48 States and the Territories of the United States, without a break-down of the democratic system of government by which we have come to the point in which we now are, is not the task of the medical profession but primarily the task of the Executive and the Legislators. It is the medical profession's task to maintain standards of medical service which have brought this country up to the present high place which it occupies. It is our purpose to endeavor to get the widest possible distribution of this high quality of medical service to the greatest number of people to whom it can possibly be distributed, and then if, in doing that, we can still maintain democracy we have achieved a very fine objective.

Senator WAGNER. The reason I was interested in cooperation is because you did state earlier that you complained because you were not asked to sit down and aid in the drafting of the legislation.

Dr. FISHBEIN. Yes.

Senator WAGNER. Which showed that somebody in your organization, probably your group—

Dr. FISHBEIN (interposing). Not me.

Senator WAGNER. No; but it showed that somebody in your group was interested in aiding in the drafting of this legislation.

Dr. FISHBEIN. I believe our function in relationship to the drafting of legislation should be to state the standards and objectives, and

after we have stated the standards and objectives it is up to the experts to draft appropriate legislation.

Senator WAGNER. I did not say you should be asked to sit down with those who were drafting the legislation.

Dr. FISHBEIN. I think we have the function of being recognized as authorities in the field of medical practice and medical service.

Senator WAGNER. Everyone wants your guidance. I misunderstood you. I thought you complained because your organization was not asked to sit in with others to draft the legislation.

Dr. FISHBEIN. Senator, I made no complaint, I merely stated a fact. We were not asked.

Senator WAGNER. You said just a moment ago you should not be asked to aid in the drafting of legislation.

Dr. FISHBEIN. I think that might very well be done by those who propose to draft the legislation, after such considerations as we might be able to present on the basis of our expert knowledge.

Senator ELLENDER. That is all we ask you to give us now.

Dr. FISHBEIN. I propose to read again now, and very carefully, and I believe with special adaptation to the circumstances that have heretofore been set up, the recommendations of our house of delegates, and in introducing it I would say we are convinced that any State in actual need for the prevention of disease, the promotion of health, and the care of the sick should be able to obtain such aid without using a system that inevitably stimulates every other State to seek to develop evidence by which it can qualify for a share of the available funds. Certainly the astute minds which conceived the system of Federal subsidies and grants in aid with matching appropriations should be able to develop some legislative technique which would accomplish the result without the obvious faults of this type of legislation. Our house of delegates suggested either a Federal agency to which any State in need of Federal financial assistance might apply, or a new agency created specifically for this purpose, or some adaptation of the relief mechanism already in existence.

We are not constitutional lawyers, and the Nation has not indicated any strong desire to change the Constitution in order to make available new techniques in the administration of medical service.

Now then, let us go back to the original plan for developing here, first of all, an assemblage of all the various functions of the Federal Government concerned with medical care. In attempting to develop legislation of this type, in reference to certain small functions, and to keep them distributed between a variety of Federal agencies is bound to result in a duplication of effort, and in a manipulation, for various reasons and in various ways, of the funds available.

Again may I say that as a practical observer in affairs of this sort I have observed on occasion the various systems of technique by which those desiring funds applied for them, and quite obviously there is nothing to prevent a man desiring funds in his State from coming to the Federal officer actually in charge of making the recommendation and saying to him, "What do we have to do in my State to get some of this money?" When he is told the rules and regulations under which he must apply and under which he must develop a plan he then develops a plan which meets the obligations and the requirements.

Furthermore, there are all sorts of techniques developed for stimulating the public request for funds. It is quite obvious if one wishes to focus upon any particular problem in the health field that there is well-established technique for focusing attention. If the committee is interested, according to my observation, the technique is simply this: A certain amount of publicity is given to the general fact that such question exists. The next step is to call a conference, to which various numbers of people are requested to come and contribute information, most of those requested having been determined in advance as being somewhat favorable to the idea; then, having had all this publicity developed through the conference, more circulation of the concept is indulged in in order to build up what is commonly called a demand for this sort of thing; then the demand having been created, someone is requested to develop legislation to meet the demand.

Now, in the present instance the medical profession has all along this route endeavored to insert here and there certain cautions, certain desires, certain requests, certain evidence, and, as I stated in the preamble to my remarks, in recognition of those desires we request a consideration of the alternative evidence.

Thank you very much.

Senator ELLENDER. Doctor, you recognize that for any State to obtain any of these funds it is necessary for such State to raise its share?

Dr. FISHBEIN. Under the present system of grants in aid with matching appropriations; yes, sir.

Senator ELLENDER. I mean under the bill we are now considering.

Dr. FISHBEIN. Yes, sir.

Senator ELLENDER. Is it your view that the same technique is engaged in by the local authorities in a State?

Dr. FISHBEIN. I did not gather the significance of the question.

Senator ELLENDER. You say that before the demand is created it is necessary that the State itself comply?

Dr. FISHBEIN. Yes, sir; and I think that such a technique may be engaged in, and sometimes quite successfully.

Senator ELLENDER. And through that medium the taxpayers of that State are asked to raise their pro rata share so as to afford the State the right to come up to Washington and get its share of the funds?

Dr. FISHBEIN. I believe if anyone presents, with a sufficient amount of urging—well, I have myself quite recently, I am very frank to say, been engaged in developing a desire for legislation in various States for the control of accidents from Fourth of July fireworks, which I believe has destroyed a great many eyes and made a great many cripples. We indicated the number of cripples that were caused each year by the Fourth of July fireworks, and we published these records and released them to the newspapers, and called attention to the fact that here is a serious situation, that something ought to be done about this, and pretty soon a lot of people said, "Why, something ought to be done about this. People are being blinded and made cripples, and something ought to be done about this."

That is the way we have approached the Wagner Health Act. People have said there are needs that need to be solved, there are needs that need to be met. We agree with them. We do not believe

in overemphasizing the need. We have certain figures, and we have had the figures checked from various sources.

Senator ELLENDER. Doctor, any plan that would be worked out you think ought to be submitted under suggestions made by you?

Dr. FISHBEIN. Made by me? By the American Medical Association.

Senator ELLENDER. You are speaking for it?

Dr. FISHBEIN. Yes, sir.

Senator ELLENDER. Any commission, or any official charged with the authority to carry out the purposes of the act, would necessarily have to listen to the citizens of their respective State?

Dr. FISHBEIN. Yes, sir. I do not say how much he should listen.

Senator ELLENDER. I am just wondering how it would be possible to hurdle the objection that you now are speaking of. In other words, in any act that is passed, Doctor, you can readily understand it is necessary to provide funds in advance.

Dr. FISHBEIN. I agree with that.

Senator ELLENDER. Very well. Now, the fund that was provided for may be sufficient to make a start.

Dr. FISHBEIN. Yes, sir.

Senator ELLENDER. And those funds must be distributed according to a yardstick laid in the bill. Now, what is the yardstick you propose for your bill?

Dr. FISHBEIN. I maintain the yardstick in this bill is so vague and indefinite in many particulars it leaves far too much authority.

Senator ELLENDER. Would you be able to write a yardstick?

Dr. FISHBEIN. I might be able to improve the yardstick and still not feel mine was better.

Senator WAGNER. Would you add or subtract?

Dr. FISHBEIN. I am of the opinion it is necessary that a system of checks and even perhaps double checks be established. In relationship to scientific research of all types, new ideas, new developments, are not accepted as such, particularly in the field where the establishment of a perfect yardstick is not yet possible. I can cite an example. I have seen a child with a harelip born of an indigent family that ought to have, at the earliest possible moment, the necessary surgery to correct that harelip. The child would otherwise be handicapped through life, it would not be able to earn what it might earn through suitable correction, and I certainly would do all I could do in my own power to aid that child, to correct the harelip, if the money was not forthcoming.

I believe in most of the States excellent facilities can be made available to people who can get the child to the place where such facilities are available.

There is also the possibility that lop-ears might interfere with the earning power of the young man, but how far out would the lop-ears be before it would be recognized as a need? What agency would determine a simple thing of that sort? Could everybody desiring a correction of his appearance, in order to make a better social appearance, be entitled to bring that in as a need to a medical agency? I can give you other diseases with much more significance. Let us say we have the question of the syphilitic, we have a bill providing \$3,000,000 the first year and \$5,000,000 the second, and

then up as far as Congress cares to appropriate to handle that particular problem. Now then, there are in the United States a certain number of syphilitics who are a menace to everyone who is anywhere around them, and there are a considerable number of cases of latent syphilis whose Wasserman test is positive but who would not be a menace to everybody around them. They have a positive test and sometimes you can treat the patient for years without getting a negative Wasserman test, they can go on with their work without bothering anybody, and the doctor can enjoy himself treating them for a long period of time, sometimes with considerable success and sometimes with no success. Who is to set up a yardstick? Shall we set up the yardstick that every man is conceded to be entitled to free treatment for his syphilis until you get a negative Wasserman test? If you do then the money you have appropriated will not begin to meet the problem, but the doctors do not feel the negative Wasserman test or the positive Wasserman test means a man becomes a charge of the community.

Senator WAGNER. Doctor, there have been diverse criticisms of those standards set up. Some say they are too restrictive. You make the criticism that they are too vague. Have you in mind now some standards that might be provided?

Dr. FISHBEIN. I do not believe I could have in mind such a standard, and I do not believe any individual you can get up here, including the best authorities in the United States, could stand here and elaborate the vast system of standards that would be necessary. I need only refer to the attempt to set up suitable standards in relationship to medical care of veterans, or in relationship to any sort of medical care at public expense. Committees have sat for days, weeks, and months, endeavoring to study these expenditures in relationship to the care of patients and even yet these standards are constantly subject to change.

Senator WAGNER. When you made the criticism I thought you had in mind some definite way in which it could be corrected.

Dr. FISHBEIN. I do not think it could be. I believe the only system would be relative based on judgment of the problem integrated in the general scheme. I do not believe the need of New York in relation to some of these conditions is as great as the need in some other States.

Senator WAGNER. That is undoubtedly true. I was trying to think nationally.

Dr. FISHBEIN. That is the way I am thinking all the time. Having the picture before us, obviously there must be some system of check, and as I have said double check, even some system of constantly observing the use of money that is appropriated. After you have given the money you should be absolutely sure that the money has been well spent. There must be investigations under the Public Health Service to go out and resurvey occasionally.

Senator MURRAY. The Government follows that system of checks in connection with the P. W. A. They have engineers on each project.

Dr. FISHBEIN. From an engineering point of view; I think there must be something similar in relationship to devotion of funds for medical purposes.

Senator WAGNER. I think there is.

Dr. FISHBEIN. I doubt that there is, or if there is, it is not functioning 100 percent.

Senator WAGNER. Is not the maternal care, child care, and the health service, is not that done very well, very efficiently, by the Federal Government today in granting aid to States?

Dr. FISHBEIN. Senator, I can send you copies of various reports that have been made by independent investigating agencies, but I do not care myself to be put into the position of standing here criticizing the conduct of any special governmental department in this field.

Senator WAGNER. I was not going to ask you to criticize any governmental department, except I always understood they were very efficiently run.

Dr. FISHBEIN. I will be glad to send you a report made by an independent and unbiased investigating agency as to the manner in which the funds were used under the Sheppard-Towner bills, as to where the money was spent, what was done with it, and what was accomplished.

Senator WAGNER. The reason I am particularly interested is because some of the other witnesses testifying, Doctor, have contended the provisions were too restrictive, that the Federal Government was attempting to control the activities of the States by simply seeing that the moneys were expended for the purposes for which they were employed. Now you take the other point of view, and I am sympathetic with your point of view, that there ought to be supervision of the moneys that are spent by the States.

Dr. FISHBEIN. Supervision and checking.

Senator WAGNER. There have been some of your fellow doctors who have taken the contrary view.

Dr. FISHBEIN. That is between you and them.

Senator MURRAY. These reports you referred to, Doctor, will be sent to the committee?

Dr. FISHBEIN. I will arrange to have the reports sent; yes, sir. I hope my associates are taking note of it. We already have referred that report on each Federal Department concerning medical care, and the amount of money spent.

Senator MURRAY. Doctor, in view of your knowledge and evident efficiency in this field, I would like to see you take this bill of ours and sit down and analyze it section by section for us.

Dr. FISHBEIN. I will ask my associates to aid in such analysis of the bill. We have gentlemen who are well versed in the public-health portions of it, who could make a complete analysis of the bill, but I would indicate the extreme difficulty, if not almost an impossibility, of doing much with this bill as it now stands.

Senator MURRAY. It is not necessary to do anything with the bill.

Dr. FISHBEIN. Well, Senator, our analysis goes to our corrections.

Senator MURRAY. Would you have difficulty in analyzing each section?

Dr. FISHBEIN. I am sure Dr. Woodward of the bureau of medical legislation and Dr. Leland of the bureau of medical economics, and Dr. West will all participate in that report.

Senator ELLENDER. Doctor, when making your analysis and criticism I want you to offer suggestions.

Dr. FISHBEIN. I have made some, and if I think of any others, I will be delighted to make them.

Senator ELLENDER. I mean with reference to each section of the bill beginning with title No. 1.

Dr. FISHBEIN. I think the chief difficulty of the bill is the endeavor to make it all-inclusive, with obviously inadequate multiple agencies. Thank you.

Senator MURRAY. Thank you, Doctor, for your comprehensive statement.

Dr. CARY. Mr. Chairman, I wish to thank you on behalf of the American Medical Association for the courteous treatment you have accorded the American Medical Association.

Senator MURRAY. Doctor, before you call the next witness there is a Miss Schpeiser from New York City here who is anxious to get away, and her statement is very short, and, if you will bear with us, I would like to have her give here statement.

Dr. CARY. With pleasure.

(The American Medical Association was asked to furnish various reports and data during the testimony of their witnesses, which was received by the subcommittee, and is inserted in the record, as follows:)

#### THE SHEPPARD-TOWNER ACT: SOME ADMINISTRATIVE ANOMALIES

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The Sheppard-Towner Act was passed by Congress to assist the several states in "promoting the welfare and hygiene of maternity and infancy."<sup>1</sup> Each year Congress places \$1,240,000 at the disposal of the chief of the Children's Bureau and of the Board of Maternity and Infant Hygiene to accomplish that purpose. But Congress did not define in the act the limits of the "maternity" and "infancy" for which it so generously manifested such solicitude.

Admittedly, the term "maternity" is susceptible of a broad interpretation. Funk and Wagnall's New Standard Dictionary of the English language defines it as "the state of being a mother." It is legally defined as "the condition of a mother."<sup>2</sup> The term "infant," in its legal signification, embraces "any person who has not attained or arrived at the age of majority as prescribed by law. \* \* \* At common law, a person under the age of twenty-one years."<sup>3</sup> If then, Congress used the terms "maternity" and "infancy" in their broadest connotations, any activity to promote the welfare and hygiene of every mother, regardless of her age and the ages of her children and the welfare and hygiene of all persons in their minority, can be justified. A fundamental rule of statutory construction, however, is that whenever the purposes of an act are not readily ascertainable from the act itself, recourse may be had to the circumstances surrounding its passage. To find out what circumstances surrounded the passage of the Sheppard-Towner Maternity Act it is necessary only to refer to the published hearings and to the discussions in the Senate and House of Representatives, on the bill from which that act was developed.

The Sheppard-Towner Maternity Act developed from a bill introduced in the Sixty-Fifth Congress,<sup>4</sup> but which did not come up for discussion on the floor of either the Senate or the House. The bill was again introduced in the Sixty-Sixth Congress.<sup>5</sup> Senator Morris Sheppard, of Texas, the sponsor of this bill in the Senate, in urging its passage, said:<sup>6</sup>

"The need for this act is shown in the appalling number of deaths of mothers in the United States due to causes connected with childbirth, and among infants under one year of age. It developed at the hearing on this bill before the Committee on Public Health that 23,000 mothers died in this country from

<sup>1</sup> 42 Stats. 135.

<sup>2</sup> 30 Corpus Juris 1388.

<sup>3</sup> 31 Corpus Juris 986.

<sup>4</sup> H. R. 12634; S. 4782.

<sup>5</sup> H. R. 10925; S. 3259.

<sup>6</sup> Congressional Record Sixty-Sixth Congress, third session, 60:417 (Dec. 16), 1920.

such causes in 1918, that nearly 250,000 infants less than one year old perished during the same year, and that most of these deaths were preventable."

Here the sponsor of the bill indicated clearly that its purpose was to reduce the number of maternal deaths incident to childbirth and the number of deaths of infants under 1 year of age. And the Senate then passed the bill. It failed, however, to pass the House and was, therefore, introduced in the Sixty-Seventh Congress.<sup>7</sup> Representative H. M. Towner, of Iowa, the sponsor of the bill in the House, testified before the Committee on Interstate and Foreign Commerce of the House, as follows:

"The origin of this bill is very briefly this: The Children's Bureau here in Washington, cooperating with other institutions, both public and private, interested in child welfare all over the United States, very early in their work came to a recognition of this very important and terribly tremendous fact, that there was in the United States an unusual, a disgraceful amount of mortality arising from maternity cases, both as to the mothers and the children of the country."

Representative Towner, then, was pleading for the passage of the bill because of the "mortality arising from maternity cases." Representative Towner asked the committee to hear Dr. S. Josephine Baker, director of the Child Hygiene Division of the New York City Board of Health. Dr. Baker offered for the consideration of the committee two exhibits.<sup>8</sup> One related to maternal mortality and bore the following legend: "The United States lost over 23,000 women in 1918 from childbirth. We have a higher maternal death rate than any other of the principal countries.—Children's Bureau, United States Department of Labor." The other was entitled "Infant Mortality Thermometer, Deaths Under 1 Year of Age Per 1,000 Births." Under this exhibit the following legend appeared: "Within the first year after birth, the United States loses 1 in 10 of all babies born. It ranks eleventh among the principal countries of the world. New Zealand loses fewer babies than any other country. Rates are for latest available years up to 1918. Children's Bureau, United States Department of Labor." This witness apparently was asking favorable consideration of the measure by the committee because of the high death rate of infants under one year of age, and because of the large number of deaths of mothers incident to childbirth.

The Senate Committee on Education and Labor in recommending to the Sixty-Seventh Congress that the bill pass said:<sup>9</sup>

"It is believed by your committee that this legislation by the National Government is necessary and of an emergency character. It is intended to stimulate and aid the states to provide means for saving the lives of thousands of mothers and infants who are annually dying in our country for want of care and attention. It was shown in the hearings that in a single year 23,000 mothers died in childbirth and nearly 250,000 infants died under one year of age, and that most of these deaths were preventable. \* \* \* One-half of infant death occur within six weeks of birth and are due chiefly to the condition of the mother and the lack of proper care and attention during and following confinement. Maternal deaths and infant deaths from maternal causes are not decreasing principally because mothers do not have the necessary care, advice, and assistance they need."

Statements of similar import are scattered throughout the hearings on the bill and throughout the pages of the *Congressional Record*. In the committee hearings, in the committee reports, and on the floor of the House and Senate, emphasis was placed solely on the number of deaths of women incident to childbirth and on the number of deaths of infants under 1 year of age. These were the conditions that the proponents of the bill wanted to correct, and it was obviously for that purpose that the bill was enacted.

But however clearly Congress may have understood the purpose for which it legislated, the chief of the Children's Bureau and the Board of Maternity and Infant Hygiene apparently felt free in administering the law to extend its scope. An examination of plans for operations under the act brings to light some such extensions that seem difficult to justify in the light of the apparent purpose for which the act was passed. The following examples have been selected from plans submitted by the several states containing proposed activities under the joint federal-state funds for the fiscal year 1927. In each case the

<sup>7</sup> H. R. 2866; S. 1089.

<sup>8</sup> Hearings before the Committee on Interstate and Foreign Commerce of the House of Representatives, Sixty-Seventh Congress, first session, on H. R. 2866, p. 7.

<sup>9</sup> Same, pp. 16 and 17.

<sup>10</sup> Committee on Education and Labor, Sixty-Seventh Congress, first session, report 61, accompanying S. 1089.

plans were submitted by the particular state agency administering the funds locally, and all such plans were stamped "Approved by Maternity and Infant Hygiene Board."

#### SOME ACTIVITIES UNDER THE SHEPPARD-TOWNER MATERNITY ACT

California, in plans submitted June 7, 1926, and approved June 25, 1926, made provision for the publication of three pamphlets during the year, one on small-pox vaccination, one on "immunization with diphtheria," and one on the handicaps caused by tonsils and adenoids.

Colorado, in undated plans, approved June 25, 1926, provided for special work with the boys' and girls' clubs at the State fair.

Delaware, in plans submitted June 7, 1926, and approved June 25, 1926, outlined an extensive toxin-antitoxin campaign for the rural districts. Reference was made to the publication of literature on diphtheria, typhoid, milk, diarrhoea-enteritis and diet for children from 1 to 4 years of age. Quoting from the plans submitted: "Since April 1926 we have been conducting an extensive toxin-antitoxin campaign. A large number of preschool children have already been immunized and it is our plan to continue the campaign until every community is reached. During the summer months a typhoid campaign will be put on."

Georgia submitted plans for furnishing free diphtheria toxin-antitoxin to clinics for the immunization of children under 7 years of age. Plans were submitted under date of Sept. 30, 1926, and were approved Nov. 4, 1926.

Idaho, in plans submitted Oct. 3, 1926, and approved Nov. 4, 1926, made provisions for the distribution of literature on "How to Correct Constipation in the Preschool Child."

The plans submitted by Indiana for the fiscal year 1927 bore the approval of the federal board as of June 25, 1926. These plans provided for cooperation with the department of immunology in advertising smallpox and diphtheria immunization as a part of health protection.

The plans of Iowa were undated, but were approved June 25, 1926. Provision was made for a dental clinician, a dental hygienist, and a nurse for advance work to conduct dental conferences for children up to 7 years of age, covering the care of teeth, with some actual demonstration of cleaning and repair work.

The budget submitted by Kentucky, under date of June 8, 1926, and approved June 25, 1926, provided for the following salaries: state health officer, \$1,000; director, \$3,000; assistant director, \$3,000; clinical instructor, \$1,800; chemist for water and milk supply, \$1,800; inspector of birth registration, \$1,500; educational instructor, \$900; six clerks, \$3,720; stenographer, \$1,500; bookkeeper, \$300.

Louisiana, on June 23, 1926, submitted plans for an intensive campaign among registrars and physicians for complete registration of birth, for dental examinations, with corrections of minor defects, for examination of milk and water and for the examination of specimens for the determination of hookworms, other parasites, and malaria. These plans were approved by the Federal Board, June 25, 1926.

The plans submitted by Maryland for the fiscal year beginning July 1 (no date) were approved July 27, 1926. The plans provided for a continuation of centers for child health work in the counties of Maryland and for an extensive system of examinations of preschool children. Plans were submitted for a survey of the cripple children in rural Maryland. According to the plans submitted, no distinct maternity center had been created, "although expectant mothers are seen in small numbers at child-health conferences." Contributions were made to the nursing budgets in 16 counties. Plans were submitted for the continuation of the dental service to preschool children throughout the year. "During last year," quoting from the plans, "this service has been considerably extended and following the preschool examinations, dentists in a number of instances have been sent with portable equipment to make the corrections found necessary."

The budget and plans submitted by Montana provided for the payment of the salary of a laboratory technician from the joint funds. It was not contemplated that this technician should devote her entire time to Sheppard-Towner work. A letter from the division of child welfare of the Montana State Board of Health, July 27, 1926, explaining this item, bears the approval of the Federal Board under date of Aug. 19, 1926. The budget and plans had therefore been approved on June 25, 1926, subject to a question with respect to the laboratory technician.

New Mexico, in plans submitted for the fiscal year 1927, approved June 25, 1926, made provision for the survey of "all milk supplies in a few counties where it is possible to have adequate follow-up."

Plans for New York were submitted June 15, 1926, and approved June 25, 1926. The following excerpt is taken from the plans: "Orthopedic clinics." This consists of a traveling unit consisting of two orthopedic surgeons, \$4,500 and \$3,500, 11 field nurses, eight at \$1,800, one at \$2,000, two at \$1,500, and one muscle tester at \$1,320. This work is carried on in connection with the post-polio cases and such other general orthopedic cases as are referred to it by the various agencies. This work will be continued with the possible addition of three field nurses at \$1,800, for the year 1926-1927. Child Health Consultations \* \* \*. A dental hygienist will be added to the unit at a salary of \$2,000, to examine the teeth of children coming to the consultations and give prophylaxis where indicated. \* \* \* Post Graduate Medical Education: This service is carried on by the Board of Regional Consultants to this division, who comprise specialists in obstetrics and pediatrics. In the postgraduate work, they have given courses of six and eight lectures each to all the county medical societies requesting them, and thus far some 30 or more have been given. Toxin-antitoxin \* \* \*. In connection with the state-wide campaign to abolish diphtheria as carried on by the New York State Department of Health in cooperation with the State Charities Aid Association and the Metropolitan Insurance Company, it is planned for 1926-27 to assist in this campaign by urging the immunization of pre-school-age children in the child health consultations carried on locally under the Sheppard-Towner funds. As this will necessitate an extra day's work each time, special consultations for this specific purpose are urged, and we have accordingly budgeted for this work in the sum of \$5,000."

North Carolina, in plans undated, approved June 25, 1926, made provision for the administration of toxin-antitoxin to children of preschool age.

Ohio, in plans submitted June 15, 1926, approved June 25, 1926, included a provision for pediatrician fellowships, budgeting \$6,000 therefor.

Oklahoma, in plans and budget (both undated), approved June 25, 1926, proposed cooperation with the University Extension Department in postgraduate courses in pediatrics and obstetrics for rural physicians. The budget carried an item, "for special payments, \$4,000."

The plans submitted by Pennsylvania under date of June 11, 1926, approved June 25, 1926, provided for a diphtheria toxin-antitoxin campaign. The budget carried an item of \$7,800 for twenty-six birth-registration clerks, all payable from federal funds. Quoting from the plans: "Records are required to be kept at the present time of preschool and school age children so as to be able to know the number properly immunized at the expense of the Sheppard-Towner fund."

The plans submitted by South Carolina called for the payment from the joint funds of a salary for a milk technician, \$2,100. This item was first questioned and later approved by the Federal board on July 22, 1926.

Virginia submitted plans and budget on June 24, 1926, and both were approved June 25, 1926. The plans provided for the expenditure of \$1,600 for scholarships for nurses. Definite health work was planned "emphasizing sanitation, malaria control, diphtheria prevention, and the lessening of infant mortality, still-births, and maternal mortality." Conferences were to be arranged exclusively for the benefit of the preschool child and infants. The budget submitted provided for the following: director, \$2,750; assistant director, \$2,500; supervisor of nurses, \$2,200; assistant supervisor, \$1,800; supervisor of midwives, \$2,000; supervisor of mothers, \$2,000; correspondence course secretary, \$1,320; three stenographers, \$1,200, \$1,140, and \$1,020; bulletin clerk, \$1,080; drugs clerk, \$1,200 (all of the foregoing personnel being on 12 months' basis). Part-time personnel was provided for as follows: dental clinician (2 months), \$400; preschool clinician (2 months), \$400; extra help, \$303. Scholarships for public health nurses, \$1,600; \$15,000 was budgeted to take care of 40 nurses in county nurse service.

#### SCHOOL AND COLLEGE WORK UNDER THE SHEPPARD-TOWNER ACT

That Sheppard-Towner money has been allotted to States for purposes recognized by the Federal Board of Maternity and Infant Hygiene itself, as not within the spirit of the Sheppard-Towner Act, is shown by the proceedings of the board as reported by the chief of the Children's Bureau. The report says: "11

<sup>11</sup> The Promotion of the Welfare and Hygiene of Maternity and Infancy. The administration of the act of Congress of Nov. 28, 1921, for the period March 20, 1922, to June 30, 1923. Bureau Publication No. 137, p. 6.

"While the board agreed that the act was intended to promote the welfare of mothers and children during the first few years of life, it was recognized that some flexibility was necessary, especially in those States in which only school health work had been done. The plans of six of these States were accepted with the proviso that the approval of certain items, such as work with the school child and courses in the hygiene of maternity and infancy in girls' and women's schools, should not constitute a precedent for the approval of such items in subsequent plants."

The attempt to explain and excuse these expenditures is hardly sufficient to protect future appropriations under the act from abuse. If it has been lawful heretofore to expend Sheppard-Towner money for work with the school child and for courses in the hygiene of maternity and infancy in girls' and women's schools, it will remain lawful to make such expenditures so long as the unamended act is in force. The fact that the Federal Board of Maternity and Infant Hygiene, as constituted on April 18, 1922, stipulated that the authorizing of such expenditures should not be regarded as a precedent for future expenditures of the same nature cannot prevent any subsequent board from taking a different view of the situation. The action of the board, taken presumably without objection by accounting officers of the Treasury Department, shows the multiplicity and breadth of the purposes for which Sheppard-Towner money may be applied, if future boards so elect.

#### AGE LIMITS IN THE SHEPPARD-TOWNER MATERNITY ACT

Too harsh criticism should not be directed against the Federal officers charged with the administration of the Sheppard-Towner Maternity Act, because they allotted funds for the benefit of persons beyond the age of infancy, as that term is universally construed in health work.<sup>13</sup> Criticism should be directed rather against the uncertain terms of the act itself. The danger of a broad construction of such terms was pointed out in the course of debate in the Senate when the bill was under consideration, but no effective voice was raised in protest against it.

In the Senate, Dec. 16, 1920, the following colloquy occurred:<sup>14</sup>

"Senator THOMAS of Colorado. Mr. President, the word 'infancy' has a legal definition, as the Senator from Connecticut knows. It includes all those under 21 years of age. Does the Senator think that it is possible under the terms of this bill that its provisions may be extended to all those under legal age?"

"Mr. BRANDEGEE of Connecticut. I think legally that would be possible, but I referred to that while the Senator from Colorado was temporarily absent from the floor. \* \* \* *Of course, I do not apprehend that any member either of the State or Federal boards would extend aid to an infant of 20 years of age unless he were an idiot or somebody who could not take care of himself.*

"Mr. THOMAS. Of course, there are degrees between the extremes of birth and 20 years of age. Does not the Senator think that it would be perfectly easy, in accordance with the terms of this bill, to apply its provisions to young children of four, five, six, or seven years of age?"

"Mr. BRANDEGEE. Yes; and I said that, on principle, if the object of the bill is to guarantee that future citizens of this country shall be able-bodied and sound in mind and body, it is not enough merely to provide that they shall be safely and sanitarily brought into the world."

The possibility that Federal officers might undertake to construe the Sheppard-Towner Maternity Act as an act "to guarantee that future citizens of this country shall be able-bodied and sound in mind and body," and not merely an act "for the promotion of the welfare and hygiene of maternity and infancy," as the title of the act implies, was recognized by Senator Brandegee, although he endeavored to make light of the danger. In the course of the debate, the senator said:<sup>14</sup>

"Of course, 'infancy' as alluded to in this bill, is undetermined in duration, unless it be the time which the law gives the word 'infant' which is until he is 21 years of age. If all the boys in the country are to be cared for by the government until they get to be 21 years of age, the other people will have to abandon the eight-hour law, and work harder than they ever worked before to support

<sup>13</sup> The infant mortality rate is the number of deaths of infants under one year of age per one thousand born alive," Ninth Annual Report, Bureau of Census, Department of Commerce, 1923, p. 30.

<sup>14</sup> Congressional Record, Sixty-Sixth Congress, third Session, 60:468 (Dec. 16), 1920.

<sup>14</sup> Congressional Record, Sixty-Sixth Congress, third session, 60:466 (Dec. 16), 1920.

them. This is an extreme case, and I do not suppose any Federal board would so rule."

But the bill was not amended so as to include any statutory prohibition that would prevent a Federal Board from so ruling. Everything was left to what was "supposed" to be the case. There the matter now stands.

#### BARTER OF CONSTITUTIONAL RIGHTS

It has been pointed out elsewhere<sup>13</sup> that the policy underlying the Sheppard-Towner Maternity Act is calculated to justify or excuse the establishment of a system of Federal subsidies whereby the government at Washington may induce the states to yield to it their constitutional rights to supervise and control intrastate activities in the field of maternal and infant hygiene. In this article it is pointed out that mere administrative practice under that act may enlarge Federal domination so as to make it cover intrastate activities seemingly remote from those named in the act. The act seems to have been intended only to provide funds through which Federal officers could dominate health activities immediately related to maternal and infant hygiene. Here one can see from official records how funds so provided have been used to acquire the right of supervision and control over special work for the boys' and girls' clubs at the State fair in Colorado; over the activities of the State health officer in Kentucky; over the examination of milk, of water, and of specimens submitted for determination as to the presence of hookworms and other parasites in Louisiana; over a survey of crippled children in Maryland; and over the activities of a laboratory technician in Montana; over a survey of certain milk supplies in New Mexico; over orthopedic clinics and certain postgraduate medical education in New York; over pediatrician fellowships in Ohio; over the activities of a milk technician in South Carolina; over scholarships for nurses in Virginia; and so on.

That the activities named are activities in which the States may properly engage, no one can deny. That such activities within a State should be supervised and controlled by Federal officers may well be denied. That Federal officers do supervise and control intrastate activities in the fields named, to the extent that such activities are paid for from Sheppard-Towner funds, is clear; otherwise the Federal officers charged with the expenditure of such funds would be derelict in their duty to see that such funds are expended in accordance with law and with the plans that have been approved by them. The act itself requires the approval by Federal officers of plans for any intrastate health activities toward the expense of which the Federal government is a contributor, before the State can enter such activities; and when such activities are under way, they are by law subject to the supervision and control of Federal officers, who may penalize any State even to the extent of the withdrawal of Federal funds, if the work is not being done in a way that meets the approval of such officers. And the supervision and control that may be made the basis for the withdrawal of Federal funds covers not only work paid for from such funds, but also the coordinated State work paid for from State funds.

The constitution gives to the Federal Government almost unlimited taxing power. It gives to the States almost unlimited power to protect and promote the health of their people, free from Federal interference. The Sheppard-Towner Maternity Act constitutes a device through which the right of the Federal Government to tax the right of the State to control its own health activities may be bartered one for the other. The Federal Government, through its taxing power, collects money either directly or indirectly from the people of the several States. Through the Sheppard-Towner Maternity Act it agrees to pay back to the people of the States, on certain conditions, some or all of the money thus taken, and in some cases more. By the return of such money, the Federal Government offsets or negatives the collection of it by taxation in the first instance. But the only condition on which the Federal Government will return the money thus collected from the people of the States is that the States, in return therefor, cede to the Federal Government their constitutional right to supervise and control health activities within their own borders, free from Federal supervision and control. If our Government is to continue as a dual Government, on its present constitutional basis, it seems essential that neither Congress nor any State legislature sanction any such system of barter.

<sup>13</sup> Woodward, W. C.: *The Sheppard-Towner Act: Its Proposed Extension and Proposed Repeal*, Bull. A. M. A. 21:126-133 (May) 1920.

It is vital, however, that if Congress or any State legislature sanctions any such barter, the limits within which it may be carried on be clearly defined by the legislative body itself. They must not be left to be determined by Federal boards, bureau chiefs or other administrative officers.

#### AMERICAN MEDICAL ASSOCIATION STUDY OF NEED AND SUPPLY OF MEDICAL CARE

The American Medical Association study of medical care had a strictly limited objective. It was a study of the need and supply of medical care. It did not undertake to develop morbidity nor mortality statistics. It sought facts, not propaganda. It followed the pattern of a scientific diagnosis as a preliminary necessity to the determination of the treatment that would be most helpful in the continuous improvement of the distribution of medical services. It did not seek arguments to justify one specific prescription.

Information was sought from every available source. The medical profession already knew that physicians were not the sole source of information concerning either the extent of illness or the need, desire, and supply of medical care. The medical profession is aware, however, that the education, training, and experience of physicians renders them more capable than nonmedical personnel in recognizing and diagnosing illness correctly and determining the need of medical care. Therefore it may be accepted as a fact that any survey of illness and need of medical care conducted by persons untrained in the art and science of medicine is predestined to produce inaccurate results, since neither the character of illness nor the need of treatment can be accurately determined by a survey conducted by nonmedical personnel.

It has always been recognized by the medical profession that physicians do not automatically come in contact with or have knowledge of all persons needing medical care. Therefore the American Medical Association survey sought to utilize all the other sources from which information as to the need and supply of medical care might be obtained.

Information was recorded on 10 different forms designed to elicit pertinent facts from all persons or groups that are concerned in some way with the administration, provision of, or arrangement for medical services. One form was prepared to obtain information from physicians and dentists. Eight forms were directed toward other sources of information. Hospital administrators were asked not only the extent of all services furnished during the previous year and the distribution of patients between pay, part-pay, and free patients and public charges but also whether additional facilities were needed and, if so, what facilities. They were also asked the number of persons who applied for medical care, either as in-patients or out-patients, who were not cared for and the reasons for such rejection.

There are far more nurses than physicians and these nurses are connected with a wide variety of organizations, such as visiting nurse associations, health departments, schools, welfare organizations, insurance companies, and industries. Nurses have a wide opportunity to observe any lack of needed medical care, if such exists. They were asked to give full details as to services furnished and "number of requests for nursing services that you have been unable to fulfill," and whether it was possible to obtain medical care whenever needed.

The activities of many health departments are such that they should know of any section of the community in which medical care seemed to be deficient. Requests for information concerning any such lack of care were addressed to such departments.

Private and governmental welfare and relief agencies should, by the very nature of their functions, be in touch with any individuals or families, who are unable because of economic conditions to procure medical care. Their spokesmen have often been among the most vociferous in making exaggerated statements of alleged deficiencies in the supply of medical care. Local organizations concerned with relief were asked for information concerning existing arrangements to provide medical care for the indigent and especially as to the number of persons for whom it was "impossible for your agency to arrange for needed medical, dental, or hospital care."

Officials of public, parochial, and private schools were requested to describe any type of medical care or examination provided for their pupils and especially

to supply information concerning any failure of their pupils or their families to secure medical treatment for defects found through the school medical examination. That no field of education might be overlooked, the colleges and universities were queried for information concerning the health and medical services arranged for or provided by such institutions for their student bodies and, also, as to the number of students who were unable to obtain medical or hospital care when needed, with reasons for such failure.

It has been estimated that at least 3,000,000 to 4,000,000 persons receive medical services through industrial, fraternal, mutual benefit, group hospitalization, community health, and other similar organizations or through prepayment county medical society plans. Information was sought from the administrators and directors of these organizations, and they were especially asked if any difficulty had been encountered in securing needed medical or hospital service for their membership.

Finally, in nearly every community there are many people who, at least for their less serious illnesses, consult pharmacists and purchase remedies in drug stores without a medical diagnosis or prescription. This places the pharmacist in a position to have knowledge concerning any persons who may desire medical care, but for economic or other reasons are unable to obtain it.

Every one of these forms contains not only a question as to any specific inability to obtain medical care but also a request of the person or organization filling out the form to supply comments and suggestions concerning any observed lack of medical care and the methods they believe should be considered in seeking a remedy for this situation.

#### NONMEDICAL COOPERATION

One of the most gratifying features of the survey was the wholehearted cooperation from nonmedical organizations. In every county from which reports have been received the percentage of returns from nonmedical sources was larger than the percentage of returns from physicians. In many localities there was a 100-percent response from all sources other than physicians, dentists, and pharmacists. The number of comments received from nonmedical sources was especially noteworthy. The nature of the survey made it impossible to select the persons asked for comment on the basis of any policy to be supported by such comments. Furthermore, all comments were anonymous to encourage the greatest freedom of expression. This is in special contrast with some so-called investigations where requests were sent to a selected list of physicians and others in order to secure replies which would support a previously determined policy. The number of comments received from all sources is many times that obtained from any previous attempt to measure the opinions of those best qualified to judge on questions of need and supply of medical care.

A somewhat unexpected phase of the study is the startling agreement of the replies received from different sources. Had there been a sharp conflict between physicians, dentists, and pharmacists, on the one hand, and hospital administrators, health department officials, and welfare workers, on the other, there would have been occasion to doubt any general conclusions assuming agreement. There is not a single county in which there is any such sharp disagreement among these groups. In the overwhelming majority of the counties there is almost complete agreement between all these sources of information as to the need and supply of medical care. Where physicians and dentists speak of a lack of hospital accommodations or of inability to care for nervous and mental diseases, the indigent, low-income group, or other classes of persons in need of medical care, this conclusion is almost invariably confirmed by the statements from all other sources of information. It is also clear that in all but a comparatively few States all sources are agreed that there are few or no instances of medical care needed and desired that has not been furnished or is not now available if the people themselves make known their desire for such services.

#### EXTENT OF COVERAGE

No other survey has so thoroughly utilized so wide a variety of sources of information. All previous surveys purporting to seek facts concerning the need and supply of medical care have covered a much smaller percentage of the population and the geographical area of the United States. Up to July 1, 1939, 605 county medical societies had sent in returns from 873 counties in 38 States, covering a total population of 47,331,000. This survey is more fully repre-

sentative of both urban and rural populations than any previous survey. Prior to 1930 the United States Bureau of the Census classified the residents of cities of 2,500 population or more as urban and all others as rural. According to this standard the 873 counties included an urban population of 31,012,140 and 10,319,466 rural.

The American Medical Association survey was not designed primarily to produce a statistical report but, rather, to obtain a consensus of opinion after a study of the facts by those closest to the situation as to the need and supply of medical care; yet it did reveal certain statistics of sufficient accuracy to be worthy of presentation. Replies have been received from 21,995 physicians and dentists. Many counties did not separate returns from physicians and dentists, and in some localities forms were not sent to dentists. The ratio of returns received from physicians and dentists in counties where a separation was made leads to the conclusion that about 17,000 of the 21,995 forms returned were filed by physicians. These 17,000 physicians reported giving medical service without charge to 3,004,724 persons. This is a little more than 8 percent of the population covered by the study.

Since the number replying was less than 25 percent of the physicians in the area covered, it is certainly within safe limits of error to assume that the amount of gratuitous service given in all the physicians' offices and patients' homes during this period was at least double the figure given. This would mean that between 10 and 15 percent of the population received this type of free service. The same physicians reported giving 1,988,498 hours of service in hospitals and clinics; these hours of free service are in addition to the care of patients at home or in physicians' offices. These facts demonstrate that the previously used estimate of \$1,000,000 daily as the value of the free services given by physicians in the United States, measured by customary charges to pay patients, is far below the actual figures.

The 4,110 pharmacists who participated in the study reported that they had filled 370,739 prescriptions free and 613,458 at reduced cost during the previous year. There is a possibility that there was some misunderstanding in interpreting the question and that some prescriptions paid for by public relief or private philanthropy were counted as furnished free. There is, however, no doubt that pharmacists have borne a considerable share of the burden of medical care for the indigent.

Reports were received from 1,256 hospitals. The total replies from nurses' organizations, which in some cases included a hundred or more nurses, and from individual nurses in localities where nursing was not organized was 1,870. Eight hundred and twenty-two health departments cooperated in the survey, as did 1,840 private or governmental welfare and relief agencies, 3,775 private and public schools, 287 universities and colleges, and 1,901 industrial, fraternal, mutual benefit, and group hospitalization organizations. The total number of forms received from sources other than physicians and dentists was 15,870. Since perhaps a majority of these were from organizations instead of individuals it is clear that others than physicians furnished much of the information. (Statistical tables giving more detailed information are given at the end of this report.)

#### LOCAL NEEDS DIFFER

The reports of State medical societies make evident the wide variations in conditions and the consequent need of diversified programs to meet local problems. The county medical society reports show a further extension of these differences and point out the different types of action needed to meet these very situations. It may appear as a self-contradiction to say that this very diversity was actually responsible for the fact that all sources of information were in complete disagreement with the sweeping generalities which have been so widely circulated regarding national conditions. The information in the American Medical Association survey was furnished by persons who were dealing daily with different phases of the same facts and not with theories or grandiloquent schemes. Physicians, dentists, and pharmacists, as well as welfare officials, nurses, and hospital administrators, all were observing the same things and could not well disagree on what they reported.

Numerous localities reported inadequate hospital facilities and many of these described plans for additional buildings as already under way. Available empty beds which could not be filled because of a lack of funds were more frequently reported. Hospital insurance was a common suggestion as a partial solution of this problem, with recommendations that this be supplemented by

public assistance to meet all or part of the payments for hospital insurance for the indigent and medically indigent. These recommendations are in agreement with the Report of the Special Session of the House of Delegates of the American Medical Association, which "favors the expansion of general hospital facilities where need exists" and approves "the recommendation of the technical committee stressing the use of existing hospital facilities" and "the principle of hospital-service insurance." This program would very closely correspond to the recommendations of those who responded to this survey. No State spoke of the need of any general national program of hospital construction. Always the needs were reported as local, specific, and limited.

Complaints of the insufficiency and often inefficiency of medical service provided by governmental agencies came from all sections of the country. The worst overcrowding exists in institutions for mental and nervous diseases, the tubercular, and persons who are feeble-minded. This verifies the annual reports of the council on medical education and hospitals of the American Medical Association which has repeatedly called attention to this condition.

The most common complaint of a lack of medical facilities voiced from the largest number of localities and the most varied sources concerns the inadequate payments of local, State, and Federal governments for the medical care of the indigent. These payments, in the great majority of localities, were so small that the main burden of furnishing medical care to the indigent falls on the practicing physicians. That this is true has already been demonstrated in the statements concerning the amount of gratuitous medical care given. Physicians are willing to bear a large portion of this burden either in the form of reduced fees to supplement contributions from taxation and philanthropy or through a reasonable amount of gratuitous service in private practice and public institutions. The house of delegates of the American Medical Association has officially endorsed "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" and "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." It would seem significant that this general complaint is offset by reports from a number of communities that mutual arrangements fairly satisfactory to relief authorities, physicians, and indigent patients have been developed and that in nearly every instance this result has been due to the initiative and continued cooperation of county medical societies. Comments on medical care for the indigent frequently instance the harmful effects of political administration and the abuse of free care and include recommendations for more efficient social service to determine need. Observers in nearly every locality stated that the primary need is increased income for the low-wage classes and employment for the unemployed.

There are "depressed regions" where the "indigent" constitute so large a percentage of the population as almost to dominate the entire situation. Even in these regions by far the majority of those reporting agree that of all the essential goods and services required for a healthy existence, medical care is probably the most adequately supplied. In some of these localities the physicians report that more than 50 percent of their services are given without pay. They also express a sense of utility because the value of those services is largely nullified by the health-destroying conditions under which the people must live. Improvement of living conditions in these areas is more needed than an additional amount of medical care.

It would seem to be a fair conclusion that there are a few localities where, if conditions are to be made livable, Federal assistance must be given. Even in these localities there are none who report that an increased amount of medical care is the primary need and the first essential in the control and cure of disease. Medical societies in these areas complain of the need of better education not only of the public but of physicians, midwives, nurses, and others concerned with the care of the sick, and they tell how all available resources are being strained to supply this education. These localized conditions do not create a national problem; they are local problems which call for local treatment, and in some instances outside financial assistance. In some such regions these conditions may be temporary. In others, much more far-reaching measures than the provision of additional medical services are the first essential to the reduction of morbidity and mortality.

Many places ask for an extension of public-health facilities, including the provision of biologicals and the extension of preventive measures, and in some small cities and rural districts express a need for public-health nursing. The further extension of county health departments is generally approved, although sometimes with the reservation that this extension cannot proceed faster than the supply of qualified personnel and local support. There are localities with inadequate hospital facilities, but more frequently reported lack of provision for hospital needs is explained as due to defects in the organization of existing resources, or to lack of funds to pay for care in existing empty beds. Physicians in several of the less populous counties in a number of States expressed a desire for better diagnostic and laboratory facilities than are provided by existing health departments and hospitals.

Close cooperation between health departments and organized medicine exists, with few exceptions, in every section of the country reached by the American Medical Association's study. State and county joint projects participated in by health departments and medical societies were described as being conducted in nearly every State. Almost universally this cooperation of organized medicine extends to governmental provisions for maternal- and child-health care, care of crippled children, workmen's compensation, prevention and treatment of venereal disease, and similar health programs. In many cases, as with the care of the indigent, these programs are expanded and subsidized phases of work long conducted by State or county medical societies. Widespread use has also been made by governmental agencies of the administrative framework created by these societies and of the gratuitous administrative services of the officers and members of these societies.

A frequently mentioned need on which there were no dissenting opinions was for more intensive and extensive education of the public. Several observers instance the fact that although vaccination for smallpox and immunization for diphtheria afford almost complete protection and can be obtained without cost in most sections of the United States, here is seldom voluntary acceptance by as much as one-third of those needing such protection. In many States the number of followers of cults with substandard medical education, and of religious opponents of medical treatment is estimated at between 10 and 15 percent. Manifestly even compulsory sickness insurance, unless treatment also was compulsory, would not cause this section of the population to receive medical care when needed. It is a sort of grim inconsistency that many of those who are exaggerating the lack of medical care received in the United States are so often found offering encouragement to these substandard medical cults. This attitude is, however, absolutely consistent with the scant reference by propagandists of sickness insurance to the quality of the medical service it is proposed to provide.

A recent study by the Massachusetts Department of Public Health<sup>1</sup> showed that after a thorough State-wide campaign to detect cancer and tuberculosis cases, less than half of those who were diagnosed as suffering from these diseases availed themselves of the free medical care provided by State and local authorities within the period during which treatment might be expected to be most effective. It was the conclusion of this survey that the greatest obstacle of medical treatment for these two most deadly diseases is lack of public education as to the necessity of procuring proper care.

This conclusion as to the fundamental importance of public education was further confirmed in the American Medical Association survey by the unanimous report from almost every section of the country concerning the lack of treatment of defects revealed by wholesale examinations of school children. Repeatedly it is stated that only a small percentage of the defects discovered in such examinations receive prompt and adequate treatment, and almost invariably this condition is explained as due to "parental indifference" or actual hostility to medical treatment. Much more than half of such defects are dental, and many of the remainder are defects of vision or hearing. There are numerous suggestions of local programs to meet this situation.

Education of the public has not been neglected. Nearly every State medical society and most of the larger county medical societies are actively engaged in campaigns of public health education conducted in cooperation with health

<sup>1</sup> Lombard, Herbert L.; Education a Major Need in Adequate Medical Care, J. A. M. A. 111: 1747-1749 (Nov. 5), 1938.

departments, schools, and other public and private organizations. The bureau of health education of the American Medical Association, in cooperation with various public and private national agencies, seeks not only to reach the general public by printed matter, radio, and public addresses, but also to assist in establishing and maintaining standards of all types of health-education material.

A few comments, coming from all sections of the United States, urge some plan to assist the low-income classes to meet medical costs. Any attempt to give exact statistics as to numbers or percentages of such comments would be as deceptive as the numerous, widely circulated statements as to the number and percentage of the population ill at any one time or receiving "inadequate medical care." There is no clear definition of the "low-income class" or of the "plans" which the commenters had in mind. During recent years literally hundreds of medical societies have been discussing and experimenting with many types of such "plans." Whether those who raised this question had such medical society plans in mind, it is seldom possible to say. A safe estimate would appear to be that between 5 and 10 percent of the possibly 20 percent who accompanied their forms with comments mentioned the need of some special provisions to assist the low-income classes in meeting the costs of medical care. Not more than 2 or 3 percent of the comments specifically and favorably mentioned compulsory sickness insurance.

The American Medical Association has repeatedly, through its house of delegates, declared that it is not opposed to the use of the principle of insurance to provide funds with which to pay costs of sickness or for unemployment due to sickness. It is opposed to the type of compulsory sickness insurance that places the control of any phase of medical care in the hands of persons who are not qualified to give that care or that depends for its financial soundness on deception of the insured. These conditions exist in all systems of compulsory sickness insurance now in operation and would exist under any system so far proposed for legislative action in the United States.

#### SUMMARY OF CONCLUSIONS

Because broad generalizations are almost never wholly true and because there has already been a plethora of such half-true or wholly untrue generalizations, this summary of the survey of the need and supply of medical care will not be used to add any more generalizations of this unreliable character.

Almost any national generalization concerning the need and supply of medical care would be false and misleading. In some States the greatest need is for increased facilities in institutions for the care of the mentally diseased. In others an extension of some phase of public health work. Many localities ask for more clinics; probably still more would abolish or restrict the scope of existing clinics. There are a few States in which medical care for the indigent seems to be adequately administered and supported, but the majority complain loudly of the inadequacy of such arrangements. There is frequent complaint in some States of inadequate provision for transients. Dental care is one of the most general problems. There would seem to be no other practical test of the adequacy of facilities for personal diagnosis and treatment except that of whether there are sufficient facilities available to supply those who express a desire for such care. Unless the public is willing to support legislation to compel anyone to accept personal medical service whenever a Works Progress Administration visitor or social-service investigator decides that such service is needed, medical care must continue to be given only when desired and sought by the individual.

A careful examination of the reported facts and of the opinions expressed by those best qualified to judge seems to justify the conclusion that, with the exception of isolated localities, some of which have been previously mentioned, there is no important section of the population of the United States that needs and desires medical care that now fails to receive such care. Physicians everywhere have shown not only by their reports in this survey but by their actions throughout many years that they have been willing to give far beyond their obligations to the profession or as citizens to ensure that no one should be deprived of needed and desired medical care. Nurses, hospitals, schools, welfare workers, and every other organization in touch with medical needs testified that there are few instances where it is impossible to secure needed and desired medical care.

This general conclusion that there is no widespread deficiency in the accessibility of medical care is confirmed by four special tests made in widely different sections of the country. State or county medical societies in New Jersey, Minnesota, Wayne County (Detroit), Mich., and five Pennsylvania counties, in order to determine whether any significant number of persons desired medical care which they had been denied, inserted notices in the newspapers covering the sections it was desired to investigate and followed this up by repeated radio broadcasts appealing to any person who had been unable to obtain needed medical care or who knew of any person unable to obtain such care to write or telephone the sponsoring medical society. It was uniformly stated that every case would be investigated and if found necessary medical care would be provided without charge. The results were practically the same in all four cases.

Out of a population of several million reached by the New Jersey publicity, 127 requests were received. The president of the State medical society, in reporting on the results of the investigation of these cases said:

"\* \* \* Each request was investigated, and medical services were provided where needed.

"But we found these applicants were not unable to obtain medical care. It was available. They simply didn't know how to go about getting it. Many of them did not lay their cases before any private physician, any municipal health department, or welfare agency. Some had already received medical care but were not completely satisfied with it. But they had been able to get it."

In Detroit 1,408 telephone calls, letters, or other types of requests were received, many of which were duplications, so that the actual number was approximately 1,000. It was estimated that this figure represents approximately one-twentieth of 1 percent of the population reached. It was found that in practically all cases arrangements already existed by which medical care could be obtained and that it was necessary only to inform the inquirers as to the methods of contracting sources of medical care. That such persons had not received it previously was due to defects in educating the public as to the sources of medical care.

In Pennsylvania the Pittsburgh newspapers published the notice, and 26 answers were received, none of which cases on investigation was found to be "unable to get medical care because he had no money, or who knew of such a case."

There is little difference in the results obtained by the Minnesota State Medical Association. Standing by themselves such experiments would not be conclusive, but they do afford strong verification of the accuracy of the similar information obtained throughout the large section of the population covered by the American Medical Association survey.

This evidence does not involve the further conclusion that there are no weaknesses and defects in the present system of medical service. Examples of such criticisms have been given. They are such as have been made by the medical profession of its own work ever since the creation of the profession. These are specific, constructive criticisms as to defects for which a remedy is available or for which it is reasonable to seek and expect to find a remedy.

The radio and newspaper publicity is but one phase of the continuous effort by the organized medical profession to hunt out and provide for all instances of unsupplied medical needs and desires. An important byproduct of this survey has been the discovery of such individual needs in the localities provided and the arrangements made to supply medical care to meet such situations.

#### A PRESENT PROGRAM

The picture that takes shape out of all these details of facts and opinions appears to be one of a fairly well correlated and constantly improving program of medical care. This program has not been planned in detail and then applied by authority, but has grown and developed with infinite diversity to correspond to infinite local and historical differences. This program has been constantly expanded by the inclusion of new elements and the assumption of new tasks. Its organization is flexible and cooperative rather than fixed and authoritative. It includes a multitude of public and private organizations which, in spite of occasional disagreements and friction, in the majority of localities have agreed upon methods of cooperation and division of labor. It is free to experiment

on any one of scores of fronts without involving the entire movement in local failures, while successful experiments are quickly and widely adopted.

This program meets the practical, pragmatic test—it works. Measured by the statistical test that is applicable to any phase of medical care—that of morbidity and mortality—it has proved to be more efficient in attaining its purpose—that of reducing illness and postponing death—than any of the autocratic and official programs existing in other countries and which are urged for adoption here. The development of this program for the future depends upon the continuance of the same methods, constant investigation and study to discover defects, regular experimenting with methods of curing those defects and development of such of these experiments as prove desirable.

#### A WORKING SURVEY

This survey not only sought to bring out the facts concerning the need and supply of medical care but to lay the foundation for whatever changes might be helpful in meeting any deficiency in the supply of medical care. Each county medical society was asked to assemble the original forms and, after analyzing the facts which they revealed, to assemble any additional information bearing on the subject of the survey and then to prepare a report not only to be sent to the State medical society and the American Medical Association but also to form the basis of improvements in the local health program. Not all of the county societies carried out all of the details of this suggestion. A considerable number, however, did prepare such reports, some of them constituting fairly large-sized bound volumes of typewritten or mimeographed material and containing agreed upon suggestions as to improvements needed and methods of introducing them.

The State medical societies also were asked to assemble the county society reports and to include a number of items of information applying to the State as a whole. Some of these State medical societies also prepared extensive bound volumes of the information supplied and recommendations as to future action. Many of the State and county medical society reports state that measures have already been taken to supply some of the deficiencies which the survey uncovered. It is already evident that one of the results of the survey will be the introduction of a great number of improvements, some of them of a minor character and others requiring rather extensive changes in the general program of medical care. Furthermore, the material assembled in this survey is available for the development of future programs. This material, which is probably the most extensive ever collected concerning the need and supply of medical care in the United States, is open for examination by any public or private body or individual interested in improving the conditions of medical care in this country.

#### COMPARISON WITH OTHER SURVEYS

A study made in 1920 showed that in the years 1902 to 1928, inclusive, there have been 3,830 "public health surveys."<sup>2</sup> These were classified as covering 56 different subjects and were undertaken by a large variety of organizations and individual investigators. It would seem probable, from the increased interest that has existed in medical matters since 1920, that the number of surveys available at the present time would be somewhere between 7,000 and 8,000. Nearly all of these surveys were made for the purpose of determining facts on which to base conclusions or subsequent action and not for the purpose of providing justification for already accepted conclusions or proposed actions.

There has been very little publicity about these thousands of surveys in comparison with that which has been given to three or four surveys made in recent years. Perhaps the reason for the difference in publicity is that these recent surveys were of a wholly different type. The first of this latter type of survey—that undertaken by the Committee on the Costs of Medical Care—set the pattern for succeeding ones. It was conducted by a staff of investigators and writers who in their previously published statements had announced practically the identical conclusions which were arrived at in the survey. The basic, preconceived conclusion was that there existed in the United States a

<sup>2</sup> Ieland, R. G.: Diagnosing the Public Health, A. M. A. Bulletin 24: 21-30 (January) 1920.

great amount of uncared for illness and that this required radical legislative action designed to change the entire pattern of medical practice.

It is not difficult to find material that may be used to support such a conclusion. To prove that there is a great amount of illness, it is necessary only so to define illness as to make it apply to conditions common to a large section of the population. The Committee on the Costs of Medical Care defined illness as follows:<sup>2</sup>

"For the purposes of this study an illness is defined as any disorder which wholly or partially disables an individual for one or more days or as any experience for which medical service of any kind is received. Any condition, symptom, or disorder for which drugs costing 50 cents or more are purchased is considered an illness."

It has been shown many times that there are very few people who do not have what would be included as an illness under such a definition. For example, there are few people who do not have some type of slight dental, visual, or auditory defect. To prove the deficiency in the supply of medical care it was necessary only to use a definition of "adequate medical care" that would involve all of the latest achievements of medical science and the utilization of specialists, laboratories, and hospitals. This survey also introduced the deceptive method of measuring the amount of medical care received by the amounts paid for medical services by different income classes. This not only completely ignored the millions of dollars worth of medical care given without charge but also what were probably many more millions that were given to members of low income classes at reduced rates.

Surveys in California and Michigan followed the pattern set by the Committee on the Costs of Medical Care. The survey used by the Interdepartmental committee as the basis of its report elaborated the pattern. It used superficially trained investigators to go from house to house and catalog all the illnesses reported by any member of the family during the previous year and all existing physical defects. It was then assumed that all of these persons were in need of medical care and that all failures to receive such care were due to conditions that could be remedied by the legislation which had been outlined before the survey was undertaken. Some of the most frequently used figures of the survey were not obtained by any sort of investigation. It is now admitted that the widely published statement that 40,000,000 people in the United States lack medical care is based on the single fact that there are that many people with family incomes of less than \$800 annually.

The American Medical Association, in its survey of the need and supply of medical care, sought the facts from all the sources that might be supposed to have information on these subjects. Its objective was to determine how large a portion of the population who thought themselves in need of medical care and desired to obtain it were denied such care. This would seem to be the central problem of medical care in any country, unless it is proposed that every person whom an untrained investigator judges to be ill is to receive unwanted medical care.

Because of the unknown factors in the two basic elements of "illness" and "medical care," no attempt was made to determine statistically the number of persons ill at any given time nor to decide what constituted "adequate medical care." It was assumed that the individuals themselves were to continue to decide when they desired medical care and that, except for such public health and preventive measures as are essential to the protection of society, they should not be compelled to accept undesired medical service. All sources of information on the need and supply of medical services were questioned as to the extent to which it was possible for the persons who desired such services to obtain them. The survey showed that, while there are undoubtedly at all times and in all places deficiencies in medical care, these deficiencies are probably less in the United States than in any other country and that in only a few special localities is any important percentage of the population unable to obtain the medical care which it needs and desires.

<sup>2</sup>The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families, publication No. 20, Committee on the Costs of Medical Care, Chicago: University of Chicago Press, p. 8.

## Statistical tables

State and county medical societies participating <sup>1</sup>	Number of counties covered	Population covered	Replies received		Free care by physicians		
			Dentists and physicians	Other organizations	Number of persons	Number of hours	
Alabama.....	17	17	1,081,160	596	514	97,802	43,018
Arizona.....	2	2	60,480	35	24	14,053	7,493
Arkansas.....	29	29	808,751	307	202	59,379	11,847
California.....	1	1	141,999	124	63	8,515	7,057
Colorado.....	18	37	403,782	248	239	45,917	8,903
Delaware.....	3	3	238,380	109	64	27,670	12,891
Florida.....	6	6	300,319	67	50	7,900	1,064
Georgia.....	2	2	343,837	95	74	6,892	9,840
Idaho.....	1	8	75,706	12	5	5,763	375
Illinois.....	8	8	4,142,189	2,059	982	278,585	298,830
Indiana.....	17	18	1,316,371	1,044	1,169	70,882	49,793
Iowa.....	18	19	532,743	318	403	26,762	2,601
Kansas.....	18	20	488,255	183	215	28,919	2,733
Kentucky.....	96	102	2,387,293	1,172	799	163,399	41,048
Maryland.....	23	24	1,631,520	430	2,189	41,090	60,618
Massachusetts.....	6	5	1,651,072	682	615	55,113	55,136
Michigan.....	15	22	2,837,913	839	306	35,173	222,289
Minnesota.....	32	80	2,491,723	733	989	101,525	48,156
Missouri.....	8	12	672,739	458	176	42,254	33,514
Montana.....	9	27	284,596	126	148	30,212	3,073
Nebraska.....	25	47	786,681	411	268	29,947	18,853
New Hampshire.....	10	10	468,293	196	274	25,551	10,423
New Jersey.....	21	21	4,041,334	2,078	894	445,561	341,802
New Mexico.....	1	1	11,036	7	3	600	.....
New York.....	4	4	133,909	100	67	34,781	1,089
North Dakota.....	2	6	100,541	24	14	3,994	.....
Ohio.....	43	43	4,011,517	2,436	616	107,702	176,326
Oregon.....	24	36	953,780	1,129	701	101,177	27,199
Pennsylvania.....	53	64	8,820,354	3,589	2,945	612,025	443,636
Rhode Island.....	3	5	687,497	284	167	17,415	34,712
South Carolina.....	2	4	81,506	23	25	5,105	970
South Dakota.....	11	01	666,291	48	30	15,713	1,305
Tennessee.....	12	17	948,659	510	231	215,707	29,038
Texas.....	41	78	2,104,103	1,018	849	145,710	65,203
Vermont.....	2	6	48,542	7	5	162	60
Virginia.....	6	7	413,011	106	69	10,716	4,785
West Virginia.....	5	10	379,692	85	46	6,547	4,439
Wisconsin.....	14	21	675,101	280	254	37,314	11,411
Total.....	605	873	47,331,606	21,095	15,870	3,064,724	1,068,418

<sup>1</sup> States from which county summary reports have not yet been received: Connecticut, District of Columbia, Louisiana, Maine, Mississippi, Nevada, North Carolina, Oklahoma, Vermont, Washington, and Wyoming. The first column of figures represents the number of county medical societies that sent in summaries.

## Number of forms returned

State <sup>1</sup>	Hospitals	Nurses' organizations	Health departments	Welfare and relief agencies	Schools	Colleges	Other organizations
Alabama.....	30	13	15	79	15	6	88
Arizona.....	7	4	2	1	0	0	0
Arkansas.....	19	33	17	28	13	5	5
California.....	4	3	2	6	2	1	0
Colorado.....	27	26	17	29	47	5	11
Delaware.....	8	4	3	40	0	2	0
Florida.....	2	23	3	0	0	0	0
Georgia.....	11	4	1	1	5	7	6
Idaho.....	0	0	0	0	0	0	0

<sup>1</sup> States from which county summary reports have not yet been received: Connecticut, District of Columbia, Louisiana, Maine, Mississippi, Nevada, North Carolina, Oklahoma, Vermont, Washington, and Wyoming.

## Number of forms returned—Continued

State	Hospitals	Nurses' organizations	Health departments	Welfare and relief agencies	Schools	Colleges	Other organizations
Illinois.....	71	16	16	285	60	17	261
Indiana.....	32	26	15	134	276	16	385
Iowa.....	23	27	10	39	148	6	160
Kansas.....	20	24	11	33	60	0	10
Kentucky.....	51	630	29	72	0	0	0
Maryland.....	48	275	25	56	1,647	17	39
Massachusetts.....	44	145	70	85	125	20	29
Michigan.....	57	20	24	72	81	11	23
Minnesota.....	73	43	166	76	596	21	9
Missouri.....	23	8	4	35	15	7	0
Montana.....	19	23	6	11	31	4	5
Nebraska.....	36	31	10	32	8	5	0
New Hampshire.....	17	41	3	8	1	2	2
New Jersey.....	94	24	89	58	152	12	22
New Mexico.....	0	0	0	0	0	0	0
New York.....	9	11	4	9	13	2	1
North Dakota.....	3	2	3	2	1	0	1
Ohio.....	71	72	58	97	66	18	38
Oregon.....	73	38	41	74	56	14	25
Pennsylvania.....	230	210	84	356	362	50	446
Rhode Island.....	11	13	7	28	14	6	18
South Carolina.....	1	3	3	2	0	1	0
South Dakota.....	10	2	1	1	0	4	0
Tennessee.....	17	10	8	17	11	3	5
Texas.....	63	110	33	46	25	15	295
Utah.....	1	1	1	0	1	0	0
Virginia.....	8	5	8	5	11	4	5
West Virginia.....	8	4	0	0	3	1	0
Wisconsin.....	35	19	27	17	40	5	12
Total.....	1,256	1,870	822	1,840	3,775	287	1,001

## Data from pharmacists

State <sup>1</sup>	Number of forms returned	Number of free prescriptions	Number of prescriptions at cost or reduced fees	State <sup>1</sup>	Number of forms returned	Number of free prescriptions	Number of prescriptions at cost or reduced fees
Alabama.....	268	14,492	24,515	Nebraska.....	146	4,404	15,668
Arizona.....	10	1,906	3,133	New Hampshire.....	200	15,600	22,400
Arkansas.....	82	15,262	12,247	New Jersey.....	443	24,529	103,560
California.....	45	500	4,312	New Mexico.....	3	300	100
Colorado.....	74	3,789	13,609	New York.....	18	457	667
Delaware.....	7	125	202	North Dakota.....	2	.....	315
Florida.....	22	1,110	4,409	Ohio.....	195	20,812	19,798
Georgia.....	39	2,000	3,825	Oregon.....	380	33,024	67,585
Idaho.....	5	96	795	Pennsylvania.....	307	30,636	63,287
Illinois.....	256	24,334	56,541	Rhode Island.....	70	2,710	14,367
Indiana.....	276	32,956	17,792	South Carolina.....	15	750	2,550
Iowa.....	50	8,221	8,845	South Dakota.....	18	12,402	2,652
Kansas.....	67	1,628	6,193	Tennessee.....	154	18,551	15,131
Kentucky.....	108	23,501	9,377	Texas.....	253	10,382	22,566
Maryland.....	182	26,314	60,122	Utah.....	1	.....	.....
Massachusetts.....	97	5,672	7,917	Virginia.....	23	4,535	4,450
Michigan.....	18	1,587	6,100	West Virginia.....	18	2,650	3,246
Minnesota.....	5	18	120	Wisconsin.....	129	9,770	15,697
Missouri.....	84	7,361	7,099				
Montana.....	49	2,315	7,266				
				Total.....	4,119	370,739	613,458

<sup>1</sup> States from which county summary reports have not yet been received: Connecticut, District of Columbia, Louisiana, Maine, Mississippi, Nevada, North Carolina, Oklahoma, Vermont, Washington, and Wyoming.

## Data from hospitals

State <sup>1</sup>	Number of forms returned	Public charges	Free patients	State <sup>1</sup>	Number of forms returned	Public charges	Free patients
Alabama.....	30	442	14,073	Nebraska.....	36	8,754	3,433
Arizona.....	7	210	2,521	New Hampshire.....	17	1,308	1,374
Arkansas.....	10	20,072	8,684	New Jersey.....	91	60,272	60,311
California.....	4	8,775	0	New Mexico.....	0	0	0
Colorado.....	27	2,828	2,212	New York.....	9	1,030	711
Delaware.....	8	0	0	North Dakota.....	3	0	0
Florida.....	2	0	0	Ohio.....	71	8,164	38,873
Georgia.....	11	143,137	10,036	Oregon.....	73	0,631	0,614
Idaho.....	0	307	0	Pennsylvania.....	230	22,020	213,210
Illinois.....	71	101,871	20,232	Rhode Island.....	11	1,076	11,713
Indiana.....	32	5,644	23,161	South Carolina.....	1	0	60
Iowa.....	23	1,537	1,336	South Dakota.....	10	1,756	1,607
Kansas.....	20	1,153	2,998	Tennessee.....	17	105	30,081
Kentucky.....	51	6,667	10,040	Texas.....	63	16,596	27,478
Maryland.....	48	4,000	29,492	Utah.....	1	6	3
Massachusetts.....	44	12,381	0,144	Virginia.....	8	210	21,470
Michigan.....	57	70,707	83,213	West Virginia.....	8	632	333
Minnesota.....	73	29,922	9,039	Wisconsin.....	35	4,632	1,701
Missouri.....	23	11,467	5,481	Total.....	1,256	563,465	670,400
Montana.....	19	1,423	1,377				

<sup>1</sup> States from which county summary reports have not yet been received: Connecticut, District of Columbia, Louisiana, Maine, Mississippi, Nevada, North Carolina, Oklahoma, Vermont, Washington and Wyoming.

## A CRITICISM OF THE NATIONAL HEALTH SURVEY

Prepared by the Bureau of Medical Economics, American Medical Association

Widespread publicity has been given to the statistics and interpretations arising out of the reports prepared by the United States Public Health Service pertaining to a survey of chronic disease and physical impairments. This survey, which is known as the National Health Survey, was a huge undertaking and so many reports have been published that an analysis of the resulting statistics and statements is difficult without reference or access to the basic material. An analysis of many of the numerous statistical tables and the accompanying textual material of the reports of the National Health Survey is necessary to a sensible understanding of the mass of data collected.

The Bureau of Medical Economics of the American Medical Association has undertaken to present a fair appraisal of some of the fundamental considerations involved in the mass of reports prepared in conjunction with the National Health Survey. The following is an outline of certain basic factors that have almost been ignored in the publicizing of the findings of the Survey.

## ORIGIN

The exact origin of the National Health Survey cannot be ascertained from available information. Apparently, the stimulus for this survey came from the Secretary of Labor as a recommendation for a project to be undertaken by the Works Progress Administration. Consequently, in 1935, one of the activities in the program of the Works Progress Administration for persons on relief was the National Health Inventory. This National Health Inventory called for four surveys: (1) a house-to-house canvass of some 770,000 families to determine the extent of chronic diseases and physical impairments; (2) a survey of the incidence and fatality of communicable diseases in 250,000 families; (3) an occupational morbidity and mortality survey based on the records of industrial sick-benefit associations; (4) a health-facilities survey utilizing the reports collected by the American Medical Association and the American College of Surgeons. Funds in the amount of \$3,450,000 were reported to be allocated by the Works Progress Administration for this national health inventory, although the amounts recorded in the Budget of the United States Government for 1939 and 1940 show actual expenditures of \$1,482,040.12 for 1937 and \$5,742.33 for 1938 for "Health survey of general population," and an estimated expenditure of \$205,000 for 1939, all transferred

from the funds appropriated under the Emergency Relief Act, 1935, to the Public Health Service which was in charge of the Survey. Inasmuch as reports are still being prepared, the total cost of conducting these projects cannot yet be ascertained.

The actual conduct of the National Health Inventory was assigned to the United States Public Health Service. The first two sections of the National Health Inventory, namely, the chronic-disease survey and the communicable-disease survey, were made a project of the National Institute of Health and received the title "National Health Survey." The occupational morbidity and mortality study was made a project of the Division of Industrial Hygiene and the health-facilities study was made a project of the Division of Public Health Methods. This analysis of the National Health Survey will be confined to the reports which have been prepared under the direction of the National Institute of Health. The several reports prepared by the Division of Industrial Hygiene and the Division of Public Health Methods are not included as they were based on entirely separate surveys.<sup>10</sup>

#### METHOD

The National Health Survey was conducted as a house-to-house canvass of some 800,000 families representing 2,800,000 persons in cities and rural areas. The total population surveyed was located in 84 cities and 23 rural counties in 19 States. Since the National Health Survey was financed as a work-relief project, its canvassing staff was drawn from relief rolls. Preference was given to relief clients who had been bookkeepers, teachers, nurses, salesmen, and social workers. After a week of intensive training with an abbreviated instruction manual, 2 sample family narratives or interviews, a schedule filled in from 1 of the narratives and a blank schedule to be filled in from another narrative, canvassers were sent into the field to make trial enumerations, after which further training was given to those who required it. Each enumerator was given a manual of instructions comprising 41 pages of single-spaced paragraphs which interpreted each of the 64-column spaces on the questionnaire form to be completed in an interview with 1 person in the household, usually the wife or mother.

Interviews with some representative of the families surveyed were held by the enumerators during a 6-month period from October 1935 to March 1936. The person interviewed was supposed to report all illnesses which kept any member of the family from work, school, or other usual activity on the day of the canvass. Likewise, the enumerator was to determine for all members of the family any chronic disease or gross physical impairment existing on the day of the canvass. Finally, the person interviewed was asked to report any illness during the 12 months preceding the day of the canvass which disabled a member of the family for 7 days or more.

Two aspects of this technique deserve careful evaluation: First, the ability of the enumerator or the person reporting to determine whether an illness, a chronic disease, or a gross physical impairment was present on the day of the canvass; and second, the ability of the person interviewed to report accurately the illness which had disabled any member of the family continuously for 7 days or more during the preceding 12 months.

The enumerator's instructions for completing the 10 columns pertaining to illness included the following:<sup>11</sup>

"A disabling illness is one which keeps a person from working or from following his usual pursuit for at least a day. The term illness is used in its customary sense, except that all persons unable to work because of a mental condition, including feeble-mindedness, persons recovering from the effects of an accident, and persons bedridden or unable to work because of some permanent effect of an accident or disease, etc., are also to be regarded as ill.

<sup>10</sup> The reports of the National Health Survey to date have been divided into three main series: (1) A "Sickness and medical care" series, with 12 completed reports; (2) a "Population" series, with 5 completed reports; (3) a "Hearing study" series, with 7 completed reports.

Reports by the Division of Industrial Hygiene on occupational morbidity and mortality have appeared chiefly in Public Health Bulletins.

Reports from the Division of Public Health Methods on health facilities have appeared in hospital journals and in Public Health Reports.

<sup>11</sup> United States Public Health Service, Scientific Research Division, Manual of Instructions for Enumerators, Health Survey, H. S. Form 14, p. 10.

"In the case of persons who are not working because of age, care must be exercised in determining whether they are actually sick. Many such persons have no particular pursuit; yet the informant will usually be able to say whether they have an acute illness or are particularly unwell.

\* \* \* For a person with a regular job, a disabling illness is one which keeps him away from work for at least a day. For a person in school, it is an illness which keeps him out of school for at least a day. For a housewife, it is an illness which keeps her from doing her usual housework. Whether an unemployed person is to be regarded as having a disabling illness must be judged on a similar basis. Does the informant think that he is so sick that he could not be at work even if employed? Illness of preschool children should be judged in the same light. In general, it may be said that a person who regularly is confined to his bed an hour or more a day because of sickness is suffering from a disabling illness. Persons who simply take an hour's rest (to preserve their health) are not included. Persons isolated or kept at home because they have a communicable disease are to be regarded as having a disabling illness."

Each enumerator was then to determine by questioning his informant whether (a) anyone in the household was sick on the day of the interview; (b) anyone had any illness which kept him from work or disabled him for 7 consecutive days or longer in the past 12 months; (c) anyone had been in the hospital during the past 12 months; (d) anyone from the household, regardless of how long ago, entered an institution for the care of disease or nervous trouble; (e) there had been any death in the household during the past 12 months; (f) there were any other cases of bedridden or totally disabled persons.

The enumerator was also instructed that he had other leads to determine the existence of illnesses, such as inquiring why John, who was over school age, had not been to school, or why he was older than other children in his grade as this probably meant some illness had retarded his schooling. If the informant's answers were indicative of any condition that might be regarded as a disabling illness, such condition was entered in the column for the listing of disabling illnesses. Another lead was to judge by the presence in the household of children under 1 year of age that maternity cases were to be entered in the disabling illness column. Likewise, for any disabling illness reported, information was solicited to determine whether a previous attack of the same condition had occurred within the last 12 months for a duration of 7 days or more. The instructions for the enumerators also pointed out that a person who was permanently disabled might have a further disablement which should be entered as a separate disabling illness.

Because of the technical nature of the information sought and the dependence on the memory of the informant for the number, nature, and duration of illnesses, would it not be impossible for enumerators to record an unprecedented prevalence and frequency of illness. While a procedure for editing and verifying the completed reports was established, it will be shown later that the editing personnel was not able to overcome the basic defects in enumeration and the verification of the recorded information was apparently not completed.

#### REPRESENTATIVENESS

It is important in the evaluation of any study of vital statistics which is not based on the entire population to determine the representativeness and adequacy of the sample population surveyed. The population included in the National Health Survey constituted about 3.6 percent of the urban population of the United States, but less than 2 percent of the total population. While information was collected from 30,801 households comprising 140,418 persons in 28 rural counties, the conclusions on the frequency and severity of illness in the National Health Survey, insofar as can be ascertained at this time, were based on the information received from the families in urban areas only. Despite this qualification on the representativeness of the population surveyed, the conclusions of the National Health Survey were published as applying to the entire United States with little attention to the fact that the inclusion of illness statistics from rural areas might have altered the reported figures as to the relative types, frequency, and severity of illness.

There is even some question as to whether the population on which the conclusions of the National Health Survey are based is representative of the urban population of the United States. The city-size distribution of the Health Survey population as compared with the urban population of the United States for 1930 shows that the Health Survey population was heavily overweighted in the cities with more than 500,000 population and underweighted in the cities with less than 25,000 population. The fact that 43 percent of the National Health Survey population lived in cities of 500,000 population or more, whereas only 20 percent of the urban population of the United States in 1930 lived in cities of this size should be evidence of the need for qualifying statements concerning the representatives of the statistical data recorded by the National Health Survey. In regard to age, sex, color, size of family, and family income, there are also some discrepancies between the Health Survey population and the 1930 census (urban) population, but for these factors there is more general agreement than with the city-size population distribution.

#### ILLNESS

Little attention has been given to the influence that the standard of illness used in the National Health Survey had on the illness data recorded.

In the first of the preliminary reports, which gives a general discussion of the survey and its objectives, illness is defined as (p. 10) "a continuous period of sickness." The indefiniteness and inaccuracy of such a definition scarcely needs comment. Also, as stated in the introductions to the preliminary bulletins of the National Health Survey:

"Several measures of illness for each person are (a) illness keeping a person from work, school, or other usual activity on the day of the canvass; (b) illness which had disabled a person in the above sense continuously for 7 days or more during the 12 months preceding the date of the canvass; (c) chronic disease present, whether or not it had caused disability; (d) gross physical impairment, including lost and impaired legs, feet, arms, fingers, etc., and total or partial blindness and deafness."

Illness thus defined and measured is the basis for the illness data recorded in the National Health Survey. But, if a person claimed he was kept away from work for 1 day or for 7 days because of sickness, was he actually ill and in need of medical care? How frequently is illness an excuse rather than a cause of absence from work or school? How greatly in need of medical care were the persons who reported "chronic diseases" and "lost and impaired legs, feet, arms, fingers, etc., and total or partial blindness and deafness?" If no medical care were needed for many of these chronic diseases or permanent impairments, are not the statistics on prevalence of illness in the National Health Survey misleading if not incorrect?

Even if the uncertain standard or definitions of illness used in the National Health Survey be disregarded, out of the 6,000,000 persons reported to be "ill on the day of the survey," 2,500,000, or more than 40 percent, were reported as ill because of disabling chronic diseases or permanent impairments which so frequently are not illness in the sense of pathologic conditions that could be remedied by medical services. The acute respiratory diseases, which include many minor conditions such as common colds, are said to account for the illness of 1,500,000 persons or 25 percent of the 6,000,000 persons reported to be ill. Such statistics for the entire United States, based on illness reports of questionable definition from less than 2 percent of the population and not representative of both the urban and the rural population, should be more clearly qualified. Primarily because of the unreal standard of illness used and the restriction of the sample to urban families only, the reported prevalence of illness in the National Health Survey is more than twice as great as the prevalence of illness reported by the Committee on the Costs of Medical Care or by the Metropolitan Life Insurance Co. in their surveys of illness.

To measure the frequency of disabling illnesses, the enumerators in the National Health Survey counted as illness all conditions that kept the person from his work, school, caring for the home, or other usual activities. While the disabling illness was ostensibly defined to be a period of illness lasting for 7 days or more, all hospital cases, all confinements and all cases ending in death were counted as disabling illnesses regardless of the duration of the disability. Also, illness of less than 7 days was recorded as disabling illness if the person was still unable to work on the day of the visit by the enumerator.

In view of such an ill-inclusive definition of disabling illness used in the National Health Survey, it is not surprising that a high frequency of disabling illness was recorded. Moreover, it should be noted that the average of 10 days of disability per person reported in the National Health Survey includes more than 6 days of disability which resulted from chronic diseases and gross physical impairments. When the disability for very minor conditions is subtracted from the remaining days of disability it becomes apparent that real disabling illness which might require medical attention constituted only a portion of the reported total days of disability.

#### MEDICAL CARE

One of the findings of the National Health Survey was that 74 percent of all disabling illnesses (that is the illnesses which were supposed to last 7 days or longer) were attended by a physician. The implication of such a statement is that the 26 percent of disabling illnesses unattended were in need of medical attention. Nowhere is there any evidence to support this contention. The wide definition of disabling illness used in the National Health Survey makes it essential that the records of the remaining 26 percent of disabling illnesses reported as unattended should be examined to determine how many real illnesses which required medical attention were not attended by a physician. Furthermore, the measure of the amount of physicians' care received which was used in the National Health Survey is also subject to questioning. The measure of physicians' care used was defined as "attention received from a doctor of medicine or other similar practitioner. Such care is in addition to that given by physicians in hospitals." This definition leads to the inference that illnesses which were treated in clinics, in outpatient departments, and in hospitals were not considered as having received the care of a physician. A special report now being prepared by the compilers of the National Health Survey to explain the scope, method, and definitions used indicates that physicians' care includes care received in clinics but excludes care received in hospitals. Uncertainty still remains concerning treatment received in outpatient departments of hospitals unless such departments are considered as clinics in the National Health Survey.

Inasmuch as 27.1 percent of the disabling illnesses were hospitalized and since the measure of physicians' care did not include treatments received in the hospitals, it becomes necessary to know how many of the 26 percent of the disabling illnesses which were recorded as not receiving physicians' care were hospitalized and received medical services in this manner before concluding that any definite percentage of the surveyed families actually did not receive medical care. Also, it would be of interest to know whether some of this 26 percent of alleged unattended disabling illnesses were treated in outpatient departments of hospitals. In any event the reports published by the National Health Survey which point out the percentage of disabling illnesses that do not receive physicians' care should include some statement to explain how many of these unattended illnesses received medical care in hospitals.

The percentage of disabling illnesses not receiving any care from a physician was reported as 17 percent for families with incomes in excess of \$3,000 and 30 percent for relief families—a difference of 13 percent. This difference has been emphasized as revealing the existence of a large amount of unattended illnesses among persons in the low-income group. As a matter of fact, the difference would probably be considerably less if disabling illnesses that were hospitalized were counted as receiving physicians' care. Certainly, hospitalized illnesses do receive medical care.

The alleged "marked deficiency in physicians' care received for illness among low-income families" as compared with the physicians' care received by families with incomes in excess of \$4,000 fails to carry conviction in the absence of a comparison of the number of physicians' calls for each income group for exactly comparable or the most nearly identical illnesses. A comparison of general averages of physicians' calls for different income groups has little meaning unless such averages are applied to like conditions for which the calls were made. It is a matter of common sense that a larger number of physicians' calls are required for serious and prolonged than for mild and brief illnesses. A proper understanding of the need for physicians' calls cannot be obtained from the general classifications "acute," "chronic," or "disabling." Although the annual frequency of illnesses disabling for 1 week or longer is given by diagnosis, this classification does not appear, in the reports available at this

time, to have been distributed according to income status or number of physicians' calls. Moreover, there appears to be no recognition in the reports on the National Health Survey of the utter impossibility of standardizing the number of physicians' calls needed by different persons for similar illnesses but under differing conditions and circumstances.

#### VERIFICATION OF ILLNESSES REPORTED

In the collection of the illness data the informant was asked to give the names of the physicians who care for any cases of illness or the name of the hospital for hospitalized cases. The informant was also requested to give permission to the Public Health Service to obtain further medical information from these sources. When the schedules with the diagnoses reported by the informant were received a separate questionnaire was sent to the doctor or the hospital for confirmation. Some 535,000 of these inquiries were mailed and 400,000 were returned. For various reasons medical information was said to be available for only 28 percent of all diagnoses and 35 percent of illnesses disabling for a week or more. According to a 5-percent sampling test of the extent of agreement between the families' and the physicians' statement of diagnoses it was reported that 90 percent of the diagnoses were in agreement, i. e., the physician's statement confirmed the family's statement of the cause of illness. This agreement is instanced as revealing a considerable accuracy of family reporting. As a matter of fact, it would be expected that the diagnoses reported by families which also gave the name of the physician treating the condition would be confirmed by the physician who had undoubtedly diagnosed the condition, particularly if the family had been informed of the nature of the condition and had remembered the diagnosis. The real verification needed in a comparison of the diagnoses for the 74 percent of all diagnoses unconfirmed by physicians with the diagnoses confirmed by reports from physicians. Such a comparison would reveal any discrepancies between the illnesses reported by the families without any confirmation by physicians and the illnesses reported which were confirmed by physicians. Not until this comparison is made can it be said that "the families' reports in general coincide with the doctors' reports." Tables to show the number and types of disabling illnesses, chronic diseases, and physical impairments that were confirmed by medical diagnoses and the number and types of such conditions that are not confirmed would permit a check on the accuracy of the illnesses reported by families as unattended. This data has not been published in any of the reports of the National Health Survey.

The acute illnesses, chronic diseases, and gross physical impairments reported which did not receive a confirming medical diagnosis by a physician should be subjected to careful verification. It is conceivable that many of the persons who reported illnesses without having the diagnosis confirmed by a physician might have been sick but they might also have given incorrect information concerning illness in the family. As an indication of the possible inaccurate reporting of illness in the families, reports of syphilis and gonorrhea were declared incomplete and were omitted because of the nature of the information that would be obtained in a house-to-house canvass. If the reporting persons could conceal syphilis and gonorrhea, would it not also be possible for them to go to the other extreme in reporting illnesses or disabilities that could not be readily checked because confirming medical diagnoses were unavailable? The inclination of persons on relief or with very small incomes to emphasize physical conditions which are beyond their control, as a cause of their economic status, may have been a real factor of bias.

The personal element, which enters most surveys, is especially significant in the National Health Survey because one member of a family was asked to recall the number and duration of all illnesses for the entire family during the 12 months preceding the day of the interview. Apparently no check of samples of completed reports was made to ascertain the influence of this personal element. Such a testing would permit the determination of a formula of probable error to be applied to the entire study.

#### ADEQUACY OF MEDICAL CARE

None of the statistics on medical care collected in the National Health Survey are by themselves measures of the adequacy of medical care. The only stand-

ard of adequacy of medical care used by the National Health Survey was the amount of medical care received by persons in the high-income classes. Inadequacy is said to be shown by evidence that persons in the low-income group received less medical care than persons in the high-income group. This standard of adequacy of medical care is determined by a ratio between the number of illnesses recorded and the amount of medical care received. The use of a comparison of the amount of physicians' care or hospitalization received by different income groups who made statements of these services from memory is of doubtful value in drawing conclusions as to the adequacy of the care received by either group. Such a method establishes no scientific standard or base with which all comparisons can be made but at once raises an economic bias.

#### SUMMARY

The National Health Survey appears to have been conceived as a Works Progress Administration project for the purpose of giving employment to some of the Works Progress Administration enrollees, and cannot be considered a study conducted entirely by qualified personnel.

The nature of the schedules used, the type of enumerators who collected the information, and the uncertainty of the replies given by the informants, introduced many possibilities of error in the conclusions of the survey.

The survey conclusions appear to have been based on data obtained solely from the urban population, only 43 percent of which lived in cities of 500,000 or more. Thus, it is doubtful that the National Health Survey could be said to represent faithfully the health conditions in the rural United States.

The definitions of illness used in the survey, and the method of collecting the information pertaining to acute illness, chronic diseases, and disabling and permanent impairments tended to produce an exaggeration rather than a true record of the number, nature, and duration of these conditions.

The conclusions pertaining to the receipt of medical services by the informants and members of their households presents, by inference, a distortion of the availability of medical services in the United States.

The verification of a certain percentage of agreement between informants' and physicians' statements of diagnoses from a 5-percent sampling test, does not constitute conclusive evidence that such agreement would be found in the 74 percent of all diagnoses unconfirmed by physicians.

These are some of the phases of the national health survey which raise doubt as to the accuracy of some of the published conclusions. Until these apparent defects are explained or corrected, the following questions must be raised whenever statistics or statements from the national health survey are used:

1. How great an influence did the standard of illness used in the national health survey have on the illness data recorded? If a real medical measure of illness were used as a standard, how much would the reported prevalence, frequency, and severity of illness be changed?

2. If the sample population is not truly representative of the population of the United States according to rural and urban distribution, age, sex, marital status, occupation, and income, can the estimates of illness be accepted?

3. Did the methods used to collect the survey data permit accurate reporting of the nature and extent of illness?

4. What is the number and type of reported illnesses that were verified by physicians? Do the illnesses not verified by physicians differ in any significant way from those verified?

5. To what extent were physical disabilities and conditions which could not be remedied by medical care included as illnesses in the survey?

6. If treatments in outpatient departments and hospitals were not considered as medical care in the survey, is the estimate of the amount of medical care received by persons in the low-income groups accurate?

7. Of the 26 percent of all disabling illnesses reported as not receiving care from a physician, how many received medical care in a hospital? How many of the persons reported as suffering from these illnesses did not choose to seek medical care?

The recording and analysis of vital statistics is a technical process. If a study of the conditions shown by such records is to be used in an attempt to improve those conditions, the greatest degree of accuracy and completeness must accompany the making of the original record. Inaccuracies and incom-

pleteness in the original records, especially if those records represent only a sampling, will be greatly magnified or multiplied when conclusions are drawn from such records for the entire population.

It is necessary, therefore, to examine carefully any study in which the original data represents the recollections of the informants on the nature, number, and duration of illnesses for an entire family over a period of 12 months. This is especially true when it is found that the conclusions of a study made in this manner differ markedly from the conclusions of studies made by day-to-day records of similar events.

**AN ANALYSIS OF EXPENDITURES BY THE UNITED STATES GOVERNMENT FOR MEDICAL, HOSPITAL, HEALTH, AND ALLIED SERVICES**

Prepared by the Bureau of Medical Economics, American Medical Association, Chicago, Ill., July 1939

The following tabulation is an analysis of the expenditures by the United States Government for medical, hospital, health, and allied services taken from the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940, published as House Documents No. 300, Seventy-ninth Congress and No. 20 of the Seventy-sixth Congress, respectively.

A complete and accurate statement of the total amount appropriated by the Congress to be expended by the several Departments and independent establishments for medical, hospital, health, and allied purposes cannot be assembled from available official sources. Although many medical, hospital, health, and allied activities are clearly stated as such in the Budget items, there are many governmental agencies that have been engaged or are now engaged in some medical, hospital, health, or allied activity that have no estimated amount in the Budget for these purposes.

In many instances some of the appropriations which are made for one governmental agency are transferred to another agency for administration. In the appended statement these amounts are included in the estimate for the agency for which the appropriation was made, and are not added to the estimate for the administering agency.

The following totals represent only the discernible amounts for medical, hospital, health, and allied purposes, as clearly set forth in the Budget of the United States Government. In one instance, Howard University, an estimate of the amount for the maintenance of the colleges of medicine, dentistry, pharmacy, university health service, social service, and graduate school activities in these fields, was made. The totals are, therefore, believed to be minimum—no other estimate could be made.

*Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940*

[Page numbers followed by (A) refer to the Budget of the U. S. Government for the fiscal year ending June 30, 1939, published as H. Doc. No. 399, 76th Cong., 2d sess.; and page numbers followed by (B) refer to the Budget for 1940, published as H. Doc. No. 29, 76th Cong. 1st sess.]

**LEGISLATIVE BRANCH**

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
Senate:				
The Budget does not disclose any amount appropriated for medical, hospital, and health purposes for the Senate, although it is known that such services and facilities are provided.....				
House of Representatives:				
Medical supplies, equipment and contingent expenses for the emergency room and for the attending physician and his assistants.....		\$3,000	\$3,500	\$3,500
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the legislative branch.....		3,000	3,500	3,500

Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued

## INDEPENDENT ESTABLISHMENTS

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Civilian Conservation Corps:</b>				
Assistant pathologist:				
1.8 positions at \$2,648..... 30 (A)	\$1,766			
2 positions at \$2,600..... 38 (B)		\$5,200	\$5,200	\$5,200
<b>Junior pathologist:</b>				
2.1 positions at \$2,142..... 30 (A)	4,498			
1 position at \$2,300..... 38 (B)		2,300	2,300	2,300
<b>Surgeon:</b>				
2 positions at \$3,200..... 31 (A)	6,400			
3.6 positions at \$3,200..... 38 (B)		11,520	11,520	11,520
<b>Medical officer:</b>				
0.8 position at \$4,048..... 38 (B)		3,238		
1 position at \$3,800..... 38 (B)			3,800	3,800
0.2 position at \$3,255..... 38 (B)		651		
Associate pathologist: 2.6 positions at \$3,256. 31 (A)	8,465			
Assistant pathologist:				
21.3 positions at \$2,043..... 31 (A)	56,295			
9 positions at \$2,633..... 38 (B)		23,697	23,697	23,697
Assistant surgeon: 3 positions at \$2,000..... 31 (A)	6,000			
<b>Junior pathologist:</b>				
16.9 positions at \$2,101..... 31 (A)	35,506			
5.8 positions at \$2,005..... 38 (B)		11,629		
4 positions at \$2,000..... 38 (B)			8,000	8,000
<b>Physician:</b>				
1.5 positions at \$1,680..... 31 (A)	2,520			
4 positions at \$2,800..... 38 (B)		11,200	11,200	11,200
<b>Medical attendant:</b>				
2 positions at \$600..... 32 (A)	1,200			
2 positions at \$600..... 39 (B)		1,200		
3 positions at \$600..... 39 (B)			1,800	1,800
<b>Nurse: 2 positions at \$1,800..... 39 (B)</b>		3,600	3,600	3,600
Transferred for hospitalization of Civilian Conservation Corps enrollees to—				
“Medical Department, Bureau of Medicine and Surgery, Navy Department.” 32 (A) 40 (B)	40,589	16,047	15,330	15,372
“Pay of personnel and maintenance of hospitals Public Health Service, Treasury Department.” 32 (A) 40 (B)	383,819	267,606	267,606	268,338
“Salaries and expenses, Veterans’ Administration.” 32 (A) 40 (B)	254,920	165,450	165,450	165,900
“Conservation of health among Indians, Bureau of Indian Affairs, Department of Interior.” 32 (A) 40 (B)	5,246	2,245	2,738	2,745
(The amounts listed for the Civilian Conservation Corps comprise only the obvious items. It is impossible to make a complete estimate of obligations for supplies, transportation of the sick to hospitals, payments to local hospitals, or the pay of local, contract, or commissioned medical, dental, nursing or other personnel employed by or giving services to the Civilian Conservation Corps.)				
<b>Total discernible amount for medical, hospital, health, and allied purposes appropriated for the use of the Civilian Conservation Corps.....</b>	<b>810,224</b>	<b>525,583</b>	<b>522,241</b>	<b>523,472</b>
<b>Civil Service Commission:</b>				
<b>Medical director:</b>				
1 position at \$4,600..... 34 (A)	4,600			
1 position at \$4,600..... 35 (B)		4,600		
1 position at \$4,800..... 35 (B)			4,800	4,800
<b>Senior medical officer:</b>				
0.9 position at \$4,600..... 34 (A)	4,140			
1.9 positions at \$4,600..... 35 (B)		8,740		
4 positions at \$4,600..... 35 (B)			18,400	18,400
<b>Medical officer:</b>				
2.4 positions at \$3,800..... 34 (A)	9,120			
2.1 positions at \$3,800..... 35 (B)		7,980		
1 position at \$3,800..... 35 (B)			3,800	3,800
<b>Graduate nurse:</b>				
1 position at \$1,620..... 34 (A)	1,620			
0.4 position at \$1,800..... 35 (B)		720		
1 position at \$1,800..... 35 (B)			1,800	1,800

Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Civil Service Commission—Continued.</b>				
Assistant medical officer:				
0.4 position at \$2,600..... 35 (B)		\$1,040		
1 position at \$2,600..... 35 (B)			\$2,600	
2 positions at \$2,600..... 35 (B)				\$8,200
Total discernible amount for medical, hospital, health, or allied purposes appropriated for the use of the Civil Service Commission.....	\$10,480	23,140	31,400	34,000
<b>Employees' Compensation Commission:</b>				
Employees compensation fund:				
Medical and hospital treatment and supplies..... (38 (A) (42 (B))	721,555	625,619	650,000	650,000
Transportation for medical care..... (38 (A) (42 (B))	31,876	33,619	36,000	36,000
Employees compensation fund, civil works:				
Medical and hospital treatment and supplies..... (38 (A) (43 (B))	16,609	4,833	6,000	5,000
Transportation for medical care..... (38 (A) (43 (B))	6,280	1,933	2,500	2,000
Employees compensation fund, emergency conservation work:				
Medical and hospital treatment and supplies..... (39 (A) (43 (B))	17,443	22,325	30,000	36,000
Transportation for medical care..... (39 (A) (43 (B))	6,279	6,363	10,000	10,000
Employees compensation fund, emergency relief:				
Medical claim auditor: 35 positions at \$1,627..... 39 (A)	56,945			
Medical audit clerk:				
5 positions at \$1,824..... 44 (B)		9,120		
35 positions at \$1,807..... 44 (B)			63,245	
30 positions at \$1,807..... 44 (B)				54,210
Medical and hospital treatment and supplies..... (39 (A) (44 (B))	4,068,191	2,234,781	2,854,567	1,000,000
Transportation for medical care..... (39 (A) (44 (B))	21,512	34,224	50,000	28,000
(These amounts are the only items that appear clearly to pertain to medical, hospital, and health purposes for the Employees Compensation Commission. If other similar activities are being supported by Federal appropriations the amounts are not discernible from the budget.)				
Total discernible amount for medical, hospital, health or allied purposes appropriated for the use of the Employees Compensation Commission.....	4,934,590	2,972,837	3,702,312	1,818,210
<b>Federal Trade Commission:</b>				
Nurse:				
1 position at \$1,740..... 45 (A)	1,740			
1 position at \$1,740..... 52 (B)		1,740	1,740	1,740
Senior medical officer: 1 position at \$4,600..... 52 (B)				4,600
Associate medical officer: 1 position at \$3,200..... 52 (B)				3,200
Reimbursement for chemical analyses to "Salaries and expenses, Food and Drug Administration, Department of Agriculture"..... (6 (A) (52 (B))	1,193	688	1,400	
(It is understood that the Federal Trade Commission has a staff of physicians but it is impossible to determine from the budgets what amount of the Commission's appropriation is devoted to medical, hospital, health, and allied purposes. The Commission, too, is actively engaged in investigations of alleged unlawful practices in connection with the marketing of foods, drugs, cosmetics, and therapeutic devices but the budgets do not disclose the sums that are specifically devoted to this work.)				
Total discernible amount for medical, hospital, health, or allied purposes appropriated for the use of the Federal Trade Commission.....	2,933	2,328	3,140	9,540

*Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued*

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Railroad Retirement Board:</b>				
Medical consultant: 0.6 position at \$4,278... 66 (A)	\$2,566			
Senior medical officer:				
6 positions at \$1,697..... 74 (B)			\$28,002	
4 positions at \$1,700..... 74 (B)				\$18,800
Medical officer: 3.4 positions at \$4,088..... 74 (B)		\$13,899		
Head nurse:				
1 position at \$1,800..... 66 (A)	1,800			
1 position at \$1,800..... 74 (B)		1,800		
1 position at \$1,920..... 74 (B)			1,920	1,920
Nurse:				
0.2 position at \$1,620..... 74 (B)		324		
2 positions at \$1,620..... 74 (B)			3,240	3,240
Total discernible amount for medical, hospital, health or allied purposes appropriated for the use of the Railroad Retirement Board.....	4,366	16,023	33,162	23,960
<b>Social Security Board:</b>				
Principal medical economist:				
0.6 position at \$4,000..... 76 (A)	3,600			
1 position at \$6,400..... 85 (B)		6,400		
Senior graduate nurse:				
0.1 position at \$1,800..... 76 (A)	180			
1 position at \$1,800..... 85 (B)		1,800	1,800	1,800
Graduate nurse:				
2 positions at \$1,630..... 76 (A)	3,260			
4.3 positions at \$1,641..... 85 (B)		7,056		
11 positions at \$1,636..... 85 (B)			17,996	17,996
Total discernible amount for medical, hospital, health or allied purposes appropriated for the use of the Social Security Board....	7,040	15,256	19,796	19,796
<b>Works Progress Administration:</b>				
Sanitation and health.....		85,275,572		
(Cumulative through Mar. 31, 1938, as stated on p. 141 of Report on Progress of Works Progress Administration Program, June 30, 1938. Distribution shown by States. The medical, hospital, and health activities of the Works Progress Administration are not itemized in the Budget. The amount given appears in a published report of the Works Progress Administration as of June 30, 1938. It is impossible to determine whether there were other expenditures for these purposes. The total given represents, therefore, only the amount that can be determined through available sources.)				
Transfers to Public Health Service, Treasury Department..... (682 (B))		1,790,452	900,000	
Total discernible amount of appropriation for the Works Progress Administration that has been used for medical, hospital, health, or allied purposes.....		87,066,024	900,000	
<b>Home Owners' Loan Corporation:</b>				
Nurse: 4.9 positions at \$1,619..... 94 (A)	7,933			
Nurse:				
5.9 positions at \$1,402..... 95 (A)	8,271			
16.7 positions at \$1,334..... 106 (B)		22,277		
14.8 positions at \$1,382..... 106 (B)			20,453	
14.1 positions at \$1,387..... 106 (B)				19,550
Nurse: 8.9 positions at \$1,248..... 95 (A)	11,107			
Group Health Association.....	40,000			
(Hearings, independent offices appropriation bill, 1939, p. 300 et seq.; H. Rept. No. 1662, 75th Cong., p. 16.)				
Total discernible amount of appropriation for the Home Owners' Loan Corporation that has been used for medical, hospital, health, or allied purposes.....	67,311	22,277	20,453	19,550

Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Federal Housing Administration:</b>				
Head nurse:				
1 position at \$1,860.....	06 (A)	\$1,860		
1 position at \$1,980.....	107 (B)		\$1,980	\$1,980
Graduate nurse:				
1.6 positions at \$1,620.....	96 (A)	2,592		
1 position at \$1,620.....	107 (B)		1,620	
2 positions at \$1,620.....	107 (B)		3,240	3,240
Assistant graduate nurse:				
0.4 position at \$1,440.....	107 (B)	576		
1 position at \$1,440.....	107 (B)		1,440	1,440
Total discernible amount of appropriation for the Federal Housing Administration that has been used for medical, hospital, health or allied purposes.....	4,452	4,176	6,660	6,660
<b>Reconstruction Finance Corporation:</b>				
Nurse:				
1 position at \$2,000.....	99 (A)	2,000		
2 positions at \$1,811.....	116 (B)		3,622	
2 positions at \$1,870.....	116 (B)		3,740	3,740
Nurse: 1 position at \$1,740.....	100 (A)	1,740		
Total discernible amount of appropriation for the Reconstruction Finance Corporation that has been used for medical, hospital, health, or allied purposes.....	3,740	3,622	3,740	3,740
<b>Federal Emergency Administration of Public Works:</b>				
Supervisor nurse: 1 position at \$2,000..... 101 (A)				
Nurse:				
1.5 positions at \$2,000.....	112 (B)		3,000	
1 position at \$2,000.....	112 (B)		2,000	2,000
Assistant nurse: 1.9 positions at \$1,800.....	101 (A)	3,420		
Nurse:				
1 position at \$1,800.....	112 (B)		1,800	1,800
0.8 position at \$1,620.....	112 (B)		1,296	
Hospital construction to Dec. 2, 1938.....	174,948,202			
(The Budgets contain no specific allotments or grants to be used for hospital construction; however, in pamphlet "P. W. A. Provides Modern Hospitals," (1937, 48 pp.) p. 2, P. W. A. reports allotments for 388 non-Federal projects (as of Dec. 2, 1936) with an estimated cost of \$146,000,688. Of this amount Public Works Administration furnished \$51,249,762 in grants and \$23,608,440 in interest-bearing loans. Local governments contributed an additional \$71,052,486 obtained from sources other than the Public Works Administration. It is impossible to ascertain from available sources whether any additional Federal funds were used by Public Works Administration for medical, hospital, or health purposes.)				
For Veterans' Hospitals.....	123 (B)		13,268,200	
(See hearings on Independent Offices Appropriation Bill for 1940, p. 637.)				
Total discernible amount of appropriation for the Federal Emergency Administration of Public Works that has been used for medical, hospital, health, or allied purposes.....	5,420	6,096	13,272,000	3,800
<b>Tennessee Valley Authority:</b>				
Wilson Dam and Reservoir, malaria control and sanitation.....	758 (A)	40,708		
Norris Dam and Reservoir, malaria control and sanitation.....	758 (A)	29,347		

<sup>1</sup> This amount not included in total.

*Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued*

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Tennessee Valley Authority--Continued.</b>				
Wheeler Dam and Reservoir:				
Malaria control and sanitation..... 758 (A)	\$143,723			
Malaria prevention..... 809 (B)		\$220,198	\$274,000	\$201,000
Public health activities..... 811 (B)		142,209	154,000	103,000
(Medical services and hospital facilities are available to the Tennessee Valley Authority employees, but the only items closely related to such activities in the Budget estimates are those listed as malaria prevention and public-health activities. It is therefore impossible from the sources available to give an accurate and complete account of the Federal funds used for medical, hospital, and health purposes by the Tennessee Valley Authority.)				
Total discernible amount of appropriation for the Tennessee Valley Authority that has been used for medical, hospital, health, or allied purposes.....	213,778	362,497	428,000	454,000
<b>Veterans' Administration:</b>				
Transferred for hospitalization to--				
Department of the Interior: St. Elizabeth's Hospital.....	69,666	57,724	59,130	59,292
Treasury Department: "Pay of personnel and maintenance of hospitals, Public Health Service".....	682,682	737,592	753,675	753,630
Navy Department:				
"Salaries, Bureau of Medicine and Surgery".....	8,280	8,280	8,280	
"Pay, subsistence, and transportation, Navy".....	157,815	212,584	265,674	265,814
"Medical Department, Bureau of Medicine and Surgery".....	203,678	272,564	301,010	362,056
"Navy Hospital Fund".....	531,565	698,115	660,466	662,070
War Department: "Medical and Hospital Department".....	1,205,819	1,396,901	1,440,323	1,444,266
Medical, hospital, and domiciliary service.....	60,446,693	62,039,037	66,618,279	72,468,019
(The Budgets do not list these amounts in such a manner that medical and hospital services can be separated from domiciliary care. It is not possible to determine from the information available whether there are other expenditures for medical, hospital, health, and allied purposes that should be included in the total Federal funds expended by the Veterans' Administration for these services and facilities.)				
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Veterans' Administration.....	63,362,428	65,423,697	70,106,737	76,017,777
<b>Summary:</b>				
Civilian Conservation Corps.....	810,224	625,583	622,241	623,472
Civil Service Commission.....	19,480	23,140	31,400	34,000
Employees Compensation Commission.....	4,934,690	2,972,837	3,702,312	1,818,210
Federal Trade Commission.....	2,933	2,328	3,140	9,540
Railroad Retirement Board.....	4,366	16,023	33,162	23,960
Social Security Board.....	7,040	15,256	19,796	19,796
Works Progress Administration.....		87,066,024	900,000	
Home Owners' Loan Corporation.....	67,311	22,277	20,453	19,556
Federal Housing Administration.....	4,452	4,176	6,660	6,660
Reconstruction Finance Corporation.....	3,740	3,622	3,740	3,740
Federal Emergency Administration of Public Works.....	5,420	6,096	13,272,000	3,800

*Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued*

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Summary—Continued</b>				
Tennessee Valley Authority.....	\$213, 778	\$362, 497	\$428, 000	\$454, 000
Veterans' Administration.....	63, 362, 428	65, 423, 697	70, 196, 737	76, 017, 777
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the independent establishments <sup>1</sup> .....	69, 435, 762	156, 443, 556	89, 139, 641	78, 934, 811

## DEPARTMENT OF AGRICULTURE

<b>Office of the Secretary:</b>				
<b>Conservation and use of agriculture land resources:</b>				
<b>Head nurse:</b>				
0.8 position at \$1,800.....	149 (A)	\$1, 440		
1 position at \$1,800.....	165 (B)		\$1, 800	\$1, 800
<b>Nurse:</b>				
2.7 positions at \$1,620.....	149 (A)	4, 374		
2 positions at \$1,620.....	165 (B)		3, 240	3, 240
Total discernible amount for medical, hospital, health, or allied purposes appropriated for the use of the Office of the Secretary.....		5, 814	5, 040	5, 040
<b>Bureau of Animal Industry Meat Inspection.....</b>	<b>(180 (A) 199 (B))</b>	<b>5, 316, 289</b>	<b>5, 453, 356</b>	<b>5, 507, 600</b>
<i>(Other activities of the Bureau of Animal Industry although pertaining directly to Animal Industry have an indirect effect on and benefit to the health of the people. It is difficult to determine, in percentage of the total appropriation for these purposes, the amount that should represent actual health protection of the people but clearly some recognition should be made of the public health benefits thus afforded the human population.)</i>				
Total discernible amount for medical, hospital, health or allied purposes appropriated for the use of the Bureau of Animal Industry.....		5, 316, 289	5, 453, 356	5, 507, 600
<b>Bureau of Plant Industry: Drug and related plants.....</b>	<b>(187 (A) 207 (B))</b>	<b>47, 139</b>	<b>47, 139</b>	<b>47, 139</b>
Total discernible amount for medical, hospital, health, or allied purposes appropriated for the use of the Bureau of Plant Industry.....		47, 139	47, 139	47, 139
<b>Food and Drug Administration:</b>				
<b>Food and Drug Act, enforcement.....</b>	<b>(267 (A) 296 (B))</b>	<b>1, 600, 000</b>	<b>1, 748, 380</b>	<b>2, 500, 000</b>
<b>Milk Importation Act, enforcement.....</b>	<b>(269 (A) 298 (B))</b>	<b>19, 241</b>	<b>19, 241</b>	<b>19, 241</b>
<b>Caustic Poison Act, enforcement.....</b>	<b>(269 (A) 299 (B))</b>	<b>24, 741</b>	<b>24, 741</b>	<b>24, 741</b>
<b>Filled Milk Act, enforcement.....</b>	<b>(270 (A) 299 (B))</b>	<b>10, 000</b>	<b>10, 000</b>	<b>10, 000</b>
Total discernible amount for medical, hospital, health, or allied purposes appropriated for the use of the Food and Drug Administration.....		1, 653, 982	1, 802, 362	2, 553, 982

<sup>1</sup> This total amount is less than the actual amount expended since it is possible in this tabulation to show only those amounts clearly designated for medical, hospital, and health purposes. This amount should be increased by the expenditures for medical, hospital, and health projects or purposes which are being supported by Federal funds but which cannot be found in the listed items in the Budget.

Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—(continued)

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Farm Security Administration<sup>1</sup>.....</b>				
(The Medical Director of the Farm Security Administration reported on May 11, 1939, that plans to assist low-income and other farm families have been developed in 207 counties in 20 States. Agreements are said to have been reached with the State medical societies and plans are under discussion with the county medical societies in 7 additional States. In a typical county group health association sponsored by the Farm Security Administration the average amount borrowed by families for medical and hospital purposes was, for 1938, \$27.15. It is stated by the Administration that 100,000 families are now being assisted with loans or grants or both to assist them in paying for their medical and hospital needs. Moreover, the Farm Security Administration estimates that out of the "more than 700,000 low-income and destitute farm families," some 200,000 families are expected to become clients of the Farm Security Administration for medical and other assistance. At the typical rate of loan now offered these families for medical and hospital purposes, an amount of \$5,430,000 would be required. No information is available concerning the number or amount of loans that have been repaid. The grants made are outright contributions and are not to be repaid. As families become self-supporting they will, presumably be removed as clients of the Farm Security Administration and in the meantime new clients will be added. This \$5,430,000 fund, more or less, will be something of a revolving fund.)				
<b>Summary:</b>				
Office of the Secretary.....	\$5,814	\$5,040	\$5,040	\$5,040
Bureau of Animal Industry.....	5,316,289	5,453,356	5,507,600	5,528,000
Bureau of Plant Industry.....	47,139	47,139	47,139	47,139
Food and Drug Administration.....	1,653,982	1,802,362	1,802,362	2,553,982
<b>Total discernible amount for medical, hospital, health and allied purposes appropriated for and to be expended by the Department of Agriculture.....</b>	<b>7,023,224</b>	<b>7,307,897</b>	<b>7,362,141</b>	<b>8,134,161</b>

## DEPARTMENT OF COMMERCE

<b>Bureau of the Census: Vital Statistics.....</b>	(318 (A) 352 (B))	\$362,980	\$570,448	\$503,014	\$606,511
<b>Total discernible amount for medical, hospital, health or allied purposes appropriated for the use of the Bureau of the Census.....</b>		<b>362,980</b>	<b>570,448</b>	<b>593,044</b>	<b>606,511</b>
<b>Bureau of Marine Inspection and Navigation:</b>					
Associate medical examiner:					
1 position at \$3,300.....	321 (A)	3,300			
2 positions at \$3,150.....	355 (B)		6,300	6,300	6,300
Assistant medical examiner:					
3 positions at \$2,400.....	321 (A)	7,200			
2 positions at \$2,600.....	355 (B)		5,200	5,200	5,200
<b>Total discernible amount for medical, hospital, health or allied purposes appropriated for the use of the Bureau of Marine Inspection and Navigation.....</b>		<b>10,500</b>	<b>11,500</b>	<b>11,500</b>	<b>11,500</b>

<sup>1</sup> It is impossible from the available data and for the reasons stated under the subheadings of the Department of Agriculture, to determine whether the amounts that are clearly designated for medical, hospital, and health purposes should be increased by allotments or expenditures that are not clearly designated for such purposes in the Budgets.

Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Bureau of Fisheries:</b>				
Alaska Fisheries Service:				
Physician:				
2 positions at \$3,200.....	339 (A)	\$0, 400		
2 positions at \$3,200.....	375 (B)		\$0, 400	\$0, 400
Medical and hospital supplies .....	339 (A)	1, 709	1, 500	1, 600
.....	375 (B)	2, 038		
Total discernible amount for medical, hospital health or allied purposes appropriated for the use of the Bureau of Fisheries.....	8, 109	8, 438	7, 900	7, 900
<b>Summary: †</b>				
Bureau of the Census .....	362, 980	579, 448	593, 014	606, 511
Bureau of Marine Inspection and Navigation.....	10, 500	11, 500	11, 500	11, 500
Bureau of Fisheries .....	8, 109	8, 438	7, 900	7, 900
Total discernible amount for medical, hospital, health and allied purposes appropriated for and to be expended by the Department of Commerce.....	381, 589	599, 386	612, 414	625, 911

## DEPARTMENT OF THE INTERIOR

<b>Bureau of Indian Affairs:</b>				
Conservation of health among Indians ..	{A48(A) A47(B)}	\$0, 170, 839	\$4, 498, 642	\$4, 950, 000
Medical relief of natives of Alaska .....	{A48(A) A47(B)}	341, 608	344, 209	375, 000
Total discernible amount for medical, hospital, health or allied purposes appropriated for the use of the Bureau of Indian Affairs.....		0, 512, 447	4, 842, 851	5, 325, 000
<b>Government in the Territories:</b>				
Territory of Alaska: Care and custody of insane.....	{465 (A) 503 (B)}	190, 600	195, 300	202, 600
Government of the Virgin Islands:				
Commissioner of Health and chief municipal physician:				
1 position at \$4,600.....	469 (A)	4, 600		
1 position at \$4,600.....	507 (B)		4, 600	4, 600
Assistant Commissioner of Health and chief municipal physician, St. Croix:				
1 position at \$4,200.....	469 (A)	4, 200		
1 position at \$4,200.....	507 (B)		4, 200	
1 position at \$4,400.....	507 (B)		4, 400	4, 400
Municipal physician St. Croix:				
1 position at \$3,000.....	469 (A)	3, 000		
1 position at \$2,000.....	469 (A)	2, 000		
2 positions at \$2,950.....	507 (B)		5, 900	
2 positions at \$2,900.....	507 (B)		5, 800	5, 800
Chief Clerk, Health Department, St. Thomas:				
1 position at \$1,500.....	469 (A)	1, 500		
1 position at \$1,500.....	508 (B)		1, 500	
Chief nurse, St. Thomas: 1 position at \$1,440.....	469 (A)	1, 440		
Director of nurses training:				
1 position at \$1,200.....	469 (A)	1, 200		
1 position at \$1,200.....	508 (B)		1, 200	
Chief sanitation inspector: 1 position at \$1,200.....	469 (A)	1, 200		
Nurse, St. Thomas: 1 position at \$1,080.....	469 (A)	1, 080		
Nurse, St. John: 1 position at \$780.....	469 (A)	780		
District nurse, St. Thomas: 1 position at \$720.....	469 (A)	720		

† No information is available to indicate to what extent, if any, medical, hospital, or health services are provided for in the appropriations for subdivisions of the Department of Commerce.

‡ Including \$2,200,500 emergency expenditures (N. I. R.).

*Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued*

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Government in the Territories—Continued.</b>				
<b>Municipality of St. Thomas and St. John:</b>				
<b>Assistant chief municipal physician:</b>				
1 position at \$3,400.....	470 (A)	\$3,400		
1 position at \$3,400.....	508 (B)		\$3,400	
<b>Municipal dentist:</b>				
1 position at \$2,040.....	470 (A)	2,040		
1 position at \$2,040.....	508 (B)		2,040	\$2,040
<b>Municipal physician:</b>				
1 position at \$2,400.....	470 (A)	2,400		
1 position at \$2,800.....	508 (B)		2,800	
2 positions at \$3,100.....	508 (B)		6,200	6,200
<b>Superintendent, municipal hospital:</b>				
1 position at \$2,000.....	470 (A)	2,000		
1 position at \$2,000.....	508 (B)		2,000	2,000
<b>Laboratory technician:</b>				
1 position at \$1,050.....	470 (A)	1,050		
1 position at \$1,050.....	508 (B)		1,050	
1 position at \$1,200.....	508 (B)		1,200	1,200
<b>Health department:</b>				
56 positions at \$269.....	470 (A)	15,064		
58 positions at \$360.....	509 (B)		20,880	
59 positions at \$374.....	509 (B)		22,066	22,066
<b>Municipality of St. Croix:</b>				
<b>Superintendent, health department:</b>				
1 position at \$2,000.....	471 (A)	2,000		
1 position at \$2,000.....	509 (B)		2,000	2,000
<b>Municipal dentist:</b>				
1 position at \$1,800.....	471 (A)	1,800		
1 position at \$1,800.....	509 (B)		1,800	1,800
<b>Health department:</b>				
108 positions at \$357.....	471 (A)	38,556		
122 positions at \$338.....	509 (B)		41,236	41,236
(These items listed under Government in the Territories are the only Budget estimates that can be identified as intended for medical, hospital and health purposes. Available sources furnish no information concerning medical, hospital, health or allied services and facilities in other territories.)				
<b>Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Government in the Territories.....</b>				
	281,550	289,936	295,942	299,182
<b>St. Elizabeths Hospital for the Insane:</b>				
Army, Navy, Marine Corps, Coast Guard (476 (A) and other.....)	514 (B)	1,183,840	1,149,750	1,182,600
Continuous Treatment Building and driveway under Nichols Ave.....	117 (A)		346,000	
Continuous Treatment Building.....	127 (B)		380,000	680,000
<b>Total discernible amount for medical, hospital, health and allied purposes appropriated for and to be expended by the St. Elizabeths Hospital for the Insane.....</b>				
	1,185,840	1,495,750	1,762,600	1,931,720
<b>Columbia Institution for the Deaf: Fees for medical and dental services.....</b>				
	477 (A) 2,855	515 (B)	2,532	2,532
<b>Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Columbia Institution for the Deaf.....</b>				
	2,855	2,532	2,532	2,532
<b>Freedmen's Hospital.....</b>				
	479 (A) 323,100	517 (B)	344,410	450,080
<b>Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Freedmen's Hospital.....</b>				
	323,100	344,410	450,080	490,000

*Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued*

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Howard University:</b>				
1937, \$1,009,734 (actual)..... A 54 (A)	\$201,946			
1938, \$1,483,485 (actual)..... A 54 (B)		\$296,697		
1939, \$1,420,000 (estimated expenditures).... A 54 (B)			\$284,000	
1940, \$740,000 (estimated expenditures).... A 54 (B)				\$148,000
(It is impossible to determine from available sources the exact amount of the total estimated budget for Howard University that is devoted to the College of Medicine; College of Dentistry; College of Pharmacy; Graduate School Instruction in Bacteriology; Preventive Medicine and Public Health; Graduate School Instruction in Social Treatment and the University Health Service. If an estimated 20 percent of the total University budget is used for these purposes the expenditure would be as stated. The exact amount, however, cannot be determined from available sources.)				
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Howard University.	201,946	296,697	284,000	148,000
<b>Summary:</b>				
Bureau of Indian Affairs.....	6,812,447	4,842,851	5,325,000	5,425,000
Government in the Territories.....	281,560	289,936	295,942	299,182
St. Elizabeths Hospital for the Insane.....	1,185,840	1,495,750	1,762,600	1,931,720
Columbia Institution for the Deaf.....	2,855	2,832	2,542	2,832
Freedmen's Hospital.....	323,100	344,410	450,050	490,000
Howard University.....	201,946	296,697	284,000	148,000
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Department of the Interior.....	8,507,748	7,272,176	8,120,154	8,296,434

## DEPARTMENT OF JUSTICE

<b>Penal and correctional institutions:</b>				
Medical and hospital service, penal institutions..... (500 (A) 530 (B))	\$500,000	\$563,040	\$657,700	\$1,000,000
United States Hospital for Defective Delinquents..... (501 (A) 535 (B))	358,010	334,626	372,260	560,000
National Training School for Boys, Washington, D. C.:				
Physician-psychiatrist:				
1 position at \$4,038..... 506 (A)	4,038			
1 position at \$4,038..... 538 (B)		4,038	4,038	4,038
Nurse:				
2 positions at \$1,560..... 506 (A)	3,120			
2 positions at \$1,560..... 538 (B)		3,120	3,120	3,120
Medical, surgical, and dental fees..... (506 (A) 538 (B))	1,397	1,386	2,600	2,600
<b>Support of United States prisoners:</b>				
Physician:				
45 positions at \$2,000..... 507 (A)	90,000			
54 positions at \$2,000..... 539 (B)		108,000	108,000	108,000
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Department of Justice..	956,657	1,014,210	1,147,718	1,677,768

\* Transfer to the Public Health Service, Treasury Department (see p. 626 (A)).

† Transfer to the Public Health Service, Treasury Department (see p. 674 (B)).

Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued

## DEPARTMENT OF LABOR

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Office of the Secretary:</b>				
Assistant medical officer:				
1 position at \$2,600.....	509 (A)			
1 position at \$2,600.....	510 (B)			
Nurse:				
1 position at \$1,620.....	509 (A)	1,620		
1 position at \$1,620.....	549 (B)	1,620		
Reimbursement to Public Health Service for first-aid services.....	549 (B)			\$5,400
<b>Division of Labor Standards:</b>				
Industrial hygienist:				
1 position at \$3,800.....	510 (A)	3,800		
1 position at \$3,800.....	551 (B)	3,800		
2 positions at \$3,800.....	551 (B)		\$7,600	7,600
Associate industrial hygienist:				
1 position at \$3,200.....	510 (A)	3,200		
1 position at \$3,200.....	552 (B)	3,200		
Industrial physician: 1 position at \$4,600.....	551 (B)			4,600
Promotion of safety and health including Workmen's Compensation.....	510 (A)	24,334		
Silicosis study.....	552 (B)		28,054	34,730
Travelling expenses: Maternal and child welfare.....	552 (B)	14,005	30,130	
511 (A)	52,082			
Total discernible amount for medical, hospital, health and allied purposes appropriated for and to be expended by the Office of the Secretary.....	87,636	54,170	37,730	52,330
<b>Immigration and Naturalization Service:</b>				
Received by transfer from "Pay of Per- sonnel and maintenance of hospitals, Public Health Service, Treasury De- partment".....	519 (A) 558 (B)	67,644	25,015	25,000
Total discernible amount for medical, hospital health and allied purposes appropriated for and to be expended by the Immigration and Naturalization Service.....	67,644	25,015	225,000	25,000
<b>Children's Bureau:</b>				
Salaries and expenses.....	521 (A) 562 (B)	358,070	359,829	363,500
Maternal and child welfare *.....	522 (A) 563 (B)	299,000	304,460	350,000
Grants to States:				
Maternal and child health services.....	522 (A) 563 (B)	2,280,000	4,604,000	3,700,000
Services for crippled children.....	522 (A) 563 (B)	2,150,000	3,549,000	2,850,000
Child-welfare services.....	522 (A) 563 (B)	1,200,000	1,676,000	1,500,000
Total discernible amount for medical, hos- pital, health, and allied purposes appro- priated for and to be expended by the Chil- dren's Bureau.....	6,827,070	10,493,289	8,683,500	8,866,680
<b>Summary:</b>				
Office of the Secretary.....	87,636	54,179	37,730	52,330
Immigration and Naturalization Service.....	67,644	25,015	25,000	25,000
Children's Bureau.....	6,827,070	10,493,289	8,683,500	8,866,680
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Department of Labor.....	6,982,350	10,572,483	8,746,230	8,944,010

\* Administrative expenses in performing the duties imposed by title V, of the Social Security Act, approved Aug. 14, 1935.

\* This total of the discernible amount to be expended by the Department of Labor for medical, hospital, health, and allied purposes must be considered as incomplete and only minimum.

Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued

## NAVY DEPARTMENT

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
Office of the Secretary: Care of lepers, etc., Is- land of Guam..... { 528 (A) 570 (B)	\$35,000	\$35,000	\$35,000	\$37,000
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Navy Department..	35,000	35,000	35,000	37,000

## DEPARTMENT OF STATE

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
Foreign Service: Medical aid for seamen..... { 567(A) 612(B)	\$131	\$10	\$1,000	\$1,000
United States contributions to international commis- sions, etc.:				
Pan American Sanitary Bureau..... { 569(A) 614(B)	30,643	30,986	31,219	31,456
International Office of Public Health..... { 569(A) 614(B)	5,097	5,105	5,105	5,015
Implementing the Narcotics Convention.. { 569(A) 614(B)	10,700	9,109	10,551	10,551
Tenth Pan American Sanitary Conference. 619(B)			3,500	
Ninth International Congress of Military Medicine and Pharmacy, Rumania..... 677(A)	9,500			
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the Department of State....	56,071	45,210	51,375	48,112

## TREASURY DEPARTMENT

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
Bureau of Narcotics: Salaries and expenses... { 613 (A) 659 (B)	\$1,325,000	\$1,267,008	\$1,267,600	\$1,332,500
Public Health Service:				
Salaries, Office of Surgeon General, for personal services in D. C. { 622 (A) 669 (B)	308,410	316,000	316,000	352,920
Commissioned personnel, pay and allow- ances..... { 623 (A) 670 (B)	1,775,810	1,820,000	1,928,000	1,969,800
Acting assistant surgeons, pay of..... { 623 (A) 670 (B)	340,200	340,200	325,000	325,000
Other employees, pay of..... { 624 (A) 671 (B)	1,000,000	1,000,000	950,000	1,009,300
Freight, transportation, etc..... { 624 (A) 671 (B)	25,450	25,450	25,450	25,450
National Institute of Health, maintenance. { 624 (A) 671 (B)	64,000	64,000	64,000	130,000
Pay of personnel and maintenance of hospitals..... { 626 (A) 673 (B)	6,870,000	6,150,000	6,400,000	6,925,000
Quarantine Service..... { 627 (A) 674 (B)	361,450	331,250	281,250	287,980
Prevention of epidemics..... { 627 (A) 674 (B)	260,000	280,000	280,000	305,000
Interstate Quarantine Service..... { 628 (A) 675 (B)	36,535	36,500	36,500	41,700
Control of biologic products..... { 628 (A) 675 (B)	45,000	55,000	55,000	55,000
Division of Venereal Diseases..... { 629 (A) 676 (B)	50,000	80,000	3,080,000	3,000,000
Division of Mental Hygiene and main- tenance of narcotic farms..... { 630 (A) 677 (B)	663,220	647,680	950,000	1,230,000
Educational exhibits..... { 630 (A) 678 (B)	1,000	1,000	1,000	1,000
Grants to States: Public health work..... { 630 (A) 678 (B)	3,000,000	8,000,000	8,000,000	8,000,000
Diseases and sanitation investigations..... { 632 (A) 680 (B)	1,320,000	1,600,000	1,600,000	1,600,000
National Cancer Institute..... 680 (B)		400,000	400,000	440,000

*Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued*

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Public Health Service—Continued.</b>				
Hot Springs Transient Medical Center Infirmary..... 682(B)		\$158,023		
Total discernible amount for medical, hospital, health and allied purposes appropriated for and to be expended by the Treasury Department <sup>10</sup> .....	\$21,476,075	22,570,011	\$25,950,800	\$27,030,650

## WAR DEPARTMENT CIVIL APPROPRIATION

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
<b>Panama Canal: Sanitation, quarantine, hospitals, and medical aid and support of the insane and of lepers and aid and support of indigent persons.....</b>				
719(A) 766(B)	\$899,793	\$918,000	\$933,800	\$962,035
Total discernible amount for medical, hospital, health and allied purposes appropriated for and to be expended by the War Department <sup>11</sup> .....	899,793	918,000	933,800	962,035

## DISTRICT OF COLUMBIA

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940	
<b>Sewers: Mosquito control .....</b>	782(A) 837(B)	\$12,000	\$12,000	\$12,000	\$12,000
<b>Health Department:</b>					
Salaries.....	797(A) 852(B)	185,790	217,690	231,990	229,330
Prevention of contagious diseases.....	797(A) 853(B)	32,500	43,830	43,830	47,230
Indigent persons suffering from tuberculosis and venereal diseases.....	798(A) 853(B)	45,330	15,380	53,220	53,580
Nursing service.....	798(A) 853(B)	120,400	143,440	151,540	154,340
Abatement of nuisances and draining of lots.....	798(A) 853(B)	1,000	1,000	1,000	1,000
Public schools, hygiene and sanitation.....	798(A) 854(B)	51,000	111,060	111,060	114,300
Laboratories.....	799(A) 854(B)	3,300	7,890	6,000	6,000
Contingent expenses incident to the enforcement of Food and Drugs Act.....	799(A) 854(B)	7,000	7,000	7,312	8,821
Maternal and child-health service.....	799(A) 854(B)	25,000	25,000	25,900	33,280
Tuberculosis sanatoria.....	800(A) 855(B)	519,850	508,440	577,000	625,320
Gallinger Municipal Hospital.....	801(A) 856(B)	692,230	743,660	800,360	899,340
<b>Medical charities:</b>					
Children's Hospital.....	801(A) 856(B)	75,000	40,000	68,000	82,000
Central Dispensary and Emergency Hospital.....	801(A) 856(B)	65,000	65,000	60,000	60,000
Eastern Dispensary and Casualty Hospital.....	801(A) 856(B)	40,000	40,000	46,000	45,000
Washington Home for Incurables.....	802(A) 857(B)	10,000	10,000	15,000	15,000
Columbia Hospital and Lying-in Asylum.....	802(A) 857(B)	5,000	5,000	5,000	5,000
<b>Public Welfare:</b>			200,000		
Florence Crittenton Home.....	815(A) 871(B)	9,000	9,000	8,000	8,000
St. Elizabeths Hospital.....	815(A) 871(B)	2,284,800	2,452,780	2,438,000	2,614,260
Total discernible amount for medical, hospital, health, and allied purposes appropriated for and to be expended by the District of Columbia.....		4,217,250	4,488,170	4,858,212	4,993,804
Federal contribution to District of Columbia is about 10 percent of total budget.....		421,725	448,417	485,821	499,380

<sup>10</sup> From the available sources of information it is impossible to determine whether the discernible total includes all the federal funds that are utilized for the purposes stated. The National Cancer Institute authorized by Public Act No. 244, Aug. 5, 1937, was erected and equipped at an authorized amount of \$750,000 (75th Cong., 1st sess.). The total discernible amount to be expended by the Treasury Department for medical, hospital, health and allied purposes must, therefore, be considered incomplete.

<sup>11</sup> It is not claimed that this amount is complete; it represents the amount that could be clearly determined from available sources.

*Medical, hospital, health, and allied services for which actual appropriations or estimated obligations are listed in the Budgets of the United States Government for the fiscal years ending June 30, 1939, and June 30, 1940—Continued*

**TOTAL TO BE EXPENDED BY THE VARIOUS SERVICES—THE DISCERNIBLE AMOUNTS LISTED IN THE BUDGET OF THE U. S. GOVERNMENT FOR MEDICAL, HOSPITAL, HEALTH, AND ALLIED ACTIVITIES**

	Actual, 1937	Actual, 1938	Estimate, 1939	Estimate, 1940
Legislative branch.....		\$3,000	\$3,600	\$3,600
Independent establishments <sup>11</sup> .....	\$69,435,762	156,443,656	89,139,641	78,934,611
Civilian Conservation Corps.....	810,224	525,553	522,241	523,472
Civil Service Commission.....	19,480	23,140	31,400	34,000
Employees' Compensation Commission.....	4,934,590	2,972,837	3,702,312	1,818,210
Federal Trade Commission.....	2,933	2,328	3,140	9,540
Railroad Retirement Board.....	4,306	16,023	33,162	23,960
Social Security Board.....	7,010	15,250	19,796	19,796
Works Progress Administration.....		87,066,024	900,000	
Home Owners' Loan Corporation.....	67,311	22,277	20,453	19,556
Federal Housing Administration.....	4,452	4,176	6,660	6,660
Reconstruction Finance Corporation.....	3,740	3,622	3,740	3,740
Federal Emergency Administration of Public Works <sup>12</sup> .....	5,420	6,096	13,272,000	3,800
Tennessee Valley Authority.....	213,778	362,497	428,000	454,000
Veterans' Administration.....	63,362,428	65,423,697	70,193,737	76,017,777
Department of Agriculture <sup>12</sup> .....	7,023,224	7,307,897	7,362,141	8,134,161
Department of Commerce.....	381,589	599,386	612,444	625,911
Department of the Interior.....	8,507,748	7,272,176	8,120,154	8,266,434
Department of Justice.....	956,557	1,014,210	1,147,718	1,677,758
Department of Labor.....	6,982,350	10,572,483	8,740,230	8,944,010
Navy Department.....	35,000	35,000	35,000	37,000
Department of State.....	56,071	45,210	51,375	48,112
Treasury Department.....	21,476,075	22,570,011	25,959,800	27,030,650
War Department civil appropriation.....	899,793	918,000	933,800	962,035
District of Columbia.....	421,725	448,817	485,821	499,390
Total for legislative branch, independent establishments, regular departments, and District of Columbia.....	116,176,894	207,229,746	142,597,624	135,193,462

**BUDGET ESTIMATES**

	1937	1938	1939	1940
Department of Commerce.....	\$41,259,006	\$30,983,018	\$31,336,900	\$51,458,280
Health activities.....	381,589	599,386	612,444	625,911
Total exclusive of health activities.....	40,877,417	30,383,632	30,724,516	50,832,369
Department of Justice.....	38,560,399	41,237,280	42,936,375	50,544,670
Health activities.....	956,557	1,014,210	1,147,718	1,677,758
Total exclusive of health activities.....	37,603,842	40,223,070	41,788,657	48,866,912
Department of Labor.....	37,241,891	33,800,619	27,821,550	30,930,280
Health activities.....	6,982,350	10,572,483	8,746,230	8,944,010
Total exclusive of health activities.....	30,259,541	23,228,166	19,075,320	21,986,270
Department of State.....	17,120,926	18,304,923	15,686,350	16,474,266
Health activities.....	56,071	45,210	51,375	48,112
Total exclusive of health activities.....	17,064,855	18,259,713	15,634,975	16,426,154
Total budget for Departments of Commerce, Justice, Labor, and State.....	134,182,222	124,325,876	117,781,235	149,407,496
Total estimated appropriation for medical, hospital, health, and allied purposes.....	8,376,567	12,231,289	10,557,767	11,295,791
Total budget estimate exclusive of health activities.....	125,805,655	112,094,587	107,223,468	138,111,705

<sup>11</sup> This total does not include Public Works Administration, \$74,948,202.

<sup>12</sup> Does not include Farm Security Administration—amount undeterminable.

The above enumeration of the amounts listed in the Budget of the United States Government to be used by the several departments, independent establishments, legislative branch, and the District of Columbia for medical, hospital, health, and allied purposes, represents only those estimates that are clearly designated for these purposes. It is recognized that several of the amounts listed should be increased on account of unexpended balances of previous appropriations which carry over unobligated balances of appropriations continued available or transfer of appropriations, concerning which exact information could not be obtained from available sources.

This listing of discernible amounts of Federal funds used by the Federal Government for medical, hospital, health, and allied purposes omits the Budget estimate for the Medical Department, War Department, which was, for 1940, \$1,601,072, and for the Bureau of Medicine and Surgery, Navy Department, which was, for 1940, \$2,070,000, since it is recognized that the Army and the Navy require their own medical establishments.

The amounts authorized by and appropriated under authority of the Social Security Act (1935) for medical, hospital, health, and allied purposes are listed under the agencies designated to administer the funds, the Children's Bureau, Department of Labor, and the Public Health Service, Treasury Department. Available sources provide no information as to whether other funds authorized by the Social Security Act are being utilized to provide some other forms of medical, hospital, health, or allied services in addition to those for which funds are specifically designated.

It is likewise utterly impossible to arrive at an accurate current amount of expenditures for medical, hospital, health, and allied purposes, by all independent establishments since the Budget does not clearly indicate amounts for such purposes.

Some of the departments and independent establishments are engaged in activities which would seem to require some medical standards, personnel, and services; many of these activities at least have an indirect public-health significance. Available sources give no information of any Federal funds designated for these purposes. The agencies which may be included in this category are the Bureau of Air Commerce, Marine Inspection and Navigation, and the National Bureau of Standards in the Department of Commerce; the Bureau of Reclamation, the Bureau of Mines, and the Columbia Institution for the Deaf in the Department of the Interior; the departments of the District of Columbia charged with the general supervision and maintenance of mosquito control, sewers and sewage treatment, collection and disposal of refuse, public playgrounds and swimming and bathing pools, and the health phases of the public-school program and the essential medical services required in connection with the District Training School, the Industrial Home for Colored Children, and the Home for the Aged and Infirm. Among the independent establishments in this category are the Canal Zone and Alaska Railroad retirement and disability funds, which are presumably required to determine the nature and extent of disability of those who apply for and are entitled to disability benefits administered by these agencies.

A report of the progress of the Works Progress Administration program issued as of the date of June 30, 1938, indicates, on page 141, that a total of \$105,454,328 was the total cumulative amount expended as of March 31, 1938, for sanitation and health, of which \$85,275,572 represented Federal funds. It appears from the report that among a considerable number of agencies engaged in the sanitation and health projects, close cooperation was secured from the United States Public Health Service.

It is impossible from the information that is available to tabulate accurately the amounts of emergency-relief appropriations that were allotted to and expended by the United States Public Health Service, or that were utilized by other agencies for medical, hospital, health, or allied purposes. The Budget of the United States Government does, however, contain reference to an allotment of \$1,506,338 from emergency-relief appropriations to the Public Health Service for assistance for educational, professional, and clerical persons for 1937; also an allotment of \$905,473 from the emergency-relief appropriation of 1936 for the year 1937 for health and sanitation activities in flood-stricken areas. It is not clear from the available information whether these items, which appear in the Budget for 1939 on pages 632 and 633, are included in the cumulative total as of March 31, 1938, appearing in the tabulation on page 8 under Works Progress Administration. They have not been placed in the tabu-

lation on the assumption that they may be included in the cumulative total as given in the Works Progress Administration report.

The Budget of the United States Government for 1940 contains an item under the Treasury Department, Public Health Service, for assistance for educational, professional, and clerical persons, allotted from the emergency-relief appropriation of 1937, of \$310,713 for 1938 (681B), and an item of \$170,432 received by transfer from the emergency relief and Works Progress Administration for similar purposes for the year 1939. These items are likewise omitted from the tabulations since it is not clear in what year the allotments were made, and therefore they may be included in the cumulative total above mentioned.

In the Budget of the United States Government for 1939, page 632, an amount of \$102,138 was the estimated allotment to United States Public Health Service from the emergency-relief appropriation for 1935 for the Hot Springs Transient Medical Center Infirmary. The actual amount used for 1938 was given in the 1940 Budget, on page 682, namely, \$150,023, is tabulated under the Treasury Department, Public Health Service, on page 32 of the tabulation. In the 1939 Budget, on page 632, an additional \$190,400 allotted to the Public Health Service from the emergency-relief appropriation of 1937 for the Hot Springs Transient Medical Center Infirmary is listed as an estimate for 1938. This amount does not appear in the 1940 Budget under the actual amounts used for 1938 for the same purpose. This \$190,400 does not appear in the accompanying tabulations since the available information does not indicate what disposition was made of this allotment.

If, therefore, it were definitely known that the cumulative total given in the Works Progress Administration report did not contain the items above mentioned, the discernible totals on page 30 of the accompanying tabulation would be increased by \$2,471,811 for 1937, \$310,713 for 1938, and \$170,432 for 1939. The 1937 total might be further increased by \$190,400 if the disposition of that amount could be determined.

The listed totals are, therefore, the nearest approximation that can be made from available sources of information. These approximations are underestimates, except for the Veterans' Administration, and would be increased if it were possible to obtain complete information from all Federal agencies representing their total disbursements for all medical, hospital, health, and allied activities.

The material contained with the tabulations and the explanations thereof was requested by the subcommittee of the Senate Committee on Education and Labor at the time of the hearings on the Wagner national health bill at which the American Medical Association presented its statements on May 25 and 26, 1939. These tabulations and the accompanying explanations are offered for consideration of the subcommittee and inclusion in the record.

Respectfully submitted.

R. G. LELAND, M. D.,  
*Director, Bureau of Medical Economics.*

JULY 1939.

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#### ANALYSIS AND CRITICISM OF S. 1620

(Prepared by the Bureau of Legal Medicine and Legislation, American Medical Association, July 1939)

The bill (S. 1620, 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) will hereinafter be referred to as S. 1620. It is sometimes denominated as the Wagner health bill and sometimes as the national health bill. By way of preface and as a background against which to weigh the extensive social, financial, administrative, legal, and political implications inherent in the bill, it must be pointed out that it seems to be intimately related to the so-called National Health Survey, made in the autumn and winter of 1935-36. This National Health Survey was primarily a Works Progress Administration project, executed under the supervision of the Public Health

Service, largely through Works Progress Administration workers who were without the technical education and training necessary to qualify them for such work. The Survey itself was "national" only in the sense that it was executed under Federal auspices and paid for with Federal funds. It did not cover anything approaching the entire national area or population.

The purpose of S. 1620 according to representations made by some of its proponents, is to provide relief for States in need of Federal financial aid to enable them 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. Apparently in order to justify legislation affording Federal financial aid to certain States in financial distress, the bill proposes to authorize similar Federal aid to every State, regardless of its needs and its resources, always, however, under Federal supervision and control. The money necessary to carry out the purposes of this bill is to be exacted from the people of every State by general taxation. No part of the money thus exacted, however, is to be returned to any State unless it submits its plans to the approval of certain Federal officials and subjects the execution of those plans to the supervision and control of those officials.

This whole procedure should be simplified and provision made for loans or grants to any State, at any time, for the relief of any distress among its people that the State itself is unable to relieve. Such relief should be afforded, however, not by rule of thumb applied to every State, but only on a showing of need in each particular case. Any State that is financially unable to provide for the needs of its people, whether those needs have relation to medical and hospital service, food, clothing, shelter, or any other necessary of modern life, should be able to obtain Federal financial aid, either as a grant or as a loan. It should not be necessary for the Federal Government to impose similar financial aid on all other States, whether in need or not, as S. 1620 proposes to do, in order that aid may be given to the State in distress.

A State in need should be able to present its case to some agency or agencies of the Federal Government authorized to afford relief, supporting its petition by evidence of need and by a plan for relief. If the evidence and plan submitted justify, it should be possible for the agency of the Federal Government having the matter in charge to award to that State, as a Federal loan or as a grant, as circumstances may indicate, such aid as State needs, without having any other State a party to the proceeding.

Under such a plan, a petition praying Federal aid for the prevention, relief, or cure of disease might be submitted, say, to the Public Health Service for determination of the existence of need and the technical soundness of the proposed plan for relief. The petition of the State, then, together with a report on the findings of the Public Health Service, might then be considered by some appropriate Federal agency, to be authorized to make such grants or loans as the State requires—the Reconstruction Finance Corporation, for instance—for determination of the extent to which the petitioning State is financially unable to provide for its own people, for the determination of the nature and extent of the aid to be granted by the Federal Government, and for the making of the necessary grant or loan if the evidence justifies.

An analysis of S. 1620, section by section, with necessary references to the various relevant statutes now in force, is impracticable at the present time and will probably add but little to what is said below. For that reason this topical analysis is submitted.

#### BENEFICIARIES

*Nothing in S. 1620 proposes to limit to the poor or to persons in moderate circumstances any of the benefits that the bill proposes to confer.*—So far as the bill is concerned, every person, rich and poor alike, may be given any service or other benefit named in it, at the discretion of the Chief of the Children's Bureau, the Surgeon General of the United States Public Health Service, or the Social Security Board, each acting within its own jurisdiction. The hospitals that the bill proposes to have erected may be designed for the rich as well as for the poor. The very fact that the bill provides in certain cases that special consideration be given to areas suffering from severe economic distress, and in one case to individuals suffering from severe economic distress, implies that the benefits of the bill are not to be limited to such areas or individuals.

The bill seems to look forward toward the establishment of universal State medical service for the entire population, the advent of which need await only the making of the unlimited appropriations that the bill authorizes. The present plans of the Chief of the Children's Bureau, or of the Surgeon General of the Public Health Service, or of the members of the Social Security Board for carrying into effect the provisions of this bill if it be enacted are not conclusive as to what the ultimate result of its enactment may be. Other chiefs of the Children's Bureau, other surgeon generals, and other members of the Social Security Board may in the future entertain different ideas and devise different plans.

#### ENLARGEMENT OF SCOPE OF ACTIVITIES

S. 1020 proposes a great enlargement of Federal activities in the field of intrastate health and medical service, under the Social Security Act.

*Maternal and child-health services.*—Under Title V, Grants to States for Maternal and Child Welfare, part 1, the Social Security Act, as approved August 14, 1935, provided for grants to States only for the purpose of extending and improving services for promoting the health of mothers and children. S. 1020 proposes to provide for grants also for supplies and facilities for the same purpose; for medical care during maternity and infancy, including medical, surgical, and other related services; for care in the home or in institutions; for facilities for diagnosis, hospitalization, and aftercare; and for the training of personnel (sec. 501).

*Medical services for children and services for crippled and other physically handicapped children.*—The Social Security Act, as approved August 14, 1935, provided for services for locating crippled children, and for providing children who are crippled or who are suffering from conditions which lead to crippling with medical, surgical, corrective, and other services and care, and for facilities for diagnosis, hospitalization, and aftercare (sec. 511). S. 1020 proposes to provide services, supplies, and facilities for the medical care of all children and services to all physically handicapped children in need of special care, whether crippled or not. It proposes to include, in addition to the medical, surgical, and corrective services now authorized, all manner of other related services and care in the child's home or in institutions; for the development of more effective measures for providing medical services for children; and for the training of personnel (sec. 511).

*Demonstrations in connection with maternal- and child-health services and medical services for children and services for crippled and other physically handicapped children.*—The Social Security Act, as approved August 14, 1935, required that a State plan for maternal- and child-health services provide for the development of demonstration services in needy areas and among groups in special need (sec. 503 (a)). S. 1020 proposes to authorize the Chief of the Children's Bureau to make demonstrations in the fields named, without defining what constitutes a "demonstration" and without limiting the place or manner of making demonstrations.

*Public-health work.*—The Social Security Act, as approved August 14, 1935, authorized appropriations to assist States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public-health services, including the training of personnel for State and local health work (sec. 601). S. 1020 proposes specifically to authorize appropriations for the improvement of public-health work for the control of tuberculosis and malaria, for the prevention of mortality from pneumonia and cancer, for mental health, and for industrial-hygiene activities, and to develop more effective measures for the extension and improvement of public health, including the training of personnel (sec. 601).

*Grants to States for hospitals and health centers.*—The Social Security Act as approved August 14, 1935, makes no provision for allotments to States to aid in the construction and operation of hospitals and health centers. S. 1020 proposes to provide for grants to the States for those purposes and for the purpose of developing more effective measures for accomplishing the purposes named (sec. 1201). The term "hospital" is defined to include health, diagnostic, and treatment centers, institutions, and related facilities (sec. 1209). The Surgeon General is to be authorized to make such studies and demonstrations as will extend and improve the quality of hospital facilities generally and promote the efficient administration of those portions of the bill that relate to grants-in-aid in the construction and improvement of hospitals (sec. 1208 (a)).

*General medical care.*—The Social Security Act, as approved August 14, 1935, makes no provision for grants to States for the general medical care of the people. S. 1620 proposes to make such grants, to extend and improve medical care, including all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability, and for the development of more effective measures for accomplishing the ends named, including the training of personnel (sec. 1301).

*Temporary disability compensation.*—The Social Security Act, as approved August 14, 1935, makes no provision for grants to States for temporary disability compensation. S. 1620 proposes to make such grants (sec. 1401). The term "disability" is defined to mean inability to work or unfitness for work by reason of injury or illness. The term "temporary disability compensation" is defined to mean cash benefits payable to individuals for not more than 52 weeks with respect to disability not arising out of or in the course of employment (sec. 1405 (a) and (b)). The bill proposes, however, to require any State desiring Federal aid under these provisions to provide reasonably adequate medical services to minimize disability covered by the provisions of the bill (sec. 1402 (b)).

#### APPROPRIATIONS

The maximum appropriation authorized by the Social Security Act, as approved August 14, 1935, for grants to States for maternal and child welfare and public health work was \$20,150,000. S. 1620, in connection with the enlargement of the scope of activities that it proposes, authorizes unlimited appropriations. What those appropriations may be expected to be in the future is shown by the fact that, the bill proposes specifically to authorize appropriations for the fiscal year ending June 30, 1940, amounting to more than \$98,250,000.

If the maximum appropriations under S. 1620 ever reach the amount stated above, nothing short of a miracle or a Government catastrophe will reduce them. There will always be the plea, such as was made in the course of arguments for the extension of the Sheppard-Towner Maternity and Infancy Act beyond its allotted span, that projects authorized under previous appropriations have been organized and are under way and cannot be discontinued except at great loss to the Federal Government and to the States, etc.

Moreover, so long as births, disease, injury, and death exist, it will be possible to make a plausible plea for the extension of Federal and State Government aid for their relief, on the ground that but few persons can afford to pay for the maximum benefits that may be derived from the highest grade of medical practice and hospital service and that Government aid is necessary. Those who make such an argument ordinarily do not realize the fact, or if they do realize it they conceal it, that the appropriations to pay for such aid are necessarily reflected back on the people through increased taxes and cover not only the cost of medical aid and hospital service but also the huge administrative expenses that in the end add greatly to the cost of such services, effecting, it may be, their wider distribution but without any proportionate increase in their efficiency.

#### COOPERATION WITH STATE AND PRIVATE AGENCIES

The Social Security Act, as approved August 14, 1935, provides that allotments for State and local public-health services shall, with the approval of the Secretary of the Treasury, be determined in accordance with rules and regulations previously described by the Surgeon General of the Public Health Service after consultation with a conference of the State and Territorial health authorities (sec. 602 (c)). Under S. 1620, State and Territorial health authorities cannot, as a matter of right, inform the Surgeon General of the needs of their respective States and Territories and of their views with respect to allotments, before the rules and regulations determining allotments are promulgated (sec. 602 (a)).

Under the Social Security Act, as approved August 14, 1935, a State plan for maternal and child health services cannot be approved unless it provides for cooperation with medical, nursing, and welfare groups and organizations (sec. 503 (a)). The same condition is imposed with respect to State plans for services for crippled children; approval is conditional on provision being made for cooperation with medical, health, nursing, and welfare groups and organizations (sec. 513 (a)). S. 1620 makes no provision for cooperation with private

agencies in either case, but requires provision for cooperation only with public agencies (sec. 503 (a) (7) and sec. 513 (a) (7)). In arriving at this conclusion it has been assumed that the word "public" means "governmental." If it has any other meaning, that meaning should be made clear.

#### ALLOTMENTS TO STATES

The Social Security Act, as approved August 14, 1935, contains certain statutory restrictions on the allotments of funds to the several States (sec. 502 (a), sec. 512 (a), sec. 602 (a)). S. 1620 leaves the determination of the amounts of such allotments almost altogether to the personal judgment of the Chief of the Children's Bureau, subject to the approval of the Secretary of Labor; to the personal judgment of the Surgeon General of the Public Health Service, subject to the approval of the Secretary of the Treasury; and to the personal judgments of a majority of the Social Security Board, each acting within his own field. It lays down no rule to guide the officials named in determining allotments but provides only that they shall "take into consideration" certain circumstances, more or less vaguely defined. S. 1620 contains no statutory provision that entitles any State to anything as a matter of right. A State has no appeal from the judgments of the Federal officials named above.

Under S. 1620, title V, part 1, relating to maternal- and child-health services, allotments to the States are to 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 such allotments, the Chief of the Children's Bureau and the Secretary of Labor are to "take into consideration" the total number of births in the last calendar year for which the Bureau of the Census has available statistics; the number of mothers and children in need of services; the special problems of maternal and child health; and "financial resources," meaning thereby, apparently, the financial resources of the State (sec. 502 (a)). If, after an allotment has been made, the Chief of the Children's Bureau finds, after giving notice and an opportunity to be heard, that in the administration of the State plan there is what she believes to be a failure to comply with the requirements of the act, she may forthwith withhold further payments under the allotment (sec. 505). With respect to the making of an allotment, the amount of an allotment, or the withholding of an allotment, an aggrieved State has no right of appeal.

Amounts of allotments under title V, part 2, of the bill, relating to medical services for children and services for crippled and other physically handicapped children, are to be determined according to rules and regulations prescribed by the Chief of the Children's Bureau, with the approval of the Secretary of Labor. In determining allotments, they must "take into consideration" the child population; the number of children in each State in need of services; the special problems of medical care of children; and "the financial resources," meaning thereby, apparently, the financial resources of the State (sec. 512 (a)). The Chief of the Children's Bureau and the Secretary of Labor, however, are not bound by any of the factors named in determining what allotments shall be made. What constitutes "child population" is not stated; that is, whether childhood ends at 10 years of age, 15 years, or 20. Whether "in need of services" means in economic need of them, as well as in physical need, is not stated. What constitute "special problems" of medical care of children is in no way indicated. Obviously, the financial resources of a State had better be determined by the proper officials of the Treasury Department rather than the Chief of the Children's Bureau. If the Chief of the Children's Bureau concludes, after giving reasonable notice and an opportunity to be heard, that any State plan fails to comply with the requirements of the act, she may forthwith withhold all further payments under allotments previously made (sec. 515). Neither with respect to the making of an allotment, the amount of an allotment, nor the withholding of an allotment has a State any right of appeal.

The amounts of allotments to the States under title VI, art 1, as set forth in S. 1620, relating to public-health work and investigations, are to 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 such allotments the Surgeon General and the Secretary of the Treasury are to "take into consideration," but are not limited by, the population, the number of individuals in need of health services, the special health problems, and "the financial resources," apparently meaning thereby the financial resources of the State. What is to constitute "an

Individual in need of services" is not stated; that is, whether the need is to be merely physical need or economic also. What constitutes "special health problems" is not stated (sec. 602 (a)). The Surgeon General of the Public Health Service is authorized, after giving reasonable notice and opportunity for a hearing, to forthwith withhold all further payments under any allotment that may have been made, if he concludes that there has been a failure to comply substantially with the requirements of the law (sec. 1205). From his judgment, neither as to the making of an allotment, the amount of an allotment, or the withholding of an allotment, a State has no right of appeal.

Allotments to the States under title XII of the Social Security Act, if and when it is amended as is proposed in S. 1620, providing for grants to States for hospitals and health centers, are to be made 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 amounts of such allotments, the Surgeon General and the Secretary of the Treasury must "take into consideration," but are not limited by, the need for additional hospitals and the financial resources of the State. What is to determine the need for additional hospitals in any community is not stated (sec. 1202 (a)). If the Surgeon General of the Public Health Service, after giving reasonable notice and opportunity for hearing, believes that there has been a failure to comply with the requirements of the law, he may forthwith discontinue payments under any allotment that has been made. From the judgment of the Surgeon General as to the making of an allotment, the amount of an allotment, and the withholding of an allotment, a State has no right of appeal.

Under title XIII of the Social Security Act as it will appear if and when S. 1620 be enacted in its present form, relating to grants to States for medical care, allotments are to be determined according to rules and regulations prescribed by the Social Security Board, the Board is to "take into consideration," but apparently are not limited by, the population; the number of individuals in need of the services; the special health problems; and "the financial resources," meaning thereby apparently the financial resources of the State (sec. 1302). What is to be the basis for the determination of the number of individuals in need of medical care is not stated. So far as the bill shows, the existence of physical need alone, without economic need, would be sufficient to justify the inclusion of an individual as "in need of services," and it is such vagueness of language throughout the bill that, among other things, leads to the conclusion stated at the outset that nothing in the bill limits its proposed benefits to persons suffering under financial handicaps. What constitutes a "special health problem" is left to surmise. If allotments are to be based on the existence of "special problems," the determination of the existence and extent of such problems would seem to fall logically within the purview of the Public Health Service and not of the Social Security Board. Even after an allotment has been made, the Social Security Board may, after giving reasonable notice and opportunity for hearing, forthwith discontinue payments under it, if it believes that in the administration of the State plan there has been a failure to comply substantially with any requirement of the law. From the judgment of the Board as to the making of an allotment, the amount of an allotment, or the cancellation of an allotment, a State has no right of appeal from the decision of the Social Security Board, made by a majority vote of a quorum of the Board (sec. 1305).

Such a scattering of authority with respect to the determination of such needs as is indicated above is hardly in harmony with good administration. The Chief of the Children's Bureau is to determine need insofar as relates to maternal and child-health services and to determine independently need insofar as relates to medical services for children. The Surgeon General is to determine need insofar as relates to public-health work and the establishment of hospitals, except that certain unnamed public-health problems seem to be left to the determination of the Social Security Board. The Social Security Board is to determine need in relation to medical care and temporary disability compensation. No provision is made for the cooperation of these agencies in the determination of the needs named, either as to their existence or the amount of allotments to be made. Each of the agencies named is to cooperate with one or more State health agencies. Each of the agencies named is to have an indefinite number of ill-defined advisory councils, every one acting independently of every other one. A better plan for creating confusion and inefficiency could hardly have been devised.

## PROMULGATION OF RULES AND REGULATIONS

§. 1020 is replete with authorizations for the promulgation of unlimited, ill-described rules and regulations having no parallel under existing law.

The Chief of the Children's Bureau, with the approval of the Secretary of Labor, is to make rules and regulations to govern allotments to the several States under title V, part 1, relating to maternal- and child-health services (sec. 502 (a)). State agencies must have authority to make rules and regulations to further the purposes of title V, part 1, relating to maternal- and child-health services (sec. 503 (a) (8)). The Chief of the Children's Bureau is to have further authority to make such rules and regulations as she deems necessary for the efficient administration of title V, part 1 of the bill (sec. 507).

The Chief of the Children's Bureau, with the approval of the Secretary of Labor, is to have authority to make rules and regulations to determine the amounts to be allotted to the several States under title V, part 2, relating to medical services for children and services for crippled and other physically handicapped children (sec. 512 (a)). State agencies must have authority to make and publish such rules and regulations as are necessary for the efficient operation of services under title V, part 2, relation to medical services for children and services for crippled and other physically handicapped children (sec. 513 (a) (8)). The Chief of the Children's Bureau is to make further rules and regulations of similar purport (sec. 517).

Allotments to the several States under title VI, part 1, relating to public-health work, are to 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 (sec. 602 (a)). State agencies must have authority to make and publish rules and regulations for the efficient operation of services under title VI, part 1 (sec. 603 (a) (8)). The Surgeon General of the Public Health Service, with the approval of the Secretary of the Treasury, is to have authority to make and publish rules and regulations of similar purport (sec. 607).

The Surgeon General of the Public Health Service, with the approval of the Secretary of the Treasury is to prescribe rules and regulations for determining allotments under title XII, relating to grants to States for hospitals and health centers (sec. 1202 (a)). State agencies must have authority to make and publish rules and regulations for the efficient administration of title XII, relating to hospitals and health centers (sec. 1203 (a) (10)). The Surgeon General for the Public Health Service, with the approval of the Secretary of the Treasury, is to have authority further to make and publish rules and regulations of similar purport (sec. 1207). The Federal Emergency Administrator of Public Works is to have like authority (sec. 1207).

The Social Security Board is to be authorized to make rules and regulations to determine the allotments to be made to the several States under title XIII, relating to grants to States for medical care (sec. 1302). State agencies must have authority to make rules and regulations for the efficient operation of title XIII, relating to grants to States for medical care (sec. 1303 (a) (8)). The Social Security Board is to make such rules and regulations as it deems necessary for the efficient operation of title XIII (sec. 1307).

The nature and extent of all these rules and regulations are vague. Obviously, such statutory authority as is here proposed is not necessary in making rules and regulations that are to apply solely to employees serving under the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, the Social Security Board, or the several State agencies seeking and receiving grants under the act. The right of a Government official to make regulations for the guidance of his subordinates in the discharge of their official duties is inherent. It may be that the proposed rules and regulations that are to be formulated with the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, and the Social Security Board are to be for the government of the several States in their operations under the act or in relation to it. The conclusion is inescapable, however, that some, if not all, of these proposed rules and regulations are for the guidance and control of the people.

The bill lays down no restrictions on the method to be pursued in formulating and promulgating any of the rules and regulations that it undertakes to authorize. Nothing in the bill requires that even after rules and regulations have been promulgated they be published anywhere for the information and guidance of those who are to be bound by them, or that copies be made available to such

persons. Publication in the Federal Register of such rules and regulations as may be promulgated by the Federal officials named is probably required, but certainly that will reach only a limited part of the general public and a limited part of the persons who must live under the rules. The bill provides for no waiting period after the promulgation of the proposed rules and regulations and before they become effective, in order that those who must live under them may learn of their promulgation and adjust their affairs accordingly.

How the proposed rules and regulations are to be enforced, the bill does not say. It is hardly conceivable that they are to be enforced by criminal prosecution, although it is by no means clear that the proponents of the bill have not so intended. Probably enforcement is to be left to the several administrative agencies by which the rules and regulations are to be promulgated, each agency to act as prosecutor and judge. As a penalty for the violation of such rules and regulations, benefits authorized by the act may be withheld. The bill provides for no appeal from any judgment or sentence that may be rendered under the proposed rules and regulations.

#### APPROVAL OF STATE PLANS

S. 1620 seems at first glance to lay down certain conditions under which a State will be entitled to allotments. A careful study of the conditions laid down, however, shows that in every instance the question as to whether an allotment shall or shall not be made rests in the discretion of the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, or the Social Security Board. From an adverse decision by either of the officers named or by the Board, a State has no right of appeal, for the courts will not review a decision of an administrative officer or board based on the exercise of discretion vested in him by law, unless it can be shown that he has abused that discretion.

Under title V, part 1, of the Social Security Act as set forth in S. 1620, relating to maternal and child health services, a State plan must be approved only if and when it provides 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 (sec. 503 (a)). If she feels that the method of administration proposed by the State is not such as is necessary for the efficient operation of the plan, she must reject the plan. From her judgment based on the exercise of discretion, there is no appeal (sec. 515).

Under title V, part 2, relating to medical services for children, the Chief of the Children's Bureau need approve a State plan only if she believes that it provides such methods of administration as in her judgment are 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 (sec. 503 (a)). From the judgment of the Chief of the Children's Bureau, based on her statutory right to exercise her discretion, there is no right of appeal.

Under title VI, part 1, relating to public health work, provisions as to the approval of State plans by the Surgeon General are found in section 603 (a) (4). They provide that the methods proposed for the administration of a State plan must be such as are found by the Surgeon General of the Public Health Service to be necessary for the efficient operation of the plan (sec. 603 (a) (4)). From the decision of the Surgeon General based on his statutory right to exercise his discretion, there is no appeal.

Under title XII of the Social Security Act as S. 1620 proposes to amend it, relating to grants to States for hospitals and health centers, there is a similar absolute control of the situation by the Surgeon General of the Public Health Service, without right of appeal on the part of the State. The law provides that the plan of administration submitted by a State must be such as is found by the Surgeon General to be necessary for the efficient operation of the plan. If he finds otherwise, the State is helpless (sec. 1203 (a) (3)3).

A similar situation exists with respect to title XIII of the Social Security Act as proposed in S. 1620, relating to grants to States for medical care. A State plan must provide such methods of administration as are found by the Board to be necessary for the efficient operation of the plan. If the Board concludes that

the methods of administration proposed by the State are not sufficient for the efficient operation of the plan, the State is helpless.

Under title XIV of the Social Security Act as proposed in S. 1620, relating to grants for temporary disability compensation, the State plan must provide such methods of administration as are found by the Social Security Board to be necessary for the efficient operation of the plan (sec. 1402). From the judgment of the Board based on its statutory right to exercise its discretion, there is no appeal.

Furthermore, the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, and the Social Security Board are to be given the statutory right to withhold payments of any allotments that they respectively have made, the moment that any of them, after reasonable notice and opportunity for a hearing, conclude that the State is not conforming to the agreed plan, and from the decision of the officer or board interested, the State has no appeal (secs. 505, 515, 605, 1205, and 1305).

#### SICKNESS INSURANCE

S. 1620 clearly looks toward the establishment of sickness insurance. Its very title says that the bill is "A bill to provide \* \* \* disability insurance \* \* \*," and disability insurance is sickness insurance. The text of the bill goes further.

State plans under title V, part 1, relating to maternal and child-health services, must "provide for cooperation and, when necessary, for working agreements between the State health agency and any public agency or agencies related to the services furnished under the State plan, including public agencies concerned with \* \* \* social insurance \* \* \*" (sec. 503 (a) (7)).

State plans under title V, part 2, relating to medical services for children, must contain a similar provision providing for cooperation between State agencies and public agencies concerned with social insurance (sec. 513 (a) (7)).

The same is true with respect to State plans under title VI, relating to public-health work. Unless they provide for cooperation and, when necessary, for working agreements between the State health agency and any public agency concerned with social insurance, they cannot be approved by the Surgeon General (sec. 603 (a) (7)).

State plans under title XII, relating to grants to hospitals and health centers, must provide for cooperation and, when necessary, for working agreements, between the State agency furnishing services under this title and any public agency concerned with social insurance (sec. 1203 (a) (9)).

State plans under title XIII, relating to grants for medical care, must provide for cooperation and, when necessary, for working agreements between the State agency administering the plan and any public agency concerned with social insurance (sec. 1303 (a) (7)).

The methods of administration of medical care by any State agency, under title XIII, relating to grants to States for medical care, must be such as are found by the Social Security Board to be necessary for the efficient operation of the plan, including methods of establishing and maintaining standards of medical and institutional care and of remuneration for such care (sec. 1303 (a) (4)). In the exercise of its discretion it would apparently be within the authority of the Social Security Board even by a bare majority of a vote of a minimum quorum, to refuse to approve any plan that does not provide for remuneration for medical care through a system of health insurance.

#### ADVISORY BOARDS

S. 1620 is replete with mandatory requirements for the establishment of nondescript advisory boards of vague authority having no authority under existing law.

A State plan under title V, part 1, relating to maternal and child-health services, must "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" (sec. 503 (a) (5)).

The Chief of the Children's Bureau is to be authorized to establish an advisory council or councils, "composed of members of the profession and agencies concerned with the 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 part 1, title V, of the act]" (sec. 506).

A State plan under title V, part 2, relating to medical service for children and services for crippled and other physically handicapped children, must provide for an advisory council or councils, to be created by the State authorities (sec. 513 (a) (5)).

The Chief of the Children's Bureau is authorized to establish an advisory council or councils to advise her with respect to services for crippled children and otherwise handicapped children in need of special care, under title V, part 2 (sec. 517).

State plans under title VI relating to public-health work must provide for an advisory council or councils to be created by the State agencies operating under the act (sec. 603 (a) (5)).

The Surgeon General of the Public Health Service is to be authorized to establish an advisory council or councils similar to that described in the preceding paragraph (sec. 606). Under title XII, State plans relating to grants to States for hospitals and health centers must provide for an advisory council or councils to be created by the State authorities (sec. 1203 (a) (7)).

The Surgeon General of the Public Health Service is authorized, but not required, to establish an advisory council or councils to advise him with respect to carrying out the purposes of title XII, grants to States for hospitals and health centers (sec. 1206).

Under title XIII, relating to grants for medical care, State plans must provide for the creation of an advisory council or councils (sec. 1303 (a) (5)).

The Social Security Board is authorized, but not required, to establish an advisory council or councils to advise the Board with respect to carrying out the purposes of the title with respect to grants to States for medical care (sec. 1306).

The councils authorized must in general be made up of (1) members of the professions and agencies, public and private, that furnish services under the State plan and (2) other persons informed on the need for or provision of such services as are contemplated. The language describing the qualifications of membership in these councils may vary slightly but generally is expressed in such a general way as is just stated. There is no limit on the number of members in any one council. There is no limit on the term for which any member may be appointed. The bill makes no provision for the proportionate distribution of membership among interested professions and agencies and the public, leaving it always open to the appointing power to add to the membership of any council in order to influence its judgment. There is no limit on the number of councils that may be appointed. If one council does not give the desired advice, another can be appointed that will give such advice, even without displacing the first council. Since there is no language in the terms on which council members may be appointed, there would be grave danger that the councils would soon be encumbered with deadwood, made up possibly of members of distinguished social standing in the community and members of the professions, whom it would be undesirable to offend by removal or suggested resignation, but who will not resign on their own initiative. How the expenses of these councils are to be paid is not clear.

#### SUMMARY

##### I

Nothing in S. 1620 proposes to limit to financially handicapped States any of the benefits that it proposes to authorize. The bill proposes to authorize Federal subsidies to every State, whether financially handicapped or otherwise, on the condition that it submits certain of its activities and funds relating to health and medical service to the supervision and control of the Federal agencies named in the bill.

S. 1620 contains nothing that requires either the Federal agencies who are charged with its execution, or the State agencies collaborating with them in dispensing the benefits named, to limit its benefits to persons who are poor or who are in moderate financial circumstances. Such benefits may be dispensed to any person in need of them, but the bill leaves the determination of need to the officers dispensing the benefits and does not require that, in order to entitle a person to the benefits of the act, the need be both physical and financial.

## II

The enactment of this bill in its present form would call for substantial increases in State and Federal taxes, probably running sooner or later into hundreds of millions of dollars annually. Nowhere does the bill propose sources from which these taxes may be drawn. The actual levying of such taxes may be postponed for a while, by resorting to the borrowing of funds by the Federal Government and by such of the States as still have credit in the financial market. Sooner or later, however, the taxpayer must pay, with a corresponding handicap on business. In the end an amount equal to the taxes collected by the Government will, according to a widely accepted principle of taxation, be passed along by the taxpayer to the ultimate consumer, with a corresponding increase in the cost of living and, unless there is a radical and unpredictable change in economic conditions, with a lowering of the standard of living.

## III

S. 1620 is apparently directed toward a single end. The accomplishment of this single end, however, is to be entrusted to three branches of the Federal Government and to 50 or more State and Territorial agencies, each of which, Federal and State, is to be supplemented by an indefinite number of advisory councils. Nowhere in the bill is provision made for the intelligent correlation of these activities.

## IV

There is an obvious overlapping of the authority that S. 1620 proposes to confer on the Federal officers named in it. The Social Security Board is to dispense subsidies for medical care (sec. 1301). The Surgeon General of the Public Health Service, however, is to dispense subsidies for the control of tuberculosis and malaria, for the prevention of mortality from pneumonia and cancer, and for mental health, and for industrial hygiene activities, which certainly calls for the provision of medical care (sec. 601). The Chief of the Children's Bureau is to provide medical care during maternity and infancy, including medical, surgical, and related services, and facilities for diagnosis and after care (sec. 501) and medical care for all children (sec. 512 (a)). What constitutes a "child" is not defined in the bill, and medical care for "children" obviously comes within the general scope of the medical care authorized to be granted by the Surgeon General of the Public Health Service and the Social Security Board. Furthermore, the Social Security Board can approve no State plan for temporary disability compensation unless it finds that reasonably adequate medical services have been provided by the State for the beneficiaries of such compensation (sec. 1402 (b)).

The Surgeon General of the Public Health Service is to dispense Federal subsidies for the extension and improvement of public-health work (sec. 601). The Social Security Board, however, is likewise to dispense subsidies and provide services and supplies necessary for the prevention of illness and disability (sec. 1301), and in doing so must consider the special health problems of the State (sec. 1302). In determining allotments for maternal and child-health services, the Chief of the Children's Bureau must take into consideration the special problems of maternal and child health (sec. 502 (a) (3)).

The Surgeon General is to dispense subsidies for the construction and improvement of needed hospitals and to provide more effective measures in respect to such hospitals (sec. 1201-2). The term "hospital" includes health, diagnostic, and treatment centers, institutions, and related facilities (sec. 1200). The Chief of the Children's Bureau is to dispense subsidies to provide for mothers and children, facilities for diagnosis, hospitalization, and after care (sec. 501).

S. 1620 provides for the promulgation of rules and regulations by the Chief of the Children's Bureau, with the approval of the Secretary of Labor; the Surgeon General of the Public Health Service, with the approval of the Secretary of the Treasury; the Social Security Board; and each of the collaborating agencies of the 48 States and the Territories. So far as the bill shows, these rules and regulations may be promulgated without previous publishing, without consultation with anyone, or with only those persons whose views are known to coincide with those of the officials or board by which the regulations are to be promulgated. No provision is made for the promulgation of these regulations in a definite way, for their publication in stated publicity mediums, or for a waiting period after publication and before they become operative. Obviously, the bill affords ample room for confusion.

## CONCLUSION

It seems obvious that S. 1020 is not susceptible of amendment in a way that will bring about proper limitation and correlation of the benefits that it proposes to dispense. It does not assure efficiency and economy. It does not adequately protect the rights of the several States, not only with respect to the Federal subsidies that it is proposed to grant but also with respect to the use of the State moneys required to supplement those subsidies. There is no logical reason for insisting on providing Federal subsidies for States not in need of them nor for limiting Federal subsidies to the specific purposes named in this bill. Some method should be provided whereby any State whose people are in physical and financial distress and which is unable to provide necessary health and medical services for their relief can obtain Federal aid as a loan or as a grant, on proof of necessity.

The bill brings forward strikingly the need for the intelligent correlation of the health activities of the Federal Government under a single agency, if not under a department of health, then under a Federal health administration, commission, or board, made up of persons competent to administer such affairs.

**STATEMENT OF MILDRED SCHPEISER, AMERICAN YOUTH  
CONGRESS, NEW YORK CITY**

Senator MURRAY. Will you state your name, and identify yourself for the record, please?

Miss SCHPEISER. I am Miss Mildred Schpeiser, of Brooklyn, N. Y., a member of the public health commission of the American Youth Congress and am officially representing the American Youth Congress at this hearing.

The American Youth Congress is a federated organization of 63 national groups and 48 local federated youth councils. In total, the membership of Congress affiliates aggregate about 8,000,000 young persons. The American Youth Congress exists as a means of bringing together youth interested in one or more common problems.

In regard to the problems of health, there is complete unanimity throughout all affiliated organizations of the Congress.

Just for a moment, I should like to outline the history of organized youth's participation in matters of health, primarily to indicate that this current interest is no passing fancy but a long-time interest.

The American Youth Congress, through the chairman of its national council officially participated in deliberations of the National Health Conference last July. Prior to that time much activity in the field of public health and social hygiene had been inspired and coordinated by the Congress.

In July of 1937, 931 "senators" and "representatives" seated in the model Congress of Youth went on unanimous record in favor of adequate public-health facilities for the control of venereal diseases. With your permission, Mr. Chairman, we would like to have inserted in the committee record a copy of the record of the model congress, with special reference to pages 39, 77, and 78.

Senator MURRAY. It may be filed with the committee and the excerpts referred may be inserted in the record.

(The excerpts referred to are as follows:)

**SEX EDUCATION**

A resolution urging the United States Public Health Service to continue to expand its plans for bringing about enlightenment on sex problems among the youth of the country and their parents through the existing educational facilities.

Miss SCHPEISER. The following resolutions submitted by Major Johnson were then read:

1. Whereas the control of the venereal diseases as menaces to the public health is in large measure dependent upon the activities, personnel, and equipment of State and local health departments; and

Whereas these departments derive both their public health powers and the funds which enable them to exercise these powers effectively from their legislatures: Therefore be it

*Resolved*, That this congress recommend the passage by all States of law authorizing and requiring health officers:

#### EXAMINATIONS

1. To examine any person who they have reasonable ground for believing is infected with an infectious venereal disease and is likely to infect or be the source of infection of any other person.

#### TREATMENT

2. To require such infectious person to take and continue treatment for such disease (under quarantine if necessary) until no longer infectious.

#### DISPENSARIES

3. To establish laboratories and clinics for the free diagnosis and treatment of these diseases in all cases of infected individuals who may be indigent or otherwise unable to pay a physician or the cost of such laboratory service.

#### PUBLIC EDUCATION

4. To conduct campaigns of public-health education by the use of all methods and media of mass education concerning the dangers of these diseases and the necessity for public cooperation in their elimination.

#### EXPERT WORKERS

5. To secure and employ the trained and experienced personnel and equipment necessary to carry out these activities; be it further

*Resolved*, That this congress particularly recommend to the Federal Congress and to the legislatures of the several States that they appropriate the funds necessary to provide these personnel, services, and equipment and carry out these activities; be it further

*Resolved*, That the permanent social hygiene committee of the congress is hereby authorized to draft and promulgate as the act or acts of this congress, a bill or bills based on the principles herein approved, many of which are embodied in the public health law of the State of New York in sections 343-m-r inclusive of article 17-B.

#### PRE-MARITAL TESTS

II. Whereas a large number of young people, who have contracted syphilis and are either ignorant of that fact or believe that they are no longer infectious, marry and infect their marital partners and unborn children: Be it

*Resolved*, That this Congress recommends the passage by all States of laws which require both the male and female applicants for marriage licenses to present at the time of such application a statement, signed by a licensed physician, that such applicant has submitted to an approved laboratory blood test not more than (1540) 40 days prior thereto, and that, in the opinion of such physician such applicant is not infected with syphilis or in a stage of that disease that may become communicable, provided that such physician's statement shall be accompanied by a record of such laboratory test which shall be made by the State health department without cost to the applicant upon request of his physician; be it further

*Resolved* That the permanent social-hygiene committee of the congress is hereby authorized to draft and promulgate as to the act of this congress a bill based on the principles herein approved which are embodied in the present law of the State of Connecticut entitled "Marriage Licenses" (sec. 1505c P. A. 1935).

## SEX EDUCATION

III. Whereas the "institution of marriage and the family still constitute the foundation stone upon which the social structure rests in spite of the severe stresses and strains to which these institutions have been subjected by changing economic and social conditions;" and

Whereas the further disintegration of these sex-stabilizing institutions would, among other serious ill effects, materially increase the incidence and spread of the venereal diseases: Therefore, be it

*Resolved*, That this congress recommend the inclusion in secular or religious systems of education of courses of instruction for young people which are calculated to prepare and train them for successful marriage and parenthood.

Miss SCHPEISER. More than mere resolutions were passed. The congress set up a permanent health commission to carry out its instructions. The commission, of which I am a member, is still actively functioning.

Interest in health, especially in regard to the particular youth problems of syphilis, gonorrhea, and tuberculosis, has been widespread throughout youth groups in every part of the Nation. Without going into detail, I will merely point out that in schools, Y. M. and Y. W. C. A.'s settlements and unions—in youth groups of all types—interest has taken not only the form of meetings to discuss the problem, but action toward obtaining better facilities. More and more, attention is being given to conditions in each community, with a view to bringing action to meet the medical needs so obvious to all those who will see.

Prior to the National Health Conference, a leadership conference of the American Youth Congress met in Berea, Ohio, early in July 1938. In a lengthy report recommending youth-health activity, the Commission on Public Health stated:

Youth's common heritage is health, a personal matter, yet a community responsibility. We, and the people we represent, are the fathers and mothers of tomorrow. We must understand the workings of our bodies and the practicalities of modern medicine. It is essential to our future well-being that we insist upon the board availability of preventative medicine and treatment for all members of the community. It has been gratifying to the Public Health Commission to note the ever-widening recognition on the part of youth groups to the fact that the health of one's neighbor is as much a community responsibility as the health of one's neighbor's cow \* \* \*

We feel that the health of the people is the direct concern of the Government \* \* \*

These statements, and the definite recommendations which were made, were unanimously endorsed by the conference. We would like also, Mr. Chairman, to have this report inserted in the record.

Senator MURRAY. That may be inserted in the record.

(The matter referred to is as follows:)

EXTRACTS FROM YOUTH LEADERSHIP CONFERENCE, AMERICAN YOUTH CONGRESS  
PROCEEDINGS

Baldwin Wallace College, Berea, Ohio, July 2-4, 1938—Published by National Council, American Youth Congress, 12 West Thirty-second Street, New York City—Price, 15 cents

REPORT ON SESSION ON PUBLIC HEALTH

Reporter: Mr. Howard W. Ennes, Jr., Intercollegiate Newspaper Association, Washington, D. C.

Youth's common heritage is health, a personal matter, yet a community responsibility. We, and the people we represent, are the fathers and mothers

of tomorrow. We must understand the working of our bodies and the practicabilities of modern medicine. It is essential to our future well-being that we insist upon the broad availability of preventive medicine and treatment for all members of the community. It has been gratifying to the Public Health Commission to note the ever-widening recognition on the part of youth groups of the fact that the health of one's neighbor is as much a community responsibility as the health of one's neighbor's cow.

It is encouraging to find that much of youth understands that our major health problems—syphilis, gonorrhea, tuberculosis—know no race, creed, or social class distinction. It is significant to find, also, that youth recognizes treatment of these diseases to be restricted by color and social lines, and that youth feels that this condition must—and will—be remedied. Youth feels, we have found, that there is a youth health problem.

Let's consider this conference, for instance. We number about 200. Thirty-two or so of us will acquire either tuberculosis or syphilis before we reach 25. Of that number, one or two of us will die. Right now we are rather healthy. Perhaps some of us don't realize that the guaranteeing of that health now is fundamental. We probably will understand a few years from now when we see the ghastly end-results of syphilis, and the early deaths of tuberculosis. We are interested in peace, in labor organization, in security, in good-fellowship. None of these may be fully realized for the youth of America unless youth is in good health—and stays so. We must recognize and assume our responsibilities in health education and preventive medicine. It is not a very spectacular program, but it is almost an understatement to say that it is fundamental.

As immediate objective we recommend that the anti-syphilis campaign of the American Youth Congress as embodied in the resolutions of the Model Youth Congress in 1937 be the basis for extended national and local youth campaigns, on legislation for premarital and prenatal blood tests, establishment of laboratories and clinics for free diagnosis and treatment, and mass public health education, including the use of films, posters, exhibit material, radio, press, magazines and other material. Care must be taken, however, that the advice and supervision of competent medical and social hygiene authorities are always secured. Adult organizations in the community should be approached for their cooperation, and guidance; social hygiene and public health groups, the board of education, parent teacher associations must be involved in any real community effort.

Passage of the La Follette-Bulwinkle bill for venereal disease control puts \$3,000,000 into the States. Appropriations will go to those communities with a well organized set-up for carrying on a forward looking plan. Youth groups have the responsibility for seeing that some of this money comes into their communities and that this year's \$3,000,000 will be spent so effectively that appropriation of the \$5,000,000 will be assured for next year.

Our commission heard two presentations of tuberculosis as a youth health program which convinced us of our responsibility in this field as well as in syphilis control. Similar methods of work will be applicable. The Commission recommends that youth councils initiating a health program start with syphilis as a more dramatic approach for the average community; increasing the youth consciousness of health will render more effective the launching of a second health program.

Certainly key facts stand out in a tuberculosis program. We must look for adequate use of the tuberculin test, the X-ray, medical treatment, and hospitalization. For the health of the community it is imperative that open cases of tuberculosis be hospitalized; inadequate facilities is one of the greatest deterrents. Discrimination against Negroes, especially in the South, increases the gravity of both syphilis and tuberculosis among a group which already exhibits an abnormal morbidity and mortality rate.

Questions of prostitution, alcoholism, increasing use of marihuana, control of venereal diseases other than syphilis, and dental care were given cursory consideration at our sessions. We suggest serious study of these problems as related to the health of the youth of your communities as a preliminary to new methods of approach.

The National Social Hygiene Commission will have as its main tasks in the coming year:

1. Assistance in every possible way to local social hygiene work, based upon close cooperation by local groups with the Social Hygiene Commission.

2. Preparations for the model youth community based on recommendations embodied in this report in connection with 1930 Congress in New York City.

3. Cooperation with the Association of Medical Students and other groups in planning the model clinic and similar projects from the model youth community.

4. Cooperation on a permanent basis with commissions dealing with education, recreation, housing, crime prevention, marriage.

5. An important task of the Social Hygiene Commission will be investigation of the possibility of a national youth health conference during the coming year, perhaps as preparation for or on the third annual social hygiene day.

In discussing a health program for youth, we cannot ignore the National Health Conference being called by the Interdepartmental Committee to Co-ordinate Health and Welfare Activities in Washington on July 18, 19, and 20. The American Youth Congress has been greatly honored by receiving an invitation to this meeting which offers an unprecedented opportunity for service. We are here faced with the grave obligation of representing American youth before the medical and public health authorities of the nation. We feel that the health of the people is the direct concern of the Government. We commend to your serious consideration the following recommendations to be considered as the basis of our stand on the health program.

1. State and local legislation making compulsory complete premarital examinations for both partners, including a blood test for syphilis and chest X-rays for tuberculosis.

2. State and local legislation making compulsory complete prenatal examinations for pregnant women, including a blood test for syphilis and chest X-rays for tuberculosis.

3. Pre-school and subsequent complete physical examinations annually including a tuberculosis test and chest X-rays of all positive reactors.

4. Recognition on the part of labor, industry, and the community that the health of the employee is a joint responsibility and should be treated as such.

5. A comprehensive health education curriculum including sex education and adapted to every age group be adhered to throughout all schools, elementary through college.

6. Health education and sex instruction be made available to adults and adolescents not reached by formal education through the organized and unified efforts of local health departments, medical societies, welfare agencies, and health educators.

7. Improved housing facilities, proper nutrition, wholesome recreation, and better working conditions to help maintain health standards.

Miss SCHPEISER. Following the National Health Conference, the report of the national health program was widely circulated throughout youth groups. Invariably the response was in support of the five general points. In March of this year, the national council of the American Youth Congress voted to support Senator Wagner's bill which is now before this committee as the first step toward meeting the problems of the Nation's health.

During Independence Day week-end the American Youth Congress is sponsoring the "Congress of Youth" in New York City. An expected 2,500 young men and women, representing virtually every organized young person in the Nation, will map out a program of youth participation in the necessary cooperation leading to the culmination of the objectives of the national health program.

This brief outline of the activities of the younger generation would seem to indicate that we are interested in our health. That should not be surprising, but someone is always saying that youth has so much health it is likely not to think about it at all.

But if we know the facts about our health, we will think about it—and a lot. The American Youth Commission has put some of these facts together. This is what they say:

In a country where three-quarters of the school children examined have physical defects of one kind or another, where seven-tenths of the industrial workers under inspection suffer from physical ailments, and where in 1 year one-fifth of the young men applying for Army and Navy service were rejected because of

physical weakness, the health of youth is apparently an item of no mean significance. If such conditions obtain among the young, when vitality is at its height, the health picture of the whole population is one which cannot be too carefully scrutinized.

The implications of this statement are clear, and need no elaboration. We could cite more statistics, but we are in no sense here to attempt to discuss the problems of health in a technical manner. We are here merely as consumers—as persons who are concerned with the well-being of this Nation in the future—our well-being, in other words.

If we are to take the commencement speeches that are now being delivered as true, we are to be the leaders of tomorrow. That fact is becoming more and more valid. The ratio between young persons and old is changing. Youth is becoming fewer, and, consequently, more important.

It would appear to be good sense for us to be interested in our health, and for you gentlemen of this committee, and the public health officials, and, in particular, the members of the American Medical Association to also be concerned with preventing us from becoming a drain on the future resources of the United States by virtue of ill health which could be prevented by intelligent action today.

It is our feeling, as consumers and future citizens, that the five points of the national health program: (1) Expansion of general public health services for public health organization, for combating specific diseases, for maternal and child health services; (2) Expansion of hospital facilities; (3) Medical care for the medical needy; (4) A general program of medical care; (5) Insurance against loss of wages during sickness, represent a foundation upon which the health of our generation and yours can be solidly built.

It is our further feeling that S. 1620 represents a substantial step toward the digging, at least, of that foundation. We support the national health program and Senator Wagner's bill not merely out of the whole cloth of social justice. We are particularly concerned with the specific problems of health which apply to our own age group—tuberculosis, the venereal diseases, mental hygiene, heart disease, maternal and child health, and so forth. We identify ourselves with the entire spread of the population in this matter. We were children yesterday, youth today, adults and parents tomorrow. Our problems of health—as our other problems—are problems of all society.

We know that in a democracy, as a "coming-of-age" group which will sooner or later be in a position to enter into active participation in government, we have a stern obligation to become intelligently informed upon matters of social importance. As organized youth—8,000,000 strong—we are already especially concerned with this matter of adequate medical care, and many of us are not yet of voting age. We see this bill as the first step toward the goal. We hope it will be taken now. But if it is not, we are determined to make our voice distinctly heard, and our will distinctly felt, as soon as "time" opens the voting booth to the rest of us.

Senator MURRAY. Thank you. Dr. Cary, you may go ahead.

Dr. CARY. I have the pleasure of presenting Dr. Charles C. Lund, of Boston, who speaks for the Massachusetts Medical Society.

**STATEMENT OF DR. CHARLES C. LUND, MASSACHUSETTS MEDICAL SOCIETY, BOSTON, MASS.**

Dr. LUND. Senator Murray, my name is Charles C. Lund, and my home is in Boston. I am chairman of the committee on State and national legislation of the Massachusetts Medical Society.

The council of the Massachusetts Medical Society, which is our legislative body, has not met to consider the Wagner health bill, Senate 1620. However, the committee on State and national legislation has given the bill very serious consideration and has authorized my appearance to discuss this bill.

I might say, however, that the vote that sent me here was not unanimous. There were some members of the committee who felt that it was not a proper function of the committee to appear at this hearing.

Senator ELLENDER. It was not due to opposition to the bill then, was it?

Dr. LUND. It was due to opposition to the bill.

Senator ELLENDER. What was the vote?

Dr. LUND. The vote was 3 to 2, with myself present as chairman, and I did not vote, so it was actually 4 to 2, because I could have tied it up and kept myself away.

Senator ELLENDER. On what?

Dr. LUND. On whether I came down here to present this material.

Senator MURRAY. That was in the committee?

Dr. LUND. That was in the committee.

Senator MURRAY. The committee on State and national legislation?

Dr. LUND. Yes, sir.

Senator WAGNER. How many members are on the committee?

Dr. LUND. Six.

Senator WAGNER. What is the membership of your organization in the State?

Dr. LUND. Roughly, 5,000.

Senator WAGNER. You are here representing that organization?

Dr. LUND. I am here representing that organization but without specific instructions from our policy-making body, which is the council of the society.

Senator WAGNER. Then you are speaking really for 4 out of the 5,000 members here?

Dr. LUND. No; I am a member of an official committee of the society that, according to our bylaws, is given the duty to look into legislative matters. I wish I had the bylaws. Would you like to see them?

Senator WAGNER. No, no. I was trying to get an idea as to how many you actually represented here.

Dr. LUND. Under the bylaws it is our duty to oppose legislation which is felt to be unsuitable, and introduce and sponsor legislation which is deemed to be suitable for the profession and the public.

Senator WAGNER. What is the membership of that committee?

Dr. LUND. Six men.

Senator WAGNER. Six men?

Dr. LUND. Yes, sir.

Senator WAGNER. That is what I was trying to find out.

Dr. LUND. Yes.

Senator WAGNER. Those 6 men passed on this legislation without consulting the other 5,000?

Senator MURRAY. They were authorized to do that under their constitution.

Senator WAGNER. I understand that, but the other 5,000 did not discuss the details of this legislation at all. Is that correct?

Dr. LUND. That is correct.

Senator WAGNER. The attitude of the 5,000 members of the society in regard to this legislation was determined by this committee of 6?

Dr. LUND. Yes.

Senator WAGNER. Was that Committee of Six unanimous in opposing the legislation.

Dr. LUND. We were unanimous in opposing the legislation in its present form.

Senator WAGNER. You were not opposed to health legislation?

Dr. LUND. We were not opposed to some kind of health legislation.

Senator WAGNER. All right. Thank you.

Dr. LUND. At the present time the United States Government, in one way or another, is carrying on or aiding medical activities through a great multitude of bureaus and departments. These activities operate under a great mass of diverse laws and regulations and are not always well coordinated. President Roosevelt has, with the consent of Congress, just made a step of fundamental importance that has met with widespread approbation even in New England. That step is the regrouping of several agencies of the Government. Is it too much to expect that the majority of the present Federal medical activities (except the Army and naval service), and all future ones if new ones are created, shall be placed together? We realize that there were probably sound reasons to explain how the present complex situation arose, but is such a situation still sound? The greatest defect in the bill is that it not only perpetuates overlapping of medical activities in separate departments, but even adds to overlapping by giving the Social Security Board new and widespread medical functions.

How cumbersome this proposed situation is may be seen by the authorization in the bill of 245 and more State and Federal advisory councils (not counting those for District of Columbia, and so forth). Now the advisory council idea is, per se, excellent. But there should be one Federal council and one council for each State and Territory—not five for each. Also, these councils should be created at once and given the broadest possible advisory powers, so that they would have under their consideration any medical problem arising in connection with any governmental activity. The councils should be so constituted that the medical profession and the public are both adequately represented. Our State health department is well run by such a council.

The provision in the bill that gives the Federal Government the power to refuse grants to States that do not have a merit system of appointment and promotion in the departments spending the grants is, in our mind, very good and one of the most important provisions of the bill. Of course, we don't want any more interference in our local affairs than is necessary. But we feel that we have a right to

be assured that any Federal funds spent on the care of the needy will not pass through the hands of inefficient political appointees.

In this connection, we have another suggestion. One item in the cost of illness is the cost of medical care of totally needless illness. We in Massachusetts naturally object to paying for the care of such patients either in our own or any other State. It would not require any Federal funds for every State to abolish smallpox. The methods of doing this have been available for years. The cost is low and well within the possibilities of budgeting by the poorest States. Nevertheless, why was the average incidence of smallpox in this country 7,600 cases per year from 1933 to 1937, inclusive? Purely because the responsible officials and the public have either failed to see that the proper control laws have been passed by their legislatures or they have not enforced their laws. We suspect that either the educational, political, or public health organization in these States is of such a nature that subsidized medical care might not be appreciated or efficiently utilized.

## SMALLPOX

*Cases during a 5-year period and annual rate per 100,000 population by type of vaccination laws, 1933-37*

	Cases	Rate		Cases	Rate
<b>States with compulsory vaccination:</b>			<b>States with local option—Con.</b>		
Massachusetts.....	0	0	Colorado.....	973	18.28
Pennsylvania.....	0	0	Oregon.....	1,466	29.08
Rhode Island.....	0	0	Total, 14.....	6,460	-----
Maryland.....	1	0.02	Cases per year.....	1,292	3.43
New Hampshire.....	2	.08	<b>States without compulsion:</b>		
District of Columbia.....	4	.14	Delaware.....	1	.08
New York.....	189	.30	Vermont.....	3	.16
Virginia.....	61	.46	Michigan.....	268	1.26
South Carolina.....	84	.62	Arizona.....	40	1.96
Kentucky.....	184	1.08	Oklahoma.....	512	4.08
West Virginia.....	110	1.22	Illinois.....	1,773	4.64
Arkansas.....	482	4.82	Nevada.....	29	5.85
New Mexico.....	103	4.88	Indiana.....	1,022	6.96
Total, 13.....	1,190	-----	California.....	2,402	8.02
Cases per year.....	238	0.57	Utah.....	260	10.10
<b>States with local option:</b>			Minnesota.....	1,729	13.14
Maine.....	0	0	Missouri.....	2,685	13.22
New Jersey.....	0	0	Wisconsin.....	2,828	19.42
Florida.....	25	0.3	Kansas.....	2,126	22.64
Connecticut.....	29	0.35	Iowa.....	3,162	24.96
North Carolina.....	109	0.64	North Dakota.....	1,096	31.32
Georgia.....	119	0.78	Washington.....	3,029	37.10
Tennessee.....	168	1.18	Nebraska.....	2,583	37.88
Ohio.....	467	1.40	South Dakota.....	1,515	43.78
Alabama.....	211	1.48	Idaho.....	1,076	44.92
Mississippi.....	166	1.66	Wyoming.....	798	68.62
Louisiana.....	212	2.00	Montana.....	2,487	92.92
Texas.....	2,515	3.28	Total, 22.....	31,332	-----
			Cases per year.....	6,266	14.1

Now, we want to discuss a purely financial question that we know is uppermost in the minds of many doctors who criticize this bill vociferously. That is, where is the money coming from to pay the bills? Only a few doctors start to practice medicine with any capital except what they have invested in their education. They expect to save money and invest it for their old age, if they can. The immediate effect of this bill would probably be to increase the incomes of some doctors. That, of course, would be of immediate benefit for

them. But doctors are trained to look beyond immediate results in all their work. Here they look at a government that has been going "into the red" for many years. They realize that much of the increase in debt was not to be avoided. Insofar as the enactment of this bill may increase the expense of Government, it will further the tendency to inflation that many people think is steadily in progress. What the doctors wonder, and in this they are like millions of other Americans, is what their savings will be worth some years from now? The doctors would look with more favor on a bill that went much more slowly and which did not contain in any place the rather frightening phrase "such sums as may be needed to carry out the purposes of this title," coming as it does repeatedly, after the mention of sums, which, while they may not be very large in the national economy, seems enormous to the individual citizen.

There are wide discrepancies among various estimates that have been made as to the number of people who for financial reasons now do not obtain medical care. Everyone admits that the group that most needs to be provided with medical care is that group which has no appreciable income on which to exist. We suggest that before starting to furnish Federal aid for the medical care of all employed people, medical care to be furnished under the bill be limited to the indigent and the medically needy.

We do not mean to say by that that there are not many employed people whose rate of remuneration is so low that it would be impossible for them to purchase medical care. That is not expressed in this, so I would like to add a little on that subject. The destitute person can pay for no medical care, no matter how simple, but there are people with higher incomes who can pay for a little medical care but not for all medical care, and there is no way that I know of by which one can set a flat figure below which one should have aided medicine and above which one should have nonaided medicine, but actually in a place like Boston, where I work, where there is plenty aided medicine available, many, many people go for little things to the family doctor and when they come to have an expensive operation they go to one of the nonprofit hospitals, or one of the very fine Boston city hospitals.

If the lowest estimate of the numbers of medically needy and indigent persons is correct it will be a very small matter to correct—but, if the highest estimate is correct, the problem is so enormous that it will take all the possible available resources in money and trained men, without at the same time taking on the other even greater problem of aiding in the care of those who are better off.

In regard to that, there seems to be no absolute limitation in this bill about giving medical care to people who actually cannot afford it. Now, what I mean by that is this: I studied this bill very carefully, I spent many hours on it, and I do not think it is the intention of the writers of the bill. If you will look at the opening of title XIII, "for the purpose of enabling each State, as far as practicable under the conditions in such State, especially in rural areas and among individuals suffering from severe economic distress." That word "especially" does not prevent people not in severe economic distress from being given aid, to my mind. I may be wrong about that.

Senator ELLENDER. What would you suggest, Doctor, so as to make it possible that none but the indigent, those that cannot really pay, will come under the act? After all, that is what we are trying to do, as I understand it.

Dr. LUND. Well, I would say "indigent and medically indigent." I could not give you any definition here now as to the limits. The limits would vary. One hundred dollars is worth more in one place than another. I mean you would have all sorts of variations.

Senator WAGNER. A major objective of the bill is to aid those in economic distress.

Dr. LUND. It is my thought "especially" does not rule out giving money to other people. That is particularly important with page 42.

Senator MURRAY. I would like to have you give me the language as it appears in the bill.

Dr. LUND. Lines 22, 23, and 24 on page 34, "for the purpose of enabling each State, as far as practicable under conditions in such State, especially in rural areas and among individuals suffering from severe economic distress".

Of course, you could use these same words, without changing any words, by changing the order there. If you said "under the conditions in such State among individuals suffering from severe economic distress, especially in rural areas." I would not object to that phrase.

Senator ELLENDER. That is just a reconstruction of the sentence. I am with you on that suggestion.

Senator WAGNER. It is very refreshing, Doctor, to have somebody come in with suggestions.

Dr. LUND. That is not the only defect in the bill.

Senator ELLENDER. Doctor, what do you think of this suggestion? Usually, as I understand it, in States where medical aid is provided to the indigent, those who really cannot afford it, it is left to the doctor to certify to the fact of inability to pay. In Louisiana we have a statute which makes it, in a measure, mandatory on the physician to state whether or not the person who is sent to a State hospital is able to pay for medical care or not. If the doctor should say that he is not, an investigation can be made, but the word of the doctor is usually taken, and then he is admitted. If the certificate from the doctor should not be obtained, the patient must go to a pay hospital. Now, would you think that would be a good method of determining who should be admitted to hospitalization?

Dr. LUND. I do not see how the doctors can complain about a method of that kind, except we all know human nature, we know that it is not perfect.

Senator ELLENDER. I am asking you.

Dr. LUND. That would be a matter for doctors to correct among themselves. If a doctor was sending patients to the public hospital who really should not be there, well, perhaps the doctors could take care of it. I do not see how the medical profession could object to such a system.

Senator ELLENDER. What I had particularly in mind, Doctor, was to devise some method of separating those who could pay from those who could not.

Dr. LUND. Yes.

Senator ELLENDER. And that burden could be left on the shoulders of the doctor treating the patient, as to whether or not any hos-

pitalization was necessary and as to whether or not the patient can pay.

Dr. LUND. It is not always perfect. There are many admissions to the hospitals in Massachusetts that are made on that same basis.

Senator ELLENDER. Can you suggest any other method or can you tell us the method that is applied in Massachusetts to separate those that are able from those unable to pay for medical care?

Dr. LUND. I do not know any other that is as good as that. I know some others, but they are not as good as that, from my standpoint.

Senator MURRAY. That would confine it exclusively, then, to the judgment of the doctor who had the patient?

Dr. LUND. Yes.

Senator MURRAY. Would it not be better if there was a committee composed of experts who would be of assistance in determining the financial ability to pay in addition to the doctor?

Dr. LUND. I would not say that that is the best possible system. I would not want to make a definite statement on that.

Senator ELLENDER. I would have enough confidence in the medical profession to say that the doctor would probably be the best judge. Usually the doctor knows most of his patients living in a certain community and he can very well tell whether they are able to pay for medical aid.

Senator MURRAY. They tell me frequently that doctors have no financial judgment at all, that they are the greatest suckers in the country when it comes to buying securities.

Senator ELLENDER. That is for themselves but not for others. [Laughter.]

Dr. LUND. I am not sure that the second statement is correct. I have only one more section before I come to the summary. I am going to talk on that, because the statement I have prepared here is a little bit short.

In Massachusetts for the last 5 years the adjusted death rate in Massachusetts for women has been decreasing, and it has decreased to an appreciable statistically valid extent. The death rate from cancer in Massachusetts for men has leveled off for the same period of time, but has not yet begun to decrease. This may seem far from the Wagner bill, but I will bring it into connection with the Wagner bill in just a minute.

Massachusetts is the only State in the Nation where that decrease is to be found, and there is no foreign country that has had the same experience. Cancer rates are still going up, even when they are adjusted—and by “adjusted” I mean adjusted for the age distribution of the population.

Now why did that happen? Twelve years ago the State of Massachusetts, through the health department, formed a State cancer hospital and State-aided cancer clinics, and following that the increase in rate slowed down, but no decrease took place.

Now, along about 5 years ago another development took place, and that is the development in conjunction with the doctors in Massachusetts, where they have gone in for the education of the public on the subject of cancer in a rather extensive way. Every women's club in every town in the State has been contacted, and it has been suggested to them that they hold meetings at which lectures on cancer are given. The clubs are not encouraged to use specialists from

Boston, New York, Hartford, or Springfield, or other cities, in the field of cancer; they are asked to get their own family physicians in the towns to give these talks.

Now, some of the doctors say, "Well, I do not know enough to give a talk of that kind," but they do not get out of it as easily as that, because then the club informs them that the Medical Society and State department have together prepared material from which to give their talk. We do not send out a prepared speech, but we send them the background of valid cancer information. The doctor studies the material and gives his speech, and, by and large, those speeches are successful.

Until this part of the program began, the duration of time from the time the patient first noticed any symptom or sign of cancer to the time he applied for medical aid was too great, and in spite of the treatment facilities the situation was still getting worse, but following this spreading of information the time interval from onset of symptoms to beginning of treatment has gone down about 1 month per year on the average—well, not as much as that, but it has been going down, so the patients are coming earlier.

I mention that, because we firmly believe that cooperation between every single medical man and State and national health departments is one of the most important ways for development of better health.

This does not mean there would not be other things in the Wagner bill that might be discussed. There is plenty of that Senator Wagner, but I do not want to take all the afternoon.

I make a plea for cooperation between the doctors and the Government. In Massachusetts a most remarkable thing has happened. The adjusted death rate for cancer in women has been decreasing for 5 years and the rate for men has become level. This is the only State in the Union where this has occurred, and it has not occurred in any foreign country. This has been accomplished by the simultaneous use of two means. First, the establishment of State-aided cancer clinics about 12 years ago helped a little. But during the first few years of operation of the clinics there was no decrease in the elapsed time from the onset of the cancer to first treatment of it, which is the most important factor in controlling an individual case.

Secondly, for 5 years, the State department of health has been promoting the education of the public in an original manner. Women's clubs are stimulated to ask for lectures on cancer. They are encouraged not to go outside their town in search of an expert, but to invite one of their general practitioners. If the doctor feels he is not prepared to give such a talk, he is provided with suitable material prepared for him by the Massachusetts Medical Society and the State department of health. This serves two purposes: One, it educates the public; and, two, it educates the doctor. The cases are now coming in months earlier and the results improving steadily.

#### SUMMARY

If Federal legislation is to be enacted concerned with the public health, it should be directed toward the following objectives:

1. Unification of most of the present medical services of the Federal Government, except for the Army and Navy services. All future Federal medical activities should be added to this group.

2. Representative medical advisory councils to work with the Federal and State medical officers.

3. Expansion of activities where clear evidence of need for expansion is proven.

4. Support of existing recognized hospitals, rather than building new governmental ones for the care of the indigent, thus reducing the number of vacant hospital beds instead of increasing them.

Senator WAGNER. Unless there is a definite need shown for a hospital the funds will not be forthcoming. That is the definite test. Do you think of any other test that ought to be provided for?

Dr. LUND. Well, at the opening of my statement you asked me whether I was giving the opinion of only four members of the society. In my official capacity, I try to keep in touch with all the various currents of opinion in the society, and I must say there was a very widespread opinion, probably founded on erroneous grounds, that it looked to these doctors as if the Government was going to plant hospitals all over Massachusetts. Now, there is only one town in Massachusetts that is 50 miles from the hospital, and that is Provincetown, on the tip of Cape Cod. Most people in Massachusetts are very close to hospitals. The doctors do not see anything in this act that, to their minds, clearly enough avoided the building of hospitals in unnecessary places.

Senator WAGNER. Of course, all you can do, it seems to me, if any hospital is required in any section of the country, is to provide a need test. I do not know any other way of avoiding the construction of a hospital that is not needed in a particular community. It is to compel the community to establish the need for the new hospital.

Dr. LUND. I will agree with that, but there is the other angle, and that is that certain of the existing hospitals are having an awfully hard struggle financially, and if you are going to build a fine unit to take care of four or five counties in Georgia which have no hospital within a radius of quite a distance, the doctors wonder why there could not be some other system in places that have reasonably good hospitals, whereby funds came down through the Government in some way and paid for some of the care of the indigent in those hospitals.

Senator ELLENDER. In that connection, how many hospitals are there in Massachusetts that are State-maintained, entirely State-maintained? Are there any?

Dr. LUND. There are a great many insane asylums.

Senator ELLENDER. I am talking about general hospitals.

Dr. LUND. There are none for acute illnesses; there is more than one for chronic illnesses.

Senator ELLENDER. Are they county or municipal hospitals?

Dr. LUND. Municipal.

Senator ELLENDER. Does the State provide a fund out of which help is afforded to the indigent for hospitalization in these private hospitals?

Dr. LUND. I do not know.

Senator ELLENDER. If you do not recall it, what would you think of this suggestion, that in the State plans that may be submitted to the Federal Government for assistance, instead of building hospitals in a particular locality the department of state that would have the duty of distributing the funds would be authorized to pay a certain

amount, say \$2.50 to \$3, whatever the rates per day are, for a bed or a room in a private hospital, per indigent person entitled to hospitalization?

Dr. LUND. I think that is what the Medical Association has in mind in its statement, in which it says "support of existing hospitals." I am sure that that theory is the one which would meet with the most approval among the members of my own society.

Senator ELLENDER. What would be the average cost, do you think, per day for a hospital room in your State? Would you have any idea?

Dr. LUND. In Massachusetts?

Senator ELLENDER. Yes.

Dr. LUND. Yes. I am not very familiar with all the hospitals, of course, but I would say they vary from \$4 to \$6 a day, in a good general hospital.

Senator ELLENDER. What service does that include besides room, board, and bed?

Dr. LUND. All services. That is without paying the physician.

Senator ELLENDER. That is what I want to bring out. Say it is from \$4 to \$6. I can conceive that in many localities it might be cheaper for the State, as well as the Federal Government, to pay a rental of, say, \$4 or \$5 a day per room, rather than build a hospital. That may be more profitable, as it were, or a better way to serve the indigent.

Dr. LUND. I think we would agree heartily with you on that point.

Senator WAGNER. Doctor, as to the need of hospitals, I would like to get your comment on this: We had a witness before us here, a Mrs. Ahart, who is the president of the Associated Women of the American Farm Bureau Federation. They are organized in 40 States, and they have a membership of over half a million farm women. In her testimony she said:

Agricultural States hold up well in contrast to the great Eastern centers where the decline in birth rate is startling. 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 of 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.

That is part of her testimony. Does not that indicate that there is need for greater medical care, particularly in the rural sections of our country? This lady speaks with some authority, because, in the first place, it was as the result of surveys made, and then she is the head of this large farm organization. That sort of thing, it seems to me, stimulates our desire to bring better medical care to these communities, so as to save these lives, if we can.

Don't you agree, Doctor, that while the initial expenditure may be a little large, may seem large to you, are not we, by improving

health and preventing disease, ultimately going to economize from such activities?

Are not we, in the long run, going to reduce tremendously the cost of protecting health and providing medical care?

Dr. LUND. Anything that prevents disease is certainly what doctors want, what we believe in, and I agree with you 100 percent. Of course, some of our doctors disagree as to whether certain schemes will carry out what is expected.

Senator WAGNER. I was going to emphasize, there is need in sections where medical care is inadequate.

Dr. LUND. I do not know any doctor who would deny that statement. The question is a matter of degree.

Senator WAGNER. It is a matter of degree.

Senator ELLENDER. Doctor, with further reference to these costs, you said the costs ran from \$4 to \$6. That included the room, the bed, the board, and the general nursing services, but not the services of a physician. Suppose a person was sent there for an operation, what additional costs would there be attached, say, for the operating room, the anesthetics, and things of that kind? What is the usual run of such costs in Massachusetts?

Dr. LUND. In the hospitals that take care of that kind of people it is usually \$10 and sometimes \$5.

Senator ELLENDER. For both the operating room and the anesthetic?

Dr. LUND. The operating room, I mean, is \$10 or \$5. What was the other part of the question?

Senator MURRAY. Anesthetics.

Dr. LUND. Usually \$5. I am talking now about the charity hospitals; I am not talking about the private hospital.

Senator ELLENDER. Dr. Cary, what I wanted to ask you—it may be possible that Dr. Fishbein may be able to furnish for the committee the average rate of cost at these private hospitals. I wonder if the Medical Association has any figures on them?

Dr. CARY. Yes, sir; we have plenty of figures.

Senator ELLENDER. Would you kindly send some to us, taken from various parts of the country?

Dr. CARY. We would be glad to furnish you with that information from various parts of the country.

Senator ELLENDER. Just the average. Thanks.

Dr. CARY. Yes.

Senator MURRAY. Thank you, Doctor.

Dr. O'HARA of Louisiana.

(The information referred to above was furnished to the subcommittee and is as follows:)

**HOSPITAL RATES FOR WARD, SEMIPRIVATE, AND PRIVATE ROOM ACCOMMODATIONS  
ARRANGED ACCORDING TO COUNTIES AND STATES**

Compiled by the Bureau of Medical Economics, American Medical Association

**HOSPITAL CHARGES IN THE UNITED STATES**

In the American Medical Association Study of Need and Supply of Medical Care, the second section of the fourth question in the forms asking for information concerning hospitalization reads as follows: "What are your daily rates for hospital care in: Wards \$—— per day; semiprivate accommodations \$—— per day; private rooms \$—— per day." The instructions of this

were: "The second part of question 4 asks for the daily rates, and not for costs. If more than one rate is charged in each of the three classifications, list all such charges."

The reports from various hospitals, if there were more than one reporting in each county, were assembled and listed with the highest and the lowest rates reported for all hospitals combined for ward, semiprivate, and private care. The figures given herewith are taken from these summary sheets of the county medical societies. Returns were received from 1,258 hospitals in 873 counties. Not all of these hospitals reported their rates, but the reports were sufficiently comprehensive to give what is probably the most accurate sample of hospital charges ever assembled in the United States.

State and county	Ward	Semiprivate	Private
<b>Alabama:</b>			
Coffee.....		\$3.00	\$3.50-6.00
Etowah.....	\$1.50-2.50	\$3.00-3.50	5.00-6.00
Jefferson.....	1.50-3.00	2.25-4.00	3.00-10.00
Limestone.....	3.50		6.00-6.00
Macon.....	2.00	2.14	3.00
Marengo.....	3.00	3.00	3.00
Mobile.....		2.40	2.90
Montgomery.....	1.50-3.00	1.50-4.00	3.00-6.00
Tallapoosa.....	1.00-2.00		3.00-4.00
Walker.....	2.00-2.50	3.50	5.00-6.00
<b>Arizona:</b>			
Gila.....	3.00-4.00		3.50-5.00
Yavapai.....	2.00-4.00	4.00	5.00-8.00
<b>Arkansas:</b>			
Arkansas.....			5.00
Benton.....	2.50-5.00		
Chicot.....	2.50-3.00	4.00	5.00
Clark.....		3.00	5.00
Cleburne.....	2.50	3.00	5.00
Desha.....	2.50		5.00
Draw.....	5.00	5.00	15.00
Franklin.....			3.00
Garland.....	3.30		5.00
Hempstead.....		3.00	4.00-5.00
Independence.....	3.50	4.00-5.00	5.00
Nevada.....			4.50
Ouachita.....	3.00-3.50		4.00-7.00
Pope, Yell.....	2.50	3.00-3.50	3.00-5.00
Pulaski.....	2.00-3.00	3.00-3.50	3.50-8.00
Sebastian.....	2.00-2.50	2.50-3.00	3.00-5.00
Union.....	2.50-3.00	3.00	3.50-5.00
California: Sacramento.....	4.50-4.60	5.00-6.00	5.00-10.00
<b>Colorado:</b>			
Baca, Kiowa, Prowers.....	3.50		5.00
Bent, Otero.....	2.50-3.50	2.50-4.00	3.50-5.00
Boulder.....	2.50-3.50	4.00-4.50	5.00-7.00
Cheyenne, Lincoln, Kit Carson.....		2.50-3.50	3.50-5.00
Delta.....		3.50	4.25
Eagle, Garfield, Rio Blanco.....	3.00-4.00	3.50-4.00	5.00
Grand, Moffat, Routt.....	2.50-3.00	2.50-3.00	2.50-5.00
Jefferson.....	2.00-2.50		
Lake.....	1.00-2.50	3.00	4.00-5.50
Larimer.....	3.50	3.50	4.00-6.00
Logan, Phillips Sedgwick.....	2.50-2.75	3.00	3.00-5.00
Mesa.....		2.00-3.50	5.00-6.00
Montrose.....	2.50-3.50		3.00-5.00
Morgan.....		2.50-3.00	4.00
Pueblo.....	2.50	3.00-4.00	5.00-7.00
Washington, Yuma.....		2.50-4.00	
Weld.....	2.50-3.00	3.50	3.50-6.75
<b>Delaware:</b>			
Kent.....	1.00-3.00	1.00-4.00	5.00
New Castle.....	3.00-3.50	4.00-5.00	5.00-8.00
Sussex.....	1.00-3.00	1.00-4.00	5.00
Georgia: Taylor.....		3.00	5.00
<b>Florida:</b>			
Broward.....	4.00	6.00	7.00-10.00
Lee.....	4.00	4.00	6.00-7.00
<b>Idaho: Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, Twin Falls.....</b>	2.50-3.00	3.00-3.50	5.00-6.50
<b>Illinois:</b>			
Cook.....	1.75-5.00	2.50-7.50	3.75-25.00
Greene.....		3.00	4.00
Knox.....	2.50	3.00-4.00	3.00-6.00
Ogle.....		3.00	4.00-5.00
Perry.....	2.75-3.00	3.50	4.00-5.50

1 Includes laboratory work and medicines except expensive serums.

2 Per capita cost—none pay.

State and county	Ward	Semiprivate	Private
<b>Indiana:</b>			
Allen.....	\$3.00	\$3.50-\$4.00	\$4.00-\$8.00
Jackson.....	2.50		3.00-4.75
Knox.....	1.45-2.15		3.25-4.30
Lagrange.....	2.50		
La Porte.....	2.50-3.50	2.50-3.50	2.50-6.45
Marion.....	1.00-3.50	3.00-5.00	5.00-15.00
Putnam.....	3.00		4.00-5.00
Randolph.....		2.50	4.00-5.00
St. Joseph.....	2.25-3.50	3.00-4.00	4.00-8.00
Shelby.....	3.00-4.00		5.00-7.00
Vanderburg.....	2.00-3.00	3.00-4.00	4.00-6.50
Vigo.....	2.50	2.50-3.50	3.00-7.50
<b>Iowa:</b>			
Audubon.....	2.15		
Black Hawk.....	2.00-2.75	2.25-2.75	2.75-7.00
Bremer.....		2.50	3.50-5.00
Chickasaw.....		2.50-3.00	3.50-4.50
Des Moines.....	2.50		3.50-6.00
Dickinson.....	3.50		5.00
Floyd.....	3.00		4.50-5.00
Hancock, Winnebago.....	2.80-4.00	3.50	4.50-5.00
Jefferson.....	2.50	2.50	4.00
Jones.....	2.50		4.00
Washington.....	3.00	3.50	4.00-5.00
Winnechek.....	2.00-3.00	3.00	3.00-5.00
Woodbury.....	2.50-3.00	2.50-3.50	3.00-5.00
<b>Kansas:</b>			
Allen.....		2.85	3.50
Anderson.....	2.25	3.00	4.00
Barber.....		2.00-2.70	3.00-4.00
Bourbon.....	2.50	3.00-3.50	4.50-5.00
Clark.....	3.00	3.00	4.00
Labette.....		3.00	3.50
Leavenworth.....	2.50	3.00	4.00
Marion.....	2.00	2.00-2.75	2.15-3.00
Morris.....			2.00-3.50
Pratt.....			2.00-5.00
Reno.....		2.00-3.00	3.00-5.00
Sherman.....	3.50		4.50-5.00
Sumner.....	3.00	3.50	4.00-7.00
Wyandotte.....	2.00-2.50	2.50-3.00	3.00-7.00
<b>Maryland:</b>			
Allegany.....	1.50-2.00		
Anne Arundel.....	2.00-2.50	3.00-4.00	5.00-6.00
Baltimore.....	2.50	5.00	5.00
Baltimore City.....	1.00-3.50	3.00-5.00	3.00-13.00
Calvert.....	1.00-2.00	2.00-2.50	3.75-4.00
Cecil.....	1.00-2.50	3.00-4.00	4.00-6.00
Dorchester.....	2.00		4.00-6.00
Frederick.....	2.00-3.50	4.00	5.00-10.00
Montgomery.....		6.00-7.00	8.00-10.00
Prince Georges.....			5.00-8.00
St. Marys.....		1.50-2.00	3.00-4.00
Somerset.....	2.50	2.50	4.00-6.00
Talbot.....	2.50		4.00-7.00
Washington.....	2.00	3.50	5.00-6.00
Wicomico.....	2.00	4.00	5.00-6.00
<b>Massachusetts:</b>			
Barnstable.....	1.00-3.57	1.00-5.00	1.00-10.00
Berkshire.....	3.00-3.50	3.50-4.00	5.00-12.00
Hampshire.....	2.00-2.50	3.50-4.75	5.00-7.00
Middlesex (South).....	2.14-5.50	2.50-6.00	3.57-15.00
Middlesex (North).....	2.00-2.50	3.00-3.50	4.00-8.00
<b>Michigan:</b>			
Alger, Marquette.....	2.14-2.57	2.14-3.25	3.00-5.75
Antrim, Charlevoix, Cheboygan, Emmet.....	2.50	3.00	4.00-7.00
Calhoun.....	3.50-3.75	3.50-4.25	4.00-10.00
Dickinson, Iron.....	3.50		5.00
Ingham.....	3.50	4.00	5.00-10.00
Lenawee.....	3.00-3.50	3.00-4.00	4.00-5.00
Lucas.....	3.50	4.00	
Menominee.....	1.50-2.30	2.50-2.60	3.00-5.00
Midland.....	3.50	4.00	5.00
Oakland.....	2.00-5.00	3.00-5.50	3.00-7.00
Ottawa.....	3.00	4.00	5.00
Saginaw.....	3.00	3.50	4.00-8.00
Shiawassee.....		3.50-4.50	5.00-6.00
Wayne.....	3.00-4.50	3.50-6.50	4.50-15.50

State and county	Ward	Semiprivate	Private
<b>Minnesota:</b>			
Aitkin, Beltrami, Cass, Clearwater, Crow Wing, Hubbard, Koochiching, Lake of the Woods, Morrison, Todd, Wadena	\$2.75-\$3.50	\$2.50-\$3.50	\$3.00-\$5.00
Anoka, Chicago, Isanti, Kanabec, Mille Lacs, Pine, Sherburne	3.00-3.60		3.00-3.60 4.00-4.50 3.00-4.75
Big Stone, Pope, Stevens, Traverse		3.00	3.00-4.50
Blue Earth	2.50-3.00	3.00-3.50	3.00-4.75
Carlton, Cook, Itasca, Lake, St. Louis	3.00	5.00	10.50
Chippewa, Lac qui Parle, Yellow Medicine	5.00	3.50-4.25	3.75-5.00
Dakota, Ramsey	2.25-3.75	2.50-4.25	3.00-10.00
Dodge, Fillmore, Houston, Olmsted	3.25-5.00	3.00-6.50	4.00-16.00
Douglas, Grant, Ottertail, Wilkin	2.00-3.50	2.50-4.00	3.00-5.00
Faribault, Martin		4.00-4.50	4.50-5.50
Freeborn	2.25	3.00-3.50	4.00-5.00
Goodhue		2.60	3.00-6.00
Hennepin	1.35-3.50	1.35-4.25	3.50-10.00
Kandiyohi, Meeker, Swift	3.25	3.00	3.75-4.00
Kittson, Mahanomen, Marshall, Norman, Pennington, Polk, Red Lake	2.70-3.60	2.75-4.00	3.75-5.00
Lincoln, Lyon	2.50-3.00	3.00	3.50-41.00
McLeod	3.00	3.50	5.00
Renville	3.50		4.00
Rice	2.40-2.50	3.60-3.75	4.20-5.00
Steele		3.75	4.50-5.00
Wabasha	1.60	2.00	3.60
Waseca		3.50	5.00
Washington	3.00	3.00	4.00-6.00
Winona	2.75	3.35	3.50-7.00
Wright		3.50	
<b>Missouri:</b>			
Audrain	2.50-3.00	3.00-3.50	4.00-5.50
Cape Girardeau	2.00-2.50	2.50-3.00	3.25-5.00
Iron, Madison, Reynolds, St. Francois, Washington	2.00-2.75	2.75	3.75-5.00
Jackson	2.00-3.00	2.50-4.50	2.00-15.00
Pettis	2.00-2.50	2.50-3.00	3.00-4.00
<b>Montana:</b>			
Carter, Custer, Dawson, Garfield, McCone, Powder River, Prairie, Richland, Wibaux	2.00-3.50	2.00-3.50	3.50-5.00
Danols, Phillips, Roosevelt, Sheridan, Valley	2.50-3.00	3.50-4.50	
Deer Lodge	3.00	3.00	4.00-5.00
Fergus, Judith Basin, Petroleum Wheatland	2.00-3.00	3.00-3.50	3.50-5.00
Lewis and Clark	3.00	3.25-3.50	3.60-4.45
Musselshell	2.00	3.00	4.00-5.00
Park		4.00	5.00
Silver Bow	3.00-4.00	3.25-4.50	4.00-7.00
Yellowstone	2.50	3.00	3.60-5.00
<b>Nebraska:</b>			
Adams	2.00	2.50	2.00-3.80
Banner, Cheyenne, Kimball	3.00-4.00	2.00-3.00	5.00-6.00
Butler			4.00-4.50
Cuming			3.00-4.50
Douglas	1.50-3.75	3.00-4.00	3.25-6.00
Garden, Keith, Perkins		3.50	5.00
Hamilton		4.00	4.00
Howard		3.50	
Kearney		3.50	4.00-5.00
Morrill, Scotts Bluff	3.25	3.00-4.00	3.75-5.00
Nauca			3.00-4.00
Nemaha		3.00	3.50
Nuckolls			2.50-5.00
Pawnee	1.50	2.00	3.50
Platte		2.60-3.50	3.00-5.00
Polk		3.00	4.00
Saunders	2.50	2.50-3.00	4.00-5.00
Thayer		2.50	3.50
York	3.00	4.00	5.00
<b>New Hampshire:</b>			
Belknap	2.60	3.50	5.00-7.00
Carroll	3.00	4.00	5.00-10.00
Cheshire	2.57-3.00	3.57-4.25	5.00-7.14
Cook	2.25	2.75	3.50-6.00
Grafton	2.50-3.00	3.00-4.00	3.50-6.00
Hillsborough	2.00-3.00	2.50-3.00	3.00-8.00
Merrimack	2.57-3.15	2.57-3.57	3.56-6.00
Rockingham	2.00-3.00	3.00	4.00-6.00
Sullivan	3.00		4.00-7.00
<b>New Jersey:</b>			
Atlantic	3.00-4.00	4.00-6.00	5.50-8.00
Bergen	2.50-4.00	4.00-5.50	6.00-15.00
Burlington	3.00	4.00	5.00-8.00
Camden	2.50-3.00	4.50-5.50	5.00-10.00
Cape May		4.00	4.00-5.00

State and county	Ward	Semiprivate	Private
<b>New Jersey—Continued.</b>			
Cumberland	\$2.00-\$2.50	\$3.50-\$4.30	\$1.00-\$7.00
Essex	1.75-4.00	2.75-11.00	5.50-13.50
Gloucester		3.00-4.00	4.50-5.00
Hudson	3.00-4.00	4.50-6.00	6.00-12.00
Mercer	3.00	3.25-4.50	4.00-10.00
Middlesex	3.50	4.00-4.50	6.00
Monmouth	3.00	3.00-4.50	5.00-15.00
Morris	2.50-4.50	4.50-5.50	5.00-10.00
Ocean	3.50	4.00-4.50	5.00-10.00
Passaic	1.50-3.00	1.00-5.00	4.00-12.00
Salem	2.00	4.00	5.00-7.00
Somerset	2.00	4.00-4.50	6.00-10.00
Sussex	3.00	4.00-5.00	5.00-9.00
Union	1.75-3.00	3.00-5.50	6.00-12.00
Warren	3.75	7.00	5.00-9.00
<b>New Mexico: Union.</b>			
<b>New York:</b>			
Saratoga	2.50-3.50	3.00-4.75	4.00-8.00
Seneca	2.50-3.00	3.50	3.50-6.00
Wyoming	3.00	4.00	5.00-8.00
Yates	3.00	3.50	4.50-7.50
<b>North Dakota:</b>			
Benson, Pierce, Ralette, Ramsey, Towner	2.00	2.50	3.00
Cass	2.50-2.75	3.00-3.50	4.00-4.75
<b>Ohio:</b>			
Ashtabula	3.50	4.30	5.00-6.00
Belmont	2.50-3.25	3.25-4.00	3.25-5.00
Champaign	2.00	2.50	3.00-3.50
Clinton			6.00
Coshocton	2.50	3.00	3.50-5.00
Darke	3.00	4.00	5.00
Fairfield	3.00	3.50	4.50-7.00
Gallia		5.50	6.00-7.00
Greene			5.00
Guernsey	3.00-4.00	4.00-4.50	5.00-6.00
Hamilton	2.00-3.50	2.50-4.50	5.00-15.00
Hancock		3.50	5.00-7.00
Henry	3.50	3.50	4.50
Holmes	3.00	4.00	5.00
Huron	3.00-3.50	4.00	5.00-6.00
Knox	2.50-3.00	4.00-4.50	3.75-6.50
Lake	4.00	4.00	6.00
Medina		3.50-4.00	4.50-6.00
Miami	2.00-3.00	3.00-4.25	4.00-7.00
Montgomery	3.00-3.50	3.00-4.50	5.00-7.00
Pickaway	3.00	4.00	5.00
Portage	3.00-4.00	4.50	6.00-6.50
Preble	2.50	3.00-4.00	5.00-6.00
Richland	2.75-4.00	3.50-5.00	4.00-7.50
Ross	2.50	3.00-3.50	4.00-6.50
Scioto	2.00-4.00	3.50-4.50	5.00-7.00
Stark	3.50	4.50-5.00	5.00-9.00
Summit	2.50-4.50	3.50-6.00	6.00-10.00
Trumbull	3.50	4.50	5.00-7.00
Wood	3.00	4.00	5.00
<b>Oregon:</b>			
Baker	3.00	3.00	4.00
Benton	3.50-5.00	4.00	5.00-7.50
Clackamas	2.75-3.00	3.75	4.50-6.50
Clatsop	2.50-2.75	3.00-3.75	3.50-4.75
Columbia	3.00	3.50	4.00
Coos, Curry	2.50-3.50	3.25-3.50	4.00-5.00
Crook, Deschutes, Jefferson	3.00	4.00	5.00
Douglas	2.00-3.00	3.50	4.00
Grant		4.00	4.50
Harney	3.50	3.50	5.00
Hood River	3.00	4.00	4.50-6.00
Jackson	2.00-3.50	3.25-4.00	4.50-5.50
Klamath	4.50-5.00	4.50-5.50	6.00-7.50
Lake		3.00-4.50	3.75-6.00
Lane	3.00-3.50	4.00-4.25	5.00-6.00
Lincoln	3.00	3.00-4.00	3.00-5.00
Linn	3.00	3.00-3.50	4.00-5.00
Malheur	2.00-4.00	3.00-4.00	5.00
Marion	3.50-4.00	3.25-4.50	4.00-6.00
Multnomah	1.25-5.00	1.50-5.00	2.00-9.50
Polk	3.00	3.00	4.50
Tillamook	3.00	3.50	4.00
Union	3.00-3.50	3.50	4.50-7.00
Wasco	3.00	3.25-3.50	4.00-7.00
Yamhill		3.00-3.50	4.00-5.00

State and county	Ward	Semiprivate	Private
<b>Pennsylvania:</b>			
Adams	\$2.50	\$3.25	\$4.00-\$5.00
Allegheny	\$1.00-3.00	\$2.25-4.50	3.50-18.00
Beaver	3.00	3.50-4.00	4.00-6.50
Bedford	3.50	4.00	5.00
Berks	3.00-3.50	4.00-4.50	5.00-10.00
Blair	3.00-3.50	4.00-5.00	4.00-7.00
Bradford	3.50	4.50	5.00-9.00
Bucks	3.00	4.00	5.00-7.00
Butler	3.50	4.50-5.00	5.00-8.00
Cambria	3.00	4.30-4.50	4.75-6.50
Chester	3.00	4.00-5.00	4.50-12.50
Clearfield	2.50-3.50	3.00-5.00	3.75-7.00
Clinton	3.00	3.50-4.00	4.00-7.00
Crawford	3.50	4.50	5.00-7.50
Cumberland	3.00	4.00	5.00-7.00
Dauphin	3.00-4.50	4.50-5.50	6.00-7.50
Delaware	3.00-4.00	4.00-5.50	5.00-8.00
Elk	3.00	4.00-5.50	6.00-7.50
Erie	3.00	3.50-4.00	4.50-7.00
Fayette	3.00	4.00-4.50	4.50-8.00
Franklin	2.50-3.00	3.00-3.75	3.75-6.00
Greene	2.00-3.00	4.00	5.00-6.00
Huntingdon	3.00	3.50-4.00	5.00-6.50
Indiana	3.00	3.50-4.00	4.00-7.50
Jefferson	3.00-3.50	3.75-4.00	5.00-5.50
Lackawanna	2.00-3.00	3.00-4.50	4.50-7.50
Lancaster	3.75	4.50	5.00-10.00
Lawrence	2.50-4.00	3.00-4.50	3.50-8.00
Lehigh	2.50-3.00	4.00-5.50	5.00-10.00
Luzerne	3.00-3.50	2.50-4.00	2.50-9.00
Lycoming	3.00-3.50	3.50	4.00-10.00
McKean	3.00-4.00	3.00-5.00	5.00-9.00
Mercer	3.00-3.50	4.00-4.25	4.50-6.50
Mifflin	3.00	4.00-4.50	5.00-6.50
Montgomery	3.00-4.50	3.50-5.50	5.00-13.00
Montour	3.50	4.00-5.00	6.00-7.00
Northampton	4.00	4.00-4.75	5.00-10.00
Northumberland	3.00	3.75	3.75-6.00
Philadelphia	1.00-4.50	2.50-6.50	3.50-16.00
Somerset	1.00-3.50	3.50	3.50-5.00
Susquehanna	3.00		4.00
Tioga	3.00	6.00	10.00
Tenango	3.00-3.50	4.00-5.00	5.00-7.00
Warren	3.00-3.50	4.00-5.25	4.00-7.00
Washington	3.00	3.50-4.00	4.50-8.00
Wayne	3.00	4.00	3.50-6.00
York	3.00	4.50	5.00-8.50
<b>Rhode Island:</b>			
Pawtucket Medical Association: Central Falls, Cumberland, Lincoln, Pawtucket	3.00	4.00-6.00	5.00-9.00
Providence Medical Association: Barrington, Bristol, Cranston, East Providence, North Providence, Providence, Warren	3.00-4.00	4.00-6.00	5.00-10.00
South Carolina: Darlington	3.00	3.57	5.00
<b>South Dakota:</b>			
Aurora, Brule, Davison, Hanson, Hutchinson (part), Jerauld, Lyman, McCook (west half), Miner (part), Sanborn (part), Turner (part)	3.00	3.50	4.25
Beadle, Hand, Kingsbury (west half), Miner (part), Sanborn (part)	3.00	3.50-4.00	4.00-5.00
Bennett, Butte, Custer, Fall River, Lawrence, Meade, Pennington		3.00	4.00-5.00
Brown, Campbell, Corson, Dewey, Edmunds, Faulk, McPherson, Potter, Spink, Walworth	3.00	3.50	4.25
Buffalo, Haakon, Hyde, Hughes, Stanley, Sully, Ziebach	2.50	3.00	3.50-5.00
Gregory, Mellette, Todd, Tripp	3.00	3.50	4.00
Lincoln, McCook (east half), Minnehaha, Moody (part), Turner (part)	3.00	3.00-4.00	4.50-5.00
<b>Tennessee:</b>			
Claiborne, Hawkins, Jefferson, Knox, Loudon, Union	2.00-3.00	2.50-3.50	3.50-10.00
Hamilton	3.00	2.00-4.00	1.11-8.50
Monroe	3.50		4.00-5.00
Oblon		3.00	5.00
Putnam	4.00-5.00		
Shelby	1.50-2.50	3.00-3.50	4.50-10.00
Sullivan	2.50-3.00	3.00-4.00	3.75-6.00
Weakley			4.00
White		3.00	5.00
Wilson		3.00-3.50	4.00-4.50

\* These are not counties, but cities and towns which make up the Pawtucket Medical Association and the Providence Medical Association.

State and county	Ward	Semiprivate	Private
<b>Texas:</b>			
Angellna.....	\$2.50	\$3.50	\$4.50
Austin.....			\$4.00-5.00
Bandera, Gillespie, Kendall.....			2.00-5.00
Howle.....	3.00	3.50	4.00-6.00
Brown, Mills, San Saba.....	2.50	\$3.00-4.00	4.00-6.00
Calhoun, Goliad, Victoria.....	3.50	4.00	4.00-7.00
Coleman.....		2.50	5.00
Cottle, Foard, Hardeman, Motley.....	3.00	4.00	5.00
Dallam, Hartley, Moore, Sherman.....		3.00	4.00
Dallas.....	\$1.50-3.00	2.30-4.50	2.50-12.00
De Witt.....	3.00	3.50	4.50-7.00
Donley.....	3.50	4.00	4.00-6.00
Galveston.....	1.50-3.00	3.00-4.00	4.00-8.00
Gray, Wheeler.....		4.00	4.75-6.00
Grayson.....	2.00-2.50	2.50-3.50	3.75-5.50
Gregg.....	3.00	4.00	5.00-10.00
Grimes.....		3.00-3.50	4.00-6.00
Harris.....	3.00-3.50	3.50-4.50	4.00-10.00
Harrison.....		3.00	4.50-5.50
Jefferson.....	2.50-3.00	3.00-3.50	4.00-8.00
Lamar.....		2.50-4.00	3.00-6.50
Madison, Walker.....	3.00		5.00
Mitchell, Nolan, Fisher.....		4.00	5.00
Montgomery.....			3.00-5.00
Polk, San Jacinto.....	3.00		3.50
Potter.....	3.00	3.00	4.00-6.00
Red River.....	3.00		4.00-6.00
Sabine, San Augustine, Shelby.....	4.00-5.00		4.00-5.00
Scurry, Borden.....	3.00	4.00	6.00-8.00
Smith.....		4.00	5.00
Taylor.....	2.00-3.00	4.00	4.00-10.00
Titus.....		3.50	5.00
Upshur.....		4.00	5.00
Washington.....		3.00	3.00-6.00
Young, Jack.....		3.50	4.00-6.00
Utah: Duchesne, Uintah.....	4.50	5.00	5.50
<b>Virginia:</b>			
Augusta.....	2.00	3.00	4.00-6.00
Chesterfield, Henrico.....	3.50-3.75	4.00-5.00	5.00-10.00
Northampton.....	3.00	4.00	4.00-6.50
Pittsylvania.....	2.50-3.00	3.00	3.50-6.00
<b>West Virginia:</b>			
Berkeley, Jefferson, Morgan.....	2.00	2.50-3.00	3.00-8.00
Braxton, Nicholas, Upshur, Webster.....	2.00-2.50	2.25-3.00	3.00-6.00
Fayette.....	3.50		5.00-9.00
Kanawha.....	3.50	4.50	5.00
Wetzel.....	2.50	3.50	4.00-5.00
<b>Wisconsin:</b>			
Adams, Columbia, Marquette.....		2.50	3.00-3.50
Ashland, Bayfield, Iron.....	2.00-3.00	2.50-3.50	3.50-6.00
Clark.....	2.50	2.50-3.00	3.50-4.00
Dunn, Eau Claire, Pepin.....	2.00-2.25	2.50-3.00	3.50-4.25
Grant.....		3.00-4.00	3.50-5.00
Kenosha.....	2.50-3.00	3.50	4.00-7.50
Marathon.....	0.66 1/4-2.00	2.50	1.50-5.00
Monroe.....	2.50	2.50	3.00-5.00
Outagamie.....	2.00	2.30	3.15
Ozaukee, Washington.....	2.50-3.00		4.00-5.00
Richland.....	2.50-2.75	3.00-3.50	4.00-5.00
Rock.....	2.50-3.00	3.00-4.00	4.30-6.00
Wood.....	2.00-2.50	2.50-3.00	3.15-5.00

### STATEMENT OF DR. J. A. O'HARA, PRESIDENT, LOUISIANA STATE DEPARTMENT OF HEALTH

Senator MURRAY. You may state your name, address, and what your position is.

Dr. O'HARA. Dr. J. A. O'Hara, New Orleans, La.; president, Louisiana State Board of Health.

I have just a few remarks to make upon the bill, as a sort of a suggestion. The biggest part of this bill is for crippled children, child health, and maternity care, and great improvement has been made in our State in regard to those things.

On page 26, line 4, it says:

operating costs 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—

I was going to say it might be better to add the hospitals that you are going to have in your general hospitals, because we are going to have some other hospitals that are private institutions in our State that should be considered in dishing out the money for the improvement, construction, and maintenance of those hospitals. You could say, therefore, after "in respect to general hospitals":

tubercular hospitals, mental hospitals, orthopedic hospitals, ear, eye, nose, and throat hospitals, isolation hospitals, and all other established hospitals that the Surgeon General, the State, and the medical profession of their respective States agree require more construction and more money for improving service.

That would touch our small hospitals in our State, of which there is quite a large number, that need expansion and need improvement in the service. I think the doctors in the State would be a little pleased with that suggestion.

Now, another memorandum that I have here is advocating the creation of a State medical advisory council, together with the State board of health, to consult with the Surgeon General of the United States Public Health Service on all matters affecting the health of the people of the Nation. This committee should be appointed by the State medical societies of their respective States.

An ancillary act, possibly in the form of a recommendation by the President of the United States under authority granted him by Congress, should be submitted, placing all health and medical services under the exclusive jurisdiction of the United States Public Health Service. This would minimize the number of agencies with which the medical profession should make contact in order to preserve and protect the best patient-doctor relationship, and at the same time it would stop cutting in on the finances that are going to be sent into the State for division.

Number 3 would be a provision that should be made for the State agencies, cooperating with the appointed State medical advisory committee from the State medical society, administering medical programs to enter into agreements with privately owned hospitals for hospitalization of patients on a per diem basis, the same as the Federal Government does, and, in this connection, perhaps some minimum fee could be established to serve as a guide for the professional services rendered by physicians and surgeons.

My next point is to point out that the national health bill is in fact an amendment to the Social Security Act, and therefore its passage will be cited as the Social Security Act because its identity as a health bill will have been lost.

My point—my next point is to bring out facts indicative of the tremendous number of individuals within the State who are presently in need of medical service. Our statistics indicate that this group represents approximately 100,000 people considered as medically indigent individuals.

For instance, in this group I have mentioned there are 6,000 cases of tuberculosis that should be in hospitals today, in bed, having bed service and rest treatment. The State of Louisiana has but one hos-

pital, and it has but 110 beds occupied today, with a waiting list of 275 patients. The time to get these 275 patients in the hospital is when they are in the primary stage, but by the time we can accept them in the hospital they will have a cavity about as big as an orange and they will be practically on their way out in the coffin. They need more hospital beds right now. That is the condition just of tuberculosis.

We have in our State, also, what we call traveling diagnostic clinics, or traveling units. One of them is a tuberculosis unit. That has been accepted by the doctors with pleasure, and I can say that in the last 14 months, 7,322 cases were examined for tuberculosis at the instigation of the doctors themselves, and of that number more than 700 proved to be active cases of tuberculosis that had never known it before. That is one clinic going around the State.

We have a dozen dental clinics going around the State doing tremendous work in caries—dental caries. They are doing splendid work. There is room for more of them.

With respect to the crippled children, it is estimated that there are approximately 10,000 children requiring treatment, and the greater number of them are in need of orthopedic surgery and hospitalization. We haven't got beds in the hospitals there for those children. We have got our clinics developed and doing splendid work for the rehabilitation of children. Those are going to depend upon the United States Government to feed and support them. They should be rehabilitated so that they will be able to support themselves. We need hospital beds for them very badly.

Now, the willingness with which the physicians of the State, through their cooperative medical societies, accepted the proposition of the Farm Security Administration in the care and treatment of the medically indigent sick has been very evident. That is where my idea came about the State medical advisory board. It was the fact that when Dr. Williams came down with the Farm Security Administration he came to the executive committee of the Louisiana State Medical Society and laid his plans out to us. We farmed them out to our medical societies in the State, we farmed Dr. Williams and Mr. Eames out to the medical societies in the State with their system of how much money they were going to appropriate to the farmer. You know more about that than I do, as to how much money would go for farming and how much money would go for medicine. Out of 13 different medical societies in the State 10 accepted that proposition, showing how much you could do, in my opinion, if the State medical advisory board were created in a State to make contact with the State board of health, with the Surgeon General in regard to health matters. They accepted it when we sent it in to them with the committee. I think if the committee is formed you can get splendid cooperation from the doctors. I think you would get cooperation in every State, but I know you will in Louisiana.

My next point would be to advocate the elimination of the distinction made in prorating Federal participation for operating costs in connection with mental hospitals. You appropriate \$150 for beds in your mental hospitals, and from my experience in mental hospitals which has not been limited, I do not think \$150 a year would

be a proper amount of money to support and maintain an insane patient in an insane asylum.

Senator WAGNER. With those suggestions you favor this legislation?

Dr. O'HARA. I certainly do; yes, sir.

Senator MURRAY. Thank you, Doctor. The next witness is Dr. A. T. McCormack, State health commissioner, of Louisville, Ky.

### STATEMENT OF DR. A. T. McCORMACK, STATE HEALTH COMMISSIONER, LOUISVILLE, KY.

Dr. McCORMACK. Mr. Chairman and gentlemen, I should first like to present a resolution which was unanimously adopted by the Conference of State and Provincial Health Authorities of North America, with the footnote "as this resolution refers to legislation affecting the United States, the provincial representatives present were excused from voting." The resolution is as follows:

Whereas the Interdepartmental Committee to Coordinate Health and Welfare Activities has submitted to the Congress and the country a national health program; and

Whereas the House of Delegates of the American Medical Association, representing the physicians of this Nation, unanimously resolved that "very definite and decisive action (on the program) should be taken now"; and

Whereas, legislation has been introduced into the Congress implementing this program: Now, therefore, be it

*Resolved by the Conference of State and Provincial Health Authorities of North America—*

I. That we urge the passage of legislation making effective recommendations I, II, III, and V of the national health program as follows:

1. The general principles outlined by the technical committee for the expansion of general public health and maternal and child health service are approved, with the provision that the expansion of public health and maternal and child health service should not include the treatment of disease except when it is determined in any State, or subdivision of a State, that this cannot be successfully accomplished through private practitioners.

2. That we favor the expansion of general hospital facilities and of special hospitals for tuberculosis and mental diseases in any State, or any subdivision of a State where actual studies show that a need exists, and where such additional facilities can be assured of adequate staffs and maintenance.

3. That we approve the principle that complete medical care of the indigent is a joint responsibility of local governments and the medical and allied professions, and should be supported by tax funds. Since the indigent and the medically indigent now constitute a large group in the population, we recognize that State aid for medical care may arise in any community and that supplementary Federal funds must be provided so that this group of people will receive a good quality of medical care. We wish to emphasize the importance of a far-reaching program for public-health education of all the people in order that they may take advantage of the good medical service now available, or which is to be made available. We favor this expansion of the public-health program providing medical care for the medically needy, because it has been approved by the American Medical Association representing the practicing physicians of the country. We especially approve the continuation of the principle which has been developed by Federal public-health agencies "that the role of the Federal Government should be principally that of giving financial and technical aid to the States (where needed) in their development of sound programs through procedures largely of their own choice."

4. That we approve of the extension of unemployment insurance for compensation for loss of wages due to illness, with the provision that the attending physician be relieved of the duty of certification of illness and recovery, which function should be performed by a qualified medical employee of the disbursing agency.

II. That we oppose the enactment of any laws encouraging or aiding so-called compulsory health insurance at either Federal or State levels as impractical of administration, extravagant, and as providing illusory and increasingly expensive costs of medical care while lowering its quality, and as opposed to the American system of government and economics.

III. That we approve the spirit of the recent Federal Reorganization Act and urge upon the President and the Congress that all Federal public-health agencies be administered through a national department of health, and that, pending such establishment, Federal health agencies be assembled in, and administered by a division of an existing department or other Federal agency, and we especially object to the assignment of any new or existing public-health function to any bureau or board not now administering such functions, because this would necessarily result in uneconomic duplication, complication, and confusion in public-health administration.

Mr. Chairman, this resolution, I will say, was adopted prior to the recent meeting of the American Medical Association, and in accordance with our understanding of the recommendations they had previously made and which, in principle, are reaffirmed with additional reservations in the action of the house of delegates in St. Louis the other day.

You know, we doctors have the reputation of disagreeing. As a matter of fact, we do not. It sounds like we are disagreeing, when we really mean the same thing, as has been brought out in the testimony of practically everyone who has spoken here today. We have the same objectives in view all the time, viz, the protection of the public health, the prevention of disease, and the provision of good medical care for all who need it. Since we have the same purposes as the distinguished author of this bill and as this committee, and as we differ about methods, we feel our opinion will have weight with your committee, as it always has had. In the formulation of such legislation as this, it is important to keep in mind that while every citizen is interested in the prevention and cure of disease, there is but one group qualified to provide either. That is the medical and associated professions. For this reason, we feel that you will welcome our advice as to administrative technique.

I had the privilege of cooperating with Senator Wagner and his associates in the passage of health titles of the original social security bill.

I am very happy to be able to report to this committee that in the operation of titles V and VI there has been, and can be, no adverse criticism, no criticism that is justifiable, and there has been none from any responsible authority. The reason for that is perfectly simple.

Now, in regard to the Children's Bureau and the Public Health Service, of course, in principle, there ought never to have been health activities assigned to the Children's Bureau; but because of our ineptitude in leadership at the time it was so assigned, those of us who were interested in public health declined to do anything in the matter of child and maternal health; Congress very wisely took the matter out of our hands and authorized the Children's Bureau to do what we were declining to do. The Children's Bureau has continued its work so well that there are two Federal bureaus that have mainly to do with public health. In regard to the cooperation with the States with both of them, and each of them, there has never been the slightest intimation of coercion, or an imposed control at any time in any State.

The State health authorities, through the local agencies in the State, originate the plans, they develop them. As a rule, they are accepted without change or amendment by the Federal authority, because they recognize that those charged with the responsibility for the actual administration of so important a function as the protection of the public health are not going to attempt to do, by and large, a foolish thing. In the well-organized States that is always the case. In some of the States, where unfortunately there is some political manipulation in regard to the State health department, that confidence does not exist, and yet even in those States the cooperation between their medical profession and the State health department has been continuous and satisfactory in every State in the Union.

There had been no conflict in regard to any of the provisions or activities under title V or title VI of this act. Those provisions were not adopted like Venus was born—out of the ocean all ready to work her various charms. They were developed from infancy through childhood to their present encouraging adolescence.

In the Public Health Service in 1912 an appropriation of \$50,000 was made for the investigation and demonstration of methods of rural health administration. That appropriation varied from \$50,000 to \$75,000 for a long time, up to the passage of the Social Security Act. It was wisely expended, in a few localities, for developing sound procedures that would meet with the approval of the organized profession, and would win the confidence of the public, and the approval of those who were qualified to speak.

The development of health work, as the development of any specialty, depends on the ability to secure the trained personnel who can readily qualify to do this job. I am a practicing physician and I am a health officer too. I am a specialist in public health and practice that specialty, but I am no less a physician because I am a health officer.

In Kentucky we have the advantage—and I think it is a very great advantage—that the State health department is a creature of the State medical association. I am selected by a board which is selected by the State medical association.

Senator ELLENDER. That is by statute?

Dr. McCORMACK. That is by statute. All of our policies are provided for us by the house of delegates of the State Medical Association of Kentucky, which, therefore, has the responsibility not only for the treatment of disease in their individual capacity but for the prevention of disease and for public-health education, and every procedure that has been adopted in Kentucky has the unanimous approval, and has had for many years, of the Kentucky State Medical Association. There can be no division of opinion between the State health department and the State medical association, because if there should be, they would just get rid of us, that is all, and the opinion would still be unanimous.

To show you that that works rather well, my father and myself are the only two State health commissioners that Kentucky has had since 1879, when the State health department was created. It just happened that after they had my father as long as they did, then they took me, and we have had, therefore, a very happy association with this public-health movement.

I am a member in practically every organization that has testified here. I am a member of the Federated Women's Clubs, in my wife's name, and the Federated Women's Clubs in Kentucky are quite as important to us in the promotion of public-health education and public-health procedures as any other organization in the State, including the State legislature, because they have to do with public opinion. Women bear the babies, they nurse the men when they are sick, they bear the burden of illness, and therefore they have a right to speak on matters of such moment to them as this, and we have listened to them and have had their support constantly.

I am a member of the Farm Bureau. I realize that the provision of good health and medical care for the farm family is one of the most important of our problems. I have a farm. I have a little landing place whenever they decide they want some other health officer.

I am an honorary member of one of the great labor organizations. I belong to everything that has to do with public health and public opinion in the Commonwealth of Kentucky.

Senator ELLENDER. Any political organization?

Dr. McCORMACK. I have never been in a political committee, nor at a political convention, since I have been State health officer.

Senator ELLENDER. Doctor, let me ask you this question: Do you find that because the Kentucky statute provides that the medical association names the health officer, that that has a tendency of keeping public health out of politics?

Dr. McCORMACK. It does. On two occasions very partisan governors—one a Democrat, the other a Republican—thinking they saw political advantage in seizing the patronage of the health department, attempted to take its control from the medical profession but an aroused and outraged public opinion prevailed and these attempts were defeated.

The State health department is the one agency in the government of Kentucky in which there has never been the slightest intimation of political control. I get letters of recommendations from governors in regard to appointments, and they always write in the letter, without a single exception since I have been State health commissioner, that this man is a good Democrat, or a good Republican, as the case may be, and "I would like very much to see him given a position, if he is fit to have a position"; but we have a merit system, he has to show he is capable of doing the job. We do not object to a man simply because he is recommended by a politician. I have had many years of experience with politicians and have found them rather more interested in good public service than less experienced citizens, but we examine the man recommended just the same.

Senator ELLENDER. What has the medical society to do with those appointments?

Dr. McCORMACK. Nothing. They have nothing to do with that. I make the appointments and the State board of health confirms them, and the members of the State board of health are selected by the medical association.

Senator WAGNER. They have veto power?

Dr. McCORMACK. Yes.

Senator WAGNER. I might say in New York we have developed a system of commissioners, and I think it is a pretty good system.

Dr. McCORMACK. I have had the privilege, sir, of being at Saratoga Springs at the last three of your public-health meetings. There is no other State, and, of course, there could be no other State, in which there has been greater development in public health, or public welfare, than the great Empire State. It is the leader of the Nation in all these respects. We bow to you. You have enough money to employ the best brains. We have got to use what brains we have because we do not have any money.

Senator ELLENDER. Doctor, you stated awhile ago, I believe, that you were familiar with the way that social security was handled in other States.

Dr. McCORMACK. Yes, sir.

Senator ELLENDER. Do the plans in the various States differ in any particulars?

Dr. McCORMACK. They differ just as distinctly as the faces of the members of this committee differ. It would be idle to say that in Maine they would have a malaria program. In your State and mine we would have a program to prevent and control pellegra. It would be ridiculous to have such an extensive program in the State of New York.

Senator ELLENDER. So it is possible for each State to easily work out its program, irrespective of what the other States do?

Dr. McCORMACK. Not only each State but each county to each State. In Kentucky we have 120 counties and 86 of them have full-time health departments.

Senator ELLENDER. You found the attitude of the Health Department here at Washington to be cooperative, as you said, and there is no effort made on its part to try to make you adopt this plan or that plan because another State has it?

Dr. McCORMACK. There has never been any such suggestion. Not only has there never been such suggestion but no officer of the Public Health Service has come into the State of Kentucky, except at my invitation, since I have been State health commissioner.

Senator ELLENDER. Very well.

Dr. McCORMACK. The same is true of the Children's Bureau. No suggestion has come from them as to any change in plans, although on many occasions I have called distinguished officers of the Service, having special qualifications, with the consent of the Surgeon General, or the Chief of the Children's Bureau, in consultation and have received most valuable advice from the great men who compose that Service and that Bureau.

Mr. Chairman, in the great constructive report of the technical committee on a national health program, those who composed it, with the approval of the Interdepartmental Committee to Coordinate Federal Activities, said distinctly that it was not practicable to put into effect immediately its maximum recommendations. It contemplated a gradual extension along well-planned lines with a view toward achieving operations on a full scale within 10 years.

In the actual drafting of S. 1620 by the several interests involved in it, this wise vision of the technical committee was largely overlooked and an attempt has been made to provide for and authorize, not only all that was contemplated by the committee over a period of years, but to make the authorization so unlimited that it would not

be necessary to come back to the Congress so we would be under its continuous scrutiny and so we could have your sympathetic reconsideration of our problems at reasonable intervals. The committee stated that progress in the protection of the public health should be developed by evolutionary methods; it is our fear that this bill proposes to do this too suddenly, too rapidly, and by methods too complicated and revolutionary.

I think the report of the technical committee presents one of the greatest programs on social welfare in the history of mankind. Of course, I do not agree with all of its recommendations but one thing impresses me more than any other, and my experience makes me feel that it is one your committee would want to make definite in the final drafting of legislation to effectuate its purposes, and that is that the approach be gradual, step by step.

Mr. Chairman, we who are to administer the law, the medical and allied professions who are to render the service under the local control provided by it, should not be required too suddenly to undertake something which we know cannot be accomplished. We have before us the example of the N. R. A. Its administration would not have broken down had it not been too inclusive; its ideals and its purposes were as admirable as the pending legislation, but, it provided an administrative impossibility.

While similar, or greater progress has been made in other States, I believe it will interest the committee, for a moment, to review the action of the Kentucky State Medical Association in regard to the problem presented in the national-health program. We had developed the first full-time health department in the United States in 1907, in Jefferson County, outside of the city of Louisville. With the financial assistance of the Rockefeller Commission for the Eradication of Hookworm Disease, we had found more than 400,000 persons in Kentucky having this one disease, the existence of which we had not even suspected in the State before that time. As we came in contact with our people in this campaign, we were forced to realize their public health and medical needs. The Kentucky State Medical Association had a special meeting at Lexington as far back as 1912 to consider this very subject; every session since has devoted a large part of its time to these problems. In 1918, our legislature authorized the development of full-time county health departments and provided State aid for their maintenance. Since 1918, such full-time health departments have been developed in 86 of our 120 counties, and 16 additional counties have already authorized their creation but we cannot make these expansions because the State is not able to provide its portion of the needed money.

During this period of years, we have had great difficulty in securing the increasingly large number of qualified medical specialists in public health, public-health nurses, sanitary engineers, and laboratory workers required in these 86 departments. In fact, Mr. Chairman, we realize that, with all the progress we have made, and with all the additional protection we are giving our people, we have only built the foundation on which future public health and medical service will develop. Our laws and our regulations prohibit our health officers from engaging in the practice of medicine, other than the specialty of public health. We had never even considered extending

public health activities into the field of treatment of disease amongst the indigent until this plan had been approved by the special session of the house of delegates of the American Medical Association last year. I hope very much, gentlemen, that you will amend that feature of the bill which requires that services under its different titles should be made State-wide, or extend to all political subdivisions before 1945. From my experience, I do not think the service should be extended to any county or political subdivision until the medical profession and the people and the governing authorities of that particular county desires that such service be rendered in their jurisdiction. You cannot impose a service on a people who do not want it.

Professional and public approval is not difficult to secure for a sound program, but no program can be developed without both. The distinguished author of the bill and the members of this committee have been so sympathetic in their repeated expressions at these hearings of their desire for the advice and cooperation of the medical profession in perfecting the bill, that it is a real pleasure to contribute to that mutual understanding which will make its success possible.

As one somewhat experienced in legislative methods, it seems apparent to me that this bill presents one extreme in attempting to attain its objectives, and those who have raised objections to it have gone their limit toward the other extreme; both, however, are united in a desire to obtain the objectives of the national-health program. The two groups are traveling on parallel tracks, and it is only necessary for them to get together on the method of arriving at their objective.

Please keep in mind that it is the purpose of the medical profession to prevent disease, and to arrest, cure, or ameliorate, when it cannot be prevented. Having that purpose, and you as representatives of the people having the desire to fulfill that purpose, we need to develop administrative methods that will, without destroying any of the good that has made public health and medical service in the United States the best in the world, add to it those things that will make it still better.

To secure the most practical and economical administration and service in this legislation I know is your objective. That is always the objective up here and has been before every committee that I have appeared. I have had the privilege of appearing before these great committees for many years, and I never appear that I am not profoundly grateful that I am a citizen of the United States. I think the way legislation is introduced and perfected and passed in this Government is the greatest tribute to the American system of government that there is. It is always a joy to come before your committee, because I have always found that one or two of you who have been particularly interested in it know more about the subject than I do, and I have learned a great deal from appearing before the committees in the administration of my problems in Kentucky.

Senator ELLENDER. Doctor, if I were a resident of Kentucky, I believe I would vote for you for health officer. [Laughter.]

Dr. McCORMACK. Thank you very much, sir. Our motto is "We want a league, offensive and defensive, with every well-wisher of Kentucky and her people." You qualify, I am sure, Senator.

I want to take your time just to read one incident, because I think it has a bearing on this. This was published in our last issue of our medical journal in regard to the action of the State Health Department of Kentucky.

Last year the Kentucky State Medical Association, acting under request from the American Medical Association, established a committee on the study and provision of medical care. This committee has had the active cooperation of many of our physicians, dentists, pharmacists, and county officials, and has enabled us to tabulate many of the inequalities and failures of distribution of medical service in such a way as to indicate that serious planning must be undertaken to solve the problems which have arisen. In addition to plans for medical service for the indigent in the cities maintaining public hospitals, experimental plans have been inaugurated, and are now successfully operated, in Fayette, Mercer, Kenton, and Jefferson Counties.

Several other counties have been added since that time.

The study has made it evident that the greater part of the burden of medical care in all of our poorer counties, and in most of our other counties, has been carried, as it always has been, on the shoulders of the medical profession.

In many of the counties of Kentucky there is not one nickel of public funds spent for medical care for anybody. They are not able to do it and have never done it.

It is becoming increasingly evident that this burden is becoming too great for the profession to carry alone, and that it must be shared, philanthropically, in this respect with the public.

The following resolution was passed at the meeting of the council of the State Medical Association:

Whereas, the council of the Kentucky State medical association—

And any action in Kentucky by the State health department is predicated on previous action approved by the council of the State medical association—

Whereas the council of the Kentucky State medical association has unanimously requested the State department of health to petition the Governor for his approval for the establishment of a bureau of medical service in the division of local health work of the State department of health, and has nominated Dr. John B. Floyd, of Richmond, Ky., as the director of said bureau when created; and

Whereas, under section 2054, subsection G. Kentucky statutes, there is provided as follows:

That in addition to the bureaus already established by law, the State board of health is hereby authorized to create and maintain other bureaus, and in the rules and regulations which they are now authorized by law to make and promulgate, to provide for their effective operation. The board shall have authority, with the approval of the Governor, to rearrange or discontinue any such bureaus, or to create new ones in the interest of efficiency and economy in conducting its work: Now, therefore, be it

*Resolved*, That the State Board of Health of Kentucky hereby authorizes the creation of the bureau of medical service in the division of local health work of the State department of health, whose duties shall be to assist the legally qualified and registered medical profession of Kentucky in providing complete service for the indigent and the medically indigent residents of the Commonwealth.

The council of the Kentucky State Medical Association shall advise and cooperate with the board in the formulation of plans and rules and regulations for making the work of this bureau effective for the protection of the health and lives of the residents of the State, and shall assist the registered profession in every county in the State in the formulation of plans for the purposes herein provided: *Provided*, That all plans formulated for any county shall provide for absolute freedom of choice of the legally qualified physician who shall

serve them from all those qualified to practice who are willing to give service: *And provided further*, That there shall be no restrictions on prescription or treatment except such as are necessary for the protection of the public health: *And provided further*, That 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 legally registered practitioner: *And provided further*, That a person is medically indigent when he is unable, in the place in which he resides, through his own resources, to provide himself and his dependents with proper medical, dental, nursing, hospital, pharmaceutical, and therapeutic appliances and care without depriving himself or his dependents of necessary food, clothing, shelter, and similar necessities of life, as determined by the local authority charged with the duty of dispensing relief for the medically indigent.

Now, Mr. Chairman, in consideration of this specific legislation, there are three major objections that we would like to offer for which we would like to suggest amendment to the bill. The first is that there are three fathers through which the States must make their Federal approach. Now, we should have either a department of health, or a Federal health agency, in which all Federal health and medical bureaus should be assembled, which would pass on all plans, instead of having to make the plans multiple and have each one find out for himself what is being done by or in the other service. It is an idle thing to think of Bill Jones out here on the creek having syphilis and his wife being pregnant, one of his children being sick with an acute disease and another one a crippled child, his grandfather paralyzed and his grandmother insane, and each of those being operated under a plan that has been formulated by the State Department of Health of Kentucky, through which a multiple lot of bills would come up. It would be almost impossible to prevent confusion and duplication and a crossing of funds under such circumstances. We could not and should not send 12 or 15 doctors to that one family. In many of our families, we have that many people in the family, because we still are increasing the number of babies in Kentucky; our birth rate is rising instead of falling; we are that prosperous, anyway, in that respect, and we are helping to create today, as we have in the past. We have had 135 Governors of other States born in Kentucky.

Senator ELLENDER. Is that increase in birth rate due to prosperity?

Dr. McCORMACK. I do not think so. I think it is lack of other forms of recreation probably. [Laughter.]

Senator ELLENDER. Seriously, Doctor.

Dr. McCORMACK. Seriously, Senator, our people are a homogenous stock—almost all from the British Islands originally. In times of stress, such as war or depression or great expansion, such a people take their responsibility for the reproduction of man-power seriously. In times like these, our people feel that the world needs more Kentuckians.

The Children's Bureau and the Public Health Service are already in existence, but there is no reason for creating medical and health functions for an additional social agency for the control of any part of this program, and that title of the bill should certainly be amended.

In regard to the hospitals, the first hospital need, of course, is for the utilization of existing hospital facilities, and for a sound loan policy for the addition of ward beds to them to be utilized by those receiving hospital service and medical care under title XIII. A

liberal policy of cooperation should be arranged with the great philanthropic and church hospitals that have added so much luster to American medicine and have been so serviceable to the American people. I think it could be easily provided for by providing that the State plan for the construction of additional hospitals should show that existing hospitals in that vicinity are having all their beds utilized and cannot be economically expanded to care for the additional load. No additional hospitals should be developed in any area unless need is shown, in the first place, as the bill provides, and in addition to that they should not be constructed unless existing hospital facilities are being utilized. Fifty-seven percent of the hospital beds in Kentucky were occupied, on the average, in the last 2 years. The reason all the others are not occupied is because our people are not able to pay the bill. That is one of the reasons we have become so interested in the provision for aid for medical care for the indigent particularly.

A notable example is the chain of Shrine hospitals for the care of crippled children; it would be a disaster to lose the intelligent and sympathetic support of this great organization by adding public institutions in competition with them. By some legislative device their facilities should be extended. This crippled-children problem splendidly illustrates its defects. In Kentucky we have 257 beds available for crippled children. The commission's income is insufficient to enable even these few beds to be filled. On our waiting list today there are 3,829 new cases needing orthopedic treatment. Not one of these has received any type of treatment or any hospitalization. During 1938 we provided treatment for 1,161 individual cases, with an average of 145 per month at a per capita cost of \$146.78. If sufficient funds were available—they cannot be secured from the State during the fiscal year ending June 30, 1940—we would be able to hospitalize 147 more cases each month than at the present time; and we would also be able to at least double the number of cases for whom orthopedic and other services can be provided without hospitalization. The cost of treating this number of additional children would be \$320,567.52. The facilities for these treatments are already in existence. Without treatment, many of these cases will remain permanent cripples and public charges throughout their lives.

The definition of a hospital in title XII in section 1209 is fantastic and indefinite, and I would recommend its deletion.

Provision might well be made for assistance where need exists in the erection of offices for the local health departments. We have been able to build only a few in Kentucky at a cost varying from five to fifty thousand dollars each, and they have practically doubled the efficiency of the health departments which have them.

Senator WAGNER. Do you see any difficulty in amending this particular bill as you suggest?

Dr. McCORMACK. Not at all.

Senator WAGNER. I could not understand, although I have been a legislator for many years, the attitude of many men, for whom I have a high regard, that there is just no way to amend it.

Dr. McCORMACK. Of course, being familiar with the procedure somewhat, that is absolutely inconceivable to me. I can understand perfectly well a man being so thoroughly opposed to a particular

piece of legislation that he can only amend by offering an inoperable substitute, hoping to delay or defeat the entire proposal.

The third main objection to the Wagner Act is that it does not provide a ceiling for the authorization for appropriations after the third year but authorizes the expenditures of as much as is necessary.

I am one who believes that executive and administrative agencies should come back to the Congress as authoritative representatives of public opinion for renewals of authorizations for appropriations at intervals of at least 5 years. Such a check on expenditures and activities prevents extravagance and limits the executive agency to service which Congress intends them to develop. It is perfectly apparent to the informed reader of the national health program that its limit on authorization for appropriations would not include any Federal subsidy for compulsory health insurance. We approve that attitude on the part of the technical committee and I think we should say so in definite terms.

If you will permit me just a second, I have drawn a suggested preamble to this bill. It contains statements that have been made by its author and by the technical committee, expressing the legislative intent in its enactment that I believe would answer much of the criticism and quell much of the anxiety on the part of those who are naturally interested in continuing to do these things the way they have been doing them, and who do not want to be too much interfered with in doing them. In other words, they very properly and sincerely say "Vital statistics prove that we have the best health and medical services in the world. We want to make these much better but we want to use methods of proven worth and progress by evolution rather than be confused by revolution." I think it can be stated specifically in a very few words:

That this Act may be cited as the National Health Act of 1930, and that it is enacted with the intent that the role of the Federal Government shall be principally that of giving financial and technical aid where needed to the States in their development of sound programs through procedures largely of their own choice; and that it shall not be construed so as to interfere with the operation of the medical practice acts of the several States—

Of course, I do not want you to think anybody could possibly reasonably construe that it could so do; but if you state that it does not, then you are answering an objection that has been raised so frequently.

and it is the express purpose of the Act that no plan approved under it shall provide for the regimentation, federalization, or socialization of the practice of medicine and that it is its express intent to provide for the continuation of the private practice of medicine which has brought to the people of the several States the benefits of scientific research and medical care.

I do not think there is any statement made there that I am not quoting either from the technical committee or that does not meet with your approval. I think that covers it.

Its adoption by the Congress would lay every ghost and destroy every bogie and scarecrow that has been so skillfully developed against the sound parts of this program. Please do not misunderstand this statement. In my opinion, the enactment of the present text of S. 1620 would do more harm than good. However, I am not alarmed about that for I am confident that these hearings are developing its defects so clearly that the great committee will be able

to clarify its provisions so as to secure a start on a national health program that the succeeding Congresses may develop so as to secure for all of the people of our country all of the benefits of medical science.

Now, after the meeting of the American Medical Association, which I attended and participated in the discussion, I tried to reach—

Senator ELLENDER (interposing). You mean at St. Louis?

Dr. McCORMACK. At St. Louis. I tried to reach a suggested plan for so amending the act as to conform to the principles both of the national-health program and of the St. Louis resolutions, and in that respect I would like to read you just a paragraph:

For the purpose of assisting States, counties, health districts, and other political subdivisions of States, where needed, in establishing and maintaining adequate services, supplies, and facilities for promoting the health of mothers and children; and to develop more effective measures for carrying out the purposes of this part of this title, including the training of personnel—

I would like to pause there just a minute, Mr. Chairman, to say that this matter of training personnel has been so completely misconstrued that it is astonishing, because we have been having the experience, since 1935, of training personnel. What we do now in getting health officers; we get a doctor who is qualified to practice medicine; we send him to the training center at Lexington; he stays there 3 months. If he wants to go on to be a health officer, and we find he is qualified to become one, we then put him out in one of the health departments under the supervision of an experienced health officer for a year or 2 years. If he still shows he is the right sort, and he is going to get there, we then give him a fellowship at Yale University or at Harvard, or at Johns Hopkins, or Michigan, where he goes for a year and takes a postgraduate course. There is absolutely no control of medical education; there is no thought of such a thing.

Senator ELLENDER. How are the expenses borne?

Dr. McCORMACK. We pay a stipend of \$125 a month to the man while he is attending the course for a year, and then he comes back and stays with us for at least 5 years. If he leaves before the 5 years, he pays us back whatever percentage of the scholarship has not been used for Kentucky. There should be no possible objection to that, and it cannot have a thing to do with the control of medical or any other kind of education on the face of heaven and earth. It is just a scarecrow, without anything in it.

Senator WAGNER. You are shocking one of the witnesses, who said that there ought not be any subsidies for medical education.

Dr. McCORMACK. That is not a subsidy for medical education, that is the State of Kentucky investing in improving a human machine that can save human lives. We are reconditioning that man's mind and giving him the mental armature with which to serve our people. We are not giving anything to Johns Hopkins; we are not controlling them.

Senator WAGNER. I am in accord with that view. I think it is a proper expenditure.

Dr. McCORMACK. It is absolutely a proper expenditure.

Senator WAGNER. I do not understand the attitude of these other gentlemen in regard to it.

Dr. McCORMACK. I do not understand it either; they must not be acquainted with the procedure which has been operating so successfully. My proposed bill further states:

The sums authorized under this section shall be used for making payments to States which have submitted proof that need exists for extending and improving such services, and State plans for so extending and improving them, approved by the council on public health needs and plans as hereby created, and hereinafter referred to as the Public Health Council.

Now, Mr. Chairman, the rest of the bill follows very closely the provisions at present.

Senator ELLENDER. Will you file that?

Dr. McCORMACK. Yes; I would be glad to file it with the committee. (The document referred to was filed with the committee.)

Dr. McCORMACK. It is just a draft of the first section, because I did not have time to even write a rough draft of anything else. If a council is formed consisting of the Surgeon General, the Chief of the Children's Bureau, a representative of the State health authorities, a representative from the American Hospital Association, the American Medical Association, and the American Public Health Association, six members, that hears these plans and digests them, then the whole administration would be under the Chief of the Children's Bureau or the Surgeon General.

I recommend that the phrase "method relating to the establishment and maintenance of personnel standards on a merit basis" be retained as included in subsection (4) of section 503, and that the rest of section (4) be omitted and that subsection (5) be amended so as to read "providing for an advisory council composed of the council of the State medical association."

This is, of course, the custom in practically every State in which successful public health procedures are administered. You will recall that the preceding witnesses have said that the council of each State medical association is composed of one representative from each congressional district, selected by its house of delegates, as its administrative body between its annual sessions. All of these councils have the distinct advantage of advice and service of the numerous standing and special committees of each State medical association.

Section 506 should be amended to provide for the Federal health council above referred to.

I would omit all authorization for hospitalization or other medical care from all of the other titles of the bill and would increase the appropriation in section 1301 of title XIII by adding the omitted allotments for treatment so that all treatment would be cared for under the same administrative authority.

The limit for carrying out the provisions of title XIII should be provided at "not to exceed \$300,000,000" and this sum should be reached by gradual increments up to the fifth year. Similar changes should be made, of course, in the other titles of the bill.

I can see no possible excuse for the provision of the administration of Title XIII by the Social Security Board. This is a welfare organization and an insurance agency without a medical officer attached to it, except as a consultant. Giving it administrative authority in the public-health field would mean, in the first place, expensive duplication of the personnel of the Public Health Service and would result in confusion in the administration by a new agency which

already has its hands full with the administration of those provisions of the Social Security Act which have been assigned to it. Gentlemen of the committee, I cannot speak too emphatically when I say that the provision of Federal aid for compulsory health insurance at the present time would be both an economical and an administrative mistake. It should be clearly understood by the members of the committee and the Congress, and by the people, that compulsory health insurance in no country on the globe makes any provision for the care of the indigent and the medically indigent.

This is the paramount medical problem in these United States, and if you will aid us in permitting the medical profession to provide the necessary facilities by bearing the actual cost for care of the indigent and the medically indigent, I am sure you will find there will be no difficulty about taking care of the low-income groups whose problem now seems so pressing. Those who are able to pay are now having to bear the burden of the whole cost of medical care. Almost, if not quite one-third of our people are indigent or medically indigent, and their care is a problem, and a proper cause of concern by local, State, and Federal governments, and should be provided for by a combination of them, wherever need exists.

If Federal aid is provided for compulsory health insurance now, when it can only be undertaken by a very few of the richest States, all of the other States would be contributing to the least pressing of the medical problems and, in so doing, would be lessening their own resources for the solution of their real needs. Let New York, or Wisconsin, who are financially able, if they will, experiment and do the same research work in compulsory health insurance that we have had for these 20 years in public-health procedures and in medical care for the indigent in all parts of the country, then if it should be found advisable and economical, it is possible some plan may be worked out that will be satisfactory to the whole country, but I submit that it is very important that we should not be tempted in the poorer States to use our limited resources for the solution of any but our pressing problems.

The low-income, industrial groups, the only beneficiaries of compulsory health insurance, are organized, and can take care of themselves; the poor are organized nowhere, and it is the purpose of the medical profession, and I am sure, of the Congress, to see that they are not forgotten.

I regret to say that even under the very much fairer proportion provided in the proposed amendment to section 1101 (2) (e) of the Social Security Act, that Kentucky would be unable to avail itself of sufficient funds to adequately carry out a good program. We have practically reached the limit in State revenue. Every candidate for Governor in both political parties, has pledged himself that there will be no increase of taxation in the next 4 years. Unless the proportions in the amendment would be changed from a 66 $\frac{2}{3}$  to 33 $\frac{1}{3}$  percent ratio to an 80 to 20 ratio, we will still be found unable to secure the benefits that should derive from being citizens of the United States.

In closing my testimony, Mr. Chairman, I want to say to you that I am sure the opportunity that has been given to the medical profession of Kentucky through the cooperation we have had with the Public Health Service and the Children's Bureau has resulted in

changing the whole picture of the lives of thousands of school children; that hundreds, yes, thousands of fathers and mothers are healthier today, working for and with their families who would have been invalids or dead, had not titles V and VI of the Social Security Act been enacted into law.

Senator ELLENDER. Dr. Underwood.

**STATEMENT OF DR. FELIX J. UNDERWOOD, SECRETARY, STATE BOARD OF HEALTH, JACKSON, MISS.**

Senator ELLENDER. Give us your name and your position in full.

Dr. UNDERWOOD. Dr. Felix J. Underwood, executive officer of the Mississippi State Board of Health.

I appear before you only because I deem it my duty as a physician, health officer, and citizen.

I may state that the membership of the State Board of Health in Mississippi is selected by the State Medical Association, and I am the first and only full-time health officer of that State, having served since July 1, 1924. My present term ends July 1, 1944.

This bill may be regarded as an effort to make it possible for the medical, dental, and nursing professions to apply to a group of our population in need the benefits of modern medical science, both preventive and curative, especially in rural areas and areas suffering from economic distress.

It is stated that the Federal Government will not under any circumstances furnish medical care. That the States under the proposed bill shall develop their own plans, and then only after careful surveys of local needs and conditions, to supplement, not displace the existing efforts of the professions, the localities, charitable organizations, and the hospitals.

The proposed act does not seem to establish a system of health insurance or require the States to do so.

Actual need is stressed, as it should be. Administration on any other basis would not only be wasteful and unnecessary but absolutely ridiculous, because it would pauperize unduly and unnecessarily all the citizens.

At the present time, due to the lack of State and Federal funds to match with counties in the promotion of full-time public health service, it has only been possible to have organized 39 counties which represent 60 percent of the population in my own State. The greatest need at the present time is to extend public health services to the other 43 counties of low assessed valuation, those of high assessed valuation having already voted in the funds necessary to have organized full-time service.

Senator ELLENDER. Do you feel it is because of lack of funds that the others have not organized?

Dr. UNDERWOOD. For the most part. There might be a few exceptions. In extending health service to these counties of low assessed valuation, of which there are 38 having an assessed valuation of less than \$4,000,000 and 17 having an assessed valuation of \$2,000,000 or less, it becomes necessary for the State and Federal sources to contribute proportionally a greater amount toward the total budget for

health services than in those counties whose assessed valuation is \$5,000,000 or greater.

To meet this need in extending health service to counties of low assessed valuation a policy has been adopted by the State board of health of grouping two or more counties into health districts so that efficient health services may be rendered more economically to both the State and the counties concerned. With sufficient funds from State and Federal sources it is felt that at least 25 additional counties could be organized with full-time health service within the next 12 months and the remainder of the State have full-time health service within 2 years.

We feel with funds available from State and Federal sources, with what the counties can do themselves, within 24 months we can have the 43 counties organized and going.

The inability to secure sufficient funds from both county and State sources may be appreciated by the fact that, according to the Bureau of the Census estimate, Mississippi has the lowest per capita wealth, this being \$1,242, and ranks second from the lowest among Southern States in its total estimated wealth.

Mr. Chairman, I should like to be permitted to confine my specific remarks to titles V and VI for the reason that I have some personal knowledge of and long experience in the conduct of such program in a State.

In some of the other titles, I find some objections which have been already and doubtless will be stated by others—my lack of knowledge—on these subjects would probably not fully justify some of the objections which I feel very deeply.

I might mention briefly that my objections coincide very closely with the speaker who preceded me with reference to filling the hospital beds now available before new hospitals are built, as provided by the act, and the administration of a medical-care program if inaugurated.

I think, in simple justice, this ought to be said, and I think the speaker who preceded me, Dr. McCormack, and I might well have gotten together a little bit about this thing, because I am saying some things that he has already said.

Since 1935, under title V and VI in the Social Security Act, with the sympathetic understanding and cooperation of the medical, dental, and nursing professions, social workers, educators, and the people generally, we have been able to build a sound, solid foundation of concrete and steel, in the field of legitimate public-health endeavor, which we hope and believe meets the approval of the professional people and laymen throughout the country, upon which we hope now to be permitted by the Congress to erect a liveable and serviceable building for the use of all the people of our country needing the shelter and protection of this, their house of health dedicated to their own needs and those of their children.

Some of the principles of administration embodied in this bill are not new. With a small appropriation the United States Public Health Service began studies and demonstrations of full-time rural health work in 1912 in cooperation with and at the invitation of the States. The remarkable success and particularly the professional

approval of these demonstrations led to their incorporation as titles V and VI of the Social Security Act by Senator Wagner. It has been my privilege and responsibility for a number of years to act as chairman of one of the important committees formulating regulations, authorized under this act for its administration.

I have taken my responsibility seriously, I have read the reports from every State in regard to the operation of these titles. I am familiar with the comments made by the committees of the various State medical associations, and I can say to you, without fear of contradiction by anyone professionally qualified to object, that there has been universal commendation of the administration of these titles by the Public Health Service and the Federal Children's Bureau. There has been no complaint from any State health administrator, coming to my attention, nor in my deliberate judgment has there ever been any justification for complaint of coercion of the States by the responsible Federal agencies or any attempt at federalization or regimentation of public-health work or workers in my State or any other State.

Every State plan for the protection of the health and lives of the people of Mississippi since 1921 has been originated and approved by the State board of health and the medical advisory group, and no plan has been amended or changed by the Federal agencies. I do not know of a single instance in which an officer of the Public Health Service or the Children's Bureau has been detailed to any State except upon the expressed request of the State health authority.

In fact, Mr. Chairman, in my own experience, because of the limited personnel available to these Federal agencies, I have often had extreme difficulty in obtaining badly needed technical assistance when I have urgently requested it.

If every State and local governmental agency could have had the experience extending over many years that has been enjoyed by the State health authorities in dealing with the Children's Bureau and the Public Health Service, "the wolf cry of bureaucracy and Federal domination and control" would never have been raised.

Senator ELLENDER. Mr. Svendsen.

#### STATEMENT OF DOUGLAS W. SVENDSON, DEPUTY COMMISSIONER OF PUBLIC WELFARE, LOUISIANA

Senator ELLENDER. Will you give your name and your present position or occupation?

Mr. SVENDSON. My name is Douglas W. Svendsen. My official position is deputy commissioner of public welfare for Louisiana. I am also president of the Louisiana State Conference of Social Welfare, and I represent here today also the Louisiana Public Welfare Association and the State Hospital Board of Louisiana.

The people of the State of Louisiana wholeheartedly favor the principles of the proposed National Health Act, because it is recognized as an attempt by the Federal Government to make available to the citizens of the several States the medical and health services that have been so badly needed for generations, and that which is so vitally necessary if we expect the children of this generation to grow to normal adulthood, and, too, if we ever hope to restore our ailing

adults to the rightful place that is theirs in industry and agriculture.

There has been constant drains of the State treasures as the number of dependents continue to mount, and our experience has indicated that ill health is the greatest factor in resulting dependency. Unless something is done, on a national basis, to preserve and protect the health of our people, the number of dependent wards will increase to such proportion that the public assistance programs will not be able to meet the demands, and consequently the public will not have been educated to pay the bill. We must all be mindful of the long-time cost to the public in caring for individuals who have become dependent wards of the State because of unmet medical needs. Persons who would otherwise be self-sustaining citizens if an orderly and well-planned program of hospitalization and medical care had been available. The State of Louisiana considers the money it spends on the State hospital board program as an investment in the greatest "stock in trade" any State could have—its people.

Right here I am going to mention the reason Governor Leche in 1936 proposed the State Hospital Board Act, and I think it might really well be said it amounts to some of the same factors perhaps that were in the minds of Senator Wagner and others who proposed the National Health Act.

Governor Leche in 1936 recognized that the practical application of the Social Security Act and the State's public-welfare laws would entail ramifications not found nor recited in either statute. Chief among these was the problem of medical care for those whom the State would take unto its bosom as dependents. With this thought in mind he asked the legislature to adopt a State-wide system of hospitalization and medical care so that individuals certified for public assistance because of ill health could be restored to a normal and healthy life, and returned to their former occupations in industry and agriculture; and to guarantee to the children in dependent families a greater measure of security of health to fit them for parenthood.

With this the philosophy behind the creation of the State hospital board in mind, and again repeating that the principles of the proposed national health bill are sound and are wholeheartedly supported by our people, it is respectfully suggested that the committee consider the following amendments which we regard as consistent with the spirit of the proposed act.

It is suggested first that there should be some provision for Federal participation insofar as the operation of facilities constructed in States like Louisiana since the advent of the Social Security Act. If section 1201 of title XII is enacted as presently written, Louisiana will not be able to share for the 3-year period in the Federal funds that will be made available for operating costs of facilities, and perhaps there are other States who would be in the same position. If, however, the bill is amended so as to include State owned and operated facilities that have been constructed since January 1, 1936, material benefit will accrue to Louisiana. Otherwise, it might well be said that our progressiveness will have been penalized.

This first recommendation presupposes in a fashion amendment 2. We would suggest that section 1203 be amended so as to permit the State health agency or any other agency to submit plans to effectu-

ate the purposes of title XII. We respectfully refer the committee's attention to the wording of subsection (3) section 1303 of title XIII as indicative of the plan of administration we have in mind.

The third and last consideration concerns the reimbursement provisions of title XIII. The committee's attention is respectfully invited to page 48 of S. 1620, wherein it is recited that the highest proportion of Federal participation being applicable to the State with the lowest financial resources is 50 percent and the lowest proportion is 16 $\frac{2}{3}$  percent. It occurred to us that this ratio under title XIII would be 16 $\frac{2}{3}$  percent under the highest proportion allowed under other titles of S. 1620. In other words, it is conceivable that the State of Louisiana, being one of the States with the lowest financial resources, would participate up to 66 $\frac{2}{3}$  percent of funds expended under the other titles with 50 percent as the maximum under title XIII.

Senator ELLENDER. You represent, you say, the State hospital board?

Mr. SVENDSON. That is right.

Senator ELLENDER. For the record, how many general hospitals has the State of Louisiana; do you know?

Mr. SVENDSON. Yes. Under the jurisdiction of the State hospital board we have the Lafayette facility which has been in operation since last September.

Senator ELLENDER. How many beds?

Mr. SVENDSON. Two hundred and sixty. In central Louisiana we have the Huey P. Long Hospital, which is now being furnished and will be ready for operation in August.

Senator ELLENDER. How many beds?

Mr. SVENDSON. It has 250. And in two of the, so to speak, Florida parishes, over at Independence, we have the Florida parishes charity hospital with 60 beds. It has been furnished, already completed, and will be in operation in August. Then the proposed northeast facility in Monroe will have 150 beds. We expect to receive bids for the construction. We have already built the foundation.

Senator ELLENDER. How about the Charity Hospital in New Orleans?

Mr. SVENDSON. The Charity Hospital in New Orleans is, of course, as you know, under the administration of a separate board of administrators. It is now nearing completion and will, I understand, have approximately 2,800 beds, depending upon the spacing.

Senator ELLENDER. And Shreveport?

Mr. SVENDSON. Shreveport has 800 beds.

Senator WAGNER. When did this almost revolutionary change in Louisiana begin, when you focused your attention and activities on the better health facilities for the people of the State?

When did that begin, about?

Mr. SVENDSON. It started with Governor Leche's administration in 1936, that is, the expansion of it.

Senator WAGNER. You built a number of hospitals since then?

Mr. SVENDSON. Yes. You see, as the result of conferences between the Governor and Social Security Board, when we adopted the three public-assistance phases of the act, and passed State legislation permitting the State to cooperate with the Social Security Board and

the creation of the State department of public welfare, it was at that time the Governor recognized that the practical application of both the Social Security Act and State acts really entailed ramifications that were not recited in those statutes, he recognized there had to be something more than just providing assistance through the aid of the dependent-children category, old age, aid for the needy, blind, and the other unemployable group that is the fourth category that we have in Louisiana which, as you know, is paid entirely out of State funds.

Senator WAGNER. You built a number of State hospitals?

Mr. SVENDSON. Yes. Since 1936 we built the Lafayette facility, we built the Huey P. Long Hospital in Pineville, the Florida parishes charity hospital in Independence, and the foundation for the northeast hospital in Monroe, and of course the charity hospital in New Orleans.

Senator WAGNER. Have you had experience long enough now to be able to say that it has been reflected in the general improvement of the health of the people of Louisiana because of these increased activities?

Mr. SVENDSON. Considerably so. I could have furnished the committee with volumes of information, Senator Wagner, that would have perhaps taken more than two days to interpret.

Senator WAGNER. It is important. I would like to have it to indicate what these increased facilities accomplished in the way of improvement in the health of the people, and ultimately, of course, it will reduce your cost comparatively.

Mr. SVENDSON. Precisely. That is the thing. It will substantially relieve the drain on the State treasury.

Senator WAGNER. We have got to look into the future when we take these things up. You are wholeheartedly for the bill?

Mr. SVENDSON. Wholeheartedly; yes.

Senator ELLENDER. All of these facilities which you have mentioned are maintained entirely by the State of Louisiana?

Mr. SVENDSON. Entirely by the State. In addition, of course, to the State-owned and operated facilities we found it necessary to enter into contract with private hospitals located in sparsely settled sections of the State.

Senator ELLENDER. How many such hospitals have you contracts with?

Mr. SVENDSON. Seventeen.

Senator ELLENDER. Seventeen?

Mr. SVENDSON. Yes. The contracts cover four to six beds each. They take care of the emergency situations that come up from time to time.

Senator ELLENDER. Have you any idea of the approximate amount of money that Louisiana has spent for these facilities? I do not mean the building of them, but the maintenance of them.

Mr. SVENDSON. Our maintenance cost at Lafayette has been running \$2.36 per day.

Senator ELLENDER. Per patient?

Mr. SVENDSON. Per patient.

Senator ELLENDER. What I had in mind was the total amount appropriated for all of the facilities. Would you know that?

Mr. SVENDSON. We spent \$2,260,000, but that includes facilities, equipment, and operation.

Senator ELLENDER. That is for the ones under the Board?

Mr. SVENDSON. That is right.

Senator ELLENDER. Now, the the ones I had in mind would be the charity hospital at Shreveport and the one at New Orleans. Would you know the figures?

Mr. SVENDSON. I would not know the figures. I understand, however, that the cost per patient at New Orleans, prior to the construction of the new hospital, was \$1.90 per patient per day. I can get those figures for you.

Senator ELLENDER. I would like to have them for the record. If you can get them for each facility I will place them in the record at this point of your testimony.

Mr. SVENDSON. Would Senator Wagner like to have them?

Senator WAGNER. I would like to have them; yes, sir. I think it is very important. I express my great gratification for Louisiana's setting an example. I want to ask you this additional question, in view of what has been said by some of our friends of the medical profession: Were you coerced by the Federal Government to accept this aid to help your people?

Mr. SVENDSON. Not in the least.

Senator WAGNER. Did not you welcome the aid?

Mr. SVENDSON. Positively. It has been a great help to us.

Senator WAGNER. Could you accomplish as much for the protection of the health of the people of Louisiana without this aid?

Mr. SVENDSON. No. It has meant a great deal to Louisiana. That is the reason that we so strongly urge that the committee accept our recommendation, because it is going to give us additional money to expand the service that we have already started.

Senator WAGNER. I did not take the statement seriously that these doctors were coerced by the Federal Government to accept this aid in order to render their services.

Mr. SVENDSON. Certainly not in any of our experience, nor in any State with which I am familiar.

Senator ELLENDER. Thank you. Dr. Lorio.

#### STATEMENT OF DR. CLARENCE A. LORIO, PRESIDENT, LOUISIANA STATE MEDICAL SOCIETY, BATON ROUGE, LA.

Senator ELLENDER. Doctor, will you give your full name for the record?

Dr. LORIO. Dr. Clarence A. Lorio, president of the Louisiana State Medical Society, Baton Rouge, La.

Mr. Chairman, I came to Washington as a country boy to see a big city. My main object was to see Senator Wagner and see what he really looked like, for I heard so many unfavorable things about him that I felt that it would be necessary for me to see him and have a word with him. My trip has proven to be a splendid success, for I have spoken to the Senator and have found him to be a man as human as anyone I have ever known.

Although the medical profession's representatives appeared here today with a red flag flaring in front of them, definitely opposed to

all form of reform, I feel that they were at a great disadvantage in that they were an instructed delegation by the house of delegates of the American Medical Association and were so thoroughly instructed before appearing before this committee that rather than expressing their own individual views, they were obligated to act according to previous instructions and were, therefore, at a loss to give to the committee what it really needed, that being the proper information, that they might properly construct this bill, which I presume will be passed in some form, not necessarily in its present form.

I personally believe that a closer contact must be established between the medical profession and the Congress of the United States. By the "medical profession" I mean that part of it recognized as organized medicine. Therefore, I trust that this committee will, in all sincerity, work with the American Medical Association and with the various State societies. The American Medical Association represents supposedly the views of the various component societies, but a word from the component societies will enlighten you more fully as to the needs of the individual States.

I do not want to take any more of your time. The one thing I ask of the committee is that you, in some way, develop a closer and more cooperative contact with organized medicine, so that that body, which I have the honor of being a member, will receive due consideration in the future in relieving suffering humanity.

Senator WAGNER. I think you have had exhibited here a desire on the part of this committee to cooperate.

Dr. LORIO. I have.

Senator WAGNER. Then you are not entirely in accord with some of the views expressed here?

Dr. LORIO. I am not.

Senator WAGNER. You are in sympathy also with the efforts by the Federal Government to aid States?

Dr. LORIO. I am absolutely in sympathy with the efforts in that regard, and I think that something must be done to care for the indigent sick.

Senator WAGNER. Thank you very much.

Senator ELLENDER. That concludes the panel of witnesses, and the committee stands at recess until June 1.

(Whereupon, at 4:35 p. m., the subcommittee recessed until June 1, 1939.)



# TO ESTABLISH A NATIONAL HEALTH PROGRAM

THURSDAY, JUNE 1, 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) and Ellender.

Senator MURRAY. The subcommittee will come to order.

Senator Shipstead, do you wish to make a statement?

Senator SHIPSTEAD. Mr. Chairman, I have no extensive statement to make. I come here in the interests of a committee of the dental profession, who are very much interested in this bill. I myself have practiced dentistry for more than 20 years before coming to the Senate. These men are members high in the profession, and I think will give you testimony on which they have professional knowledge that may be helpful to the committee in forming and establishing a bill with the objective in view that the author of the bill has, and for the benefit of the Senate, if the Senate decides to enact legislation of such a character as that now before the committee, or any other kind of a bill to carry out the purpose that is expressed by the authors of the bill.

I will introduce Dr. Camalier to the committee. He is past president of the American Dental Association and past president of the National Association of Dental Examiners, and a man of very high standing in the profession, as are all of the other gentlemen of this committee.

I take pleasure in introducing Dr. Camalier.

Senator MURRAY. Thank you, Senator, for your statement. We will be glad to hear from Dr. Camalier and will be glad to hear from the entire dental profession as far as they are willing to give us advice and help in working out this bill.

## STATEMENT OF DR. C. WILLARD CAMALIER, PAST PRESIDENT, AMERICAN DENTAL ASSOCIATION, PAST PRESIDENT, NATIONAL ASSOCIATION OF DENTAL EXAMINERS

Dr. CAMALIER. Senator, this committee this morning represents the American Dental Association, composed of approximately 46,000 members in the United States and its possessions. We represent thoroughly the dental profession of the United States, and we feel qualified to speak in that regard.

I would like to say, before our detailed consideration of S. 1620, that the association is celebrating next year its one-hundredth anniversary of the establishment of the first dental school in the United States, and we feel that in those hundred years that the profession has made phenomenal strides along scientific lines and in connection with its ministrations to the health of the people of the United States.

I might say in connection with my administration last year—and I think that also can be vouchsafed by Dr. Miner, the dean of Harvard University, who was my predecessor, and Dr. Marcus L. Ward, who is the current president of the American Dental Association and regrets his inability to be present today—that in all of our visits throughout the States we found our profession vitally interested in this subject and also quite concerned with some of the approaches which have been made toward it. However, we are strictly—as I think you realize—we are strictly an American organization; we have no subversive influences within our ranks; and we are only interested in doing that which is best for the health of the people of the United States.

So, with that preliminary statement, Senator, I would like to introduce the members of our committee, and then finally, the chairman of our committee, who will present in detail the consideration of the bill.

SENATOR ELLENDER. Doctor, how many dentists are there in the United States?

DR. CAMALIER. About 62,000 practicing dentists in the United States.

SENATOR ELLENDER. And your association has a membership of approximately 47,000?

DR. CAMALIER. Just under 46,000.

I should first like to introduce Dr. R. M. Walls, chairman of the economics committee of the American Dental Association, and president of the Pennsylvania Dental Association.

Next, I should like to introduce Dr. Harold Hillenbrand, editor of the Bulletin of the Chicago Dental Society, and secretary of the national health program committee of the American Dental Association.

Dr. Lon W. Morrey, director of the bureau of public relations of the American Dental Association.

Dr. Leroy M. S. Miner, dean of the Harvard University School of Dentistry, past president of the American Dental Association, and member of the national health program committee of the American Dental Association, was with us all day yesterday, but he was unavoidably called back to Boston.

Also, Dr. Alfred Walker, member of the State board of dental examiners in the State of New York. He is not here, but he has also signed this statement.

I would like to present Dr. Harold Oppice, chairman of the national health program committee of the American Dental Association, and editor of the Illinois State Dental Society Journal, who will consider in detail the provisions of this bill.

**STATEMENT OF DR. HAROLD OFFICE, CHAIRMAN, NATIONAL HEALTH PROGRAM COMMITTEE OF THE AMERICAN DENTAL ASSOCIATION**

Dr. OFFICE. The organized dental profession in the United States, through its official body, the American Dental Association, has repeatedly expressed its deep interest in the relationship between dentistry and the public health and in the problems of distributing more dental care to larger groups of the population. To the rise of American dentistry, which is now universally acknowledged as having achieved world leadership, the American Dental Association has made many definite and substantial contributions.

There are approximately 62,000 practicing dentists in the United States and there are 45,768 members in the American Dental Association. This high percentage of representation and its long record of interest and activity in the matters of public health give the association the competence and right to speak on any program that involves dentistry. Since S. 1620 proposes to include the services of dentists in a national health program, the American Dental Association is appreciative of this opportunity to place before you its views on the subject.

In spite of the fact that the American Dental Association represents dentistry in this country, it was not officially invited to participate in the National Health Conference, held in Washington July 18, 1938, although four of its members were extended personal invitations to attend and its president was granted the privilege of the floor during the conference. It was at this conference that the national health program, which S. 1620 attempts to translate into legislation, was first revealed.

At the first opportunity thereafter, October 24 to 28, 1938, the house of delegates of the American Dental Association nevertheless considered the published proposals of the conference and, in the best interests of the public and of the profession, evolved a group of principles that should govern the participation of dentistry in any national health program.

In an effort to place these essential principles before the proper agencies the American Dental Association asked for a conference with President Roosevelt's Interdepartmental Committee to Coordinate Health and Welfare Activities and appointed a committee for that purpose. This conference was held with several members of the technical committee, and the association presented its opinion of the changes and suggestions that should be incorporated into the national health program.

The report of the Interdepartmental Committee was later transmitted to the President and by him to the Congress for study. This report was supposed to furnish the basis for future legislative proposals, of which S. 1620 is the first. It must be noted that not a single change or proposal suggested by the association is incorporated in either the final draft of the national health program or in S. 1620. This points plainly to the fact that both the program and the bill were prepared without making any use of the available experience

and knowledge of the only body professionally qualified to speak on the subject.

The attitude of the American Dental Association toward all efforts to formulate an efficient, feasible, and comprehensive national program for dental health has been one of leadership and cooperation. The association has consistently favored, upheld, and fostered the same objectives which motivate the national health program and S. 1620. The American Dental Association is professionally concerned with four of the main divisions of both the national health program and S. 1620 because only these have dental applications. In considering these four divisions the association has expressed its opposition only to the principle employed in one division—that which makes possible the establishment of a system of compulsory health insurance in this country. In all of the other divisions, however, the association has cooperated by suggesting various changes by which these common principles could be more effectively advanced.

In addition to this single objection to principle—namely, that of compulsory health insurance—the further objections which we now present are directed against the methods or mechanisms provided in the bill, and against the essential methods or mechanics that have been omitted.

A short, preliminary statement on the unique position of dentistry in a national health program is essential to a full understanding of the association's position in regard to S. 1620.

There are certain definite differences between the problems of dentistry and the other health-service professions. These differences arise out of the peculiar problems presented by dental disease and are based on the following facts: (1) the occurrence of dental caries (decay of the teeth) is almost universal; no other disease afflicts such a large part of the population almost constantly with the result that no other profession is confronted with similar problems in prevention and control; (2) dental decay, unlike many other diseases, never heals of itself and always requires the technical intervention of the dentist; (3) dental disease does not ordinarily manifest itself in the striking, unmistakable way that many other diseases do, and thus dental disease is often allowed to go untreated, even when treatment is readily available, until its extent is so great that repeated attacks of pain, an unsightly appearance or systemic involvements demand a service that is more extensive and consequently more costly; therefore, any successful dental program must involve the education of the public to recognize the danger in these insidious attacks of dental disease; (4) the cause of dental decay is not yet scientifically established in spite of intensive research, most of which has been conducted by the American Dental Association, dental schools and foundations. The United States Public Health Service, in cooperation with the American Dental Association, has also made some studies in this field; (5) the present state of knowledge of the cause of dental decay indicates that the prevalence of the disease can be reduced by proper measures of diet, oral and general hygiene, and early corrective treatment for children. These measures can be made more definitely effective when the cause of dental decay is scientifically established.

In the light of these facts, the objections of the American Dental Association to S. 1620 are more easily understood.

The American Dental Association is opposed to S. 1620 in its present form. It takes this opportunity to explain this opposition in relation to the principles established by its house of delegates for the participation of the association in a national health program.

The first principle established by the house of delegates of the American Dental Association, October 1938, is as follows:

In all conferences that may lead to the formation of a plan relative to a national health program, there must be participation by authorized representatives of the American Dental Association.

This principle has been consistently ignored by those charged with the formulation of the national health program upon which S. 1620 is supposed to be based. The American Dental Association was not officially invited to participate in the national health conference. This association did not receive an invitation to confer with the technical committee until one was requested. The association, however, felt that it must make its contributions to these enterprises and submitted its principles and proposals. Not one of these suggestions or changes has been incorporated into either the national health program or S. 1620.

This indicates a refusal to recognize the official body of American dentistry and to make use of the knowledge and experience which that organization has acquired and also raises the question of future policy in regard to this important matter. It does not seem logical that this association should not have something of value to contribute to the formulation of a national health program after its many years of constructive service to the public health.

The second principle established by the house of delegates of the American Dental Association, October 1938, is as follows:

The (national health) plan should give careful consideration to: First, the needs of the people; second, the obligation to the taxpayers; third, the service to be rendered; and, fourth, the interests of the profession.

1. "The plan should give careful consideration to, first, the needs of the people \* \* \*." The American Dental Association is of the opinion that S. 1620 will not satisfy the needs of the people because it implicitly promises a program which government would be unable to deliver under the appropriations established by the bill.

On the other hand, S. 1620 is worded so vaguely and its authorities are so obscurely designated that it would be possible for administering officials arbitrarily to withhold essential dental service from a national health program. The association feels that there can be no debate as to the value of dental service to the general health of the Nation. Irrefutable scientific and clinical evidence has demonstrated that some dental service is absolutely necessary in any program that proposes to have a permanent and effective influence on the national health.

The "needs of the people," in the opinion of the association, are not satisfied by any bill which allows such extreme latitude in the inclusion of dental service in a national health program.

2. "The plan should give careful consideration to \* \* \* second, the obligation to the taxpayers." Organized dentistry, as such,

does not have its primary concern with the origin of funds that are to be used to furnish dental service to the public in a national program. The members of organized dentistry, however, do have an interest in this source because: (a) They are obligated to pay taxes the same as other citizens; (b) they are engaged in a professional health service which has its first duty to the public and community welfare. Therefore any program which proposes the collection of community funds for dental service immediately becomes of interest to the dentist; (c) dentists, as members of the profession, individually and collectively, have always made substantial contributions of their time and services to those who were in need of them. If a program is to be established which proposes to pay dentists for this service heretofore freely rendered, they have a right to know who is to assume the burdens of such payment.

(a) This bill does not curtail any existing activity of government and therefore proposes new expenditures out of tax moneys. Further, if Federal subsidy is to be matched by State fund, the States will have to curtail existing activity or raise new tax moneys to participate in the program. This could be justified if the mechanisms proposed by the bill could be clearly shown to achieve the desired objectives. In the absence of such demonstration S. 1620 works unfairly against those who must pay for the enterprise.

(b) S. 1620 employs the proper principles when it specifies unification of health activities in the State. S. 1620 does not, however, provide for this essential integration in the health activities of the Federal Government. In support of this we cite the fact that at least one important health bureau of the Federal Government has not been placed under the jurisdiction of the newly proposed Bureau of Federal Security. The cost of maintaining these agencies without proper integration in both Federal and State Government will be an unjustifiable burden on the taxpayer.

(c) The expenditure of tax money for a dental program that does not include essential measures for the prevention of defects and therefore a future lessening of the tax burden is uneconomic and an unnecessary burden upon the taxpayer.

3. "The plan should give careful consideration to \* \* \* third, the services to be rendered." S. 1620 places ultimate control of medical and dental services in the hands of agencies which are at present under lay control. Therefore, the bill does not provide sufficient guarantees to insure a high quality of service; to allow dentistry to advance unhampered under the normal impetus of scientific investigation and research, and to prevent its deterioration under improper control, lax standards, and lay administration.

S. 1620 does not provide for professional policy boards whose advice will be effective. Thus a mechanism for administering professional services could be provided under the terms of the bill without giving consideration to those specifically trained and experienced in that work.

S. 1620 provides that the Federal Government will not participate in an expenditure "in excess of \$20 annually per individual eligible for medical care under such a plan." There is satisfactory evidence that even if this entire sum were to be devoted to dental service, as assuredly it cannot be, it would not be sufficient to provide for each individual the necessary amount of quality dental service that

is needed. This fact makes it extremely important that expenditures for a national dental program primarily be used for the definite purpose of decreasing the need for dental care in the future so that the burden of cost will become of manageable proportions.

4. "The plan should give careful consideration to \* \* \* fourth, the interests of the profession." No provision is made in S. 1620 to make the seeking or the acceptance of professional advice mandatory in dental matters. This, plus the power of the Federal Government to grant or withhold subsidies, can result in the establishment of standards for education, practice, and personnel which are contrary to the basic principles of the profession and which are essential to a proper quality of dental care.

S. 1620 also places in the hands of those not qualified, the ultimate power to fix professional fees. There is no guaranty in the bill that such remuneration will be sufficient to make possible satisfactory dental service.

The third principle established by the house of delegates of the American Dental Association, October 1938, is as follows:

The plan should be flexible so as to be adaptable to local conditions.

S. 1620, through its power to grant or withhold subsidies, can force compliance with standards that do not recognize or satisfy the specific needs of a community with regard to methods of practice, treatment, administration, and remuneration.

The fourth principle established by the house of delegates of the American Dental Association, October 1938, is as follows:

There must be complete exclusion of nonprofessional profit-seeking agencies.

S. 1620 does not explicitly set up any such agencies at the present time but there is, however, also no guaranty that such agencies will not be developed in the future.

The fifth principle established by the house of delegates of the American Dental Association, October 1938, is as follows:

The dental phase of a national health program should be approached on a basis of prevention of dental disease.

S. 1620 does not contain any assurance that this logical approach to the problem will be employed. Under the terms of the bill it is possible to approach the problem on the basis of providing complete reparative and restorative dentistry for the entire population. Such a program involves high expenditures and is scientifically and economically unsound because it does nothing to diminish the future burden of dental disease or to lessen the future burden of paying for dental care. Such a program is only a stopgap measure that would have little permanent or constructive effect on the national dental health. The association will have a recommendation to make in regard to this very important part of the bill.

The sixth principle established by the house of delegates of the American Dental Association, October 1938, is as follows:

The plan should provide for an extensive program of dental health education for the control of dental disease.

S. 1620 does provide for public-health programs in the eradication of specific diseases, such as malaria and tuberculosis, pneumonia and cancer, but it does not include provisions for a similar program against the most prevalent of all diseases—dental caries. The bill

makes it possible for administering agencies to refrain from instituting such a program of education which is essential to the success of the dental program. The American Dental Association is of the opinion that a sound national-health program must include dentistry and that a national-dental program must rest fundamentally and finally on a plan for widespread dental education in conjunction with other preventive efforts and the early discovery of the cause of dental caries.

The seventh principle established by the house of delegates of the American Dental Association, October 1938, is as follows:

The plan should include provisions for rendering the highest quality of dental service to those of the population whose economic status, in the opinion of their local authorities, will not permit them to provide such service for themselves, to the extent of prenatal care, the detection and correction of dental defects in children, and such other services as is necessary to health and the rehabilitation of both children and adults.

S. 1620 does not include these provisions. The bill does, however, make possible a complete system of tax-supported, dental care for all groups of the population (which is contrary to the above principle), and for which it does not provide sufficient appropriations.

The eighth principle established by the house of delegates of the American Dental Association, October 1938, is as follows:

For the protection of the public the plan shall provide that the dental profession shall assume responsibility for determining the quality and method of any service to be rendered.

S. 1620 does not safeguard this principle but allows the quality of dental service to be determined and influenced by various agencies which are not under professional supervision or control.

From all of this it can be seen that the American Dental Association is of the opinion that S. 1620 does not recognize the principles which the association insists are fundamental to an effective national-health program, and includes principles that the association has declared are detrimental to the welfare of the public and of the profession.

The American Dental Association reiterates its opposition to S. 1620 in its present form, because—

I. It will allow for the creation of a system of compulsory health insurance—a form of practice that has been unconditionally opposed by the American Dental Association.

II. It is vague and obscure in its wording regarding methods of procedure and assignments of authority.

III. Its provisions will not permit the full development of a national-health program because it fails to recognize that dentistry is an integral service necessary to the improvement of the public health.

IV. It does not recognize the importance of preventive dentistry as the basis of a national-dental program which has been consistently recommended by the American Dental Association.

V. It makes possible methods of practice that would be detrimental to the dental health of the public and to the continued progress of the profession and does not specify important mechanisms by which the quality of the health services rendered to the public will be controlled.

VI. It makes possible an unscientific and uneconomic expenditure of tax moneys for a program that the American Dental Association believes will not achieve its objectives.

VII. It places under Federal control and supervision methods of practice, treatment, administration, and remuneration which should be determined by, and acceptable to, local communities.

VIII. It does not recognize the essential differences between dentistry and the other health-service professions.

IX. It has disregarded the fundamental principles proposed by the American Dental Association for the protection of the public and the profession.

X. It does not provide for the integration of all Federal health activities in one agency.

The attitude of the American Dental Association, however, is not destructive of any proper effort to advance the interests of the national health. For this reason it submits the following proposals by which a national health act can be made beneficial to the people of the Nation.

#### PROPOSALS

1. All Federal health activities, with the exception of the military services, should first be combined in one agency.

2. A national health bill should consider and make use of the principles established by the house of delegates of the American Dental Association.

3. A separate title should be devoted to dentistry in any national health legislation in order to:

(a) Make provision for the essential differences between dentistry and other health services; and

(b) Augment with a comprehensive research program the efforts of the organized dental profession to determine the cause of dental diseases.

4. The following dental program should be carried on until the discovery of the cause of dental diseases enables a more informed attack on the problem:

(a) A program of preventive dentistry for children that would be based on the present knowledge of the subject in order to decrease the future accumulation of dental disease. This would include a development of the educational program, initiated by the American Dental Association, to preserve the natural teeth and to teach both children and parents the importance of preventive dentistry during the prenatal, infant, preschool, and school periods.

(b) A program of education for dentists to make available to them the latest advances in preventive dentistry as they are revealed through clinical experience and research.

(c) A program for providing "the highest quality of dental service to those of the population whose economic status in the opinion of their local authorities, will not permit them to provide such care for themselves, to the extent of providing prenatal care, the detection and correction of dental defects in children, and such other services as are necessary to the health and rehabilitation of both children and adults."

## SUMMARY

A. The American Dental Association has outlined the principles that should govern the participation of the dental profession in any national health program.

B. The American Dental Association has demonstrated that S. 1620 consistently ignores or violates these principles.

C. The American Dental Association has expressed the reasons for its opposition to S. 1620.

D. The American Dental Association has made proposals by which dentistry can participate in a national health program that will contribute to the health and welfare of the people of this Nation.

Senator MURRAY. Doctor, from your statement I feel you are in favor of the national health program, but you feel that the program should consist principally of research, education, and preventive methods, and not so much a program of dental care to individuals direct?

Dr. OFFICE. For children, dental care, if they are in the indigent class, or if they are dentally indigent. For adults in the same class who need to be rehabilitated, and by that we mean individuals who would be handicapped from making a normal salary or working at their usual occupation if they had such dental defects.

Senator MURRAY. You accentuate, however, the need for research and methods of preventing the necessity of dental work; is that correct?

Dr. OFFICE. That is very true, and for the particular reason that any dental program must be a long-time program. We must reduce not only the incidence of caries which research would do, but we must reduce the prevalence of it by prevention and early correction.

Senator MURRAY. This country has made more progress in dentistry than almost any other nation in the world, has it not?

Dr. OFFICE. That is correct.

Senator MURRAY. Do you attribute the health conditions of the country largely to that fact, the superior health conditions of this country, to the fact that it has made such splendid progress in dentistry?

Dr. OFFICE. I would not say entirely so, but I would say partially.

Senator MURRAY. It has had an effect?

Dr. OFFICE. Yes; it has had an effect.

Senator MURRAY. Have you prepared any proposed amendments to the bill? Have you taken the bill and can you submit to us any proposals that should be incorporated in the bill, aside from your general statement?

Dr. OFFICE. Not in the form of amendments; no, sir; we have not.

Senator MURRAY. You have never prepared those?

Dr. OFFICE. No.

Senator MURRAY. Do you desire to prepare any and submit them for us?

Dr. OFFICE. I could not answer that on the part of the association. The association's house of delegates will not meet until July 17, in Milwaukee, and so far as the committee is concerned we have never considered it.

Senator MURRAY. You feel, however, that there should be particular sections added to the bill that should consider and give effect to these proposals that you have submitted here this morning?

Dr. OFFICE. That is right.

Senator MURRAY. Don't you think in view of the fact that your profession is in the possession of superior knowledge in that regard, that you ought to try to assist us by presenting what you think would be proper provisions to be incorporated in a national health bill?

Dr. OFFICE. We would be very happy to do so. I might give my personal opinion about writing amendments for this particular bill, for dentistry and dental services are not mentioned in any line or title of it. They are included under a general term of "other allied services"—I believe that is the wording of it.

Senator MURRAY. Doctor, the reason we are holding this hearing is to find out what the defects are in this proposed bill, and to enable the committee to formulate a bill and make changes to it even to the extent of substituting an entirely different bill for it if necessary in order to give the country the kind of a health bill that it ought to have.

Dr. OFFICE. I did not understand that before, but, if that is the case, I would add that in my personal opinion the bill would have to be entirely rewritten to include dentistry or dental services under a separate title of the bill.

Senator ELLENDER. Unless you put it in a separate title?

Dr. OFFICE. Yes.

Senator ELLENDER. This would take care of the health part, medical care as we define it here, and the dental aspect could be written under a different title?

Dr. OFFICE. That is right.

Senator ELLENDER. Doctor, I notice that one of your objections is that the bill allows for the creation of a system of compulsory health insurance. Will you point out any language in the bill leading you to that conclusion?

Dr. OFFICE. I believe that is very easily understood in this statement, that the States are first requested to prepare a program or mechanism for carrying out this program; therefore, as I understand it, any State could prepare a program which included under title 13, a compulsory health-insurance system for that State. They would then present that program for that particular section to the Social Security Board.

Senator ELLENDER. Is it not a fact that all the State would have to do would be to prepare a health program, and then match whatever money it raises with the moneys that would be provided for under this bill? Is that not really after all what this bill provides for? I fear that you are probably comparing this bill with the first bill that was introduced, or the first program that was proposed and which was severely criticized by the American Medical Association last September. Dr. Booth appeared here about 3 or 4 weeks ago as representing the American Medical Association and used practically the same language as you do, and that was one of his first objections that it would lead to compulsory insurance, and personally I am opposed to that and I should like for you to point out in this bill any specific language on that subject? I would rather

negative that phase of the problem; I would want to take it out of the bill.

Dr. OFFICE. Your statement that you have just made that it is our opinion that this bill would lead to compulsory health insurance is erroneous; our statement does not say that. We say that it would make it possible. Leading to it and making it possible might be considered the same, but I do not think so.

Senator ELLENDER. You mean to say that, instead of raising money by taxation, the State should force its inhabitants to pay in proportion to the medical attention it received?

Dr. OFFICE. No; I do not think this has anything to do with the paying. A system of compulsory health insurance as a matter of fact, at the present time, without regard to this bill, could be instituted in any State if the legislature passed it.

Senator ELLENDER. What do you mean by compulsory health insurance? We may not understand each other on that subject.

Dr. OFFICE. Well, that is a system as I understand it—

Senator ELLENDER (interposing). Of forcing a man to go to the doctor?

Dr. OFFICE. Oh, no. It is a system of forcing a man for the payment of everybody in a certain group to go to the doctor.

Senator ELLENDER. In other words, you fear that the State may develop a plan whereby instead of obtaining this money through taxation to match whatever the Government would put up, that it would force everybody to pony up, as it were?

Dr. OFFICE. That is right. We are not so much interested in the forcing of people to pay for it as we are in the system or method that would come under that program. That is the thing that we are opposed to—that the association is.

Senator ELLENDER. Your association is not against the Federal Government providing funds?

Dr. OFFICE. For a health program?

Senator ELLENDER. Yes.

Dr. OFFICE. Absolutely not.

Senator ELLENDER. You stated in criticism that you felt the amount of money appropriated was rather small.

Dr. OFFICE. For what the bill promises, I do.

Senator ELLENDER. Of course, some of us would like to get all of the money necessary. But the bill provides for an appropriation in the space of 3 years of I think something like—the first year it is 90 or 93 million; the next year it is 100-and-some-odd million, and the third year it is 200-and-some-odd, and at the end of 10 years it may reach four or five hundred million. Your idea would be to start out with a large sum?

Dr. OFFICE. In regard to that, I believe that the bill should be as particular about what it promises to give the people of the country as it is specifically the amount of money that should be spent, in other words, all of these programs—and this is a personal opinion—all of these programs are apt to be considered by certain individuals as political footballs, they are apt to be taken that way, and whenever you promise the people so much and only provide a limited amount of money for doing it, in other words not enough, you are apt to class that bill as a political type of bill in order to get votes.

That seems to me as valuable as the objectives of this bill. The bill should not be given that sort of a color because it leaves the amount of service that can be given as an intangible quantity. It is very vague on that particular point and yet it is very specific on the amount of money that is going to be used from the Federal Government and also from the State.

Senator ELLENDER. How would you remedy that? Would you limit the bill in the field in which it is to operate, or would you raise the amount of money to be needed?

Dr. OFFICE. I would be more specific in what the money was to be spent for, and particularly as long as we are talking about dentistry, how much was to be spent for dentistry, and then the dental profession would tell you how much service you would get for it.

Senator ELLENDER. You say that you are not included under the terms of the bill and you should be treated under a separate title, and as far as I am concerned, I think that you are right. Well now, how much money would you say that we should appropriate to take care of the dental aspect of this problem?

Dr. OFFICE. I do not think that we can answer that offhand.

Senator ELLENDER. Make a beginning. Remember that we in Congress here have got to go at it very slowly. We cannot ask for and obtain five hundred million when as a matter of fact it might require that much.

Dr. OFFICE. May I have Dr. Morrey, our director of public relations, answer that question for you?

Senator ELLENDER. Yes, surely. I hope he sharpens his pencil before he comes up to testify.

Dr. MORREY. Very roughly, we estimate it would take \$60,000,000 to take care of the children aspect.

Senator ELLENDER. \$60,000,000 per year?

Dr. MORREY. Yes; indigent children.

Senator ELLENDER. How many children would that take care of?

Dr. MORREY. Between 15 and 20 million.

Senator MURRAY. Are there 15 or 20 million indigent children in the country?

Dr. MORREY. No. That is not all for operative care. That is for an educational program plus operative care for those children who would need it, indigent children. You see, we are just as much concerned about the poor little rich child as we are about the poor little poor child, and we have found from experience in putting in a good educational program that many of these children will get their work done if the parents learn that it is necessary to have it done. On the other hand, there are some that do not, and for those children we must provide care.

Senator ELLENDER. In other words, you figure that \$3 per child will be needed for the educational aspect?

Dr. MORREY. I believe it would. In some communities it would cost more than that, and of course in some communities it would cost less than that.

Senator ELLENDER. What would be included in the program that you have in mind for this \$60,000,000?

Dr. MORREY. Very intensive educational program for all of our children. And taking in, as was pointed out in these suggestions, a

program of care during the prenatal, the infant, the preschool, and the school periods.

Senator ELLENDER. Would that be in the nature of lectures and things of that sort?

Dr. MORREY. Lectures, literature, and every means that we could use to educate these parents, to feed these children properly and give them the right amount of care, plus early preventive operative care for these children.

Senator ELLENDER. It would not mean visits to the dental office by the individuals or anything like that?

Dr. MORREY. For those indigent children we would have to provide some means to give them dental care.

Senator ELLENDER. After what age would you care for them?

Dr. MORREY. I would say up to and including the age of leaving school, 14 years of age.

Senator ELLENDER. And all of that could be done for approximately \$60,000,000 per year?

Dr. MORREY. We think so.

Senator ELLENDER. Now, what other phase of dental care would you prescribe and how much would it cost?

Dr. MORREY. For the adults?

Senator ELLENDER. For the adults; and I guess you would have to take care of these children after 14, wouldn't you?

Dr. MORREY. I see what you mean. From 14 years of age on?

Senator ELLENDER. Yes.

Dr. MORREY. Frankly, I would not be prepared to give you an answer on that; I would not know.

Senator ELLENDER. To what extent would you say the Government should aid children above 14 and adults?

Dr. MORREY. Our association has gone on record to that effect. We believe that these people who cannot afford to provide dental care for themselves, or for their children, should be given dental care that will put their mouths in a healthy condition.

Senator ELLENDER. And you would not know how much that would cost?

Dr. MORREY. I would be very hesitant to quote a figure on that.

Senator ELLENDER. How would you suggest that it be done, assuming now that you have got the necessary funds?

Dr. MORREY. I think I can state this—

Senator ELLENDER (interposing). To what extent would you expand the program?

Dr. MORREY. We believe that in most instances that should be done in the office of private dentists.

Senator MURRAY. Doctor, are you going to appear here as a witness?

Dr. MORREY. Not unless I am requested.

Senator MURRAY. I was going to say that if you are going to make a separate appearance here, that we would finish with the present witness, and then hear your statement.

Dr. CAMALIER. No; we did not anticipate a separate statement by Dr. Morrey.

Senator MURRAY. Very well then; go ahead.

Senator ELLENDER. You say they will have to visit the offices of the dentist. Would you provide separate clinics, or would you provide

for a system of fees to be paid to the dentists for doing this dental work for the indigent?

Dr. MORREY. I think that would be determined largely by local conditions. In some communities, you would have to provide for care in one manner, and in another community you would have to provide for it in another manner, depending upon the local conditions. I can readily visualize in these remote areas you would have to provide a dentist to go out and take care of these people in the rural areas, and in the valleys, back in the mountains, but in other areas that would not be necessary.

Senator ELLENDER. The reason I suggest that is in Louisiana—I think Louisiana is the first State in the Union—we provide dental clinics that are built in trailers that go about in the country. We have I think, 10 or 12 of them.

Dr. MORREY. Yes; you do have.

Senator ELLENDER. You think that method would be advisable?

Dr. MORREY. I can readily see down in your part of the country in certain areas of your State where that would be all right.

Senator ELLENDER. How would you handle it in the larger centers? Would you let the dentists who have regular business take care of a certain amount of indigent patients at certain fixed price?

Dr. MORREY. I think that could be done.

Senator ELLENDER. Or would you have a clinic supported from public funds?

Dr. MORREY. At the present time we believe it can be done just as economically and just as well in the offices of the dentists now in the area. We can see no reason for spending large sums of money for establishing clinics where they cannot provide a service much if any cheaper than in the private offices.

Senator ELLENDER. To what extent would the profession be willing to help in carrying on this work at a minimum cost or at a reasonable cost?

Dr. MORREY. Well, I would say from my own personal opinion and judging from past experience, that they would be willing to cooperate 100 percent.

Senator ELLENDER. And you say that you do not have any ideas as to how much that would cost?

Dr. MORREY. No; that is too big a problem.

Senator ELLENDER. Would you be able to do this for us? What would be the average cost per adult, let us say, to take care of him properly? And when I say the cost, I mean this—I do not mean to make your costs like you would here in Washington or in New York.

Dr. MORREY. A fair fee?

Senator ELLENDER. I mean a fairly low fee.

Dr. MORREY. Of course, that is a debatable problem; it is a debatable subject. I do not know whether we want to go into that.

Senator ELLENDER. You can make it a minimum and a maximum, depending upon the particular locality or area.

Dr. MORREY. We do not pay the grocer low fees for food if he supplies it to indigent people; we do not pay a coal dealer a low price for the coal that he supplies to these people. We pay them the retail prices, but it is debatable whether we should insist on paying the physician and the dentist a low fee for necessary work for these

people. However, that is a debatable point. I think that you will find from past records that the dentists in this country have always been willing to reduce their fees considerably to take care of these indigent people; there is no dispute about that. We are on record on that.

Senator MURRAY. At the present time, are there not many people in fairly decent circumstances that avoid going to the dentist because they feel that it might cost too much? That is true, is it not?

Dr. MORREY. I think that is true in some instances. Of course, many people do not go to the dentist because they fear pain. That is the main thing.

Senator ELLENDER. What do they charge, for instance, for X-ray pictures of teeth? What is the cost of that service?

Dr. MORREY. You mean a full mouth X-ray?

Senator MURRAY. For a single tooth.

Dr. MORREY. That varies; that varies according to the community and according to the dentist that they go to.

Senator MURRAY. Why should it vary to such a great degree? Why can't they give a fair price for that thing and have it fairly uniform, because that is a very well-established mechanism now, and it seems to me that one doctor should not charge four times as much as another.

Dr. MORREY. Well, I don't know; that is debatable.

Senator ELLENDER. You mean as to whether he should charge more than the other?

Dr. MORREY. Yes. Why not? Why should he not?

Senator ELLENDER. I would like to get your view.

Dr. MORREY. A dentist has two hands to work with, he has so many hours of the day to work with. If one dentist is satisfied, we will say, to go along on a pittance of \$1,500 a year, then he charges accordingly; but if another dentist wants to increase his income and wants to increase those things which he wishes to give to his family, he has to charge higher fees.

Senator MURRAY. And you think that is legitimate, do you?

Dr. MORREY. I certainly do.

Senator MURRAY. You think, for instance, a corporation, if it wanted to make more money in order to allow the officers of the corporation to live better, that they would be entitled to charge as high prices as the trade would permit?

Dr. MORREY. Oh, no; you have got to use judgment.

Senator MURRAY. You have to have some judgment?

Dr. MORREY. You have to use judgment, but the point I wish to make here for you is that you cannot standardize fees. We would not want to do it in our American way of doing things.

Senator MURRAY. Well, an X-ray picture of a tooth is a very simple operation, is it not?

Dr. MORREY. Yes.

Senator MURRAY. Some dentists, you can go into their office and sit in a chair, and they take the picture just like that, and it is all over, and they never make any reference to it. Another dentist, you go to his office and he will go through a lot of detail and have you go over and give your name to a secretary, and she will send you over to another desk, and then they will send you back into another room, and great ceremonies will precede the actual taking of the picture, and

then when you finally get through you are charged a big price for having that one picture of your tooth taken, when it is a well-known method in this country and can be found away out in the country districts sometimes, where a simple country dentist will give you a picture of your tooth without batting an eye.

Dr. OFFICE. May I answer that question for you?

Senator MURRAY. Yes.

Dr. OFFICE. I might start with a comparison of the law profession. I don't know whether you happen to be a lawyer or not. But you can go into a lawyer and pay almost any price for his services. That is a service. The taking of an X-ray as a procedure does not cost so much nor is there very much charged for the taking of it. But the diagnosis of the X-ray is where you get into the cost, and the individual few dentists that you cite, the ones who put you in the chair and snap the picture or snap the machine and the picture is there in a moment's time—of course it does take some time to develop the X-ray the same as it does with any picture—and then he does not refer to it afterward, that dentist perhaps is not giving you a very good service, and he is not charging you very much for it.

The other dentist who perhaps had this girl in his office who did all of these things that you spoke about—and it sounds a little facetious to me to talk about it, I will agree with that—but nevertheless, he was using his time—

Senator MURRAY (interposing). I do not see anything facetious about it.

Dr. OFFICE. When you talk about it, it does.

Senator MURRAY. It should not seem facetious, if it is an actual fact. Then you cannot call it facetious.

Dr. OFFICE. I will tell you why it is necessary in the second place. This dentist's time is very valuable. The reason for the extra cost is not for taking the picture or for the use of the girl that you spoke of. It is because he takes time to diagnose that picture and go over it with the patient and educate that patient as to what he should or should not have in the way of dentistry to improve his oral health. That is the reason you pay one price in one place and another in the other.

But let me say this, that in practically every location in this country—not all—there are some areas in this country where these things are not available without going some distance and where the cost is perhaps a little greater than others, there are some places, some laboratories or dentists' offices or physicians' offices, where you can get an X-ray of an individual tooth for 50 cents, and if you can show me any other such service where you can get a picture taken of any kind, X-ray or otherwise, for the small fee of 50 cents, I would like to know where it is.

Senator ELLENDER. I can get some three for 35 cents. [Laughter.]

Dr. OFFICE. You mentioned Washington prices, Senator. X-rays in Washington, I understand, are usually \$5 for the entire mouth.

Senator ELLENDER. Does it not depend upon the dentist that you go to, the amount of work he has, and the reputation that he bears in his community? I am not blaming the man for it.

Dr. OFFICE. For the taking of the picture?

Senator ELLENDER. Yes

Dr. OFFICE. Absolutely it does. I am not defending the X-ray specialist particularly, but I do think from what the Senator says, they need some defense. We can even compare that to the taking of a portrait picture. You can get that for any price that you want to pay, and you do not get any more than you pay for. The same thing is true with X-rays; you can take one of these pictures in the manner that you spoke of, and you will get a blurred picture, or you will get one with the bony process superimposed over a tooth, and which is worthless, yet that is done in many instances carelessly.

Senator MURRAY. It all depends, of course, upon the particular dentist. If he is a competent dentist and if he is a graduate of a well-established school, for instance of the University of Michigan, he would be considered a reputable and competent man, would he not?

Dr. OFFICE. Competent; yes; when he graduates. And that brings out the point in this whole program that I want to emphasize—he is competent when he leaves school. If he becomes discouraged because of a lack of a proper fee, a very low fee, we will say, if he was engaged on one of these programs where the fee was at a minimum cost, he would soon become discouraged because he would be making very small fees. What, then, incentive would he have to do the kind of X-ray work, as an example, that he should do?

Senator MURRAY. That is all very true, Doctor. It all depends upon the particular locality where he is operating.

Dr. OFFICE. His fees would depend upon the locality. If he was in one community that had higher standards, he would get more fees.

Senator ELLENDER. Then there is the investment which he has. You would have to consider that too. X-ray machines are rather high priced, aren't they? They cost quite a sum?

Dr. OFFICE. Oh, yes.

Senator ELLENDER. That is a little off the subject. I was trying to get from Dr. Morrey the information, if we should find it feasible to provide for a separate title, and I would be personally interested in finding out about how much money it would require. Could you give us a scale of prices, the average price that you think it would cost, let us say, to the Government should it desire to enter into a contract with certain dentists in certain localities?

Dr. MORREY. There is a scale of prices now that the United States Public Health Service has worked out that are fairly reasonable. You have them on the record. You are using them now. I cannot give them to you offhand, because I do not have them with me.

Senator ELLENDER. Is that for the indigent?

Dr. MORREY. Yes. Those fees have been fairly well accepted by the different State societies as being fair fees.

Senator ELLENDER. Are they uniform?

Dr. MORREY. I will modify that by saying in some communities they may be lowered a little bit. In other communities they would have to be raised. You take, for instance, in a city like New York; we all know that the cost of living in New York and the overhead and everything is much higher than it is in some rural communities, and so we have to adjust our business accordingly, and we have to adjust our fees for the indigents very greatly, but the United States Public Health Service does have a scale of fees that are fairly acceptable, and with a little variation could be accepted.

Senator ELLENDER. And those would be acceptable in your opinion to the dental societies?

Dr. MORREY. In my opinion.

Dr. OFFICE. Might I answer a little further your question as to the cost for dental service?

Senator ELLENDER. Certainly; I wish you would.

Dr. OFFICE. So far as we know, this is the only survey on the cost of dental care for adults under health insurance that has ever been made. I am not going to go through it, but I am going to answer your question as far as I can and as this record states, and I am going to tell about the fee schedule that it was compiled from. In the first place, the report was made 3 years after—I mean that the study was made 3 years after the program was evolved and carried out by the Chicago Dental Society to examine the mouths of all of the individuals employed in certain large industrial organizations. Everyone from the lowest paid employee to the highest was examined; X-rays were used in making the best examination possible, and after that, these charts of their examination were taken and gone over carefully by a committee of intelligent dentists, high-type men, and transferred into terms of work needed in these people's mouths. Then 3 years afterwards—and I am pointing that out to show that the original undertaking was not made for this particular purpose—this study was made of those figures, employing the fee scale which was set up, which was an average fee scale for the city of Chicago, not a low-fee scale and not a high-fee schedule, and as a result of that, this report shows that it would cost approximately \$48 per female individual to put their mouths in good shape and \$53 per male individual. Mind you, that is not a yearly figure that would be necessary; that is not the upkeep service or the cost of an upkeep service.

I will be very happy to leave copies of these reports with you, and you can get the rest of the details from these reports.

I would like to add to that that the association at the present time is undertaking a greater survey on this matter, and Dr. Walls here, a member of this committee, is the chairman of the economics committee who is making this study and perhaps he would like to add something to this now.

Senator ELLENDER. Let me ask you this—assuming that you would have taken care of these adult persons to which you have just referred by putting their mouths in good shape, what would be the cost of maintaining that service per person? Have you indicated that?

Dr. OFFICE. This survey did not include that.

Senator ELLENDER. Perhaps Dr. Walls could answer the question.

Dr. WALLS. Of course, Senator, you must consider that if you are going to be able to keep ahead of the inroads of dental disease, you have got to see your patients frequently. In a well-established dental practice, we insist that our patients come to us at least twice a year, and my personal feeling is, as the result of some work that I have been doing, it might be possible in an average community with the average person, starting with a mouth in proper condition, to take care of that for about \$12 a year, but I would rather not have you be too critical of the figures that you have before you until we have had an opportunity to complete the survey which is under way at

the present time. We shall be very glad to furnish you then the information which we are securing.

Senator ELLENDER. Would you be able to tell us what salary should the average individual receive so as to be in a position to take care of his dental work and that of his family?

Dr. WALLS. You mean when does a family of four become self-supporting?

Senator ELLENDER. Exactly; that is what I mean. From a dental standpoint, and depending upon the locality, of course.

Dr. WALLS. That is the first consideration.

Senator ELLENDER. Would you be able to give us an idea in various parts of the country? Have you worked up any figures along that line?

Dr. WALLS. Yes, sir; I have; but I do not have them with me. I think we can supply those to you; in fact we would be glad if you would give us an idea of what you would like to have, we would be glad to dig up the information.

Senator ELLENDER. That is the purpose of our hearings. We have been having them for 5 weeks for the purpose of getting information.

Senator MURRAY. The principal thing, Dr. Walls, in lowering the cost, would be in the education of the people in how to take care of their teeth and how to frequently consult the dentists?

Dr. WALLS. That is correct.

Senator MURRAY. In that way, the cost of taking care of their teeth could be greatly reduced?

Dr. WALLS. Yes.

Senator MURRAY. And an ordinary person with an ordinary income could, under those conditions, be able to sustain himself and take care of his own teeth?

Dr. WALLS. Yes. We feel that the only proper solution of the dental problem is through the children.

Senator MURRAY. Has not the dental profession for a great many years been contributing voluntarily in trying to educate the children in dental care through the schools?

Dr. WALLS. Yes.

Senator MURRAY. Have they been paid for that?

Dr. WALLS. We have on the pay roll of a great many schools dental hygienists and nurses who are teaching oral hygiene.

Senator MURRAY. And in many communities, the dentists are contributing that service?

Dr. WALLS. Oh, yes; we are doing that all the time.

Senator MURRAY. As Senator Ellender has said, the purpose of this hearing is to find out what is necessary for us to formulate a bill which will be effective and will be in the best interests of the country and of the profession, and we would welcome any criticism that you have to make or any amendments on the proposals that you have to offer to help us in getting out the kind of bill that we should have.

Dr. WALLS. We appreciate that very greatly, and one of the reasons we have come here today is to determine just how much help you want from us and in which form to give it to you, because we are interested in your bill and we want to give you all the constructive assistance that we can.

Senator MURRAY. I think if you would present to us the kind of provisions that would be effective in a health bill we would be glad to have you submit them.

Dr. WALLS. Would it be too late by the 1st of August?

Senator MURRAY. I do not think so. It is not going to be possible for us to have this bill enacted at this session, so that would be perfectly proper.

Dr. WALLS. The reason I make that point is that our house of delegates would have to give us an additional authority in July, and we would at that time be ready.

Senator ELLENDER. In approaching this problem, Doctor, it may be that we could make some start in it in this way. For instance, it was suggested by your economist that \$60,000,000 a year would take care of the educational feature of getting the children to learn how to take care of their mouths, and probably that would be a step forward. Personally I would like for us to be able to get enough funds to do it all at once, but the thing that we have got to realize is our inability, as it were, to obtain the funds necessary in order to do what some of us think ought to be done.

Dr. WALLS. Would you do this for us, Senator? Is there any possibility that a sum of money could be set up immediately in some way—I don't know how—you may be able to advise us—so that research work might be started immediately?

Senator ELLENDER. It could probably be made a part of this bill. In order to get money out of Congress, it has to be appropriated from year to year, and in order to be able to obtain it we must be specific as to what it is for and show the necessity for it. We cannot simply propose a bill and say that we want so much. That is why these hearings are being had. We have got to make out a case in support of this bill or any suggestions we make, and that is the purpose of these hearings. Now the mere fact that Senator Wagner has introduced this bill, S. 160, does not mean we are going to submit it as written. When it leaves this committee, you might not recognize it. This bill simply forms a basis upon which we are to build. We may take that bill and simply write a brand new one, and if a proper showing is made I do not see why it is not possible for us to include dentistry, because I think that is one of the essential things in health—a clean mouth. In most cases it means good health. If a person has a clean mouth and good teeth it will go far toward keeping the rest of his body in good shape.

Dr. WALLS. Senator, I want to say that this is the first time we have felt that official Washington considers that dentistry plays a big part in the health of the Nation.

Senator ELLENDER. I am expressing my own personal opinion. Senator Murray and I, with four other Senators, and with the aid of others will have to take all of this evidence and sift it, and then prepare what we think is a proper bill, and personally I would be inclined to include dentistry specifically and not just by reference—but specifically.

Dr. WALLS. You come from a State which is certainly recognizing that.

Senator ELLENDER. Absolutely. We have been pioneering right along.

Dr. WALLS. We appreciate that.

Senator ELLENDER. In dentistry as well as in medicine. In other words, Louisiana today has done what the Federal Government is now advocating. We have been doing that since away back as far as I can remember, but more so since 1928.

Dr. OFFICE. Yes.

Dr. CAMALIER. Senator Ellender, may I put this thought in? The association is not emphasizing the adult program. We are emphasizing the children's program.

Senator ELLENDER. That is just why I suggested to the doctor here that we may not be able to undertake the whole program.

Dr. CAMALIER. We are not asking for that.

Senator MURRAY. Let us make a modest start.

Senator ELLENDER. That is exactly it.

Senator MURRAY. I think we have had a pretty good meeting of the minds here now. We have a number of other witnesses to take care of before we conclude.

Dr. OFFICE. May I make one little closing statement?

Senator MURRAY. Certainly, doctor.

Dr. OFFICE. I would like to congratulate you gentlemen on the attitude that you have taken here at this hearing, and I would like to assure you that we will carry the message that you have given us here this morning back to our house of delegates when they meet in Milwaukee in July, and we will urge that body to prepare an amendment to S. 1620 which will include dentistry under a single title and put our thoughts into that amendment as to just how dentistry should be included in a national-health program.

Senator MURRAY. We will be very glad to have that.

Senator ELLENDER. Doctor, you have heard a few of the questions?

Dr. OFFICE. We will get a copy of the testimony?

Senator ELLENDER. We will send you a printed copy of it after it is corrected, if you will leave your address. What we would like to have is a more complete statement along the lines we have been talking about as to the cost. In other words, that will be the first thing—how far can we go with \$60,000,000, let us say. In order to determine that, we will have to find out how many people are in need, how many people can be taken care of, and how much per person, and the like? What returns would be obtained by spending that much money? Do you see the point?

Dr. OFFICE. We will be very glad to do it.

Senator ELLENDER. If you will just impart this knowledge, we will be glad to give it our earnest consideration.

Senator MURRAY. We are sure that you will approach the matter in a public-spirited attitude in an effort to aid the Government in carrying out this program. It is going to be very expensive and costly unless we can get the medical profession and the dental profession and the other professions interested in aiding us in trying to get this thing as reasonably as possible. So that we hope that you will help us along those lines.

Dr. OFFICE. We will be very glad to do so.

Senator MURRAY. The next witness is Dr. Parke G. Smith. Dr. Smith, will you give your name and address and such other information as you desire for the record.

**STATEMENT OF DR. PARKE G. SMITH, PRESIDENT, OHIO STATE  
MEDICAL ASSOCIATION, CINCINNATI, OHIO**

**DR. SMITH.** My name is Parke G. Smith, of Cincinnati, Ohio, president of the Ohio State Medical Association. I am speaking for them today.

**Senator MURRAY.** Affiliated with the American Medical Association?

**DR. SMITH.** Yes.

**Senator MURRAY.** You may proceed, Dr. Smith. You desire to be heard now so that you can get away?

**DR. SMITH.** If that is possible.

**Senator MURRAY.** We are putting you on ahead of some other witnesses in order to enable you to get away.

**DR. SMITH.** Thank you very much, sir.

As a preface to certain remarks concerning Senate bill 1620, known as the national-health bill, permit me as president of the Ohio State Medical Association to state that for many years the medical profession of Ohio, composed of more than 6,000 physicians, residing and practicing in the State of Ohio, have maintained that the health of the people is a direct concern of government and that governmental responsibility is not discharged unless the Government maintains at least an active interest in disease prevention and all illness, which by its presence may adversely affect the health of the community where it is found. Just as we are strong in the belief of that principle, we are likewise strong in the belief that the responsibilities for public-health administration and professional care of the individually ill patient are primarily those of the local community and the individual practitioner of medicine. We of the medical profession point with pride to the fact that we have always been leaders in the establishment of public health safeguards and that the primary purpose of all of our activities is the lessening of the hazards of illness.

We have decreased the incidence of illness by initiating, sponsoring, and cooperating with programs setting up all types of health safeguards. That this statement is accurate is attested by a comparison of today's vital statistics with those of a decade ago. As we have increased the incidence of disease we have thus lessened its hazards.

The spirit of friendly competition among the members of the medical profession fosters and stimulates the personal initiative of every doctor and causes him, by study, to constantly strive to make a better doctor of himself. This healthy, most valuable, and necessary state of affairs is the direct result of the fact that, as medicine is practiced in the United States, no part of the doctor's responsibility to his patient is diverted to any type of supervising or directional authority. This personal initiative is the dominant and vital factor which has led, and is leading, us in our steady progress toward a better understanding of disease. This again we are lessening its hazards. That the efforts of the medical profession, particularly the American, have met with a marked degree of success is evidenced by the fact that life expectancy of the citizens of this country is greater today than it is or ever has been in any other place in the world.

Moreover, the American people are receiving better medical care than the people of any other nation.

The medical profession has far outstripped all others interested in contributing to the social and economic progress of the world, for we are making it possible for a constantly greater number of people to reach an advanced age without physical or mental dependency. Satisfactory adjustments have not as yet been made that will assure these people either social or economic independence. Permit me to quote the following statement made by Dr. Haven Emerson, an eminent public-health authority:

We are now, in fact the possessors of better general health, are less afflicted with disease known to be preventable, are more secure in the survival and growth of our offspring to maturity, and have an average expectancy of life greater than that of any population in the history of man.

This achievement is not accidental or a mere coincidence. It is the result of the present completely satisfactory partnership of representative Government and the practitioners of medicine, and could have resulted in no other way.

The purposes of Senate bill 1620 as stated in paragraph 1 would entirely destroy this desirable partnership which has been of such great benefit to the citizens of this country for, through the provisions and wide authority granted in the body of the bill, a centralized Federal bureaucracy would be created that directly or indirectly would completely dominate all things medical, from the care of the individually ill patient to the education of doctors.

As the official representative of the Ohio State Medical Association, may I urge that for that reason, if for no other, you voice your disapproval of this most dangerous proposed piece of legislation.

Let us now briefly consider several sections of this bill: Title 5, part 1, provides for an expansion of maternal- and child-health services by indirectly placing in the hands of one individual, namely, the Director of the Children's Bureau, in the Department of Labor, the opportunity of interpreting the purposes of this bill, determining the methods of carrying out those purposes, and after 1942 provides him or her with an absolutely unlimited fund to carry out his or her program.

By implication the expansion of this program is to be practical, carried on only where needed, and adapted to local conditions, but broad powers granted by this bill to this one individual allows him or her to determine the practicability, the need for the plan, and the extent to which it shall be adapted to local needs, for all State plans must meet with his or her approval.

There is nothing in the bill which required the Director to give any consideration whatever to the ability or desire of any of these people to take care of their own problems. The possibilities of a dictatorial bureaucracy as provided in this single section is completely undemocratic, and the placing in the hands of any one individual—even the best trained of doctors—such complete supervision of the health of all children, potential mothers, and mothers would subject their physical welfare to unwarranted and absolutely unnecessary hazards.

There are a number of other serious objections to, and bad provisions in, this proposal. In my opinion one of the most serious is the

so-called grants-in-aid on a matching basis. This policy, although not new, is essentially unsound, for the following reason:

It results in infringement on the right of the several States by the Federal Government. It encourages extravagance and waste. It coerces the several States into taxing and appropriating for activities which are unnecessary in some States. It lessens the ability of some States to do things for themselves. It creates what amounts to a system of triple taxation. It places practically complete control of activities so financed into the hands of the Federal Government despite the fact that the States provide part of the money.

In general, 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, at a price whereby the State surrenders its rights and permits the Federal Government to determine how and for what such funds shall be spent. Too often such grants are regarded as a Federal gift, and consequently the taxpayer is less vigilant as to his rights and as to how the money is spent than he is in connection with local expenditures and locally administered activities.

Provisions of part 2 of title 5, dealing with medical services for crippled children and other physically handicapped children, and part 1 of title 6, dealing with the expansion of Public Health Service, are open to the same type of criticism, for these are equally all-inclusive and are all-powerful in the delegation of authority. Even though we should grant that the basic principles and ideals of the Wagner bill were correct, duplication of effort and authority of each of the various sections of the bill, if carried out, would absolutely defeat its aims and ideals.

This problem of medical relief, we believe, is rapidly approaching a satisfactory answer through the present efforts of the medical profession and cooperative efforts of governmental agencies. We have a right to expect further interest and activity on the part of governmental agencies in the matter of public health. Some expansion of programs of maternal-health, child-welfare, and routine public-health services may be necessary, but expansion of these services must be orderly, definitely adapted to local needs, and carried on in cooperation with the medical profession, for we are more familiar with the problems of health than any other group.

We would not be so foolish as to contend that the Federal Government never should use its resources to assist the individual States. In times of dire emergency States which are in actual need of financial assistance for health and medical activities as well as others should be provided with such assistance in as unencumbered a manner as practical. These cases should be judged on an individual basis. All States may not need Federal assistance. Simply because one or several States are in need of assistance from Washington certainly does not justify imposing on all States a permanent system of subsidized and federally controlled medical relief like the expansive program called for by the Wagner bill.

For example, we have no real emergency in Ohio insofar as medical relief is concerned. Our people are and have been taken care of. Millions of dollars in State and local funds are being expended annually in Ohio for official public health work, care of the disabled and

handicapped, care of those injured in industrial accidents, and for medical services for those unable to pay for such services. Ohio has 20 State welfare institutions efficiently maintained and operated for the institutional care of unfortunate citizens. The State is adequately supplied with hospitals, medical centers, and clinical facilities. Almost 9,000 physicians are in the active practice of medicine in Ohio. There are at present 198 local health departments, well-manned and operating efficiently under the guidance of the State department of health. Under the department of public welfare, Ohio's dependent children and widows, the crippled and the blind, are being supplied with medical attention at public expense. In the large urban centers medical societies are initiating medical service plans to assist the low-wage earner in budgeting for medical care or for protecting himself and his family against the costs of sickness by voluntary prepayment arrangements. It is a fact that some of the activities enumerated have been financed in part through Federal funds. However, we are of the opinion that these programs at present are adequate to meet Ohio's need, and that there is no need for a broad expansion of Federal assistance such as proposed in the Wagner bill. We know that medical, if under bureaucratic control as provided in each of the several sections of this bill, would deteriorate and health standards be lowered. As our only interest is the maintenance of our present high standard of health, we urge that for the sake of the health of all people you will voice your disapproval of this bill.

In that portion of the bill designated as title 12 there is proposed a broad expansion of hospital facilities. It would be well to attain a complete utilization of present general hospital facilities before contemplating any expansion program, and additional facilities should be provided only after a definite need is proven. I believe that of this entire bill that portion which has been given the least consideration by the proponents of the bill is the only one which is worthy of serious thought. I refer to the evident need for an increase of facilities for the institutional care of infective tubercular cases and of those who are mentally defective.

Title 13 is another addition to the Social Security Act which is for the purpose of extending and improving medical care, including all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability, and empowers the Social Security Board (a lay group) to develop more effective measures to carry out this purpose, including the training of personnel. They are directed, and properly so, to pay particular attention to those in rural communities and those suffering from economic distress, but there is not the faintest suggestion that their plan of medical care shall not include all citizens. In addition, they have been given funds sufficient to carry out any plan of medical care that they may wish to develop in accordance with their own interpretation of the purposes of the act. Has there ever been in the history of legislation a more all-inclusive delegation of authority, or anything more dangerous to the health of our citizens, present and future? Ecclesiastic and Government supervision of medical care have been tried in the past and, yes, are being tried today with the uniform result that there is a definite lowering of health standards for all people and a consequent marked increase in the hazards of illness.

Medical care today is more costly than it has been in the past, but at no time has its unit value been so great, or have people received so much for money spent as they do today. This increased cost is the result of the necessary employment of costly technical diagnostic and therapeutic (X-ray and radium for instance). This increase in total cost of medical care has emphasized the fact that there is an inequality in the availability of medical care, particularly noticeable in what might be called the low or limited income group.

The medical profession is more keenly aware of this problem and more eager to find its proper solution than any other group. In at least six communities in Ohio the doctors of those communities are preparing and putting into effect medical care plans which will guarantee to the subscribers of the plan an absolutely complete medical service at a cost which they can easily afford to pay. Plans of this sort are being put into effect throughout the country by doctors of the community for the benefit of the health of their people. Although these plans may, and frequently do, mean a definite financial sacrifice by the doctor, these plans are meeting with the universal approval of the profession because it is realized that by this method we are able to see disease earlier in its course and are better prepared to meet it. Successful operation of these plans means there is immediately available to all people the sum total of the medical knowledge of the community, not simply that of a small group of doctors. We are better prepared and more advantageously situated to answer this problem of the apparent inequality in the distribution of medical service in a way that will be of continuing benefit to all people than are the members of any other interested group.

The supervision, as provided in this portion of the bill, of all things medical for all people by any board, particularly a lay board, will in the light of experience and recorded history be followed by a definite deterioration in both the quality and availability of medical care, and is absolutely contrary to the spirit of personal initiative and freedom that are the very foundation of this republic.

Title 14 is another addition to the Social Security Act and can only be interpreted as a very broad enabling act, allowing for the establishment of a system of compulsory sickness insurance or in the terminology used in the bill, "Temporary disability compensation."

Although the Wagner bill does not specifically establish a federalized system of compulsory sickness insurance, it encourages the establishment of such systems by the individual States. While it focuses attention on the needy, the bill is applicable, nevertheless, to all classes of people. Nothing in the bill defines the particular type of medical service that is to be provided. It is a time-tested axiom that who supplies the money, dictates the policies.

Therefore, it would seem apparent that the Federal agency handling the money and dictating the policy would be at liberty to refuse to furnish funds to any State, or approve the medical care program adopted by any State, unless such program happened to meet its ideas of social economics, which might include compulsory health insurance. In the last analysis, therefore, any State program for medical care set up under the provisions of the Wagner bill

would not be a "State" program but would be a "Federal" program—or at the most a "Federal-State" program.

Boiled down, the Wagner bill is a coercive measure, providing cash incentives to those States who are willing to yield to Federal dictation, and penalties for those who refuse to do so.

It is a well-known fact that Government-controlled medical service, which is what compulsory health insurance really is, is quite likely to produce low standards and poor medical care, and to afford an incentive for careless and incompetent work. Government-controlled medicine at its best is not good enough for the American people and certainly is not comparable to that which is being furnished under the present system, the essence of which is quality, personal initiative, and personal responsibility.

Senate bill 1620, at its best, is only in effect a palliative measure. The additional money which would be spent under its provisions should be expended in efforts to solve the basic problems of health and sickness. Elevation of wage scales and minimization of unemployment would permit many families who now believe that the best of medical care is not available to them to obtain it without embarrassment. Poor nutrition, bad housing, inadequate clothing and fuel, mental depression, and so forth, are accountable for much illness. There is a direct relationship between preventable disease and these social and economic conditions. If these conditions were attacked scientifically, such disease would be conquered and illness would be diminished manyfold.

Let us encourage thrift and saving so that the contingencies of illness can be set. Let us reduce expenditures so that some of the money now paid out in taxes may be used by the individual for preventive and curative medical services and for protection against sickness and accident through the purchase of insurance against such hazards. Let us dissipate the economic confusion which has engulfed us and, in so doing, give some consideration to the fact that illness is the sequel of economic burdens and social problems rather than chiefly their cause.

In conclusion, permit me to point out that I have not discussed the enormous financial implications of this bill with its almost unlimited appropriations. I know that you already have received competent evidence from many sources as to its absolute impracticability, particularly in view of the present financial condition of the Federal Treasury and the treasuries of many of the individual States.

On behalf of the medical profession of Ohio, allow me to express sincere appreciation to the committee for having permitted me to appear before you today to present a few reasons why the physicians of Ohio believe the Wagner bill should not be enacted into law.

Senator MURRAY. Thank you for your statement, Doctor. I am very much in accord with your views with reference to the bearing of the economic conditions on this subject of national health. I think that your observations there are very wise, and I think that improvements in that field will go a long way toward remedying the health situation, too. As I understand it, you feel from your survey of the situation in Ohio that there would be no need for the grants-in-aid system, that the program should be confined more to a study of health

conditions, research and education, and preventive methods. Is that the idea?

Dr. SMITH. Not exactly. I feel that there should be a continuance of the present completely cooperative efforts between the medical profession and the governmental agencies, whether they be local, State, or Federal, and a slow careful expansion of those programs. Of course, the expansion of those programs will require financial assistance from some governmental agencies, in all probability, a portion of it to be borne by the Federal Government, but that assistance I feel should be given in as unencumbered a manner as possible in order that the local problems can be answered best by those who are attempting unselfishly to answer them, knowing full well their entire complexion.

Senator ELLENDER. Well, Doctor, under the present program, the Federal Government is and has been furnishing money to the State of Ohio has it not?

Dr. SMITH. Surely.

Senator ELLENDER. Has the Government tried to dominate the activities of the medical profession in Ohio?

Dr. SMITH. I have had a rather interesting conversation with one of the gentlemen who is quite interested and quite active in the work of the crippled children's department in Ohio. I might say that they feel that their work has not been assisted particularly.

Senator ELLENDER. You mean in Ohio?

Dr. SMITH. In Ohio. Because we had a magnificent set-up prior to Federal aid, and there have been certain changes that are necessary in the handling of the crippled children, which this one particular individual feels has not allowed for the steady progress that was being made previously.

Senator ELLENDER. If that change was necessary, then how can you conclude as you do?

Dr. SMITH. I do not quite get your question.

Senator ELLENDER. You say the change was necessary?

Dr. SMITH. The change was made because it was a condition of the granting of Federal aid financially.

Senator ELLENDER. Would you be able to tell us what that was?

Dr. SMITH. I cannot give you the details of that because I am not familiar with it.

Senator ELLENDER. Have you heard any criticism from any other department in Ohio wherein the Federal Government has furnished money?

Dr. SMITH. I don't know that I can say that I have heard any criticism, but I believe that as a general principle when one is asking for money they are inclined to modify their own ideas.

Senator ELLENDER. That is what they all say, and that is what you say in your statement here that you have a fear of—

Dr. SMITH (interposing). Yes.

Senator ELLENDER. The Government has been furnishing money for roads to my knowledge for the past 25 years, and I do not know of a State that can say that the Government tried to take control of its highway department. The Government has furnished all the States for a Public Health Service program, and I have yet to find anybody to come up here and say that the Federal Government tried

to encroach on the rights of the State to handle its public-health problems. We have had a Social Security program since 1936 or 1937. We have had many witnesses come before us who made statements just as you have, that they feared the Government was going to take control, go down and dip in and take charge of the situation, and yet not one of them has come with specific evidence to show that the Federal Government at any time attempted to take over any of the duties imposed on the States. On the contrary, the aid furnished by the Federal Government was just in the nature of a helping hand in attempting to carry on the purposes for which the money was being furnished.

Dr. SMITH. I might say in explanation that in the crippled children's work in Ohio we had local communities and local organizations and local people educated to the place where they were assuming the responsibility for a great deal of this work. Today that is not true.

Senator ELLENDER. That is because the Federal Government has put up the money?

Dr. SMITH. Yes.

Senator ELLENDER. And they can get somebody else to do it?

Dr. SMITH. Apparently so.

Senator ELLENDER. Well, you know, Doctor, if all of the States of the Union were in the fix that Ohio is, according to your statement—that is, that it needs no medical attention and no medical aid—there would be no use for this bill.

Dr. SMITH. Pardon me, I do not think that I said that. I stated that at the present time we have no real emergency in the State of Ohio insofar as public-health affairs are concerned.

Senator ELLENDER. In other words, you don't need it?

Dr. SMITH. We are proceeding satisfactorily; we are looking forward to an expansion of all of your programs; we hope to carry them out, and with continuing success.

Senator ELLENDER. Ohio happens to be one of the States of the Union that does not get all of its income from Ohio, a great deal of it comes from Louisiana, a great deal of it comes from Texas. It just happens that you have centers there—you have the rubber industry, don't you, in Ohio?

Dr. SMITH. Yes, sir.

Senator ELLENDER. You make millions of dollars out of rubber. If you depended on the automobiles used in Ohio to obtain your revenues you would not get anywhere. We have got these other poorer States that have the natural resources but somehow the laws are such that they cannot obtain just revenues. You take the great State of Texas, as I pointed out here on two or three occasions—Pittsburgh, Chicago, and probably Cleveland and New York got \$8,000,000 profit in 1 year out of four corporations that dealt in gas and electric power in that State, and the said great State of Texas got \$100 out of it.

That is the record. Personally, I believe that under our present form of government, when a State like North Carolina, where practically all of the cigarettes that you and others smoke are made, some of the revenues therein collected should be used to help poorer States. If North Carolina were to depend on the smokers within her borders she would make little or nothing; but by furnishing

cigarettes—Chesterfields, Camels, Lucky Strike, and other popular brands—from coast to coast and from the Gulf to Canada, it is able to reap a lot of revenue from other States. We need legislation of the kind that we are now proposing; it is to help these poorer States because of the peculiar system of economics that has developed in this country since the Civil War.

Senator MURRAY. I think from listening to your testimony, Doctor, you conceded that.

Dr. SMITH. I conceded that; I believe in it. I believe in it implicitly. We have no argument.

Senator ELLENDER. Judging from his statement, Ohio does not need it; it can do without it. New York can probably do without it. But you take from New York and Ohio the revenues they now get from other States and they would be as poor as we are and maybe poorer.

Dr. SMITH. I do not believe that is a question of argument today.

Senator ELLENDER. Well, it is just the way our economic system has grown. It has been stated here that the great State of New York produces—is it 65 percent of our income? New York happens to collect millions in customs. Whenever you want to manufacture a thing or popularize it, advertise it as being made in New York, even if not made there; somehow the biggest corporations establish there; they have their main offices there, but they do business in Colorado, in Montana (Senator Murray's home State), in Louisiana, and in Texas, and we southerners from Louisiana do not own the State of Louisiana, you know. The northerners, northern capital, own it; they come out there and dip down and make money; they get the persimmons and we just get what Paddy got—nothing. Fortunately, Louisiana is now getting a little more than it received in the past. That is what is causing this demand from the Federal Treasury. It is not only going to be relegated to health, but it is going to extend to education and things of that kind, and it is just because of the system that has grown up whereby, no matter how rich a State is in natural resources, it is possible for citizens or corporations of other States with capital to come in and take the cream. What we are trying to do is to get some of that cream back to help the people back home.

Dr. SMITH. There is nothing in my statement in opposition to Federal aid at all.

Senator ELLENDER. I understand.

Dr. SMITH. But I feel that it should be in as unencumbered a manner as possible, and I feel if it was handled in an unencumbered manner when it came to your State—

Senator ELLENDER (interposing). What do you mean by "unencumbered"?

Dr. SMITH. To allow you and your State of Louisiana to solve your problems in the same way you said a moment ago in dental care. Perhaps it is necessary for you to have traveling dental clinics in trailers and things of that sort as you do have in the State, and possibly medical care in exactly the same manner. But why should you be obligated because someone wishes to establish a large clinic to which people must come; to have to do that? Why not let you solve your

problem in the manner that you think is best? You have the same as other communities, absolutely unselfish and disinterested people who are absolutely interested in the problems of health.

Senator ELLENDER. Along that line, Doctor, I must make this confession: That it is not every State in our Union that has been as fortunate as Louisiana has been and is, in having the natural resources and having had a government that took hold of the situation and made the big interests pay their just proportion of taxation in recent years. It is not every State that is able to do that. They have tried to do it time and again in Texas, but the corporate interests are so deeply entrenched in Texas that the people cannot get proper control over these natural resources for the purposes of adequate taxation, so that today the State of Texas is not owned by the Texans. The same applies to Senator Murray's State, and the same to Idaho and Colorado and many other States. The legislatures in those States do not seem to be able to function in behalf of the masses and they do not seem to be able to get the proper taxable returns on their respective natural resources, and all of that results in private capital from some other sources getting in and taking the cream, as I said a few moments ago.

Dr. SMITH. I should like to suggest that in this problem of medical care that one very definite difficulty at the present time is the inability of community groups to form an association to provide medical services upon a prepayment basis. We had introduced into our State Legislature in Ohio this year an enabling act somewhat similar to the type of enabling act that allows the writing of group hospitalization contracts in which under the direction of the insurance commissioner there would be issued a certificate to a community in which it had proven that the subscribers to this medical service contract would have the benefits of the services of the entire medical profession of their community, but we did not get it through in our State. I understand that a similar act has been passed in Michigan—and possibly recently in New York State. I am under the impression that in Utah a similar act failed. Some attempt to facilitate the formation of community organizations to allow medical-service contracts for what is their low-income group in their own community, which may be different in Cincinnati than it is in Louisiana, and at a cost that the people can afford to pay, giving those people the services of all of the doctors of the community so they can have the best, so that they can have the most refined of diagnostic and therapeutic procedures immediately available would solve this problem much easier and in a much less expensive manner than in this bill or by any approach which has as yet been offered.

Senator ELLENDER. But we have millions, Doctor, who do not have enough to get edibles and clothes to wear, much less medical care.

Dr. SMITH. Yes. Spend this money for—

Senator ELLENDER (interposing). That is our purpose.

Dr. SMITH. Spend this money to enable them to have a better physical condition to withstand illness.

Senator ELLENDER. We are doing that with other departments, you know; the Federal Housing Administration, the United States Housing Authority for slum clearance. All of that is taking place.

Senator MURRAY. Thank you for your statement, Doctor. I think that you have contributed some very valuable help to us here.

Dr. SMITH. Thank you very much, sir. I appreciate the opportunity, sir.

Senator MURRAY. The next witness is Dr. J. G. Crownhart, secretary, State Medical Society of Wisconsin.

### STATEMENT OF J. G. CROWNHART, SECRETARY, STATE MEDICAL SOCIETY OF WISCONSIN

Mr. CROWNHART. If I may correct the chairman, I am not a doctor. I am a layman and secretary of the State Medical Society of Wisconsin. I am here at the request of that organization.

STATEMENT SUBMITTED TO THE SUBCOMMITTEE OF THE SENATE COMMITTEE ON EDUCATION AND LABOR ON S. 1020 BY J. G. CROWNHART, MADISON, WIS., SECRETARY, STATE MEDICAL SOCIETY OF WISCONSIN, JUNE 1, 1930, PERTAINING TO TITLE XIII OF THE BILL

Inasmuch as Wisconsin, according to the National Resources Board, enjoys the distinction of being one of the three leading States in the United States in health accomplishments and achievements, the medical profession of Wisconsin, which has been the initiating force for much of the health legislation of the State, feels a particular interest in all efforts that will truly and permanently advance the public health. Favoring, as we do, measures to advance the public health, we are impelled because of that interest, to oppose the bill now before you.

In the limited time at my disposal, I address myself in particular to title XIII, "Grants to States for Medical Care," beginning on page 34, and ending on page 40.

Anxious to study and to develop in Wisconsin any procedure to further the use of health services and sickness care facilities among the citizenry, the State Medical Society of Wisconsin, as part of an extensive threefold field study, authorized me to study firsthand the European systems for the distribution of sickness care, and in particular the only system that has been widely and continuously advocated by the groups proposing this measure—compulsory sickness insurance.

As background for that study completed just last summer, I have had the privilege for 10 years of being the lay secretary of the State Medical Society of Wisconsin, and during 7 years of that period, secretary of the Wisconsin Hospital Association. Recently I had the privilege for more than a year acting as chairman of the health section of the Governor's committee on public welfare in Wisconsin. Throughout, my particular interest has been in the field of the distribution of health services and sickness care, and my studies abroad were materially aided by extensive credentials that gave me entree to authentic and widely varied sources of information.

1. There have been many detailed studies of laws relating to compulsory sickness insurance. Accepting these as accurate, my studies were made to ascertain the major point of real importance—how and with what degree of success the health services and sickness care under compulsory systems actually reached the insured population on the receiving end, for unlike other social insurances, compulsory sickness insurance pays in terms of services and not in terms of money.

2. The whole purpose of the studies was to determine then whether that framework of compulsory legislation, either as it stood or with modifications, could be brought back and applied in our own State of Wisconsin as a means of further advancing the health of our people.

The laws on this subject in France, England, Norway, Sweden, Denmark, Germany, and other countries vary widely, and yet out of each of the studies, and all of them, the observer is increasingly and constantly impressed that there are certain factors and elements that come to the fore in every country that has such a law. It is self-evident from intensive first-hand observation that these elements are inherent to the system.

Because they are inherent to the system, they would operate in this country under any State law either to secure the presumed advantage of compliance with the proposed Federal law or to prevent loss of the State's share of Federal subsidy offer.

The Wagner bill is so designed as virtually to insure the inauguration of State compulsory sickness-insurance plans subject to the control and direction of the Federal Government. Consequently these inherent elements that permeate the European systems to the destruction of scientific advances and to the prevention of the delivery of proper medical care would be brought into play as domestic plans became effective.

In the brief time at my disposal it is my purpose to outline to you some of the more important of these inherent elements which everywhere operate to defeat the announced purpose of compulsory sickness insurance:

1. The tax contribution of the employee is fixed in the initial legislation, and remains fixed in that amount throughout years to follow. It having been announced to the public that the benefits of complete and thorough medical care will be furnished for that contribution, and the tax applying in volume to the small pay check, it may be economically impossible and always politically inexpedient to increase that contribution. But, on the other hand, the total amount received and available for care of the sick may vary with economic conditions of the country and changing costs of administration, with no corresponding changes in the total amount of benefits promised. The funds may be vitally affected by waves of health fads that periodically sweep every country, or by epidemics of unanticipated character. As the people affected become health-conscious and then "policy-conscious," so do their demands, warranted or unwarranted, increase. The end result is a system wherein the administrator loses his social-service concept and of necessity becomes the trustee and conservator of funds instead of the guardian of health. He furnishes the insured population with the bare essentials, and often less than that, instead of all that is needed, keeping a skeptical eye and the purse strings tight on the advances of science and improvements in the rendition of medical care.

2. Unlike sickness care rendered under workmen's compensation acts, there is no penalty upon the administration for the furnishing of a service deficient in quality or amount, or both, and, on the other hand, there is the budget necessity for balanced books. This driving force results in cheapening the health services.

3. The administration is not only interested in securing its medical service at a fixed cost per patient per year in order to have certainty of balanced books, but obviously it must be interested from a financial viewpoint in what the physician does and prescribes because that costs the insurance administration money. The result is that in each system there is to be found the book of rules and regulations, ad infinitum, within the limits of which the physician must stay at the risk of a money penalty—and, may I add—within which the physician, dependent upon the system for a substantial amount of his income, learns to stay if he is to remain in the system.

4. The systems do not administer themselves any more than insurance companies administer themselves, and from an admitted 12 percent administrative cost to what appears to be a more nearly actual 18 to 20 percent administrative cost is found everywhere. The administrative force must include the system physician to check on the treatment in unusual illness; the prescription checker to determine whether the physician has stayed within the prescription rule book and the pharmacist abided by the fixed price; and the sick visitor who endeavors to detect the malingerer; the accountant who checks the pay-roll deductions; and office staffs that result in a total administrative force in the estimation of the International Labour Office of from 1 person for every 50 to 1 person for every 100 that are insured. This vast administrative army of laymen, which, in my own State of Wisconsin, would number 3,000 or more, becomes as large and larger than the number of physicians giving actual sickness care. The administrative army diverts part of the funds and controls all of them, which, in turn, results in a State and Federal control of medical service itself. This is inherent in a law such as is here contemplated.

5. Finally, I direct your attention to the fact that under this type of legislation, and under bills proposed in my own State, written by the Social Security Board staff, the administrator is politically appointed, selects the physicians, and he may discharge them at will so long as he complies only with the procedure. He is responsible to no court for the reasons. In Germany this system has resulted in the observer being unable to find medical scientists of yesterday of international importance. And there is no safeguard against such misuse of this type of control that inherently exists in such legislation.

I say to you that these concepts of sickness care are foreign to every concept of our physicians in Wisconsin and that type of care that has resulted in our

own State having a record of health achievements excelled by no country that has adopted such legislation. The inherent elements in any system of compulsory sickness insurance are such as change both the concept of the people and the role of the physician from the present-day American concept of health attained by prevention and individual care to a limited treatment of disease with the physician in the salvage role.

In conclusion, may I remind you that the authentic report of political and economic planning, after 2 years of study of the British health services points out: "The nation needs sickness services, but a nation which regards them as a substitute for health services is going to find the confusion expensive in money and suffering. \* \* \* It is no less necessary for those concerned with national health to examine the diseases of insurance schemes than it is to study heart disease and cancer."

If it is possible, I should like the record to show that a copy of my studies abroad will be left for the information of each member of the committee.

I say to you in all sincerity and with all the earnestness at my command, that the health achievements of Wisconsin and of this Nation have not been made, as some would have you believe, in spite of our failure to adopt European systems of compulsory sickness insurance, but because of our foresight in avoiding the very concepts of control that are inherent to such governmentally systematized services. The social purchase price for the adoption of such legislation is the surrender for all time of our concept of education for health and in times of illness, our concept of the sick man, woman, or child as an individual with highly individualistic reactions requiring, deserving, and securing a personalized service.

Senator ELLENDER. There is just one question I would like to ask you. Will you point out any language in the bill leading you to believe that this will mean compulsory health insurance?

Mr. CROWNHART. In the section that I have reference to, Senator, it provides for State-wide plans, and then a State-wide program eventually, with economy of service and I know of no other plan that has been suggested than compulsory sickness insurance.

Senator ELLENDER. But the bill itself does not provide for it?

Mr. CROWNHART. It is the enabling law for it, sir. Secondly, may I point out that in all previous publications of the committee's study, and the original proposals that resulted in this bill, there has been a continuous advocacy of sickness insurance, and finally that inasmuch as this act is to be administered under the Social Security Board, and a member of the staff of the Social Security Board has drafted a bill for compulsory sickness insurance that was presented to the Legislature of Wisconsin 2 years ago and is being re-presented in that State this year, I think it is perfectly fair to assume that this bill is an enabling law for compulsory sickness insurance.

Senator ELLENDER. Would you suggest any language by which we could negative the language so as to make it certain that it won't lead to the apprehension expressed by you?

Mr. CROWNHART. No, sir; not under the approach that is set up in the bill.

Senator MURRAY. In the concluding part of your statement which you have submitted to us here, you stated that you would like to have the record show that a copy of your studies abroad are left for the information of the committee?

Mr. CROWNHART. Yes, sir; I have those studies here and will leave them for the committee.

Senator MURRAY. We will be very glad to have them.

We will adjourn now until 1:30.

(Whereupon, at 12:05 p. m., a recess was taken until 2 o'clock of the same day.)

## AFTERNOON SESSION

(The hearing reconvened at 1:30 p. m.)

Senator MURRAY. We will resume the hearing now. Dr. James Slocum will take the stand.

**STATEMENT OF DR. JAMES E. SLOCUM, RESEARCH DIRECTOR FOR  
THE NATIONAL CHIROPRACTIC ASSOCIATION**

Dr. SLOCUM. I am here as the official spokesman of the National Chiropractic Association. It is my duty to detail the attitude of the chiropractic profession on this health-security program insofar as that position has been determined at this time. Unfortunately our annual convention is not held until the week of July 23. It is not possible, therefore, to report that the chiropractic profession has gone on record as officially endorsing or opposing this proposed legislation as represented in its present form. However, the National Chiropractic Association has taken favorable action with reference to the activities of the President's Interdepartmental Committee to Coordinate Health and Welfare Activities, by the adoption of the following resolution:

*Be it resolved*, That the executive board of the National Chiropractic Association go on record as favoring the efforts of the President's Committee to Coordinate Health and Welfare Activities, and recommend to our agencies and affiliated organizations that they give every cooperation to this committee in their efforts to bring about a better health service to our Nation. We further recommend that the committee always keep in mind the right of the citizen to choose his own doctor and method of healing and urge that the committee include doctors of chiropractic in the Federal health program.

It is the position of the association that the Government should act in the interests of the great percent of our population who are being denied adequate medical attention. The National Chiropractic Association, however, feels that the Federal Government should take cognizance of all modern legally recognized healing sciences in its planning for the health betterment of its people. When a State recognizes a healing science by licensing the practitioners of that science, the United States Government should necessarily consider this in planning health programs within the State. This association does not feel that the Federal Government can legally or rightfully withhold from the people their right to the licensed doctor of their choice.

Our profession takes a definite stand that the best interests of public health can only be served when all people have a right to the doctor of their choice. It is because we do not feel that this bill insures that right we have asked the privilege of appearing before your committee. We here acknowledge with thanks and appreciation our having been granted this hearing.

It is our intention to confine our argument to two propositions, namely:

1. In any health security plan to be adopted by our Government, the right of the people to the doctor of their choice must be kept inviolate.
2. The chief emphasis of the chiropractic profession in the field of healing.

## 1. THE RIGHT OF THE PEOPLE TO THE DOCTOR OF THEIR CHOICE

It is our belief that the best health interests of the American people would not be served if the Government is placed in the position of advocating the medical theory of health and disease. In any planned program for raising the level of the Nation's health, it is fundamental that it be recognized that no system extant has been able to solve any major portion of the problems presented by sickness and disease. It is, we believe, consistent with logic to recognize that there is much of good in all systems of healing. There are two well established, rational approaches to the questions raised by sickness. The American citizen seeks solution of his health problem through either the drug or drugless approach. Both of these systems are in the process of development and in neither group do we find even relative perfection. Millions of our people will testify to the failure of either group and the success obtained by the other. To recognize one group to the exclusion of the other would, in our opinion, be a costly mistake. Medicine, the dominant school of healing has consistently manifested an adverse attitude toward all drugless schools of healing. This opposition is not found so much in the field of science but more especially in a political way. The medical profession is numerically greater than the drugless profession and it therefore has greater political influence. We feel quite sure, however, that any careful investigation will reveal that public patronage of drugless methods is greater in ratio to numbers than of the medical profession. To permit absolute control by the medical profession of a health-security program, would result in a definite loss to both the people and science. Scientific progress is best insured by competition.

Our Government must take cognizance of the sharp conflict existing between the drug and drugless theory of approach to the problem of disease. Failure to recognize this obvious fact would in our opinion foreordain any health-security program to failure. Our reason for this conclusion is simple and yet quite adequate to withstand a most rigid investigation. In the last analysis, no law can long prove effective if it is in fact opposed to prevailing public opinion. The conflict between public opinion on the drug and drugless theories of health and disease is so definitely established that no law is likely to change that opinion. The right of the people to the doctor of their choice is second only to their right to select the minister of their choosing.

The right of the people to the doctor of their choice is sound reasoning because that choice is usually born through private personal experience. Personal experiences bring private convictions both in the field of religion and healing systems. Logically, in a democracy, laws can no more effectively propagate the conclusions of one group than it can eliminate the conclusions of the other.

In the quest of the sick for relief there are certain questions involved in selecting a healing system. It has been contended that science alone must answer this query and that the people must abide the findings of science. Medicine being the dominant school of healing has contended that the people are not capable of determining a scientific approach to disease, therefore, their health problems must be turned over to the medical professions for final determination.

With this contention we entirely disagree. A cure may be scientific and at the same time entirely wrong in practice. There are certain questions that good judgment dictates must precede and follow the public adoption of any scientific discovery and its ultimate application. For example: Is this remedy effective? Is it logical? Is it scientific? The sick public may make a careful investigation of a newly heralded scientific discovery by the medical profession and find a positive, affirmative answer to each of these questions. All too frequently this represents the end of public investigation. All too often the question, "Is it scientific?" represents the end of medical investigation. It is our contention that there remains still another question that is equal or exceeds in the range of importance the former questions. That question is: Is this effective, logical, scientific system I have under consideration a rational approach to my problem? A system of healing may be effective, logical, and scientific and still be quite irrational. One of the large contributing factors to the tremendous following of the drugless school of healing is to be found in the fact that much of a scientific nature discovered by medicine proved later to be irrational.

If this proposed health-security program is to become workable, then it must be flexible enough to permit the people to choose their system of healing. In any health-security plan to be adopted by our Government, the right of the people to the doctor of their choice must be kept inviolate. If this right is guaranteed in the present proposed legislation, then it is so vague as to permit a reasonable doubt in our part of its existence. We, therefore, urge that it be written into the proposed legislation in such language as will not later permit of either doubt or controversy.

Therefore, we respectfully submit that the Federal act require, among other things, each State to permit its citizens the right and privilege of choosing their own methods of healing. Thus, any State not conforming with the primary requirements of the Federal act should be denied its advantages and benefits.

## 2. THE CHIEF EMPHASIS OF THE CHIROPRACTIC PROFESSION IN THE FIELD OF HEALING

During the past decade remarkable results have been attained in the correction of the physical ailments of mankind. Much of the progress is attributed to the newer knowledge of the action of the invisible forces through the body mechanism. We have long known and used effectively the invisible forces of electricity and gravity. But in recent years a newer application of the force of gravity in relation to the vital force of the body has gained widespread interest.

It would perhaps be best, at the very beginning, to answer the natural query that must arise from any mind which has not made a special study of the science of chiropractic. That query is: "In what disease are doctors of chiropractic able to produce results?" In the present stage of intellectual attainment it is but natural for the layman to think only in terms of disease. The study of individual diseases has become so common that unless one frequently investigates the conclusions he may become prone to think of disease as being an entity.

The chief emphasis of the chiropractic profession on postural distortion and its relationship to disease. We do not mean by this statement that the underlying principle of chiropractic is applicable only to postural deviations. The doctor of chiropractic considers disease as evidence of violation of natural law. He contends that in the main, functional perversion (dis-ease) is impossible without structural distortion. He recognizes that nothing can make us live but life and affirms sickness to be an absence of life in a greater or lesser degree, depending upon its state of development. He accepts the thought that this life force depends upon a free and unhindered nervous system. It is his thought that nerves become involved in their ability to carry on and coordinate function when postural distortion occurs within the physical body.

To answer the query as to what particular diseases chiropractic fundamentals and technique are applicable we must do so with a general statement to be later qualified. Wherever there are nerves and life force involved in any disease, there the principles of chiropractic are an important consideration.

Since the above general statement covers almost the entire range of disease, we will therefore qualify it. We do this that it may not appear that we are attempting to claim the impossible and as a result unreasonable in the position taken. Heredity, environment, and habits, both in the physical and mental field, enter the equation of most diseases. While our principles are as broad as the nervous system itself, yet we recognize the fact that any specific disease can and sometimes does progress beyond the range of our work and definitely into the scope of surgery. Our profession is best qualified to determine whether our principles are applicable in any given case. We are likewise willing to concede the same point to any other profession insofar as determining the scope of their work is concerned. We are equally sure that the complete and final answer to all the questions presented in human misery have not yet been discovered. It is therefore not only advisable but most necessary that all avenues of research and approach to the problems of sickness, both from a drug and drugless standpoint, remain open. Much of merit will be found in both systems and the followers of each are numbered in the millions.

Returning now to our statement that the chief emphasis of the chiropractic profession is postural distortion and its relationship to disease, we can more clearly present our viewpoint. We believe this to be one of the most vital subjects and its influence on matters of health makes it of paramount importance.

A well-known physician, who is a splendid student of posture, stated recently:

I am persuaded that to know posture in its entirety would be to have the Rosetta Stone in mankinds early story and the prescription for man's future physical welfare.

In this statement, our profession fully concurs. We believe that postural distortion and disease are synonymous terms. We do not believe that postural defects are the only cause of disease, but we do contend that they are by far the most common cause. Good posture indicates the successful effort of the vital mechanism to meet, under all conditions, the elemental law of gravity. The human body is an

organic unit and in the final analysis all structure and every function is definitely and completely adjusted to the force of gravity. The doctor of chiropractic finds himself in opposition to the usual contention that matters of good posture depend entirely upon the will and habits of the individual. We are convinced that most postural defects are the consequence of structural displacements. We recognize that distortions of the skeletal framework can and do occur. The slipping of any or all of the articulations of the physical body from their normal position is brought about by various accidents, strains, occupational stresses, and family habits. There are other conditions of faulty posture that no doubt have their origin in organic weaknesses of an hereditary nature, and those of mineral and vitamin deficiencies as well as great emotional upheavals.

The White House Conference on Child Health, as early as 1930, recognized the importance of body mechanics in relation to health, as noted by the following quotations from their report:

The part played by body mechanics, or "posture" as it is generally termed, in the health and well-being of the child, is another subject receiving more and more attention \* \* \*

While the majority of medical schools give instruction on this subject, it is usually scanty or incidental and very inadequate. Yet body mechanics has a part to play in the child-health program, and lack of training facilities for those who must do a large part of the educational work in this field is a serious matter. Definite information on the prevalence of bad body mechanics, its recognition as a causal factor in disturbances of health, and the methods of satisfactory treatment are needed.

An exhaustive study of the needs of crippled children proved that the number of crippled children in the United States may be put at 300,000. A crippled child is one whose future capacity for self-support is threatened by disease or defect of the bones, joints, or muscles.

Since we find good posture and health on one hand and poor posture and disease on the other, the development and formative years of childhood are a period of time when greater good could be accomplished by chiropractic methods. The correction of faulty body mechanics, inequalities in the lower extremities, spinal curvatures, all varying phases of postural defects as manifested in children would lay a more secure foundation for healthy adult life.

Dr. L. J. Steinbach, of Pittsburgh, Pa., in a recent issue of the *National Chiropractic Journal*, declared:

Twenty years ago the sacroiliac joints were still buried deep in the archives of human biology. Today the public is on speaking terms with the sacroiliac joints; in fact, these joints are more mentioned or inquired about than any of the articulations of the human framework. It has become common experience in the practice of chiropractic to have patients solicit attention for an ailing sacroiliac joint.

The casualty-insurance companies are receiving more reports of sacroiliac trouble than any other type of casualty. The corsetiers and orthopedic specialists are inventing corsets, pads, and belts of new and varied designs to help hold the sacroiliac joints for the rapidly increasing number of people who cannot keep properly coupled down where the back ends and the lower extremities begin. A high official in a prominent casualty-insurance company—himself the victim of a misbehaving sacroiliac joint—told the writer that sacroiliac strain has become the most common report in casualty insurance. Some of the statistical data makes interesting reading. Here it is:

"One in every seven adult subjects coming under the influence of compensation or casualty insurance develops reportable cases of sacroiliac strain—65 percent of those who had been originally reported have repetition of the same trouble; 75 percent of cases are in people beyond the age of 40; 56 percent of original reportees repeat the trouble more than twice. As many as 14 reports

of sacroiliac strain had been observed for 1 individual as found in the records of this company."

The same insurance official made the frank observation that chiropractic attention had been more valuable in controlling the loss of time from employment and had been more adequate in preventing recurrence of similar complaints than any other method.

The outstanding cause of all structural deviations is mechanical. Much of the fatigue complained of in all ages is a direct result of wasted energy because muscles are forced to do the work originally delegated to bones in the constant fight to keep some semblance of normal postural balance.

In pointing out the relationship of structural displacements to the problem presented by disease, we do not close our minds to other basic causes such as dietary errors, emotional excesses, mineral, vitamin, and glandular deficiencies as well as toxins and infections. There is ample room for a profession to specialize in any of these basic causes. Nor is it our contention that we have, in our research work, exhausted the subject of posture in relationship to health. We do know now that much human suffering can be eliminated by doctors trained in the correction of distortions. This has been our field and the results obtained in this specialty are the greatest single reason why millions of people each year consult doctors of chiropractic about their health problems.

In any general program planned to better the health of the people of this Nation, the field of posture and structural distortions must be considered if the very highest degree of success is to be attained. Because of the millions of proponents of the chiropractic idea and the years of specialization of our profession in this field, it is remarkably qualified to assume responsibility for the correction of the many disorders resulting from such distortions.

Chiropractic has achieved legal recognition in the District of Columbia and 43 States of the Union. It has been recognized as a separate and distinct science and has been granted separate State boards of chiropractic examiners in the following 33 States: Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington, Wisconsin, and Wyoming.

More than 175 insurance companies have recognized chiropractic as being the most efficacious form of treatment in many cases of illness and injuries, and have granted recognition to the claims of their policyholders who were under the care of chiropractors during the time they were incapacitated. This extensive recognition has been gained because of authentic proof that chiropractic offers the most efficient method in the restoration and maintenance of health. Progressive insurance companies the world over are coming to recognize the validity of claims submitted by chiropractors in restoring health and well-being to their policyholders.

Nearly 40,000,000 people subscribe to and have benefited through the application of the principles of the natural healing arts. Should these citizens, many of whom may be indigent cases, because of the adverse economic situation, be forced to place themselves under medical

and drug treatment when they have found from past experience that medical physicians offer inadequate care for their particular case? Should they, as citizens, not be entitled to the doctor and method of their choice?

Dr. Benjamin Rush, one of the signers of the Declaration of Independence, must have anticipated just such a situation when he declared:

We have provided for religious freedom; but, unless we make provision for medical freedom, our best efforts to establish a government of free men shall prove abortive, and the American people will forever live in bondage.

The 48 States in which they are licensed to practice as general practitioners of the healing arts surely expect chiropractors to accept the same responsibilities as other professions, and this they gladly do. It is, without question, therefore, intended that they be granted all the rights and privileges granted every other branch of the healing art.

While chiropractic is a specific branch of the natural healing arts, it must not be considered to be a specialty or a limited practice in the sense that one views a dentist or an optometrist, for example. In other words, the comprehensive principles of chiropractic may be effectively demonstrated in dealing with the majority of the many ills and ailments with which mankind is afflicted. The efficient application of the principles of chiropractic has clearly demonstrated this in millions of cases during the past 40 years.

Several years ago, the Bureau of Chiropractic Research and Review compiled a report covering authentic statistics in nearly 100,000 cases covering 110 specific diseases. To be exact, this report covered 99,976 cases which were handled by 412 chiropractors located in the various States.

A summary of these statistics was as follows: 84,571, or 84.59 percent of the cases completely recovered or were greatly improved. In 14,554, or 14.56 percent of the cases, the condition remained unchanged or slightly improved. 851, or only 0.85 percent died under the care of chiropractors. The death rate was equivalent to 8.5 percent per thousand, compared with a general death rate of 12.3 percent per thousand throughout the United States for the year 1923, the last year for which final figures were available. This remarkable showing of nearly 25 percent less fatalities should prove to any disinterested party the remarkable results which are obtained when patients are placed under the care of the chiropractic profession.

It is estimated that the average chiropractor handles about 20 patients each working day. On this basis, he gives approximately 6,000 treatments a year. This would make a total of 90,000,000 treatments given annually by the profession. Just how many are new patients and how many are repeat patients it is impossible to estimate but it is believed that around 16,000,000 people take their health problems to chiropractors annually.

The chiropractic profession asks no special privileges that are not accorded to other professions. All it asks is a fair field and no special favors. It asks this in the interest of justice and fair play. Surely it is entitled to nothing less. The 40,000,000 citizens who subscribe to and have benefited through the application of the principles of the natural healing arts should be entitled to the doctor and the method of their choice in every State in the Union which would

be denied them by the politico-medico monopolists who exercise political control.

Senator WAGNER. You made a statement there about medical monopolies; what did you have in mind?

Dr. SLOCUM. I was referring back to a statement made earlier wherein I said that the differences of opinion did not lie so much in the field of science as in the political propaganda and the field of the differing medical sciences.

Senator ELLENDER. Are there any colleges in the country that teach your profession exclusively?

Dr. SLOCUM. Yes, sir.

Senator ELLENDER. How many are there?

Dr. SLOCUM. I would say approximately 30, now.

Senator ELLENDER. Do students study through a regular 4-year course?

Dr. SLOCUM. There are a number of our colleges that have been standardized on the 4-year course, and that is the course that is advocated by the National Association, but there are a number of them yet where, according to the statutes of certain States, the standards are lower than that and we have been unable to control those colleges by bringing the standards up to a 4-year course. That is the objective of our national association. We were born in 1895 and are a comparatively young profession as the years go by, therefore we have not been able to standardize all of our colleges at the present time.

Senator WAGNER. How many do you graduate per year now?

Dr. SLOCUM. I could not give definite figures, but I would say somewhere over 2,000; I would say between 2,000 and 2,500. That at best is a guess.

Senator WAGNER. I did not hear all of your statement. Did you state anywhere how many practitioners there are altogether in your profession?

Dr. SLOCUM. I did not state, but there are between 15,000 and 16,000 practitioners.

Senator MURRAY. What is the difference between your profession and osteopathy?

Dr. SLOCUM. The difference is primarily, you might say, a philosophical one. As I understand, the osteopathic concept as developed by Dr. Andrew Taylor Still, he places emphasis upon the thought that the rule of the artery is supreme. The thought behind chiropractic profession—that I can state definitely—is that so long as there is free and uninterrupted flow of life force over the nervous system, there is health, other things being equal. But interference with the flow of life force or a displacement of the articulations in the body bring about a condition of disease. I think that is the chief point of difference between osteopathy and chiropractic.

Senator MURRAY. Has the medical profession opposed the theory of chiropractic?

Dr. SLOCUM. Of recent years I do not think so much. There was a time, of course—I think at least 10 years ago—when if I would refer to one individual, the spokesman of the American Medical Association, Dr. Fishbein, who said that the displacement of a joint in the body, pinching a nerve, was an impossible theory, but I do not think they take that position today, because I have seen articles pub-

lished in the American Medical Association Journal that indicates that they believe the joints of the body do slip and do pinch nerves.

Senator MURRAY. Your profession is licensed now in 43 States?

Dr. SLOCUM. Forty-three States.

Senator MURRAY. Thank, you, Doctor.

Senator ELLENDER. What other recognized methods are there for treatment besides chiropractic and medicine?

Dr. SLOCUM. Of the drugless methods, you mean, Senator?

Senator ELLENDER. Yes. In other words, I am just wondering how many classes we would have to provide for.

Dr. SLOCUM. I believe I could give approximate figures. There are approximately 40,000 drugless practitioners in America.

Senator ELLENDER. No; I am speaking of other methods. Take Christian Science; they might want to have special or separate treatment in this bill. How can we go about doing all of that? Can you give me an idea?

Dr. SLOCUM. Yes; I think I can.

Senator ELLENDER. You say you want to give everybody the right to be treated by whatever method he desires. Are we to draft this bill so that the Christian Scientists can come in and have their own methods of healing administered?

Dr. SLOCUM. On that point I may misunderstand, but I think that Christian Science is not interpreted as being a drugless practice. I think it is a religious practice, but holding it down to drugless methods there are the naturopaths and optometrists and chiropractors and the osteopaths, and our suggestion here as to a method, to go back to our statement, we say that we respectfully submit that the Federal act require among other things each State to permit its citizens the right and the privilege of choosing their own method of healing. Thus any State not conforming to the primary requirements of the Federal act should be denied its advantages and benefits.

Senator ELLENDER. This bill does not prevent a person from keeping on being treated by a chiropractor if he so desires. I am just wondering how it would be possible for us to draft a bill so as to allocate funds or private facilities for treatment by chiropractors or by Christian Scientists or by osteopaths and various other methods.

Dr. SLOCUM. If I understand that correctly, Senator, the ultimate decision on that could be well placed up to the State as to determining the fact that the citizens would be permitted to choose a doctor of any school of thought so long as that was in our Federal act. Our worry about this whole matter is—

Senator ELLENDER (interposing). The fact that it is not in the pending bill—I don't know that it would make any difference, because as I understand the bill we are now proposing, the State is to draft its own plan and submit it to the Federal Government so as to make it amenable to receive funds under this act.

Dr. SLOCUM. Yes; but if in the Federal act, if we see this correctly, if in the Federal act there has not been placed any provision for any other system of healing than medicine, I do not see how the State could conform, even though they desired to recognize the existence of drugless schools of thought. Our worry in this whole matter is that the Federal act if there is no allusion to it at all—I don't know just where it is, where it would permit a State to grant privileges to their

people to select drugless doctors. That is our only concern in our appearance here in discussing this matter. We feel that if the Federal act should provide specifically for all recognized schools of healing, that that is a problem that the State could then work out.

Senator WAGNER. Doctor, are you from New York?

Dr. SLOCUM. No; I am from Iowa.

Senator WAGNER. I was going to ask you something with reference to the compensation law of New York, but since you are not from New York, I shall not ask you that question.

Senator MURRAY. That is all, Doctor.

The next witness is Abraham Epstein.

#### STATEMENT OF ABRAHAM EPSTEIN, AMERICAN ASSOCIATION FOR SOCIAL SECURITY

Mr. EPSTEIN. My name is Abraham Epstein, executive secretary of the American Association for Social Security.

Senator MURRAY. Doctor, we are very glad to have you here. I have heard you on several occasions before, and I have a high regard for your opinion.

Mr. EPSTEIN. My testimony will probably be a little different from what you have heard, so I don't know whether I should prepare you for a shock. I think the committee has heard a great deal of testimony by this time which I believe has done a great deal more to confuse the thinking about this law and the situation, really, than enlighten it. You have heard, of course, a little bit about the blessings of the act and a great deal more about the calamities under it, and I think my function ought to be that of a clarifier, since I am no enthusiast of the bill, and am not against it.

Actually, I believe the problem before you is very simple. I think the whole problem of medical care can be divided into three parts in accordance with the three chief population groups in the country.

There is first of all the well-to-do or the wealthy group. I do not care where you begin with them, whether you begin with \$3,000 or \$5,000 or \$8,000, but certainly there is a group that can afford medical care and can get it. Our problem today is not a problem of a lack of medical services; everybody knows that we have plenty of doctors and too many empty beds in hospitals. There is no problem for those who can afford the money. Everybody who has got over a certain income can get all of the medical care that is necessary, and you can dismiss that group from your consideration. As Members of Congress you are not faced with the problem to provide for that group, because they create no problem before you.

The other group is the indigent group, those who are already on relief or who are earning incomes below a minimum standard of living. They are your problem, but you do not have to set yourself up to worry about that problem suddenly because for several hundreds of years we in this country, like in all other countries, have recognized from the days of Queen Elizabeth that society is responsible for indigents, and we have made provisions for them, and we are making provisions for them, and we will probably continue to make better and better provisions for them. To the extent that this bill seeks to improve the lot of these people, this bill is in the right direc-

tion and provides for improvement, which we should do. The problem here, as I said, is primarily extending the present facilities, and I think we are doing it and will probably continue to do it.

The group, however, that has not been brought before you and the group that really presents the problem is the wage-earning group; that is, the people earning an income of, say, \$800 to \$3,000 or \$5,000. Here is the problem that I believe should be your chief consideration, for here both the problem and the solution is complicated. Your studies have got to be very careful, because it is not like the other two groups where in the one case you have no problem at all and in the other case the problem is simple, as in the case of the indigents, where you know you have got to provide medical care for them without any cost to them, because they cannot pay even if they wanted to do it.

The problem of the wage-earners' group is more complicated because as all studies have shown the lower-income groups suffer from more and longer illnesses than the upper-income groups. Then the problem created here is not because this group could not bear the average cost of an illness, for instance, the average illness of a workman is 7 or 8 days per year. That in itself, if it were evenly distributed, would not create a social problem. Anybody that works all but 8 days in a year would create no social problem, but, like all other things, and specially in sickness, the problem lies in the fact that sickness is not evenly distributed and that those workers, the percentage of them that suffer for more than the average, for weeks or for months, cannot afford from their existing wages to buy medical care, not because there is no medical care, not because there is not an ample supply, but simply because whenever they are confronted with a higher-than-average illness they are unable to buy it. In other words, because medical care is a commodity like anything else, and you have to pay for it to get it, these people who have not sufficient income, and suffer from more and longer illnesses are less capable of buying protection against that illness. And the solution here is complicated because this group not only cannot afford to buy it but does not want medical charity. I think one of the important points that you have got to bear in mind is that no system of extension of medical aid will fundamentally meet that problem, because this group does not want public charity any more than it wants private charity.

For instance, there is a good case the doctors make that a lot of these people could get treatment because we have ample clinical and free medical service, and so forth, but the fact is, that all studies have shown that from 40 to 50 percent of this group do not get medical care today. And that problem is not going to be solved merely by extending public aid because they do not take advantage of that now because they do not want public charity. What they want is a self-respecting independent system whereby they could distribute their costs—whereby they could themselves buy adequate medical care without becoming recipients of charity.

We believe that the problem before you is largely that problem; that is, the problem of inadequacy of medical care by that group, which is the largest group. We believe that is the most important problem before you because, after all, even today, regardless of our relief rolls and all of our poverty, the fact is that most of our workers are still employed, so that you cannot set up the indigent group as

the problem in America because there are still more people working, even though they earn low wages, than people not working. In terms of bulk, in terms of size, that problem certainly is the biggest problem that is confronting you.

Also, it is this group which fundamentally creates all of the professional problems. The low-income doctors, the low working time, the lack of work for nurses, the idle doctors and hospital beds are essentially a result of this fundamental lack of medical purchasing power on the part of the workers; that is, the great mass of wage earners, who cannot provide for themselves and cannot buy the medical care that they should get and need to have; in other words, from every point of view it seems to me that the problem of the wage earners is essentially and certainly the biggest slice of the problem. I am not minimizing the problem of the indigent, but by far the largest and the basic problem that you should consider is the problem of the wage earner who does work, who does not want a free medical system of aid, but wants to help pay for his care in a self-respecting manner so as to be able to get the proper medical care when he needs it.

In view of the fact that it is not the indigent group, which represents the biggest problem, in view of the fact that the wage earners constitute the biggest slice of the entire problem, and in view of the fact that the problem is preeminently created by the fact that some people suffer no illness at all while others suffer very serious illnesses, the problem is primarily that of distribution. Indeed the most interesting thing about this whole problem is that unlike any other problem with which Congress was confronted in the last few years, it is a problem which requires no additional money than what you are spending today. When you legislated on old age, you had the problem of how to raise more money; when you legislated on social security, it was a problem of more money, because the problems required a new undertaking on the part of the Government with new money.

On the question of sickness you have no such problem at all. You are not confronted with the problem of how to raise money; your problem is primarily how to distribute the existing costs in a way that you will achieve your desirable purposes, and that is to give medical aid to all in need of such aid, and at the same time to solve the corollary problems of idle doctors and empty hospital beds, and so forth, and so on.

Nothing throughout the history of modern civilization has shown itself a better mechanism for distributing this kind of a burden or solving such a problem than the method of insurance. In all of our civilization from the very beginning insurance has been the one method by which a common risk that all of us are confronting is distributed so that each one of us pays a small amount for the sheer value of protection, and those of us who do suffer that disaster get at least the protection. The whole principle of insurance is based on that idea. People insure themselves against burglary; why? Because all of us are exposed to that risk and we are willing to pay a small amount a year for protection, and the satisfaction that, if we do suffer that loss, we will get compensated. The same thing is true of fire; in other words, for hundreds of years, the method of insurance has been the device which has been used to meet exactly these problems

the problem of distributing the cost of a common risk so that those of us who suffer the loss will actually be compensated, while those of us who do not suffer pay a small amount which it is not burdensome and at the same time gives us a feeling of protection.

In no scheme of social insurance does the method of insurance fit in so beautifully, so aptly, as in the case of sickness. More than in old age, much more than in unemployment, much more than in any other phase, here you have the simplest kind of a problem, because we know or can easily determine the morbidity rate, we know just approximately what we need, and we do not need any reserve there, because it is a problem that can be met every year. It is not like in old age, where, when a man becomes 60 years of age, you give him a pension and then lives on forever. Here you know that there will be so many appendicitis operations, there will be so many of this and of that, and we know almost exactly what to expect, just like in life insurance. The problem here is only of those who suffer the expensive risk, just like in fire, the problem is only of those whose houses do burn. There is no problem of all of the houses. And here you get the same thing—we are willing to pay fire insurance because it gives us a feeling of protection. The same thing applies here. We are willing to pay a little money here for the protection.

Senator ELLENDER. Witnesses have testified here on two or three occasions that where persons can obtain medical aid of that kind, the tendency is for them to remain sick longer and stay in the hospitals longer, and they are prone to want to go to the doctor too often. What answer have you to such a charge?

Mr. EPSTEIN. The answer to that is a double one. First, this particular terror, Senator Ellender, has been used against every form of legislation in this country. I can cite, for instance that when workmen's compensation laws began—Senator Wagner can bear me out on this—when that was being legislated in this country, they said at that time, "If you are going to compensate a man for an injury because he has cut his arm off or his leg off or has his eye out, there won't be a workingman who would not deliberately cut his leg or his arm off or gouge his eyes out to get it." [Laughter.]

Senator WAGNER. That sounds amusing. You will remember that I introduced the bill in the State legislature, and that was actually the testimony before the committee.

Mr. EPSTEIN. I might tell the whole story now as it is applicable to the question. When mothers' pension laws were being enacted they said that if a woman is going to get a pension when her husband is dead, she will poison her husband. Then when old age came around, and I faced that argument for years, Senator, in every State of the Union, especially Pennsylvania, they said that if you are going to promise a woman or an old man that at 65 they are going to give them a pension of \$7 a week, they will stay in bed and refuse to work and wait for their bonus. And they have used that everywhere. I am not worried about that, because after 25 years of compensation laws—

Senator ELLENDER (interposing). I am not worried, either.

Mr. EPSTEIN. But I think it is important for the record, Senator.

Senator ELLENDER. That is why I asked you.

Mr. ERSTEIN. After 25 years of compensation and mothers' pensions we have become neither a nation of cripples nor a nation of widows poisoning their husbands, have we?

But in the case of sickness that would really be a wonderful thing. For one of the things I hope that a health-insurance program would accomplish would be to induce more people to go to the doctors. Dr. Fishbein has used figures showing that under health insurance people visit their doctors more often. But, he does not tell what that actually means. It is true I believe that under health insurance people will go to the doctors more. In that I believe he is right, but that is what you want. People do not go to the doctors today because it costs \$3, and they cannot afford it. What you want is to encourage those people that they should go with a headache as soon as they have a headache, because that headache may turn into a very serious thing. In England they do go more to the doctors, and in Germany the same—for the simple reason that it does not cost anything.

As for the idea that people love the blue bottle that the doctor gives them and will constantly go for it—well, if they find that they like the blue bottle too much, the doctor can prescribe a brown bottle for them. The number of the bottle lovers will be just about as many as the widows who poison their husbands because of the widow's pensions.

Senator WAGNER. I used to listen to a radio announcement for many years—to use a dental wash and to go to your dentist at least once a year, whether you need it or not. It is not a bad idea.

Mr. ERSTEIN. Now, the reason that I suggest a health-insurance program as the most important method for you is that because it is the one program that meets best your outstanding group, and it is also best from the doctor's point of view. Indeed, in trying to understand the American Medical Association's position, what goes beyond me is their opposition to health insurance because if there is any program which tampers less with the existing medical profession it is a health-insurance program. This opposition is amazing to me since I think that Senator Wagner's bill was drafted largely to ensnare the doctors, because they advanced this program at their convention in September. And it is for this reason that I am not enthusiastic about the bill because it tries to compromise with the A. M. A., I believe, and practically gives them everything. What amazes me is their insistence that the one thing they object to is a health-insurance program, while the one thing that will do less to tamper with the existing situation is a health-insurance system.

Why? The health-insurance program would not tamper with the well-to-do group. If the bill would exclude people with \$3,000 or over, the doctors would not lose any one of their paying patients. We do not have to worry what they will charge a millionaire; there is no social problem there, and we will leave it to them. Moreover, a health-insurance bill would do the best thing for the doctors, because it would make paying patients out of charity patients today. The big problem they tell you is that they have got to give so much time to people who cannot pay and also to people who cannot pay the bills even if they do promise to pay. Who are these people? They are largely these low-income people. All that a health-insurance

program would do would be merely to coordinate or consolidate the expenses of this group so that the doctors would be able to convert their nonpaying patients today into paying patients. What more could any doctor want? What form of medical care could possibly do more for the medical profession than a system of insurance which would primarily cover the people with the low incomes and convert these people into paying patients? At the same time such a system would provide a self-respecting system by merely distributing the cost without too much Government interference.

They warn you against politics, and so forth and so on. As a matter of fact, in a health-insurance program, you can have the least governmental interference because, for instance, in most European countries, it is not a governmental plan. All that the government does is to make collections obligatory, but the insurance funds generally operate by themselves except under government supervision. There is little governmental interference in a constructive health-insurance program—at least there is less governmental interference than in many other phases such as education or traffic.

When you come down to the present bill, I cannot disagree with anything in the bill. Everything in the bill is in the right direction except for the last provision, the strategic wisdom of which I question not because I am against it but because of its administrative feature. We endorse everything in the bill and we believe that providing more aid for the indigent is absolutely in the right direction. We feel, however, that even if you do all that, even if you pass that bill in toto, we could not say that you have really accomplished anything by passing the whole bill. For in terms of the big problem, as I just outlined before you, you would still accomplish very little, even if everything in the bill was adopted in toto. This bill—this present bill—applies much more to the indigent group than to the group that I discussed before; that is, the wage-earning group which does not want merely necessary medical care but a system of insurance which can meet their problems. You do not have to have any more evidence today that the American people believe in insurance and want to pay for the costs directly than what has happened to the Social Security Act. A few years ago we were tremendously concerned—none of us knew whether we were talking essentially correct or not when we said that the American people would accept an insurance program. It was difficult to tell. But during the last 3 years you have seen this amazing social-security program adopted and accepted by almost everybody in this country. You have had no complaint from the workers or from the labor unions as to their paying for old age. You have not had any complaints from the employers on that score, so that the American people have shown themselves as absolutely enthusiastic—as absolute believers in a health-insurance program. Thus, the question of public acceptance is certainly not a question for you to worry about, because the American people have declared themselves as will and ready to accept a constructive program.

At the same time, I feel that while no program of medical care is a panacea that can solve all of our ills, not even a health-insurance

program, it is, nevertheless, the one method that can do most to meet the problem that exists today. The thing which surprises me, as I said before about this bill, is the strategy that was adopted. Senator Wagner will remember that I did not know anything about this bill even the day before he introduced it; I was in his office and they would not tell me what was in the bill. I do not know why it should have been a secret, but I think the main reason for that bill was that here was the A. M. A. coming out in September and saying that it believes in this and that and the other, and the framers must have said: "Let's go and give them a bill which they approve." This is what must have happened. If they had asked me, and I am an old bird at that thing, I would have said right at the start that there is no chance for you ever to get Dr. Fishbein and his clique to accept anything, no matter what statements they issue. The issue has got to be a frank and open fight between the American people and the American Medical Association. You cannot avoid that battle. When we fought for social insurance, Senator Wagner, and you actively participated in that, we did not compromise, we did not go around and say that would please the Manufacturers' Association, so let's have that bill. We went ahead and said, "This is right," and we stood for it and we fought for it and then finally they liked it. That is why everybody is for social security today! And the doctors will discover that, too. You are never going to sell a program by ensnaring the American Medical Association; you cannot do it. This is an open and aboveboard fight on what we believe is right in health insurance. Dr. Fishbein will come around to health insurance only when the thing works and all the doctors will tell him, "What a fool you have been all your life," and then he will discover that there was something wrong with his views.

The chief defect of this bill is, therefore, that it has tried to avoid the most important phase of the question, that is, health insurance. Senator Wagner, for example, has made several statements. Before the doctors he generally points to the fact that there is no health insurance here. On the other hand, our friends are given to understand that you really could have a health insurance program under this bill. I don't think that these tactics will do any good. That is no way of ensnaring the American Medical Association; it cannot be done, and I do not think that there is any possible chance of converting them.

Senator WAGNER. I think you have unintentionally misstated what I have said. I said that there is nothing in this bill to compel a health-insurance program by any State.

Mr. EPSTEIN. Absolutely, and that is my very criticism. This bill is not a compulsory health-insurance bill; it is only a grant-in-aid in the extension of medical care. I believe in this and I have advocated this principle all my life. But I do not believe, unless you specifically state in the bill, that any State under this bill will adopt a health-insurance bill, and that is the reason why I would like to have seen in the bill a frank statement that a State can have a health-insurance bill and prescribe what should be in it. Just as we have done in the Capper bill, for instance.

My chief criticism of this bill, therefore, is that it is not frank enough, that it does not touch the basic problem of the wage-earning group and does not provide for a system of health insurance to meet the largest portion of our problem today.

Now, gentlemen, since this is the first congressional hearing on this question—I have been around Congress and hearings for about 18 years, but this is the first time that there has ever been a hearing on health insurance or on the whole problem of medical care—I believe that your committee ought not to confine itself at this time to merely Senator Wagner's bill or to the problem of medical care only in terms of extending medical aid. I believe that you should definitely consider the Capper bill, S. 658. I am going to leave a copy of it with you, and I hope that it will go into the record. I would like to ask permission to embody it in the record.

Senator MURRAY. What is the length of it?

Senator WAGNER. Is that a health-insurance bill?

Mr. EPSTEIN. Yes.

Senator WAGNER. What committee is it before?

Mr. EPSTEIN. The Committee on Finance.

Senator MURRAY. The bill has been printed and we can secure such copies as are necessary.

Senator WAGNER. There have been no hearings on this bill?

Mr. EPSTEIN. No; but this bill provides a definite system—it does not go against this bill—you can embody it as a part of this bill so that in addition to what the State may set up for Federal allowances, you have a definite scheme as to what type of health-insurance system the State may adopt for which the Federal Government will give allowances.

This bill, by the way, was drafted 4 or 5 years ago and there should be a lot of minor changes, so that I want to state in the record that we do not today recommend every provision in this bill. Some day we will go over it and make corrections. There are a few errors in this bill that should have been corrected, but we never got around to it because we did not feel that Congress was going to enact it right away.

I do not think I need to take any time to tell you how silly the American Medical Association arguments are unless you want me to do it. I think the arguments themselves are enough. I have said yesterday that the best advocate for health insurance in this country is Dr. Fishbein; he has given more publicity to this movement than anybody else. We could not possibly do it, and I believe in the old slogan of Senator Penrose, "publicity, good or bad, but publicity." So I think that they are doing the best campaign for health insurance, better than any other group could possibly have done. They get into the papers and they even get front pages sometimes, which we never could.

Senator WAGNER. They have been circularizing pretty well too, through the so-called Gannett organization.

Mr. EPSTEIN. I do not believe that that hurts us.

Senator WAGNER. You are talking about publicity.

Mr. EPSTEIN. The more the merrier, I say, because we could not get health insurance mentioned until the American Medical Association started campaigning against it.

Senator MURRAY. How much longer will you take with your statement, Mr. Epstein? I ask because I promised to give the afternoon to the hospital associations.

Mr. EPSTEIN. I am practically through.

One other thing that I would like to mention in this bill. The only objection I have to this bill—I mean a theoretical objection—is the last title in the bill, which provides for a cash disability benefit. I am not against cash disability benefits; on the contrary, I have advocated that all my life, but I do not believe that the strategy used in this bill. I fought the people in the Social Security Board on this issue for years. I have not converted them nor have they converted me. You cannot separate cash benefits from medical services. I think it is the wrongest type of strategy to separate cash benefits from medical benefits.

I am convinced that even if we should succeed in getting one phase it will only block the other one because vested interests will be set up on that phase and we will never get the medical benefits. Moreover, the wage earner's problem in sickness is one problem; it is the problem of getting medical care and feeding his family, and the two cannot be separated. In no country on earth have they ever separated these two problems, and I think that this bill makes a woeful mistake by attempting to introduce one phase of a problem without touching the other one, that is splitting the problem into two without realizing that once you get off on a tangent we will probably never get to the other tangent.

So I urge upon you that when you have a disability title, the two—cash benefits and medical care—must be linked together. They cannot be separated and should not be separated.

That is about all, really, that I have to say, Mr. Chairman, unless there are any questions.

Senator MURRAY. We thank you for your statement, Mr. Epstein. I promised the afternoon to the hospital associations, and they have a number of witnesses here and I would like to have them proceed now with their testimony.

Who will represent the hospital associations?

Mr. MONTAVON. I am the director of the legal department of the National Catholic Welfare Conference. I am connected with the hospital associations only very indirectly as an advisory member of a committee of nine that has at different times represented hospital associations in national matters. I am not speaking for that committee of nine nor for any hospital association, but for the National Catholic Welfare Conference.

I have prepared a brief statement, and I have accompanied this statement with an analysis of S. 1620. There have been frequent calls for suggested amendments. I have not suggested amendments, but I have made some criticisms of the bill.

I regret that I am not as enthusiastic about this bill as the man who just preceded me felt about compulsory insurance, nor do I feel so bitter against others who have testified before your committee. I feel that there is a great deal of right on both sides, but the brief statement I have prepared I will read, which is as follows, with your permission.

Senator MURRAY. You may proceed.

**STATEMENT OF WILLIAM F. MONTAVON, DIRECTOR, LEGAL DEPARTMENT, NATIONAL CATHOLIC WELFARE CONFERENCE**

Mr. MONTAVON. My name is William F. Montavon. I am director of the legal department, National Catholic Welfare Conference. My office is located at 1312 Massachusetts Avenue NW., Washington, D. C. I appear as the representative of the administrative board of the National Catholic Welfare Conference.

For a decade now the Nation is suffering economic distress. Widespread suffering has quickened interest in widespread relief.

The bill before us emphasizes the need for relief in the field of medical care. Based on the present emergency, it proposes a national health program as a permanent policy and would bring to the support of that policy the power to tax of both Federal and State governments.

We are acutely aware that elements contributing to human welfare are not available equally to all. In the health field, particularly, existing wide discrepancies are said to constitute an unnecessary waste of human resources and thus result in detriment to general well-being.

In our country—and I have noticed the frequent references to Europe as a place to get inspiration—I like to get my inspiration from home, particularly from the splendid traditions that have developed under the flag of the United States. In our country the elements contributing to human welfare have been developed historically not by the efforts of political authority alone. Our present standards of culture, and particularly in the field of medical care, are the achievement not of government alone but rather of society, as distinct from government, working through a cooperative partnership of governmental and nongovernmental agencies to meet the social need. Liberty under constitutional law and a spirit of cooperation animating government and civic associations has been a powerful factor for good in the process of national development. This is true particularly in elements which promote general well-being by protecting health and providing medical care; and through its splendid educational institutions, hospitals, and health centers, welfare and nursing associations, medical and hospital societies, unexcelled anywhere, have been developed.

In this characteristic of American culture the church has found an opportunity for the expression of her supernatural charity, applied in the relief of human needs through the exercise of the corporal and spiritual works of mercy. To this end she has been encouraged to found agencies varied in character and in great numbers to carry on her mission of service.

In all ages of the church, men and women have sacrificed their all to dedicate their lives to supernatural charity.

In our own United States at present more than 30,000 Sisters and Brothers in more than 700 hospitals and 300 related agencies are carrying out the social program of the church in health service to approximately 2,000,000 patients each year. The effectiveness of that service is derived no less from lofty spiritual ideals and motivation than from progressive objectives in the achievement of professional excellence.

This field of service is vastly extended beyond the walls of institutional facilities by the thousands of graduates, educated in the schools for nurses conducted by these Catholic institutions, and thus influenced by the same ideals of charity and the same standards of service as our hospital Sisters and Brothers.

Within the limitation of human resources these elements have brought medical services to the poor and are extending them in rural regions.

The promotion of this vast enterprise through the forward-looking Catholic Hospital Association is a splendid manifestation in the United States of the social mission of the Catholic Church.

The same can be said with reference to the general field of social service, and particularly with reference to child welfare, and to maternal and infancy care. Numerous Catholic schools of social service prepare workers in this field. Their services, Nation-wide, are strengthened and coordinated through the National Conference of Catholic Charities, the St. Vincent de Paul Society, and so forth. Every Catholic parish is a unit in a Nation-wide service to the needy.

Prolonged depression has reduced the income customarily derived by these institutions and services from fees paid by clients, from endowments and from gifts from an appreciative public. This falling off in income occurs precisely at the time when the free services provided by these groups and facilities are most in demand. The load on voluntary agencies, a capacity load at all times, grows heaviest precisely when the human power to bear it grows less. These institutions, redoubling their effort, frequently at great personal sacrifice, always in a spirit of true charity, have accepted added burdens and new responsibilities with confidence and faith in the future.

To meet this emergency and to prevent its recurrence, the President's Interdepartmental Committee to Coordinate Health and Welfare Activities prepared its report and S. 1620 has been introduced.

We view with interest and approval the growing concern of Government for the health of all the people. We are not convinced that an acute emergency, a crisis, is a proper foundation upon which to erect a permanent program for the future. Relief of human need in the field of medical care, particularly, is more than an economic problem. It is a problem that cannot be reduced to a function of political authority alone.

To view human needs as nothing more than an economic problem and relief as nothing more than a function of political authority would do away with the supernatural source, motivation, and exercise of the virtue of love of neighbor.

At their meeting in 1920 the bishops of the National Catholic Welfare Conference issued a pastoral letter. They discuss in that letter social problems arising after the World War. Referring to charity, they say:

Let us not persuade ourselves that we have fully complied with the divine law in regard to our relations with our fellow men, when we have carefully discharged all the obligations of justice. For its safeguard and completion, the stern law of justice looks to the gentler but none the less obligatory law of charity. Justice presents our fellow man as an exacting creditor, who rightly demands the satisfaction of his rightful claim. Charity calls on us as children of the one universal family, whose Father is God, to cherish for one another active brotherly love second only to the love which we owe to Him. \* \* \* After justice has rendered impartial decision, charity brings men back to fellowship.

In that same statement the National Catholic Welfare Conference referred to the rights of labor and pertinently with regard to the bill now being discussed said as long ago as 1920:

The right of labor to a living wage, authoritatively and eloquently reasserted more than a quarter of a century ago by Pope Leo XIII, is happily no longer denied by any considerable number of persons. What is principally needed now is that the content of that right to a living wage be adequately defined, and that it should be made universal in practice, through whatever means will be at once legitimate and effective. In particular, it is to be kept in mind that a living wage includes not merely decent maintenance for the present, but also a reasonable provision for such future needs as sickness, invalidity, and old age. Capital likewise has its rights. Among these is the right to a fair day's work for a fair day's pay, and the right to returns which will stimulate thrift, saving, initiative, enterprise, and all those directive and productive energies which promote social welfare.

The Social Security Act of 1935 is an effort by the Government of the United States in cooperation with State governments to establish a right balance between the rights of the employer and the employed.

S. 1620 would amend, revise, expand, and in some respects radically change this Social Security Act of 1935. Particularly, this bill makes the health of all the people primarily, and tends to make it exclusively, a Government concern and to make the provision of medical care primarily, if not exclusively, a political function.

It is important that every provision, every word of a bill like this be weighed and carefully considered at this time, so that final legislative action may accomplish the right social purpose of balancing the rights of the employer with the rights of the employed and the rights of both of them with the general welfare.

Thus having stated briefly our attitude, I desire to make it clear that the National Catholic Welfare Conference believes that the State and Federal Governments have a duty in the health field. Any sound, progressive program to bring adequate medical care to those to whom it now is not available is welcomed and supported.

Upon examination, however, we find that S. 1620 is not a clear expression of the spirit of partnership and cooperation that in our country exists between Governments, Federal and State, and between governmental and nongovernmental agencies. This spirit of cooperation has developed and is the true national tradition. It should be recognized and encouraged by whatever bill is finally reported favorably by this committee. Only by mutually trustful cooperation between social agencies, voluntary and nongovernmental in character, and agencies of Government, local, State, and Federal, can the full purpose and possibilities of such a health program be realized.

The National Catholic Welfare Conference, therefore, endorses the proposal made to the National Health Conference held in Washington last summer, that in the case of the needy and of those unable to provide themselves with the medical care and services they require, every effort be made to secure full cooperation of governmental and nongovernmental agencies.

We record particularly at this opportunity our approval of the following proposition:

It is sound public policy to expend governmental funds for the care of individuals through private agencies performing a social function.

We find that S. 1620, in its present form, fails to provide for, indeed, would make impossible in some cases, any cooperation of governmental and nongovernmental agencies.

Provisions which the act of 1935 requires to be embodied in approved State plans under title V, part 1 and part 2, for the precise purposes of securing cooperation between governmental and nongovernmental groups and agencies would be repealed by S. 1620.

S. 1620 would substitute for these repealed provisions other provisions which would restrict cooperation to the relations of the State health agency to other public agencies.

S. 1620 would deny to members of the professions and agencies the right to membership on advisory boards to be established by the State agency, unless they are serving under a State plan.

S. 1620 would place complete control of the so-called "national health program" and its administration in Federal executives by amending the provision of the act of 1935 requiring that the State plan and rules and regulations, to be made by a State agency, be approved by a Federal authority who is himself empowered to make rules and regulations and to withhold payment of the Federal grant to a State not complying substantially.

S. 1620 would divide the elements now providing medical care into two rival groups, those serving under a State plan, and those not so serving.

Between these two groups there would be no place for the nongovernmental agency. Under this bill medical care would be a public service. Proprietary facilities operated as a private business might be tolerated. More than 2,500 charitable hospitals and numerous other facilities could not exist under this act as charitable agencies serving the poor.

These and other objections which will be presented by competent representative spokesmen impel the National Catholic Welfare Conference to recommend to this committee that no favorable action be taken with regard to S. 1620 in its present form and that grants in aid to the States under the Social Security Act be made in increased amounts, if necessary, but in the manner now provided by that Act as offered in 1935.

Senator MURRAY. We will have to leave for the Senate now to vote on a measure. We will recess for 10 minutes.

(At this point a short recess was taken, after which the hearing was resumed.)

Mr. MONTAVON. In order to save time, as some of these gentlemen want to get away I have this analysis, and I would like to read portions of it, but I feel that it will take so much time.

Senator MURRAY. Just as you see fit. It will be made a part of the record. Of course, if there is any part of it that you want to accentuate, you may read from it now, but it will be made a part of your testimony.

Mr. MONTAVON. There is an analysis of title V which has been rather favorably considered, but the point that I made in a general way has to do with cooperation with agencies.

In the Social Security Act, at the instance of private agencies, there was inserted in title V, part 1 and part 2, a provision in the State

plan that made it compulsory on the State to cooperate with nursing and medical welfare groups and organizations, and it is a little stronger in part 2. That is the language. In S. 1620, that is eliminated from the Social Security Act. That is No. 6 in the plan in the Social Security Act, and it is in both part 1 and part 2. In S. 1620 there is substituted for that a cooperation and, when necessary, working agreements between the State health agency and any public agency or agencies administering services related. Under S. 1620 the State agency, in carrying out the provisions of part 1 of title V, the Social Security Act, would be able to cooperate with the juvenile court, but it would not be able to cooperate with an orphan asylum or welfare agency doing maternal and child welfare.

You have a great many agencies in America who render maternal and child welfare service, and they are mentioned as agencies with which this agency cooperates in the Social Security Act.

Senator ELLENDER. To what extent do you think that the money contributed by the Federal Government and raised by the States ought to be used toward defraying the expense of any private hospitals for taking care of the indigent?

Mr. MONTAVON. I do not believe in grants to private hospitals, but I believe—

Senator ELLENDER (interposing). I did not mean grants.

Mr. MONTAVON. I believe that it should be compulsory on the Government to give preference to the private hospital, which is an American tradition.

Senator ELLENDER. Rather than to build new ones?

Mr. MONTAVON. Rather than develop a public agency to replace that hospital.

Senator ELLENDER. Do you think the hospitals would be inclined to make a special rate for indigent patients?

Mr. MONTAVON. I think there should be a working agreement between the particular hospital and the particular locality that is getting the service which would regulate standards and which would regulate prices.

Senator MURRAY. That would vary in different parts of the country?

Mr. MONTAVON. Yes; that would vary in different parts of the country. That is one thing that is in this plan. The plan calls for standardization of a Federal basis of costs. I do not think that is at all justifiable.

Senator ELLENDER. Have you in your statement in figures to show what the approximate cost would be, let us say, per bed or per room?

Mr. MONTAVON. I think that is a question that Mr. Munger, who is speaking for the American Hospital Association, or one of the other witnesses that will appear here this afternoon, can answer better than I can.

Senator ELLENDER. Are they present?

Mr. MONTAVON. Yes; and they will speak here this afternoon.

There is another statement in this analysis that I think is important: The hospital associations appeared for conference with the interdepartmental committee, and in that conference I was assisting in an advisory capacity as a member of the Committee of Nine at that conference, and the hospitals had reached a sort of a meeting of minds with the interdepartmental committee, and during the noon

recess, at the request of the indepartmental committee, they formulated their minds and presented it, thinking that it would be perhaps of some influence in drafting subsequent legislation. That has not been done. That influence has never been exercised. In that statement, the hospitals referred to the address by President Roosevelt on the Mobilization for Human Needs, and said:

It is not our place at this moment to urge upon those who are to formulate our legislation the motives we believe should urge them to recommend any particular pattern, but it is our place here to stress what we believe to be the important, guiding, and controlling principle in any future development, namely, the principle that whatever program and procedures are drafted, they should be such that in the words of a particularly valuable and experienced member of our committee, "they may alter to the least necessary extent the existing plan of cooperative understanding between public and private agencies. \* \* \* " Wherever possible, the governmental agencies should place at the disposal of the private agencies those resources which are required to accomplish the work which the private agencies could perform more effectively than the governmental agencies.

Commenting on that, the president of the Catholic Hospital Association of the United States and Canada has said:

For the Catholic sisterhoods, the plea for the continuance of the hospital's privilege to care for the indigent has, as has been so often pointed out, a very special significance. We, as Catholics, cannot accept the theory that hospitals are merely a business nor that we are conducting our institutions for the sake of financial return. Our sisterhoods were formed for the purpose of caring for the neglected and underprivileged members of our Nation. Through the care lavished upon these less-favored individuals, our own religious spirit is kept alive, our vocations are strengthened, and our love of God is permitted to manifest itself in the manner in which Christ himself expected it to be shown, by the care of the poor. It is unthinkable that all of this should pass away, no matter what the social realignments may be and no matter what social upheavals may have come to disturb the traditional relationships between private and public agencies.

I have a little discussion here on the approval of State plans and grants-in-aid, which I should like to read:

The practice embodied in recent Federal legislation whereby funds of the United States are pooled with funds of the several States is referred to as Federal-State cooperation. It is not cooperation. Cooperation implies liberty on the part of those who cooperate. A particular State is not wholly free to reject the program offered to it to be financed jointly by Federal and State appropriation. Funds of the Federal Government are the property of all of the States in the Union. A particular State, rejecting a Federal-State program authorized by Federal law, by that act makes a serious material sacrifice for which it receives no material compensation, namely, it renounces its right to participate in the benefits of an appropriation of Federal funds. Thus is the liberty of the State restricted.

In the titles of the Social Security and other Federal acts the amount contributed by the United States is referred to as a grant-in-aid. It is properly an allotment to a fund made up in part by the particular State.

Before this allotment can be made legally, the State must bind itself to do specific things in a way stated in the Federal statute. The submission of a plan by the Government of a particular State and the approval of that plan by the Federal Government establishes a contractual relationship between the State and the Union and the new Federal-State administration assigns funds and duties. Neither party to that contract may modify or exceed the terms of that contract without forfeiture of its rights. It is even probable that a particular State administering a Federal-State appropriation would forfeit its right in the Federal-State fund if it set up a parallel program in the same field of activity, but financed wholly by State funds; that is, it is possible that the Federal-State partnership exercises a monopoly of all public activity in the field and is restricted in its methods of operation by the terms of the approved plan, and by regulations adopted pursuant thereto. Unless cooperation of

charitable and voluntary agencies is clearly provided in the plan, it is probable that the Federal-State plans providing for the operation of the plan may not be used for cooperation with the nongovernmental agency.

This interpretation is the basis for the provision embodied in section 505 of S. 1620. This section reads in part:

"Wherever the Chief of the Children's Bureau finds \* \* \* that in the administration of a plan approved, \* \* \* their failure to comply substantially with any requirement of subdivision 503 (a) (the plan), he shall notify such State agency that further payments will not be made to the State."

The use of the word "substantially" could not justify the State agency in interpreting "public" as used in section 503 (a) to comprise both "governmental" and "nongovernmental" agencies.

The authority thus granted to the Children's Bureau leaves no doubt but that the Federal Government is to exercise its position as senior and controlling partner in the partnership established under the act.

To have a share in this kitty, a State must submit its statute in the form of a plan to a Federal officer and obtain his approval. Thus the State legislature grants to a Federal bureau chief the power to veto an act of its sovereign legislature, a power otherwise granted to no one but the chief executive of the State, and otherwise always subject to the superior power of the legislature. Thus a Federal agency not elected by the people of the State is given supreme legislative authority over an act of the State legislature.

I say this because I feel that the provisions required to be inserted in the plan throughout this bill in S. 1620 are very sweeping. They even cover regulations, so that practically every act carried on under the bill, even the regulations, any minute detail of those acts, are a part of this contract.

Senator ELLENDER. How does that differ from the present Social Security Act?

Mr. MONTAVON. The present Social Security Act restricts the regulations that are required to be contained in the plan or the provisions in the plan largely to the safeguarding of moneys and to the accounting for these moneys, and in general terms outlines the purposes for which those moneys are to be used; they go in detail, and it contains a provision for the regulations.

Senator ELLENDER. You would have no objection if that same provision were in there?

Mr. MONTAVON. I think it would be a great improvement. We have made no objection to the Social Security Act. That is, I do not believe you can get away from Federal grants-in-aid; but I think the rights of the States should be circumscribed and carefully protected.

Senator ELLENDER. I personally have stated that on several occasions here during these hearings.

Mr. MONTAVON. I am sure that a great many people believe that. I congratulate you on that.

I would like very much, Senator, to leave this analysis with you in connection with my testimony.

Senator MURRAY. That will be filed and printed.

This bill seeks to amend certain titles of the Social Security Act of 1935, and to add new titles to that act incorporating the recommendations of the President's Interdepartmental Committee to Coordinate Health and Welfare Activities.

Titles I, II, III of the Social Security Act have been the subject of prolonged hearings conducted by the Committee on Ways and Means, and it is stated that a bill to amend these titles will soon be reported to the House of Representatives.

These three titles provide for a Federal-State system of old-age assistance, a Federal system of old-age benefits, and grants to the States for unemployment-compensation administration.

Title IV of the Social Security Act, which provides grants to States for aid to dependent children, is not to be amended.

S. 1620 would completely rewrite this title, as follows:

Title V, part 1—Maternal- and child-health services: Section 501 of the Social Security Act does not define the scope of the maternal- and child-health services to be promoted but emphasizes that these services are to be promoted especially in rural areas and in areas suffering from severe economic distress.

S. 1620 restates the emphasis on rural areas and areas suffering from severe economic distress.

S. 1620 defines maternal- and child-health services to include: Services, supplies, and facilities for promoting the health of mothers and children, and specifically to comprise:

Medical care during maternity and infancy, including medical, surgical, and other related services.

Care in the home or in institutions.

Facilities for diagnosis, hospitalization, and aftercare.

S. 1620 would add a new purpose to those embodied in section 501 of the Social Security Act, namely, to develop more effective measures, including the training of personnel. Thus the Children's Bureau would be given an educational function in competition with existing nurse and welfare education now given in a large number of schools.

Section 501 of the Social Security Act authorizes \$3,800,000 for the extension of maternal- and child-welfare services.

Section 501 of S. 1620 would authorize \$8,000,000 for this purpose for the first year, to increase to \$20,000,000 for the fiscal year ending June 30, 1941, and to \$35,000,000 for the fiscal year ending June 30, 1942, and annually thereafter.

Section 502 of the Social Security Act sets forth the manner for making allotments to the States. The fact that the Children's Bureau is in the Department of Labor is recognized, and the Secretary of Labor makes the allotments.

Section 502 of S. 1620 would change this provision of the Social Security Act, and under it the Chief of the Children's Bureau would make the allotments.

The Social Security Act provides a \$20,000 allotment to each State, and the distribution of a total of \$1,800,000 on the basis of relation between total live births in the State to total live births in the United States. Thus the State is encouraged in which infant mortality is reduced. The Secretary of Labor is authorized to distribute \$950,000 on the basis of relative financial need of the States.

S. 1620 repeats this method of allotting the funds and provides for allotments determined by taking into consideration the following factors:

(a) Total number of births. (Thus, the encouragement to a State which reduces infant mortality is out.)

(b) The number of mothers and children in need of services. (Presumably all mothers and children at birth need services; S. 1620 does not define the word "need.")

(c) The special problems of maternal and child health. (This is too vague to guarantee justice in the distribution of \$35,000,000 of taxpayers' funds.)

(d) The financial resources.

Nowhere does S. 1620 say that the facts upon which allotments are based are to be publicly ascertained or known. Nowhere does S. 1620 require a stated relationship between these facts in a particular State with the total for the United States. S. 1620 leaves too much to the discretion of the allotter, is too vague, and is open to log-rolling and politics. Nowhere in S. 1620 is the relative weight to be given to each of these factors stated.

#### APPROVAL OF STATE PLANS

##### Social Security Act

##### S. 1620

SEC. 503 (a). To be approved, a State plan for maternal and child-health services must provide:

1. Financial participation by the State. (The amount to be appropriated by a State is left open.)

2. Administration by or under supervision of State health agency.

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

1. Same.

3. Administration by State health agency or other public agency under supervision of State health agency.

3. Methods of administration must be approved, other than those relating to selection, tenure of office, and compensation of personnel.

4. Reports to be submitted by State health agency to Secretary of Labor.

5. Extension and improvement of local services rendered by local child-health units.

6. Cooperation with medical, nursing, and welfare groups and organizations. (This was embodied in the Social Security Act to protect private enterprise in the field of maternal and infancy service.)

7. Development of demonstration services.

Private and local initiative is fostered.

4. Must be approved and must include: Establishment and maintenance of personnel 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."

6. Reports to be submitted by State health agency to Chief of Children's Bureau.

2. State-wide program or extension of program each year so that it shall be in effect in all political subdivisions of the State not later than July 1, 1944.

7. Cooperation and, when necessary, working agreements between the State health agency and any public agency or agencies administering services related. (This repeals the cooperation with private agencies and would restrict cooperation to public agencies.)

No corresponding provision. Added requirements are:

5. Advisory Council or Councils composed of professional persons or agencies serving under State plan, and persons informed on needs for or provision of maternal and child-health services.

8. State agency authorized to make rules and regulations. (Such rules and regulations would have the force of law and thus the State agency under the Children's Bureau would be given absolute control within the limitations of this bill.)

#### CHARITABLE AGENCIES IMPERILED

The program of maternal and child-health services recommended by the interdepartmental committee and embodied in S. 1020 is no longer a welfare program as provided by the Social Security Act for the relief of rural and needy persons, but in the words of the report of the committee (H. Doc. 120, 76th Cong.) is as follows:

"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."

In doing this under a law that authorizes no cooperation with any but public agencies, the existing charitable and voluntary agencies in this field would not survive.

On November 21, 1938, a joint committee representing the three hospital associations, comprising practically all the charitable and voluntary hospitals in the United States, appeared by invitation before the interdepartmental committee to coordinate health and welfare activities and after conference presented a statement embodying views on which they were in agreement among themselves and with the interdepartmental committee. In that statement the hospitals referred to the address by President Roosevelt on the Mobilization for Human Needs, and said:

"It is not our place at this moment to urge upon those who are to formulate our legislation the motives we believe should urge them to recommend any particular pattern, but it is our place here to stress what we believe to be the important, guiding, and controlling principle in any future development; namely, the principle that whatever program and procedures are drafted, they should

be such that in the words of a particularly valuable and experienced member of our committee, 'they may alter to the least necessary extent the existing plan of cooperative understanding between public and private agencies.' \* \* \* Wherever possible the governmental agencies should place at the disposal of the private agencies those resources which are required to accomplish the work which the private agencies could perform more effectively than the governmental agencies."

Commenting upon the above statement of the three hospital associations, the president of the Catholic Hospital Association of the United States and Canada has said:

"For the Catholic sisterhoods the plea for the continuance of the hospital's privilege to care for the indigent has, as has been so often pointed out, a very special significance. We, as Catholics, cannot accept the theory that hospitals are merely a business nor that we are conducting our institutions for the sake of financial return. Our sisterhoods were formed for the purpose of caring for the neglected and underprivileged members of our Nation. Through the care lavished upon these less favored individuals, our own religious spirit is kept alive, our vocations are strengthened, and our love of God is permitted to manifest itself in the manner in which Christ, Himself, expected it to be shown, by the care of the poor. It is unthinkable that all this should pass away, no matter what the social upheavals may have come to disturb the traditional relationships between private and public agencies."

S. 1620, page 2, clearly defines the nature of the maternal and child services to be rendered and restricts them to the health field. The language of the act of 1935 leaves those details to the discretion of the State in adopting its plan and does not subject the State to the strait jacket of regulations as is provided by S. 1620, page 8. I have just as great confidence in the ability of the State government as I have in that of the Children's Bureau. Maternity and infancy care should not be made to conform to rigid standards uniformly imposed under a Nation-wide system. The time has not come yet when a Federal bureau should have power to regulate the services to be rendered by State and local authorities, in the field of maternal and child welfare. To lay the dead hand of bureaucratic regimentation on a service so intimately related to personal life and the family would violate our tradition as a free people. When I say that, I say it because of the interest those for whom I speak have in a sound program of maternity and child-welfare service.

#### FEDERAL-STATE PARTNERSHIP

The practice embodied in recent Federal legislation whereby funds of the United States are pooled with funds of the several States is referred to as Federal-State cooperation. It is not cooperation. Cooperation implies liberty on the part of those who cooperate. The particular State is not wholly free to reject the program offered to it to be financed jointly by Federal and State appropriation. Funds of the Federal Government are the property of all the States in the Union. A particular State, rejecting a Federal-State program authorized by Federal law, by that act makes a serious material sacrifice for which it receives no material compensation, namely, it renounces its right to participate in the benefits of an appropriation of Federal funds. Thus is the liberty of the State restricted.

In the titles of the Social Security and other Federal acts the amount contributed by the United States is referred to as a grant-in-aid. It is properly an allotment to a fund made up in part by the particular State.

Before this allotment can be made legally the State must bind itself to do specific things in a way stated in the Federal statute. The submission of a plan by the government of a particular State and the approval of that plan by the Federal Government establishes a contractual relationship between the State and the Union and to the new Federal-State administration assigns funds and duties. Neither party to that contract may modify or exceed the terms of that contract without forfeiture of its rights. It is even probable that a particular State administering a Federal-State appropriation would forfeit its right in the Federal-State fund if it set up a parallel program in the same field of activity, but financed wholly by State funds. That is, it is probable that the Federal-State partnership exercises a monopoly of all public activity in the field and is strictly restricted in its methods of operation by the terms of the approved plan and by regulations adopted pursuant thereto. Unless cooperation with charitable and voluntary agencies is clearly provided in the plan,

It is probable that the Federal-State fund provided for the operation of the plan may not be used for cooperation with the nongovernmental agency.

This interpretation is the basis for the provision embodied in the section 505 of S. 1620. This section reads in part:

"Wherever the Chief of the Children's Bureau finds \* \* \* that in the administration of a plan approved, \* \* \* there is failure to comply substantially with any requirement of subsection 503 (a), (the plan), he shall notify such State agency that further payments will not be made to the State."

The use of the word "substantially" could not justify the State agency in interpreting "public" as used in section 503 (a) to comprise both "governmental" and "non-governmental" agencies.

The authority thus granted to the Children's Bureau leaves no doubt but that the Federal Government is to exercise its position as senior and controlling partner in the partnership established under the act.

To have a share in this kitty a State must submit its statute in the form of a plan to a Federal officer and obtain his approval. Thus the State legislature grants to a Federal bureau chief the power to veto an act of its sovereign legislature, a power otherwise granted to no one but the chief executive of the State, and otherwise always subject to superior power of the legislature. Thus a Federal agency not elected by the people of the State is given supreme legislative authority over an act of the State legislature.

Perhaps in time of emergency or unusual conditions such a surrender of power might be understandable. The Social Security Act is not an emergency measure. It embodies a permanent policy. In the Social Security Act of 1935 there are seven titles which require the State to surrender its legislative power. In S. 1620 that act would be amended by adding four more titles making the total 11. I submit that when a single act of Congress provides a device whereby the several States are obliged to surrender their sovereign legislative and executive authority in 11 sections of the all-important field of human welfare and relief, we are on our way, well on our way, making giant strides, away from our present status as a Federal republic, to that of a centralized realm the like of which has failed wherever it has been tried.

In the Social Security Act of 1935 a State plan for maternal and child-health services must provide:

1. Financial participation by the State.

S. 1620 does not change this.

2. Plan to be administered by or under the supervision of State health agency.

S. 1620, section 503 (a) (5), makes no essential change.

3. Such methods of administration as are necessary for the efficient operation of the plan, but not relating to selection, tenure of office, and compensation of personnel. (This provision of the act of 1935 recognizes and respects the autonomy of the State in an essential matter, namely, control of the employees of the State.)

S. 1620, section 503 (a) (4), subjects this essential element of autonomy to Federal control by requiring that the State plan include: "Methods of establishing and maintenance of personnel on a merit basis," and adds to this "methods of establishing and maintaining standards of medical and institutional care and of remuneration for such case, such methods to be prescribed by the State agency after consultation with such professional advisory committees as the State agency may establish."

The full import of this provision becomes clear when one refers to page 8 of S. 1620, "Rules and regulations." Under section 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 title as may be necessary to the efficient administration of this title."

The State plan must provide that the State agency "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 the service."

The making of these rules and regulations is one of the functions relating to the efficient administration of this title and is, therefore, subject to the veto power given to the Chief of the Children's Bureau. Under this provision of S. 1620 the degree of autonomy remaining vested in the State legislature approaches the point of zero.

5. Extension and improvement of local maternal and child health services administered by local child health units.

S. 1620, page 4, section 503 (a) (2), provides that the plan must provide a State-wide program, or for the extension of the program each year at a rate that will insure that it shall be in effect in all political subdivisions of the State on or before June 30, 1944. The Social Security Act of 1935 permits normal growth, respects prevailing conditions, and safeguards local autonomy.

S. 1620 would foster, under fear of losing the right to a share in the Federal kitty, an artificial, hothouse growth which would defeat the sound social purpose of the act.

Moreover, the act of 1935 recognizes the rights and interests of the community to set up its own local child-health units. No such recognition is to be found in S. 1620.

S. 1620 restricts cooperation to a public agency "administering services that are related to the services furnished under the State plan." Under this provision the State agency could cooperate with the juvenile court, but not with a group of public-spirited citizens concerned with medical, nursing, and welfare services. The provision I have quoted was written into the Social Security Act of 1935 to win the support of the private agencies. To repeal it now would betray those private agencies.

Nowhere does S. 1620 require the State agency to consult members of the professions. On page 4, section 503 (a) (4), there is a most casual reference. This section provides for administrative control by the Children's Bureau over the State administration, including personnel, and says that methods of establishing and maintaining standards of medical and institutional care and remuneration for such care are to be "prescribed" by the State agency after consultation with such "professional advisory committees as the State agency may establish." What the State agency may do, it equally may not do. This casual reference to professional advisory committees gives no assurance whatever that the medical profession or hospital administrators will have any representation on any professional committees that may be established. These professions are not recognized as having any interest or right in this matter which affects them so vitally. They must accept the standards which the State authority prescribes or remain outside the purview and scope of the act.

Advisory councils provided for in S. 1620, page 4, section 503 (a) (5), are to have a membership from which the medical profession, hospital administrators, the nursing profession, technicians, etc., are to be excluded unless they are furnishing services under the State plan; that is, are receiving compensation and therefore are bound by contract to the State agency. These professions would by this device be split into two classes—those who serve under the State plan and those who do not. These professions at present are united in strong national associations. No reason is advanced why these should be denied the right to serve as members on an advisory council.

On the other hand, any person not a "member of the profession," can qualify for membership if, in the judgment of the State agency, he is "informed of the need for, or provision of, maternal and child health services."

An advisory council thus established is not representative in any sense. It has no stated right, no defined jurisdiction, is not responsive to the community, and its members have no fixed tenure under the bill. The advisory council seems to be a device for evading responsibility.

This criticism is equally applicable to advisory councils provided for under other titles of the bill.

Social Security Act, title V, part 2: In the Social Security Act the title of this part 2 reads: "Services for crippled children."

In S. 1620 the title is amended to read: "Medical services for children and services for crippled and other physically handicapped children."

It seems clear that the purpose of this change of title is to provide for a National system financed jointly by the several States and the United States in the field of medical services for all children and a particular service for crippled and physically handicapped children.

This is wholly different from the purpose of the Social Security Act of 1935.

Section 511 of the Social Security Act authorizes an appropriation of \$2,850,000.

Section 511, S. 1620, would authorize \$13,000,000 for 1939-40, \$25,000,000 for 1940-41, \$35,000,000 for 1941-42, and annually thereafter.

As is indicated by the changed title and the higher appropriation, section 511 of the Social Security Act is completely rewritten in section 511 of S. 1620.

Here again a Federal-State agency is set up under an approved plan with a partnership control of a Federal-State fund. The chief of the Children's Bureau controls and has authority to withhold payments on allotments to the

particular State for failure to comply with the plan in its regulations or administration.

The Federal-State agency is to extend and improve services, supplies, and facilities for the medical care of children; and services to crippled and 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, hospitalization or other institutional care, and after-care, and to develop more effective measures for carrying out the purposes of this title, including the training of personnel.

The above is all to be done under a Federal-State plan which authorizes "cooperation and, when necessary, agreements between the State agency and (only) any public agency." (S. 1020, sec. 513, (a) (7).)

Section 513 of the Social Security Act of 1935 authorizes cooperation with existing agencies in the following provision:

"Sec. 513 (a) (6). A State plan must provide for cooperation with medical, health, nursing, and welfare groups and organizations and with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children."

Under this provision cooperation with existing private as well as public agencies is required by law. This provision would be repealed by S. 1020 and replaced by a requirement only that the State agency cooperate with other public agencies.

The amount to be allotted to a particular State under S. 1020 is to be determined by taking into consideration:

1. The child population;
2. The number of children in each State in need of the services. (Probably every child in the State will at some time be in need of medical services.)
3. The special problems of medical care of children. (How this would affect a general hospital which provides medical care for children is not stated. There is some reason to believe that in both sections 503 and 513 of S. 1020 specialized maternal and children's hospitals are envisioned.)
4. The financial resources.

Section 514 (a) of S. 1020 adds a new general regulation, to be known as section 1101 (e), to the Social Security Act, as follows:

"S. 1020, Sec. 514 (a) \* \* \*. Payments shall be made to each State which has an approved plan in such proportion to the total amount of public funds expended under the State 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 of this Act or any other Act of Congress."

#### ADVISORY COUNCILS

The Social Security Act, title V, provides clearly for cooperation with non-governmental professional persons and agencies.

S. 1020 makes no such provision but provides instead advisory councils. We have seen that in the maternal and child health section a professional person to be eligible to membership on a State or local advisory council must be one who furnishes service under a State plan. To be a member of a Federal advisory council under this section the member of a profession and the agency represented must be "concerned with the promotion of maternal and child health."

In the crippled children section, S. 1020 provides for advisory councils, State and local, and for Federal advisory councils. Membership in these is subject to the restrictions stated in the preceding paragraph.

In this manner no professional person or agency can have membership in a State or local advisory council unless he or it furnishes services under the State plan. Nonprofessional persons are not subject to this restriction but must be informed "on the need for, or provision of medical services."

Title V, part 8, of the Social Security Act, regarding child welfare services, and part 4, regarding vocational rehabilitation, are not to be amended by S. 1020.

Title V, part 5, regarding administration, is to be revised.

The Social Security Act of 1935 divides this part 5 into three clauses, as follows:

1. Authorizes \$425,000 for cost of administration;
2. Authorizes Children's Bureau to make studies and investigations;
3. Requires Secretary of Labor to report to Congress.

As amended by S. 1620, title V, part 5, would:

1. Authorize an appropriation of \$2,500,000 to the Children's Bureau for administrative year 1939-40, and thereafter a sum that will be sufficient.
  2. Direct the Secretary of Labor to report to Congress.
- S. 1620 would also authorize the Children's Bureau to make studies, investigations, and demonstrations.

#### TITLE VI.—PUBLIC HEALTH

In Social Security Act, title VI, section 601, the purpose is stated to be to assist States, counties, health districts, and political subdivisions of the States in establishing and maintaining adequate public health services.

(This provision recognizes existing agencies and activities and provides for cooperation with them.)

In S. 1620, title VI, section 601, the purpose is stated to be to enable each State 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, including training of personnel.

The act of 1935 authorizes \$8,000,000. S. 1620 would authorize \$15,000,000 for 1939-40, \$25,000,000 for 1940-41, \$60,000,000 for 1941-42, and thereafter a sufficient sum.

To qualify for an allotment the State must have a plan approved by the Surgeon General of the Public Health Service.

The act of 1935 does not require the State to submit a plan for approval. Under this act the State autonomy is respected.

S. 1620 requires an approved State plan and thus makes the Public Health Service a Federal-State service.

This State plan must provide for financial participation by the State. The proportional amount to be provided by the State is not stated in the bill. In addition, the State plan must be State-wide and provide a program for the extension of the services to all political subdivisions of the State not later than July 1, 1944. Every State agency administering any part of the plan must do so under the supervision of the State health agency. The methods of administration must be approved by the Surgeon General, including establishment of personnel on a merit basis and methods of establishing and maintaining standards of medical and institutional care and of remuneration for such care to be prescribed by the State agency.

There are, under S. 1620, to be advisory councils to be composed of members of professions and agencies, public and private, that furnish services under the State plan.

(This phrase, "public and private, that furnish services", appears repeatedly as a condition of membership on the advisory councils. There is no clear provision which would enable private persons and agencies to furnish such services. Senator Wagner has said that if the bill is not clear, he would not object to a clarifying amendment.)

The plan must also provide for reports to be submitted by the State health agency to the Surgeon General. The State health agency must be authorized to cooperate with other public agencies.

The State health agency is authorized to make rules and regulations.

#### PAYMENTS TO THE STATES

Under the act of 1935 the allotments are based on: (1) The population; (2) the special health problems; (3) the financial needs of the respective States.

Under S. 1620 the Federal allotment is to be in such proportion to the total amount of public funds expended under the State plan as is determined in accordance with section 1101 (2). This section 1101 (2) is a new section and will be discussed later along with other general provisions.

In computing the public funds expended under the plan, there is not to be counted that part of the total expenditures as were (1) expended for the care

in hospitals, institutions, and other organized facilities as are not in excess of average expenditures for this care in the 3 years prior to enactment of this bill, or (2) included in any State plan submitted for grants to the State under any other section of this act or any other act of Congress.

When a State fails to comply substantially with the approved plan, the Surgeon General shall authorize no payment to that State.

The Surgeon General is authorized to make rules and regulations.

The Social Security Act authorizes \$2,000,000 for investigations. Subsequent legislation especially with regard to cancer and venereal disease has substantially augmented this sum.

S. 1020 authorizes \$1,500,000 for the Surgeon General to administer this act as amended. No similar appropriation is authorized in the Social Security Act.

Section 611 authorizes the Public Health Service, through the National Institute of Health, to make investigations of health, disease, sanitation, and matters pertaining thereto, and for that purpose an appropriation of \$3,000,000 is authorized for 1939-40 rising to \$4,000,000 for 1941-42.

There has been very little opposition to the proposed expansion of the Public Health Service.

#### ADDITIONS TO SOCIAL SECURITY ACT

S. 1020 would add to the Social Security Act of 1935 the following new titles:

XII. Grants to State for hospitals and health centers.

XIII. Grants to State for medical care.

XIV. Grants to State for temporary disability compensation.

We will consider briefly each of these three new titles and the contribution their enactment would make to social security.

S. 1020, title XII—Grants to States for hospitals and health centers:

The purpose is to enable each State so far as practicable under conditions in that State:

(1) To construct and improve needed hospitals.

(2) To aid the State for 3 years by contributing to operating costs of added facilities.

(3) To develop more effective measures for effecting 1 and 2.

Special consideration is to be given to rural areas and areas suffering from severe economic distress.

The bill would authorize the following appropriations:

(1) General hospitals: For 1939-40, \$3,000,000; for 1940-41, \$50,000,000; and for 1941-42, \$100,000,000.

(2) Mental and tuberculosis hospitals: For 1939-40 a sum, not named, that would be sufficient to carry out the purpose of the bill in respect to such hospitals, and thereafter a sufficient amount each year.

(This provision is too vague. At best there should be an appropriation for research purposes.)

Plans: Each State, to become eligible for a grant, must submit to the Surgeon General its plan for constructing and improving needed hospitals in the State, and the plan must meet with the approval of the Surgeon General.

A State plan to win approval must provide:

1. Financial participation by the State.

2. Administration by State health agency or under its supervision. (This subjects local and county agencies to the State agency, and the State agency subjects itself to the Federal agency through its approved plan.)

3. Methods of administration subject to approval of Surgeon General including personnel on a merit basis; establishment and maintenance of standards for institutional management and remuneration of such management, such standards to be prescribed by State agency after consultation with such advisory committee as State agency may establish. (The language of this provision is such as to give the State agency dictatorial control over the management of every hospital rendering service under the act.)

4. Ownership of real estate, improvements, and equipments vested in State or its political subdivisions.

5. Safeguards to assure title, location, design, construction, and equipment. (These two provisions would prevent the use of the Federal-State fund from being used to construct or improve a non-Government-owned hospital.)

6. Systems of financial support to assure continuing operation of added hospitals and of their availability to all groups of the population in the designated area. (There is no mention here of any financial support for existing hospitals.)

7. 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 of the need for, or provision of, hospitals. (There is nothing in the bill that justifies the expectation that any nongovernmental hospital will be able to serve under any State plan.)

8. State agency reports to Surgeon General.

9. Cooperation and, when necessary, working agreements between the State agency and any public agency. (No provision for cooperation with any private agency even under a working agreement. This means that no private agency could be remunerated for service.)

10. State and local public agencies may make rules and regulations.

11. Prevailing wages to be paid to laborers and mechanics in construction of added hospitals; provided that if the added hospital is a mental or tuberculosis hospital, plan for which is submitted after June 30, 1939, and before July 1, 1941, the plan must provide for administration by a State agency.

The allotment to any State is to be determined in accordance with rules and regulations not stated in the bill but to be prescribed by the Surgeon General, who must give consideration to (1) the needed additional hospitals and (2) the financial resources.

(This provision of the bill is too vague. It does not provide any method for determining when an additional hospital is needed; it gives no assurance that existing nongovernmental hospitals will be considered either in appraising the need for an additional hospital or for improving existing hospitals either by new construction or added equipment or improvement. I heard Dr. J. W. Mountin, speaking publicly for the technical advisory committee on a national health program, say to the Pennsylvania Hospital Association in a prepared address that the "inadequacy or inefficiency" of a nongovernmental hospital would be considered evidence that an additional hospital is needed. Dr. Mountin on this occasion was defending this provision of S. 1620.)

Payments to a State shall be in such proportion to the total amount of public funds expended under the State plan as is determined in accordance with subsection 1101 (e) of this act.

The Surgeon General may withhold Federal funds to any State failing to comply substantially with its approved plan.

#### FEDERAL ADVISORY COUNCIL

The Surgeon General is authorized to establish an advisory council or councils, composed of members of the profession and agencies concerned with the construction and operation of hospitals, and other persons informed on the need for, or provision of, such facilities.

(There is no recognition of either the American Medical Association or of any hospital association. Individual hospitals would have equal authority with an association of thousands of hospitals. No compensation or expense money is provided for advisory councils.)

S. 1620 would authorize an appropriation of \$1,000,000 for administration by the Surgeon General. Presumably expenses of advisory council could be paid out of this fund. After July 1, 1940, the bill authorizes the appropriation of a "sufficient" fund for administrative expenses.

#### HOSPITAL DEFINED

S. 1620, section 1200, would define the term "hospital" to include health, diagnostic, and treatment centers, institutions and related facilities. (There it becomes clear that this bill contemplates a type of health center relatively new in most parts of the United States and makes no provision for the conversion of existing facilities to conform them to this new definition.)

#### THE NONGOVERNMENTAL HOSPITALS

In their joint statement to the interdepartmental committee, the committee representing the three hospital associations recorded their position as follows:

#### "EXPANSION OF HOSPITAL FACILITIES

"With reference to the increase in the number of hospitals, the representatives of our three associations recommend a measure of prudent reserve no less than

of effective activity. On the one hand, it is clear that there is need of increased hospital facilities in certain areas of the country. On the other hand, it is equally clear that at times considerations other than those of a local need have entered into the erection of governmental institutions which, once they have been erected, have not only consumed enormous sums in their operation but have also tended toward weakening the effective operation of existing institutions. It is strongly recommended by all three associations that the extension of facilities should take place only after an impartial survey of local needs.

#### "THE SIGNIFICANCE OF SURVEYS

"This raises the whole question of the significance of surveys of local needs and of the techniques to be employed in this survey. The question is too large a one to enter into here; nevertheless our three associations desire to point out at least this at the present moment: That in making the survey not only professional competence of the surveyors be considered but also the necessity of adequate representation of the parties at interest in formulating the recommendations based upon a survey. Various groups have suggested a diversity of plan to insure such representation. This might be done through a national agency created by the Government or, again, it might be left to local agencies responsible to the Government. But it certainly seems to be the part of wisdom to authorize the expenditure of public funds only when the need for which they are to be expended has been frankly ascertained and when the multiplication of facilities does not operate against the continued employment of facilities already created.

#### "EXTENSION OF THE SPECIAL-HOSPITAL SYSTEM

"With reference to the extension of the special hospital system; that is, of hospitals for tuberculosis, for nervous and mental patients, and so forth, the three associations endorse the program of the Interdepartmental Committee, again, however, subject to the restriction that such extensions as might be contemplated be made only after a carefully elaborated survey."

The method for determining the need for an additional hospital provided in S. 1620, has none of the safeguards suggested and insisted upon by the hospital association. S. 1620 seems to be a bill to revolutionize hospital service in the United States rather than a bill to expand and improve that service.

#### MEDICAL CARE

S. 1620, title XIII, provides grants to States for medical care.

The purpose of this title is to enable each State to extend and improve medical care as far as practicable under the conditions in the State.

Emphasis is on rural areas and such individuals as suffer from severe economic distress.

Medical care as used in the bill includes all services and supplies necessary for the prevention, diagnosis, and treatment of illness and disability.

An additional purpose is that which is repeatedly stated in the bill, namely, to develop more effective measures. (Thus the bill seeks to stimulate original work, research and experimentation under the direction of the State health agency. Such work now is done in medical schools, laboratories, and by individuals with greater liberty but less material resources than could be provided by a health agency.)

Under this heading, "to develop more effective measures," is included the training of personnel.

Appropriation of \$35,000,000 is authorized for 1939-40, and for each subsequent fiscal year "a sum sufficient to carry out the purpose."

#### STATE PLAN

To qualify for a grant the State must have a plan approved by the Social Security Board.

This plan must provide:

1. Financial participation by the State.
2. A State-wide program or a program which would extend the service each year so that by June 30, 1944, it would be effective in all political subdivisions of the State.

8. Administration by State health agency (or by another State agency). The State agency supervises any other public agency serving under the plan. (Clearly the bill does not encourage the administration of this medical care by any State board of public welfare or of institutions. It clearly wants the administration to be under the public health department and thus indirectly would subject medical care to the Public Health Service and the Surgeon General, who, together, supervise State health agencies. The medical profession would probably be more comfortable if the service could be administered by the State board of public welfare, and the distinction between medical care and preventive medicine thus preserved.)

4. Methods of administration subject to approval must provide for personnel on merit basis and standards of medical and institutional care and remuneration for such care.

5. Advisory council or councils composed of members of the professions and agencies rendering services under the plan.

6. State agency reports to Social Security Board.

7. Cooperation with other public agencies.

8. State agency authorized to make rules and regulations. Any other State agency rendering services under the plan also authorized to make rules and regulations.

#### ALLOTMENTS AND PAYMENTS TO STATES

The amount of allotments is to be determined by the Social Security Board which shall take into consideration:

1. The population.
2. The number of individuals in need of services.
3. The special health problems.
4. The financial resources.

Payments are to be determined in accordance with subsection 1101 (e). In determining payments to the States there shall not be counted that part of any expenditure that is (1) in excess of \$20 annually per individual; (2) expended for care in hospitals, institutions, and other organized facilities, of cases of mental disease, mental defectiveness, epilepsy, and tuberculosis (such expense is provided for through public health); (3) provided for in any other State plan submitted for grants.

The Social Security Board may suspend payment when a State fails to comply substantially with its approved plan.

#### FEDERAL ADVISORY COUNCILS

The Social Security 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. (Here, again, there is no recognition of the medical or hospital associations.) The bill does not state how these advisory boards are to be continued nor how members are to be selected. It leaves all to the discretion of the Social Security Board and State agencies.

The bill would authorize an appropriation of \$1,000,000 for administration the first year and a "sufficient" amount for each succeeding year.

#### ATTITUDE OF THE HOSPITALS<sup>1</sup>

##### "The Care of the Indigent and Medically Indigent

"The problem of the care of the indigent and of the medically indigent is, needless to say, in the focal point of interest in this question. It must be pointed out that one of the chief reasons for the existence of private hospitals is the fact that they give care to the indigent and to the medically indigent. This is the basis upon which the private institution appeals for public voluntary support. It is for this reason, furthermore, that the American Government, in all its various subdivisions, has recognized the validity of the contention that these hospitals are to be held immune from certain tax obligations. It is recognized, furthermore, that the institutional attitudes developed through the

<sup>1</sup> "The Three National Hospital Associations and the National Health Program," Bulletin No. 85, p. 13, Catholic Hospital Association of the United States and Canada.

care of the indigent have been a valuable resource by reason of which these institutions have been able to do so much for the national health. It is through these institutions that philanthropy and charity have found their most effective expression. All of these gains cannot but be considered national assets of the first importance. Our three associations desire that these assets should be retained undiminished in their magnitude and in their effectiveness for American life.

THE CARE OF THE INDIGENT A RESPONSIBILITY OF SOCIETY

"In the pronouncement of the interdepartmental committee great stress is laid upon the Government's responsibility for the care of the indigent. With this again we are in accord, but that responsibility surely cannot be visualized as an exclusive responsibility nor as one which must absorb the social resources that have been developed through our existing American procedure. Here again we should like to emphasize the development of cooperative plans by the public and private agencies. Here again if the cooperative plan is to be intensified, there may be an opportunity for the wise and profitable expenditure of public funds to remunerate in part the private institutions for the public service which they are rendering and thus to increase their effectiveness for the promotion of the public welfare. The allocation of tax support for these public services would stimulate the private institutions toward still greater efforts, and would, we hope, place at the disposal of the medically indigent and the indigent, facilities which the Government would undoubtedly find it extremely difficult to duplicate. If tax support were granted to the private institutions for these public services, a viewpoint of certain less privileged groups, especially among the laboring and the agricultural population, would be effectively met. They contend that they wish to receive sickness care, not as charity but as a right. If they were admitted into private institutions on the basis of part pay rendered by the Government agencies, they would feel that they have a claim upon the service of the private institutions, and the odium of receiving charity—a viewpoint, by the way, which it is very difficult to evaluate—would be effectively removed. It is for this reason again that we enter here a plea for a continuance of the historical relationship between the public and private agencies and an intensification of this relationship."

There is no conflict of principle between the medical program provided in S. 1020 and the program advocated by the hospitals. Both hold that medical care should be provided for those who now are unable to obtain it.

There is, however, a radical difference of policy.

The hospitals and the medical profession hold that existing facilities can be expanded until they are adequate and seem to desire to have Government remunerate them for their services in amounts that will enable them to provide adequate services to all.

S. 1020 contemplates a new system centered around a relatively new type of hospital—a medical center operated by Government and not exclusively for persons in the lower income groups. There is no detailed description of these proposed medical centers in S. 1020. They doubtless would be organized largely as are health centers now operated by the Army, the Navy, the Veterans' Administration, etc. In that case, they would have their paid staff of professional men and women and a private practitioner would be at a disadvantage, obliged to subject himself to the rules and regulations that had been made without consulting him.

Under such a system of governmental health centers there would remain no place for the charitable hospital.

Under such a system the country eventually would have health centers operated by Government and proprietary hospitals operated for profit. Catholic hospital Sisters would be forced into the ranks of the unemployed, or forced to contract with the Government for an opportunity to serve the poor under Government supervision.

TEMPORARY DISABILITY COMPENSATION (TITLE XIV, GRANTS TO STATES FOR TEMPORARY DISABILITY COMPENSATION)

The purpose is to assist the States in developing, maintaining, and administering plans for temporary disability compensation.

Appropriation of \$10,000,000 for the first year and a "sufficient" sum for subsequent years is authorized.

Temporary disability compensation is to be administered by the Social Security Board through State agencies under State plans offered by the Board.

## STATE PLAN

To be approved a State plan must provide:

- (1) A single State agency.
- (2) Methods of administration satisfactory to the Board, including personnel standards on a merit basis.
- (3) Fair hearings for all whose claims are disallowed.
- (4) Reports to Social Security Board.
- (5) Cooperation between State agency and other public agencies.
- (6) (a) Rights, privileges, or immunities conferred by the State temporary disability compensation law subject to repeal or amendment.
- (b) Reasonably adequate medical service, including preventive services.
- (c) Social Security Board for cause after a hearing may suspend payments.

## PAYMENTS TO STATES

The Federal grant is to be an amount equal to one-third of total sum expended by State as temporary disability compensation and one-third of amount spent for administration.

Appropriation of \$250,000 to Social Security Board for administration is provided.

## BENEFICIARY

Temporary disability compensation means cash benefits payable to individuals for not more than 52 weeks with respect to their disability not arising out of or in the course of employment.

Disability means inability or unfitness to work by reason of injury or illness.

Employment means any service performed by an employee for his employer, except agricultural labor; domestic service in a private home; casual labor. City and travelling salesmen are eligible employees and those who employ them are employers within the terms of the act.

Charitable, nonprofit agencies and institutions, religious, charitable, educational, etc., and their employees are not excluded from the provisions of this title.

The manner in which the State is to finance temporary disability compensation is not provided in this bill. The set-up resembles the unemployment compensation system provided under title IV which is paid for by a tax on employers both State and Federal.

## AMENDING TITLE XI

Section 1101 of the Social Security Act is amended by adding a new subsection: 1101 (e). This subsection would define the method for measuring the financial resources of the States as that term is used as a basis for determining allotments under the Social Security Act as amended.

Under this amendment financial resources of a State are measured by the per-capita income accruing to the inhabitants thereof.

The State with the lowest financial resources is to receive an allotment not greater than 60% percent and the State with the highest financial resources an allotment not to exceed 33 $\frac{1}{4}$  percent of the total amount of public funds expended under titles V, VI, XII, and under title XIII the maximum is to be 50 percent and the minimum 10 $\frac{2}{3}$  percent.

Senator MURRAY. The next witness is Msgr. John O'Grady, secretary of the National Conference of Catholic Charities.

### STATEMENT OF MSGR. JOHN O'GRADY, SECRETARY, NATIONAL CONFERENCE OF CATHOLIC CHARITIES

Monsignor O'GRADY. Catholic charities is anxious to cooperate with all groups who want to bring more adequate medical and health care to those for whom is it not now available. It recognizes provision for ill health, preventive or remedial, as an essential part of a social-security program. Other countries have made provision for

ill health a part of their social-security programs and in time the United States will do likewise, that is as soon as we can get a meeting of minds. Many authorities believe that our national social-security program should have begun with provision for ill health. However, when the social-security program was being formulated, we were preoccupied with more pressing problems—unemployment and old age, and still are as is evidenced from discussions in the House in the last few days. Unemployment insurance, old-age assistance, and old-age insurance were therefore made the foundation stones of our social-security program. The Social Security Act also provided grants-in-aid to the States for the care of dependent children. It was hoped that this would become sort of an American counterpart of the European systems of survivors' insurance.

The Social Security Act, however, did make an important beginning in national participation in the field of health. Title V of the act provided grants-in-aid to the States for maternal and child-health services and for services for crippled children. It made Federal funds available to assist the States and their subdivisions in maintaining adequate public-health services.

S. 1620 seeks to bring about a great enlargement of the functions of the Federal Government in health. With the basic objectives of the bill, Catholic Charities in the United States is wholly in sympathy. These are disease control and prevention, the providing of more adequate medical and hospital care for the needy, and assistance to workers in building up earned benefits against medical costs, and wage losses growing out of illness.

Catholic Charities believes that public agencies alone cannot meet all problems in the health field any more than in any other field of social welfare. Without active support and participation by private agencies, public welfare is liable to become harsh, rigid, and even cruel. This is precisely what is happening in many communities in the United States today in which there are no private welfare organizations. Many local public agencies in the United States, even those whose relief funds come in part from the Federal Government, are a reflection on American standards of humanism. To be specific, Catholic Charities believes that any law granting Federal funds to the States for medical care, should provide for the use of not only public but also private agencies in the program. All advisory councils set up under the program should include representatives of private as well as public agencies. That policy has been established in State after State, but we do not believe that it is sufficient merely to let the States do it. We think that it ought to be a matter of sound governmental policy. Private as well as public agencies should be used in personnel training programs.

The United States Public Health Service should be able to extend its services into the new areas contemplated by S. 1620 without building up a new pattern. Why should it have to enter into the whole health program of the State in order to reach neglected areas? Why should it have to implement the services of cities like New York and Chicago in order to lend assistance to communities in which there are very limited or practically no health facilities? The Public Health Service now deals with the States on a very flexible basis. It is able to serve them without becoming too

much involved in their entire administrative machinery. All the Public Health Service needs is more money and somewhat greater authority. It doesn't need to change the basic pattern on which it operates in dealing with the States.

Every person who has moved around the country knows that in many American communities there are large numbers of needy people who cannot secure proper medical care. We have been entirely blind to the facts if we believe that this lack of adequate medical care has been due entirely to lack of resources. Medical care of the needy has been traditionally a part of the poor law, and the poor-law attitude, with all that it implies, still remains in many places.

In our large cities on the whole there are fairly adequate facilities for the care of the indigent sick. The Federal Government has an obligation to the medically indigent whose needs are not being met by existing resources, public and private. The Federal Government can discharge its responsibility in this field without entering into entire State programs. The United States Public Health Service again should have the authority and the funds to plan with the States and even with local communities for the care of the medically needy. I do not see anything sacred to confining ourselves to planning with the States. We have been planning with many local communities. It should be provided specifically that the United States Public Health Service in this field should cooperate with and make the fullest use of existing private facilities.

The national health bill provides Federal grants to States to assist in the construction, improvement, and maintenance of needed hospitals in rural areas and in areas suffering from severe economic distress. Under this proposal, the Federal Government would be able to assist in building, improving, and maintaining not only general hospitals but also tuberculosis and mental hospitals. Before providing funds for the construction, improvement, and maintenance of hospitals through the national health bill, we should reckon with the fact that the States and local communities have had Federal funds at their disposal through P. W. A. and W. P. A. for the building and improvement of their hospitals. The P. W. A. has been making grants of 45 percent to States and local communities for hospital construction and improvement of local hospitals. It has assisted the States in the improvement of their State hospitals. And the same stands for W. P. A. I have seen many splendid hospitals in the United States that have been constructed through the aid of the W. P. A.

The ordinary American community that has recognized the need for additional hospital facilities and is able to carry a considerable part of the cost of maintenance could have secured such facilities through P. W. A. and W. P. A. Of course, many people tell me that this form of Federal assistance is not reaching the poorer communities. But there is no evidence to me that this program proposed under S. 1620 will reach the poorer communities. Counties are not taking on added responsibilities at present. They are gradually shifting their part of the responsibility for the care of the aged to State governments. They are having a hard struggle in carrying their share of aid to dependent children and in raising sponsor fees for W. P. A. projects. State governments, too, are not able to secure

sufficient funds to give adequate assistance under the old age assistance and aid to dependent children programs. Witness the debates in the present session of our State legislatures.

In view of the great number of vacant beds in private hospitals at the present time, we are not surprised when those who are interested in them question the need of additional public hospital facilities. Moreover, there has been a marked falling off in the income of private hospitals from pay patients. Private hospitals have therefore been compelled to look more and more for support to the per capita payments from local governments for free patients, and they have been on the increase. Many cities and counties have been assuming an increasing share of responsibility for the indigent sick. There are whole areas, however, in which there is practically no recognition of this important government function. In these areas there is a great need for Federal leadership and assistance. The first task of the Federal Government then should be to make funds available in areas in which there is very little or no provision for medical and hospital care. In so doing it should endeavor by every means possible to secure local participation. It should, of course, make the fullest use of existing private facilities.

After the Federal Government has built up a body of experience in the field of medical and hospital care of the needy, it will be in a better position to tell what, if any, additional hospitals are needed.

S. 1620 proposes certain important additions to the maternal and child-health services and the services for crippled children provided for in title V, parts 1 and 2, of the Social Security Act. The present maternal and child-health services are entirely educational. The Wagner bill would add facilities for medical, hospital, and institutional care. These are highly desirable extensions of the security program. Since the services of which they are an extension are administered on the traditional grants-in-aid basis, the same pattern should be continued for the larger program. In the services for crippled children at present the fullest use is being made of private hospitals and institutions. There should be provision in the law in regard to both services requiring the use of existing private agencies.

The whole question of securing medical and hospital care for the ordinary wage earner at a price he can afford to pay, and of compensating for wage losses due to illness, is one of America's most important social problems at the present time. While at first sight it appears to be two separate questions, it is really part of one question. We cannot separate wage losses due to illness from medical care. I say with the greatest feeling of disappointment that, in my judgment, we are not yet ready to face the question of health insurance on a constructive basis. Frankly, I should hate to see adopted a pattern which we might regret in years to come. Those who have any experience in social legislation know how difficult it is to change patterns.

Senator ELLENDER. To what extent should the government—and when I say “the government” I mean the local government—use money that it obtains from the Federal Government and from its own treasury to pay for hospital facilities in private institutions?

Monsignor O'GRADY. It has been doing it from the beginning.

Senator ELLENDER. I say, to what extent?

Monsignor O'GRADY. We have, I think, arather complete review of that situation, which I can later submit for the record.

Senator ELLENDER. Have you that in a statement which you could submit to the committee?

Monsignor O'GRADY. Yes.

Senator ELLENDER. I think it would be well to have in the record, for instance, what it would cost per day per person.

Monsignor O'GRADY. We have that; we have the rates that are being paid. They vary considerably not only from State to State but from county to county. For instance, take the State of Illinois, you find a variation even from county to county; and the same thing in Iowa.

Senator ELLENDER. You say you have that in good form?

Monsignor O'GRADY. In pretty good form.

Senator ELLENDER. Would you mind submitting it to us?

Monsignor O'GRADY. Yes; I will.

Senator ELLENDER. So that we could put it in the record at this point in your testimony.

Monsignor O'GRADY. Yes. Our contention has been that this policy has been pretty much of a pattern in American community life, and we feel that any national legislation that tends to stimulate or to develop a new program should reckon with this practice. Of course, I know in your State you have a different pattern; you have a traditional pattern in Louisiana which is somewhat different.

(Additional information requested appears in a supplemental statement at the end of Monsignor O'Grady's testimony.)

Senator ELLENDER. For over a hundred years.

Monsignor O'GRADY. It is greatly different from Texas, and very much different from Florida and very much different from the other Southern States.

Senator ELLENDER. I do not think that there is a State in the Union that has the facilities that Louisiana has in proportion to its population.

Monsignor O'GRADY. Yes; but, of course, they have not reached down by all the bayous yet. I think you have made some progress in the past few years, but you know what the conditions were 10 years ago, I suppose. It is pretty difficult to get down to Prairie Pere. People told me that I was taking my life in my hands when I went down there by your bayous.

Senator WAGNER. What is the doctrine there that is different from ours?

Monsignor O'GRADY. I think the tendency there is for the State, rather than the parishes, to assume responsibility for the indigent sick. They started with a big State hospital which was originally a Catholic hospital operated by our Sisters. While it is located in the city of New Orleans, it is a State hospital and has been developed on that pattern. In New York State, care of the indigent sick is a county responsibility. At least, I used to believe that until I got into all of those towns of yours, Senator Wagner. I can never make up my mind what it is in New York State. It is so difficult and varies so much from one county to the other and it is so complex—I believe that it would be more correct to say that in New York State it is a town responsibility.

Senator WAGNER. Except in the larger cities.

Monsignor O'GRADY. Of course, the larger city can become an independent welfare unit like New York City and Buffalo and Rochester—there I think it is city responsibility.

Senator WAGNER. Getting down to one or two questions that I would like to ask you as to the encouragement to the private hospitals. Of course, I am in strong sympathy, as my record in the New York State Legislature will show. If you will look at my health bill there and also later on I was able to help New York City because we did a great deal through private hospitals. The only time I was ever in the hospital as the result of a serious operation was in a Catholic hospital, St. Joseph's, so I know something about what these hospitals do and what the Sisters do in these hospitals, the self-sacrificing work that they do. That work has won my admiration for all time and I want to help that situation. I have said so time and time again, and if there is any clearing up that this legislation needs on that score, not only not to impair but to encourage and enlarge upon that program, I certainly will be the first to propose such amendments.

Senator ELLENDER. I feel that way also, Senator Wagner. I have expressed it on several occasions.

Senator WAGNER. I think there is unanimity about that.

Senator ELLENDER. We may be faced with this difficulty in the States. For instance, under the constitution of Louisiana, no money can be used for private institutions.

Monsignor O'GRADY. Even though the payment is on a service basis? That is all that we are suggesting—a payment for services rendered.

Senator ELLENDER. That is what I was trying to develop awhile ago with the preceding witness, and that is why I was anxious to have in the record the approximate amount of cost per person that would be entailed so that we might be able to set aside, Senator Wagner, a certain amount for that purpose.

Monsignor O'GRADY. Workmen's compensation under all of the compensation commissions of the States have an agreement with the existing hospitals.

Senator ELLENDER. We have that in Louisiana. Although we have the charity hospitals in New Orleans and in Shreveport and five others, we have set aside funds to take care of emergency cases at several private hospitals located in different parts of the State.

Senator MURRAY. I was going to ask you, Father, if in the State relief organizations that give aid to the needy sick, do they fix fees that are uniform throughout the State?

Monsignor O'GRADY. Very few of the State relief administrations enter into the care of the sick. New Jersey did on quite a large scale; I am not so sure about Illinois, but I do not think so. In the original appropriation, the original bond issue made for the Texas Relief Administration, there was a provision for the use of a part of it for the care of the sick in the hospitals. Of course, the F. E. R. A., I think, made grants-in-aid for a while for the care of the sick in hospitals.

Senator MURRAY. In those cases, did they fix a schedule of fees for that care?

**Monsignor O'GRADY.** Yes, sir.

**Senator MURRAY.** Was there any claim at any time that they charged excessive rates?

**Monsignor O'GRADY.** Where the hospitals charged excessive rates?

**Senator MURRAY.** No; the doctors.

**Monsignor O'GRADY.** I don't know anything about that at all.

**Senator MURRAY.** I heard rumors of a case out in Montana where one doctor collected as high as \$1,500 in 1 month. Could that be possible?

**Monsignor O'GRADY.** There have been some questions like that.

**Senator MURRAY.** Don't you think that that would be outrageous?

**Monsignor O'GRADY.** Of course, that would be an entirely separate account from the hospital account. I question if the hospitals got very much. Of course, this whole question of rate making for the hospitals, in dealing with public funds is a matter to which we have been giving a good deal of attention in recent years and of which there is a considerable body of experience now with improved accounting methods in the hospitals. It is a live question locally in the States. New York City has given a great deal of attention to the actual question of rate making for free patients in the private hospitals, and the same is true in Illinois and in Indiana.

The recognized pattern is what this group has been concerned about most in this bill. You know how a great many people have pretty good memories and they know what happened under the Veterans' Administration. They know about the public hospitals that were set up and are being set up right now for which there is not any particular need; everybody knows it. For instance, the situation where they went ahead and built a public hospital without any particular need for it, and now they are receiving private patients as well as free patients. Everybody who is interested in hospitals knows about those situations; they know of cities, for instance, in which they have duplicated the existing facilities and provided one bed for each of less than a hundred people in the city. They know all about those situations.

You say this is going to be stopped, but you know very well the drive that you are going to have for new public facilities. Of course, you cannot blame anybody—it is our democracy. The people back home would like to have a brand-new public hospital; maybe they have nothing in the way of funds; there is no hope of being able to maintain it except the Federal Government puts it up and maintains it itself.

**Senator WAGNER.** On the other hand, if there is really need for a hospital, there ought to be some way of securing aid, isn't that so? You have to safeguard it so that political influences do not get into these activities.

**Monsignor O'GRADY.** Unless it is done directly by the State government—of course, a great many people say that it won't get to the needy area, but I have sat in recently with county officials in a certain Texas county and they were talking about a new hospital, and they had about reached a decision. They were making a very interesting combination which I have seen in many other places—of a 45-percent grant from the P. W. A., and some W. P. A. labor. I won't

mention the name of the county because I do not want to interfere with that plan; it is in a needy area. What they were really planning to do was this—they were planning on using W. P. A. labor to do the excavating and to build the foundation just as they have done in many other public buildings in the United States—the W. P. A. builds part and the P. W. A. builds the other part.

So that you are not without resources. It is not a question of just waiting until this thing comes to get resources for the improvement of your hospitals. Take what the the W. P. A. and the P. W. A. are doing for the hospital for the insane at a certain place. The place was uninhabitable. The W. P. A. is making over the old buildings and the P. W. A. is building a new hospital.

I think the first thing is to develop a sense of responsibility. Most of these counties do not recognize that they have any responsibility for the care of the indigent sick. They do not do it at all. If you are a Spanish worker in certain parts of the United States of America, or if you belong to a minority racial group, say that you are a Mexican, and you try to get some assistance from some of these local communities, you are going to have a tough job, even if there are Federal funds available. I know parts of the United States of America where that is true, and I think that the same thing will be true of medical care.

I think that the first thing to do is to get recognition of responsibility for medical care and see what we can do with existing resources. I have been in about a hundred counties of the United States in the past 3 months, a great many States I have been down in these rural counties. I know them first-hand; I have talked to the poor people there and to the farmers and the county judges and all of these folks, and I always like to think of this whole program from their standpoint and not from the standpoint of New York City or New Orleans, or Chicago.

Just two things stand out in the minds of these poor people with whom I have talked, and the biggest is the W. P. A. and the next is the old-age system. That is social security for them right now, and the other things are utterly unknown in these small towns. You may have five or six families getting aid to dependent children, but it is a poor relief system.

Senator WAGNER. What about medical care? Is there lack of it in many of these communities?

Monsignor O'GRADY. Yes; there is a lack of it.

Senator WAGNER. I feel almost like apologizing to you for asking this question, but it was really stated by doctors who were eminent in this profession, and they deprecated this program on entirely different grounds. They were afraid of giving too much free medical care. They say it will encourage people to stay in the hospitals that ought to be out; that they will pretend to be sick when they are really not sick, just to spend their time in the hospitals.

Monsignor O'GRADY. Of course they tell me the same thing about all public benefits; they tell me in the beet fields in Colorado they cannot get any workers because of the W. P. A. We have heard that about workmen's compensation and other things.

Senator MURRAY. Are you about completed?

Monsignor O'GRADY. Yes; I am finished.

(Additional information to be furnished by Monsignor O'Grady follows:)

SUPPLEMENT TO STATEMENT ON NATIONAL HEALTH BILL BY MSGR. JOHN O'GRADY,  
SECRETARY, NATIONAL CONFERENCE OF CATHOLIC CHARITIES

The Catholic hospital, more than any other private agency, has been recognized as a part of community-welfare programs in the United States. It has served members of all groups. Its medical staff has been fully representative. In many instances it received its first impetus from a community-wide group of citizens. All social agencies have availed themselves of its resources for the care of the indigent sick. As the private hospital continued to carry a large share of the responsibility for the hospitalization of the indigent, community leaders began to suggest that the local government should provide at least partial compensation for its services.

The first compensation given private hospitals by local governments was in the form of a lump-sum grant. This was made without any definite reference to the volume of free care given. State, county, and city governments participated. In a recent study information has been compiled from 179 hospitals in 18 States, covering 39 dioceses, in regard to Government payments for indigent care. During the year 1937 these hospitals received from States a total of \$170,850 in lump-sum grants, \$148,066.70 from counties, and \$170,700 from cities. St. Vincent's Hospital, Jacksonville, Fla., received an appropriation of \$8,000 for that year from the city. St. James, Butte, Mont., received \$1,200 from the city. Among the hospitals receiving lump-sum grants from counties it was found that St. Francis at Trenton, N. J., received \$46,916.59; the Emergency Hospital in Buffalo, \$4,000, and Mercy Hospital, Buffalo, \$3,000 from Erie County; Our Lady of Victory in Kingston, N. Y., also received an appropriation of \$3,000 from the county. State lump-sum grants were given during 1937 to five Catholic hospitals in Maryland, two hospitals in Connecticut, and five hospitals in Pennsylvania, included in the study. In Pennsylvania, however, the State appropriations are worked out on a per capita basis.

As a general rule, local communities compensate Catholic hospitals on a per capita basis for the care of the indigent sick. This practice is quite general throughout the United States. We find the system of per capita payments from tax funds for hospitalization of the indigent in the States of New York, Illinois, Montana, Oregon, Minnesota, North Dakota, New Jersey, and the same is true in a great many counties in Minnesota, Iowa, Colorado, Ohio, Indiana, Arizona, South Carolina, Florida, Alabama, Michigan, and Washington. Information from the 179 hospitals in 18 States covered by the study shows these hospitals received for the year 1937, \$1,957,704.65 in the form of per capita payments from cities, counties, and States. In both lump-sum and per capita payments these hospitals received a total of \$2,448,221.35 during the year 1937.

Government compensation for the care of the indigent sick in Catholic hospitals has developed without much planning. Until very recently most of the hospitals have been willing to take whatever the cities or counties were willing to give them for indigent care. It is only within the past few years—in fact, within the years of depression—that Catholic hospitals have come to recognize the obligation of local governments to assume their fair share of responsibility for the hospitalization of the indigent. They have had a considerable decrease in the rates paid by private patients. Besides an increasing number of people who formerly were able to pay at least part of the cost of medical care are now, for reasons of unemployment or business losses, no longer able to pay anything.

In comparatively few communities has there been any discussion of actual hospital costs and rates. Depending on the good will of local officials, we naturally find a great variation in the rates paid to the 179 hospitals from which information was secured. We find the city of Baltimore paying \$1.55 per day for the hospitalization of the indigent sick in Catholic hospitals. The city of Detroit pays \$4 a day, the city of Waterbury, Conn., \$1.44 a day, and the city of Vancouver, Wash., \$1 a day. Besides caring for indigents for rates that inadequately meet the costs of bed, board, and general nursing in many instances, the hospitals have given 980,798 days of free care and other part-pay care without governmental assistance.

In dealing with local governments Catholic hospitals are now going through an experience similar to that experienced with workmen's compensation commis-

alons a few years ago. When workmen's compensation legislation was first enacted, the commissions endeavored to make the best deal they could with the hospitals. They were anxious to hold the hospital rates to the lowest figure possible so as to secure lower insurance rates for employers. This virtually meant that the hospitals were doing a work of charity for industry. The program was carried on in much the same way as under the old employers' liability when the industries of the community were expected to make an annual contribution for the care of injured workers. As a matter of fact, many of the hospitals found themselves in a much worse financial condition as a result of the arrangements with workmen's compensation commissions. They received much less for the care of the injured workers under workmen's compensation than they received in the form of employers' contributions for the care of the injured under employers' liability.

The necessity for setting fairly adequate rates for the care of injured workmen was one of the first problems that created a solidarity of interest among the hospitals. They had been traditionally isolated from the community and from one another. The discussion of workmen's compensation rates for hospital care served to bring them together; it made them analyze their costs on an intelligent and objective basis; it provided a foundation on which they could work in discussing with local governments the whole question of rates for the care of the indigent sick.

Catholic hospitals are still very far from the objective of having local communities recognize their responsibility for the care of the indigent sick and for the payment of rates that are reasonably adequate. Existing rates which are higher in some localities than in others, when analyzed, may be actually lower by reason of the services included under the rates. Following the pattern of workmen's compensation, the variable elements of medical care are better excluded from the basic rate for bed, board, and general nursing; a set schedule of rates should be allowed for other specific services as needed. This means, therefore, hospitals should have accurate information in regard to costs, especially for the costs of ward care on a per diem basis, exclusive of special services. It means that the hospitals must be ready to interpret their costs to government and to the community. This interpretation must be done in a way which the ordinary citizen can understand. It is a task confronting the hospitals of each community in which they must act jointly that through cooperative effort they may interpret their program to the community and thereby secure adequate payments for indigent care. Governmental agencies cannot be expected to deal with hospitals on an individual basis. Increasing governmental responsibility for the care of the indigent sick is a challenge to Catholic hospitals to present their case to local communities.

Through present study, information has been secured in regard to the bed occupancy of Catholic hospitals during the year 1937. While a hospital operates best at 85 percent of its capacity, a group of 52 Catholic hospitals, widely scattered geographically, has an average occupancy of 67 percent. Several scattered throughout Western States were operating below 60 percent and some as low as 50 percent. While this condition is not due to overhospitalization but rather to an increasing lack of ability on the part of patients to pay for their care, some hospitals have been called upon to extend their services over as many as four and five counties.

Since Catholic hospitals, like other private hospitals, throughout the years have been regarded as part of the community program for the care of the indigent sick, since communities have looked to them to carry a considerable part of the load, it is only natural to expect that in any extension of governmental responsibility for the care of the indigent sick existing Catholic hospital facilities will be needed and should be utilized to the fullest extent. Local government cannot carry the entire burden; to an increasing degree the State must do its share, and the Federal Government must also enter the picture. Generally speaking, medical care of the indigent is a responsibility of the local government. Even though private hospitals have assumed a large share of this responsibility through free care of part-pay rates, local governments have not been able to carry their fair share of the burden; hence other resources are needed. This, however, should not necessarily mean a change in the fundamental pattern and program of care for the indigent sick that local communities have developed in the United States. Why should State and Federal participation in a health program mean the elimination of private hospitals? They are part of the welfare program of the community; they were organized to serve without profit; they are willing to provide care for the indigent at actual cost; but at present many of the beds for the indigent sick remain empty.

Senator MURRAY. Father Schwitalla wants to catch a plane, and I would like to put him on.

### STATEMENT OF REV. A. M. SCHWITALLA, REPRESENTING CATHOLIC HOSPITAL ASSOCIATION

Father SCHWITALLA. Senator, in answer to your question about the costs of this service, in private institutions of the United States there is a daily average free census of 71,000 patients, 20 percent of 355,000. The average rate at which some of the hospitals are compensated for the care of poor patients is \$4 a day. If the entire free load were carried by some form of financial subsidy or grant or through some agreement, it would reach \$104,660,000. The way it is actually worked out, however, is this—in a recent little special study, 62 hospitals received some measure of Federal compensation. Those 62 gave care to 1,352 patients and averaged about 26 patients per hospital.

The hospitals received from this source an indicated total of \$51,280, an amount per hospital of \$812 and per patient of \$31.31. Assuming that these patients stayed in this hospital for 10 days on the average, the cost would be \$3.13 a day to the Federal Government.

Senator ELLENDER. What does that service include?

Father SCHWITALLA. By the way, that total includes not only the routine care of the hospitals, and also extras in the last figure I quoted. In the \$4 a day rate, which is the rate made by the Federal Employment Compensation Commission in our institutions, it is \$4 a day plus extras. Does that answer your question that you asked?

Senator ELLENDER. Yes.

Father SCHWITALLA. Mr. Chairman, I would like to make a statement on behalf of the Catholic Hospital Association, and since I believe that this is the first time that the Catholic Hospital Association has ever been before any committee of the Senate or of Congress, I think a word about the association may not be out of place.

#### I. THE CHARACTER OF THE CATHOLIC HOSPITAL ASSOCIATION

The Catholic Hospital Association is an organization which comprises 673 hospitals and 90 allied agencies, the latter all rendering some institutional form of health and sickness care. All of these institutions are conducted by members of religious orders of the Catholic Church, nuns for the most part, with only 5 hospitals conducted by Brothers. This group of hospitals which has been well organized in an association since 1915 constitutes 12.4 percent of all the hospitals of the United States. It also constitutes 8.3 percent of the total hospital bed capacity of the United States. The group constitutes 17.2 percent of the nongovernmental hospitals and in excess of one-fourth (27.8 percent) of the beds under nongovernmental control. It represents 27.9 percent of the nonprofit hospitals and has one-third of the beds (33.2 percent) of these hospitals. In these 673 Catholic hospitals and 90 allied agencies there were laboring in various professional and semiprofessional activities, in addition to approximately 23,000 student nurses and 18,732 professional persons.

nel exclusive of doctors, 13,429 Sisters, the latter group laboring entirely unremunerated except for the board and lodging afforded to them in their institutions. This large sector of the nongovernmental hospital field is solidly and firmly held together not only by their organization but also by common purposes and motivations as well as by traditions and viewpoints which have become an important and effective influence in the health service to the public.

In its membership the association contains a group of hospitals which should represent a fair cross-section of hospital experience throughout the United States. As far as size is concerned, for example, 39 hospitals in its membership are under 25 beds in size, 99 have between 26 and 50 beds, and 175 between 51 and 100 beds. One-half of its total membership therefore is made up of those institutions through which it is assumed, in the thinking of the Interdepartmental Committee, that health and hospital care are most effectively diffused among one of the most needy groups of the population. We find these hospitals located at strategic points on all important health frontiers in the United States. In industrial centers, both large and small towns, in centers of population having the concentrated densities of population of our metropolitan cities, as well as in counties having population densities of less than five per square mile, throughout the Rocky Mountain States, and in the Central Northwest and in the far West. In all of these areas where surveys are said to have revealed a great need of medical care, the Catholic hospital has been established and has attempted to supply the needs of the people wherever those needs have manifested themselves.

It is important to note that a study of the drift in the density of Catholic-hospital distribution follows population trends rather than trends in church-membership growth, so that this group of hospitals, while in name, in spirit, in organization, and in activity distinctly Catholic, has nevertheless taken an effective part in the distribution of health facilities throughout our land. A recent study places the center of Catholic-hospital distribution within less than 100 miles of the center of population of the United States but probably more than 400 miles away from an estimated center of distribution of Catholics. This fact correlates well with the further fact that the Catholic hospital serves the needs of the country without regard to the religious affiliation of its patients, since in 1936 a trifle less than one-half (49.1 percent) of its patients were Catholic.

Equally important with all of this for the purpose of the present discussion is the fact that the sisterhoods have been able to locate their institutions in areas in which it would have been frankly impossible to establish a non-tax-supported hospital under other auspices. The reason for this is clearly due to contributed services of the Sisters and to the limited demands they make for their board and lodging. They are thus able when necessity demands to conduct their hospitals at a per diem rate approximately \$1.08 per patient per day (1935) lower than the nonprofit hospitals as a group. As has just been pointed out various factors enter into this difference. It can be shown for example that the Sisters' contributed services represents 42.7 percent of the pay roll of a non-Sister nonprofit hospital of similar size and in a similar locality. For the smaller hospitals, the

influence of contributed service is even greater. In some of these it can be shown to be the equivalent of 70 percent of the pay roll required in a non-Sister hospital of equal size and in similar localities.

The purpose of offering these statistics at this point is to show that the experience of the Catholic Hospital Association should have a bearing on the solution of the problems for which the National Health Act is expected to supply the answer. The significance of this statement is accentuated by the fact that the Catholic hospital group constitutes 27.9 percent and its beds 33.2 percent of the bed capacities of the nonprofit hospitals.

These statistics are therefore offered here as a basis for the discussion which is to follow chiefly to show (a) that in addition to the present governmental system of hospitals, hospitalization facilities for all classes of patients, including the indigent and the medically indigent, are available in a paralleling private system which gives well-founded promise that as needs develop, it can be indefinitely expanded, limited only by the limits of available funds; and (b) that before any widespread plans are made effective through legislation for modifying the health care of the American people, adequate provisions must be made to safeguard a cultural resource of the highest value to public welfare lest through inadvertence or misunderstanding this cultural heritage be imperiled or destroyed.

The funds invested in the Catholic hospital total not less than \$480,000,000. A sum of money which, it should be noted, was raised for the most part through private initiative with relatively few large donations. The creation of these resources was due in large part to the contributed service of the sisters, and the liberality of the members of the Catholic Church and of those sympathetic with the work of its sisterhoods. The cost of operating these hospitals exceeds \$80,000,000 in actual cash outlay, in addition to \$18,000,000, the statistically established value of the contributed service of the Sisters. The cost of operating of the allied agencies in this group amounts to a still further \$10,000,000, so that \$108,000,000 a year may be regarded as a very conservative estimate for the value of the service rendered by these institutions. This amount represents the 3 percent interest on \$3,000,000,000.

It cannot appear surprising, therefore, that this group of institutions which traditionally has kept itself aloof from seeking participation through legislative or political action and which has been content to render its service to the public under the stimulation of its ideal motivations should now appear before this subcommittee to safeguard the facilities which a history full of sacrifices has created, and to seek to retain the opportunities for service to the public which are the direct outgrowth of the religious faith and motivation of its members.

Lest the significance of these facts in the present question be lost sight of, it should be pointed out that in the year 1938 there were treated in these institutions 2,126,497 patients, of whom only 49.1 percent paid sums equal to the average per diem cash cost to the hospital, while fully 19.3 percent made no contribution whatsoever to the cost of maintenance or of their hospital care and only 31.8 percent made a partial contribution to those costs. In other words, in 1938, 410,788 patients were treated in this group of institutions en-

tirely without cost to themselves and 672,539 with only a partial cost to themselves. In previous years, especially in the dark days of 1930 to 1934, these totals and percentages were even more pronouncedly weighted on the side of free and part-pay service.

## II. THE ACTION OF THE JOINT COMMITTEE OF THE THREE NATIONAL HOSPITAL ASSOCIATIONS

The Catholic Hospital Association has given its most careful attention and study to the work and recommendations of the Interdepartmental Committee and to the National Health Act. It has joined the other two national hospital associations in defining its attitudes on the national health program. It expressed to the Interdepartmental Committee its confidence in the public pronouncements of the President concerning the cooperation of the public and private agencies. It accepted with trustfulness the assurance given by the members of the Interdepartmental Committee that they were seeking to facilitate and augment the cooperation between governmental and private agencies. It welcomed the promises bearing upon this point given by individual members of the Interdepartmental Committee in public utterances. In this spirit of confidence and trustfulness in the leadership of the Interdepartmental Committee it presented to that Committee jointly with the American Hospital Association and the American Protestant Hospital Association a sympathetic memorandum, welcoming their commendations which were made for the extension of public-health services and of maternity and child-welfare services, for the cautious expansion of hospital facilities where needed, for the extension of the system of special hospitals, and for the development of plans for wage-loss compensation. The three associations pleaded, however, that the historical right which the charitable hospital of the United States has possessed of sharing with the Government in the care of the indigent should not be withdrawn, either directly or indirectly, through new legislation, lest a national cultural asset of the greatest magnitude and effectiveness should be thus destroyed.

With the other two national hospital associations, the Catholic Hospital Association pleaded "that the path of understanding which has been historically developed and which has been found pragmatically so efficient (be regarded as) capable of indefinite expansion to the progressive benefit of all of those interests which are involved in the national health care." Furthermore, the Catholic Hospital Association, in union with the other two associations, asserted "that consistent with American trends, the Government has allowed the private agencies the fullest exercise of their initiative and their prudent zeal in the promotion of ever so many of our national responsibilities. Now that we welcome the increased interest of the Federal Government, as well as of the State and local governments, inspired by the Federal Government, in the health problems of the Nation, we are convinced that this increased and stimulated interest should manifest itself in deeper insight into and a far-reaching influence toward the relationships between the private and the public agencies."

I have noted these, Mr. Chairman, from a document that is entitled "The Attitude of the Hospital Associations to the National Health Program," and as the other speakers this afternoon will refer to this

same document, I wish to enter this into the record at this time with your kind permission.

Senator MURRAY. It will be filed and placed in the record.

Father SCHWITALLA. The three associations also warned against administrative procedures which would out-run the present level of scientific knowledge and which would change the accepted order of things through which the health care of the American people has been brought to its present high level of excellence.

In view of the sympathetic understanding achieved by the three national hospital associations with the Interdepartmental Committee, and in view of the hopes which grew out of that understanding, it cannot be considered surprising that the Catholic Hospital Association was disappointed to discover in the National Health Act tendencies and trends which it deems precipitate rather than prudent; tendencies and trends which endanger historical foundations and threaten the traditional dedication to public service of persons whose lives and labors have been given to God and their fellow man, not for economic gain but for the gains revealed to them through a supernatural faith. The association sought in the National Health Act for a recognition of the accepted patterns of cooperation between public and private agencies. It sought for plans by which that cooperation can be facilitated and augmented. It is disappointed to find that the National Health Act ignores the partnership which is so characteristically expressive of the spirit of American democracy.

The National Health Act not only ignores the partnership which has existed traditionally between the public and private agencies but it places the public agencies into a position in which we believe they will sooner or later constitute an actual menace to the non-tax-supported hospital.

I should like to enter here at this point a paragraph from the analysis of the act that Mr. Montavon has just given you a few moments ago. It reads as follows:

The program of maternal and child-health service recommended by the Interdepartmental Committee and embodied in S. 1620, is no longer a welfare program as provided by the Social Security Act for the relief of rural and needy persons, but in the words of the report of the committee, House Document 120 of the Seventy-sixth Congress, is as follows:

"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." In doing this under a law that authorizes no cooperation with any but public agencies, the existing charitable and voluntary agencies would not survive.

Instead of the traditional pattern, the act recommends a pattern of governmental dominance over health care tried in its implications only in those countries in which the American form of democracy is unknown. The National Health Act vests huge powers over health care in the Federal authorities. It contains no provisions looking toward an augmentation and facilitation of the functions of partnership between private and public agencies. It permits the use of private agencies, if at all, only by implication in a few isolated areas of health care. It makes no provisions to enable private agencies to share in governmental grants, and thus destroys all concept of a partnership by keeping for one of the partners all of the financial resources through which the work of the partnership could be ac-

completed. It entrusts to the governmental authorities the drafting of all rules and regulations, suggesting only that advice may be sought from professional persons by the health official, but almost immediately weakens even this provision by suggesting first, the competent professional opinion must be considered advisory only and secondly that it must be submitted for administrative approval and authorization to Government officials. When the respect of one partner for the other in a partnership is destroyed by the action of one of the partners the partnership itself is already destroyed. In the present case, the Government would sooner or later absorb the other partner, the non-tax-supported hospital, and we should see reenacted on a national stage the tragedies which we have witnessed on smaller stages in some of our State plans.

### III. THE NATIONAL NEEDS

Why, it may be asked, does the National Health Act make such short shrift of the rights and the functions of the non-tax-supported institutions? The obvious answer which surely is too much on the surface to be the true answer, is because those who have introduced this legislation are in favor of Government dominance in all matters affecting national life. But if this is not the true answer, is it because the non-tax-supported institutions are not rendering public service? The Catholic Hospital Association voices in answer an emphatic "No." The association is aware of the statistics that have been adduced to emphasize the inadequacy of the national health service as now given to our people. It recognizes the fact that there are shortcomings in health care as there are shortcomings in supplying other necessities of life and in giving to our people the services of which they stand in need. But to regard the inadequacy as a menace to national stability or to regard it as being of greater emergency than for example, the present need for relief or national employment or national security in business, is surely to ignore the vital statistics assembled by the Government itself. It is to close one's eyes to the enormous developments in our health facilities and health services which have given to the American people the best health care ever developed in the history of the world. Ample statistics bearing upon this point have been brought before this subcommittee by other groups and these statistics amply substantiate the statements we are making.

The incidence statistics of certain diseases, such as heart disease are not going to be materially affected by such provisions as are contained in our National Health Act. If we are looking for reducing the incidence of nervous and mental diseases why not make adequate provision for the Nation's sound mental hygiene and why not face the problems of youth so eloquently pointed out by the surveys conducted by the National Youth Administration. There is nothing inherent in the situation that would lead us to believe that the multiplication of facilities or personnel will substantially alter our morbidity or mortality statistics. To alter them means more medical science and more medical art; it means better housing and living conditions; better recreational facilities and more content in living; more moral living and the creation of higher ideals; it does not mean more admin-

istration. It means more personal devotion and more conscientious competence, but not necessarily more money, desirable though that may be, in certain aspects of health care.

Do we need more facilities for hospitalization? During 1938 the Catholic hospitals of the United States showed an occupancy of 64.8 percent. Obviously this occupancy figure is not equally applicable to all sections of the country. In various regions we find occupancy percentages ranging from 61.5 percent in the Central West to 69.7 percent in the Far West. In the country as a whole, however, in our group of hospitals not fewer than 7,000,000 hospital days could have been utilized for patients giving facilities for more than 700,000 additional patients without over straining hospital facilities and allowing for only a theoretically desirable average of 85-percent occupancy.

If we bear in mind that this group of hospitals represents only somewhat less than one-third of the nonprofit hospitals it is obvious that no fewer than 2,000,000 patients could each have been hospitalized for 10 days in the beds that were unoccupied in these non-tax-supported institutions during 1938. Add to this the beds unoccupied in the many excellent proprietary hospitals and this number could be increased by a fourth of a million. There may be localities in which additional facilities should be made available to the people but the facts do not suggest an all-comprehensive national legislation to care for a few well-defined and clearly recognized local needs which in default of local resources could well be met by an enlightened liberal national policy in the granting of one of many forms of payment for services rendered to patients unable to pay their own sickness bills.

It has been said that not the persons who need hospitalization but those who pay for it are getting it today. No competent person would contend that all people who need hospital care are receiving it today to the extent of their needs, but neither will any competent person express the opinion that all persons needing hospital care will receive it if we merely add additional facilities and increase the salaried personnel. Factors are effective in this question which would defy merely an economic solution. Generally speaking, we would expect that if the need for hospitalization were a pressing national need the hospitals with which our out-patient departments are connected would be loudest in their insistence for more facilities. Yet such is by no means the case in all such institutions. Private physicians moreover are finding no difficulty as a general rule in hospitalizing patients in need of hospital care in their private practice. Statistical methods which have been applied in this area are notoriously susceptible of ambiguities and are subject to local variations, and these conditions cannot be assumed to exist on a national level. The enormous discrepancies between generalizations based on statistical studies in these matters must be explained on the basis of the neglect or the ignoring of local differences.

It would lead us too far at this point to pursue this line of reasoning and to analyze illustrations of the contention that while the health needs of the American people, and especially hospitalization, obviously exist, the needs are not of the order of magnitude throughout the Nation which has been quite generally assumed by some contestants in this discussion; and, secondly, the facilities for hospitalization are

sufficiently available in by far the larger area of the Nation to take liberal care of a major fraction of persons needing hospitalization. There is one limitation, to be sure, to this statement which is generally recognized, and that is that the statement applies to general hospitals and to that group of the population which is defined as acutely ill.

The National Health Act offers another source of disappointment to the Catholic Hospital Association. It was expected that the new legislative proposal would offer a solution of the problem of those who have thus far been unable, allegedly, to secure hospitalization when they needed it. It was expected that plans would be proposed for taking care of the indigent and the medically indigent. There can be no doubt but that in some localities these groups stand in need of further facilities. The hospitals of the country which have borne the burden and the privilege, as one may look at it, of caring for these groups during the depression know this fact even better from first-hand experience than economists who have ascertained it through second-hand testimony.

In many localities, perhaps in most of them, the need would not exist if the partnership between the public and private agencies had been made effective. To be sure, if the Government commits itself to the theory that the indigent is a ward of the State and interprets this to mean that the indigent may be taken care of solely in public hospitals, a great need for such public facilities may exist in some localities. But the Catholic Hospital Association must emphatically repudiate such a theory; for our association the indigent is the ward of society. In America, thank God, society and the State are not as yet coterminous, and, please God, they never will be. The Catholic sisterhoods have been founded, many of them centuries ago, to care for the sick poor, and they have lived up to this purpose, under the sublime motivations of their supernatural faith even to the point of indescribable hardships and sufferings. They do so not in a spirit of condescension but in pursuit of a blessed privilege regarding the sick poor as images of Christ Himself. Should we now substitute the impersonalities of government for this personal, devoted, and self-sacrificing service? Are we dropping from our culture one of its more cherished and valuable components? If the Catholic hospital is willing to accept remuneration for the care of the indigent, it will do so to increase its opportunities for service and not because it has tired of its idealism or defaulted in its motives, nor because it recognizes the State's right to the exclusive care of the indigent. It is the privilege of both governmental and nongovernmental agencies to care for the indigent, and if government will assist by a contribution to enable the nongovernmental agencies to use this privilege, such a contribution will be the expression of the partnership between public and private agencies.

#### IV. THE NATIONAL HEALTH ACT

It has been suggested that the Senate committee in charge of the National Health Act is aware of the importance of maintaining the partner relationship between the public and the private agencies and that amendments to the act would be welcomed. The Catholic Hospital Association deeply values these expressions of good will. It questions seriously, however, the possibility of amending an act in

the formulation of which the basic considerations which we are here adducing were not kept in mind. Efforts have frankly been made to draw up possible suggested amendments. The changes would have to be made in so many places to safeguard the position of the private institution that the process would be tantamount to the formulation of a new act.

First and foremost, there is need of a clearly formulated statement that nothing in this bill should be regarded as impeding the free use of the non-tax-supported institutions in providing for the national health needs. But such a principle would be far from satisfying what we believe to be the legitimate demands of the Catholic Hospital Association. It would be necessary also to confer authority upon those upon whom the bill now confers it, to enforce the prescription that no State plan would be approved which did not provide for representation and use of private agencies, placing the private and the public agency on an equal footing before the law for the achievement of the purposes of this act. Furthermore, all of this would not be sufficient, because mechanisms would have to be devised which would guarantee to the private hospital the complete maintenance of its individuality, even if the supervisory function of governmental authority, with reference to the areas of activity of the private institution and public wards, would be fully recognized.

In other words, it would be necessary to safeguard, for example, the present admission policy of the private institution; the methods by which its staff appointments are made; the methods by which its educational functions are carried out; the methods by which its public relations are maintained; and, most of all, as far as the Catholic institutions are concerned, the procedures by which the Catholic institution has traditionally maintained its health activities in conformity with the moral teachings of the Catholic Church, with reference to certain areas of medical practice. All of this would have to be done while still leaving governmental authorities free to exercise the measure of supervision through which an equitable distribution of available funds for services rendered could be effected. It is precisely in this area that the interests of the hospitals cannot well be separated from the interests of medical practice. In this area, too, the freedom of individualized hospital practice and the freedom of individualized medical practice would find themselves essentially united against any plans by which socialization of medicine or socialization of hospital service, no matter how defined, might be contemplated.

#### V. CONCLUSION

In conclusion, may I leave these thoughts with the members of the subcommittee? The Catholic hospitals are convinced that—

1. The present plan of hospital service, that is, the manner in which hospital service is organized in the Nation, is fundamentally sound and administratively, economically, and medically justifiable. It is serving the Nation effectively.

2. The traditional partnership between the public and the private institution must, by all means, be maintained if we wish to safeguard not only the status of the national health at any moment, but also provide for an intensification, a scientific improvement and an ethically sound development of medical and hospital practice.

3. Additional hospital facilities for certain classes of patients are needed, so that hospitalization of nervous and mental patients, for example, and of chronically ill patients, might be facilitated.

Furthermore, that certain areas of the public health program should be extended, especially by making more accessible certain supplies, such as, sera, and drugs, and by intensifying certain educational activities of the Public Health Service for the better instruction in health matters of our people.

5. As far as our hospitals are concerned, what is needed is not more hospitals, but more opportunities for the private hospitals to provide for those indigents who, without becoming public charges, should be given the opportunity of entering hospitals of their choice and, thereby, extending to those patients at least a measure of the privileges enjoyed by their less handicapped fellow citizens who purchase, in times of sickness, the services which they personally desire.

6. The Catholic Hospital Association is convinced that for the betterment of American health it is important to aim at obliterating the distinction between the indigent patient, and the pay patient, as far as the essentials of medical care are concerned.

If this objective can be regarded as a legitimate objective, a national health act should be devised which will respect the institutions that have traditionally cared for the health of our people and have, during the last century, formed the foundation of any national health program. Such an act will make available, with a minimum of administrative machinery and with a minimum additional burden of taxation for our people, funds which will give to those institutions which desire it, additional opportunities through remuneration for services to render constantly enlarging public service to the people who need it.

7. Finally, the Catholic Hospital Association is convinced that only through a broad liberalization of the provisions for intensifying the partnership between the private and the public agencies can the purposes of the National Health Act and of the stated purposes of the interdepartmental committee be achieved. President Roosevelt has insisted that "private community effort is not contradictory in principle to government effort, whether local, State, or National—all of these are needed to make up the partnership upon which our Nation is founded."

Senator ELLENDER. Father, would you mind expanding on your statement on page 12 as to the present policy of the private institutions?

Father SCHWITALLA. Senator, I am sure that the safeguarding of the partnership between the public and the private agencies is not only achieved by the payment of any amount for the services rendered by the private hospitals, but it has to go further than that. There are very definite differences between public and private institutions. For instance, the public institution for the most part recognizes the physicians in a given locality who have met certain standards of approval. Very often it is membership in a medical society; often it is not even that much.

In private institutions, the right to staff appointments, for example, must be safeguarded if they are going to cooperate adequately

with public government. That is one instance of the thing that I am talking about. Not every physician is allowed to bring patients to a private hospital.

Secondly, I think many hospitals have rules and regulations for the acceptance of patients. They will not accept, for example, a patient suffering with certain kinds of disease. I think all of those things have to be kept in mind—in other words, the individuality of the private hospital should not be destroyed merely to purchase, as it were, a little grant or a little remuneration for services that might be rendered to the Government.

Of course, the admission rules of various hospitals are decidedly different. I am thinking of one hospital that will not accept any patients at a reduced rate, but I am also thinking of another hospital that will not accept any patients who can pay a full rate. All of those differences are, I think, extremely significant and must be maintained in any adequate partnership between public and private institutions.

Senator WAGNER. Father, you addressed the American Medical Association, did you not, at its last convention?

Father SCHWITALLA. I beg your pardon, Senator. I wish I had addressed the American Medical Association.

Senator WAGNER. I thought you had.

Father SCHWITALLA. I addressed a private hearing of a special committee of the house of delegates.

Senator WAGNER. On this bill?

Father SCHWITALLA. On this bill. But I did not discuss hospital matters with that group.

Senator WAGNER. I mean, you expressed the same views that you expressed here?

Father SCHWITALLA. I do not believe that I referred to the private hospitals at all. I think I was discussing medical practice, as I recall it. Perhaps I did.

Senator WAGNER. The only reason I asked you is because you are taking exactly the same attitude as the Medical Association that this bill—which is something new to me in legislative procedure—that there is just no way of amending it. The view I take of it is that we can amend a bill in the committee even by having a brand new bill.

Father SCHWITALLA. Senator, if you will accept the suggestion that we draft a new bill and consider that an amendment to S. 1620, I think it could be done.

Senator ELLENDER. Suppose you do that for us.

Father SCHWITALLA. I beg your pardon; I am not omniscient. I will take the commission to be of some service to anybody that wants to use whatever facilities I have or opportunities I have or talent that I might have.

Senator WAGNER. We will be glad to have it.

Father SCHWITALLA. But I would not want any bill on a national level to be created by any one brain. I think it would be a very futile and hopeless job.

Senator ELLENDER. That is why we are having these hearings, to get the different views and ideas.

Father SCHWITALLA. I think you are proceeding quite properly in the right direction.

Senator ELLENDER. Senator Wagner may not recognize his bill after it leaves this committee.

Senator MURRAY. In your interpretation, that would cover the hospital features—

Father SCHWITALLA (interposing). Excuse me. Senator Wagner, I did not want to mean that you might not possibly want to change this bill.

Senator WAGNER. I perhaps will in many respects.

Senator ELLENDER. This is only a skeleton.

Senator WAGNER. You suggest that the purpose of those who introduced the bill was to dominate American life. I think I have a record behind me beginning with my boyhood days in the State legislature which has been devoted to helping those who cannot help themselves, and that was the purpose behind this legislation. It may be poorly drafted from your standpoint, but I think it is rather overstating a little bit to say that I, as the introducer, am trying to do something to dominate the life of the people of America.

Father SCHWITALLA. Now, Senator Wagner—

Senator WAGNER (interposing). It may be that you did not mean it that way.

Father SCHWITALLA. I did not mean it about you personally. As far as I recall, I said that the bill dominates; I did not say that Senator Wagner is dominating public life, as far as I recall.

Senator WAGNER. I am not sensitive about those things, but I think that I have a right to point a little bit to things that I have done, when those suggestions are made. I am rather proud of the record that I have made.

Father SCHWITALLA. I think that you should be; I think that any American citizen would be proud of it and every Senator would be proud of it, but I still insist that the bill is dominating the hospital field—it has a tendency or is attempting to do that.

I would like to clear that point. I expressly stated on page 8:

The obvious answer, which surely is too much on the surface to be the true answer, is because those who have introduced this legislation are in favor of Government dominance in all matters affecting national life.

May I preface by saying that the obvious answer to the question I suggest is that it is too obvious to be true. My limited experience in life has always been that when the solution of the problem is so obvious, that I am so fully convinced of it at the first blush, that I am on the wrong track.

Senator WAGNER. It is not serious, but I did not want you to misunderstand.

Father SCHWITALLA. There was no personal reference.

Senator WAGNER. So far as criticism is concerned, one who does not invite constructive criticism is just not worthy of being a legislator. I am delighted to have all of your criticism and I hope that you will help the committee.

Father SCHWITALLA. I gave you a promise last evening, Senator, and I want to reiterate here that, as far as the Catholic Hospital Association is concerned, I think that we shall be at your beck and call and any governmental agency at any time, to lend our little help and present our viewpoints on national legislation.

Senator WAGNER. I wish that I had visited you before the bill was drafted.

Senator ELLENDER. It is not too late, Senator Wagner.

Senator WAGNER. No; this is really the beginning of it.

Senator MURRAY. You think that there would not be a great need for the building of new hospitals if we utilize those now in existence?

Father SCHWITALLA. In some localities, I think that you will have to erect more new hospitals to give adequate care to the American people.

Senator MURRAY. And some localities where you would have to extend or make additions to existing hospitals?

Father SCHWITALLA. Yes. You have ample precedent for this scheme, Senator; you have ample precedent for the remuneration to private hospitals for services rendered. I do not have to tell you that.

Senator WAGNER. I am for that, and I always have been, and have done it by legislation when I was a member of the legislature in the State of New York. You and I won't quarrel about that. If there is anything in this legislation that does not assure that, it ought to be changed.

Senator ELLENDER. Senator Wagner, suppose a State should formulate a plan and in that plan it has that provision; what is in your bill to prevent it?

Senator WAGNER. Nothing to prevent it. But in justice to myself, I expressly said in my first presentation before the committee, that if there is any doubt about whether the cooperation and the encouragement of private hospitals is covered in this legislation, I certainly welcome, and I will welcome, any amendments to clear it. However, I think it is a very constructive statement, and we all are indebted to you.

May I ask you one other question, as long as you are here. Perhaps there is something that is not in this bill. Do you favor health insurance or are you prepared to answer that question?

Father SCHWITALLA. Senator Wagner, would you mind if I transmitted that question, which I do not want to express myself upon here for this simple reason—that I am here to represent the Catholic Hospital Association, and the association as a group has not yet considered this.

Senator WAGNER. I do not mean that you should speak for the group. I took advantage of your presence, because I know you are a student of these matters and you speak with some authority and thoughtfulness.

Father SCHWITALLA. If I were not, I think I would express myself.

Senator WAGNER. It is not in this legislation. I asked Mr. Epstein because it was not in the legislation.

Father SCHWITALLA. I have not touched upon it at all; I have not even mentioned it in this whole document.

(By direction of the chairman, the following is inserted at this point in connection with Father Schwitalla's statement:)

#### ATTITUDE OF THE HOSPITAL ASSOCIATIONS TO THE NATIONAL HEALTH PROGRAM

The representatives here assembled of the American, the American Protestant, and the Catholic Hospital Associations, of the United States, together with a selected group of their technical advisers, express to you, Mr. Chairman, their grateful appreciation for this opportunity to voice their opinions and to present to you the resolutions of their respective associations on the national health program. The hugeness of the undertaking and its probable significance for the future of our Nation imply moral responsibilities not only for our

hospital associations but for the Government as well to bring to bear upon the formulation of a national program all the acumen and the combined experience of those who for a century and a half have carried, many decades without Government support, the responsibility for the safeguarding of the Nation's health. The three hospital associations, therefore, thank you for this opportunity and we hope that the mutual understanding that may be developed between the social and the private agencies dealing with national health may result in a program in which cooperation between these two groups of agencies may prove to be the dominant and the controlling characteristic.

In saying this the three hospital associations are greatly encouraged by a recent pronouncement of President Roosevelt himself. In his address on the Mobilization for Human Needs he calls attention to the fact that "there are some persons who say that the need for voluntary private agencies has decreased. They say that the Government—Federal, State, and local—has moved in and taken over part of the jurisdiction of the private agencies. Such persons talk as if the scope of voluntary action and of mutual aid had been limited, or even eliminated.

"Private community effort is not contradictory in principle to Government effort, whether local, State, or National. All of these are needed to make up the partnership upon which our Nation is founded. The scope of voluntary action cannot be limited because the very desire to help the less fortunate is a basic and spontaneous human urge that knows no boundary lines. It is an urge that advances civilization. I like to think it is a national characteristic."

#### THE RELATIONSHIP BETWEEN VOLUNTARY AND GOVERNMENTAL AGENCIES

The three hospital associations are also encouraged in their attitude by the fact that in the documents submitted to the national health conference on July 18 and 19 of this year mention is occasionally made of the anticipated cooperation between the governmental and the private agencies. Furthermore, repeated expressions by various individuals close to the interests and activities of the Interdepartmental Committee have from time to time expressed the necessity of maintaining the relationship through which the present level of excellence in the national health has been achieved and through an intensification of which no doubt, especially if the private agencies receive the increased support and sympathetic understanding of the Government, still greater results might be confidently expected. All three hospital associations are convinced that the path of understanding which has been historically developed and which has been found pragmatically so efficient is capable of indefinite expansion to the progressive benefit of all of those interests which are involved in national health.

It is not our place at this moment to urge upon those who are to formulate our legislation the motives which we believe should urge them to recommend any particular pattern, but it is our place here to stress what we believe to be the important, guiding, and controlling principle in any future development; namely, the principle that whatever programs and procedures are drafted, they should be such that in the words of a particularly valuable and experienced member of our committee, "they may alter to the least necessary extent the existing plan of cooperative understanding between public and private agencies." This principle does not imply that the representatives of the hospital associations have blinded themselves to shortcomings in our present system. We may well admit that on the part of the voluntary agencies there should be developed greater coordination, continuity, and unity of effort; that on the part of the governmental agencies there should be extension of function into hitherto unaffected geographical, psychological, and social areas; and with reference to the mutual cooperation of the two that there should be more careful and effective planning, more extensive mutual subsidy of effort. Wherever possible the governmental agencies should place at the disposal of the private agencies those resources which are required to accomplish the work which the private agencies could perform more effectively than the governmental agencies.

All of this we frankly admit. There still remains, however, the outstanding fact that consistent with American trends, the Government has allowed the private agencies the fullest exercise of their initiative and their prudent zeal in the promotion of ever so many of our national responsibilities. Now that we welcome the increased interest of the Federal Government as well as of the State and local governments inspired by the Federal Government in the health problems of the Nation, we are convinced that this increased and stimu-

lated interest should manifest itself in deeper insight into and a far-reaching influence toward the relationships between the private and the public agencies. It seems unnecessary to point out that this thought could be indefinitely amplified if time and the occasion permitted.

In pursuance of this fundamental principle our three associations now turn to an expression of opinion on various elements of the national health program. With reference to the extension of public-health services our three associations are in accord concerning the need of such extension. If any further words are to be added, they would necessarily take the form of a word of caution. It is certainly unnecessary to state before a group such as the Interdepartmental Committee, that administrative procedures must follow available scientific achievements. The danger must be recognized that in the formulation of a national program administrative prescription may easily outrun the present level of scientific knowledge and may assume scientific progress in areas where a cautious scientist himself might hesitate to counsel a social program which applies a scarcely well-formulated scientific position. This caution is all the more needed when in one's enthusiasm concerning the achievements of public-health work one is apt to forget that the different medical and disease conditions require different administrative procedures if scientific knowledge is to be applied to their control and prevention.

#### THE EXTENSION OF PUBLIC-HEALTH SERVICES

A further consideration which we should like to bring before the Interdepartmental Committee is the recommendation that in the extension of public-health facilities full recognition be given to the work of the private agencies in conformity with the principle already discussed. In the pronouncement of the Interdepartmental Committee stress is laid upon the fact, for example, that the out-patient departments and clinics of the country are at present inadequate to cope with the national needs. This we readily admit. On the other hand, somewhere in public thinking there must be an emphasis upon the fact that after all these out-patient departments and clinics the country over have achieved literally enormous results which if they were now discontinued or reduced in their effectiveness, would throw upon the Government resources a strain which could not be justified in view of the enormous sums of money already invested for the purpose of serving the public.

Similar comments might well be made with reference to the organizations which, through their educational, social, and medical influence, have promoted health consciousness in the American mind and have in specific fields achieved a truly phenomenal success.

#### ADDITIONAL GRANTS-IN-AID FOR THE CARE OF SPECIAL GROUPS OF BENEFICIARIES

With reference to the enlargement of grants under the Social Security Act for the care of the sick unemployed, child welfare, maternity welfare, and the care of crippled children, the three associations again are in complete accord in giving their wholehearted approval. They would heartily subscribe, however, an addition to the financial allotments for the care of the chronically ill in the old-age group and would recommend the addition of the chronically ill of all ages as beneficiaries under this act if its provisions can be extended to this deserving group.

#### EXPANSION OF HOSPITAL FACILITIES

With reference to the increase in the number of hospitals, the representatives of our three associations recommend a measure of prudent reserve no less than of effective activity. On the one hand, it is clear that there is need of increased hospital facilities in certain areas of the country. On the other hand, it is equally clear that at times considerations other than those of a local need have entered into the erection of governmental institutions which once they have been erected have not only consumed enormous sums in their operation but have also tended toward weakening the effective operation of existing institutions. It is strongly recommended by all three associations that the extension of facilities should take place only after an impartial survey of local needs.

## THE SIGNIFICANCE OF SURVEYS

This raises the whole question of the significance of surveys of local needs and of the techniques to be employed in this survey. The question is too large a one to enter into here, nevertheless our three associations desire to point out at least this at the present moment, that in making the survey not only professional competence of the surveyors be considered but also the necessity of adequate representation of the parties at interest in formulating the recommendations based upon a survey. Various groups have suggested a diversity of plan to insure such representation. This might be done through a national agency created by the Government or again, it might be left to local agencies responsible to the Government. But it certainly seems to be the part of wisdom to authorize the expenditure of public funds only when the need for which they are to be expended has been frankly ascertained and when the multiplication of facilities does not operate against the continued employment of facilities already created.

## EXTENSION OF THE SPECIAL HOSPITAL SYSTEM

With reference to the extension of the special hospital system, that is, of hospitals for tuberculosis, for nervous and mental patients, etc., the three associations endorse the program of the Interdepartmental Committee, again, however, subject to the restriction that such extensions as might be contemplated be made only after a carefully elaborated survey.

## THE CARE OF THE INDIGENT AND MEDICALLY INDIGENT

The problem of the care of the indigent and of the medically indigent is, needless to say, in the focal point of interest in this question. It must be pointed out that one of the chief reasons for the existence of private hospitals is the fact that they give care to the indigent and to the medically indigent. This is the basis upon which the private institution appeals for public voluntary support. It is for this reason, furthermore, that the American Government, in all its various subdivisions, has recognized the validity of the contention that these hospitals are to be held immune from certain tax obligations. It is recognized, furthermore, that the institutional attitudes developed through the care of the indigent have been a valuable resource by reason of which these institutions have been able to do so much for the national health. It is through these institutions that philanthropy and charity have found their most effective expression. All of these gains cannot but be considered national assets of the first importance. Our three associations desire that these assets should be retained undiminished in their magnitude and in their effectiveness for American life.

## THE CARE OF THE INDIGENT A RESPONSIBILITY OF SOCIETY

In the pronouncement of the Interdepartmental Committee great stress is laid upon the Government's responsibility for the care of the indigent. With this again we are in accord, but that responsibility surely cannot be visualized as an exclusive responsibility nor as one which must absorb the social resources that have been developed through our existing American procedure. Here again we should like to emphasize the development of cooperative plans by the public and private agencies. Here again if the cooperative plan is to be intensified, there may be an opportunity for the wise and profitable expenditure of public funds to remunerate in part the private institutions for the public service which they are rendering and thus to increase their effectiveness for the promotion of the public welfare. The allocation of tax support for these public services would stimulate the private institutions toward still greater efforts and would, we hope, place at the disposal of the medically indigent and the indigent, facilities which the Government would undoubtedly find it extremely difficult to duplicate. If tax support were granted to the private institutions for these public services, a viewpoint of certain less privileged groups, especially among the laboring and the agricultural population, would be effectively met. They contend that they wish to receive sickness care not as charity but as a right. If they were admitted into private institutions on the basis of part-pay rendered by the Government agencies, they would feel that they have a claim upon the service of the private institution and the odium of receiving charity—a viewpoint, by the way, which it is very difficult to evaluate—would be effectively removed. It is for this reason again that we enter here a plea for a continuance of the his-

torical relationship between the public and private agencies and an intensification of this relationship.

#### PREPAYMENT PLAN FOR HOSPITAL CARE

Concerning the prepayment of hospital care, our three hospital associations are in accord that through nonprofit plans, on a voluntary basis, sound programs under professional leadership, and extension of these plans to rural areas with a liberalization of the membership requirements and the extension of benefits, should be strongly urged. The hospital insurance plans which are so young have, nevertheless, already shown their ability to face the national needs with a vigorous effectiveness. These plans should be given the fullest encouragement. If effective, as they undoubtedly will be, they will reach larger sections of our population. They will reach down more and more into the less-privileged groups as financial reserves are built up which will make them actuarially and financially sound and will encompass, we honestly believe, a major part of the need toward the alleviation of which the national health program is devised. The suggestion has been made and is seriously entertained to request the Interdepartmental Committee that steps be taken to formulate legislation enabling these associations to secure Federal charters not only as a stimulation to them in their endeavors but also to facilitate administration and extension.

#### COMPULSORY HEALTH INSURANCE

With reference to compulsory health insurance, our three associations have not as yet reached a complete unanimity. To this much all three associations would subscribe, that if provisions for compulsory health insurance are to be understood as a prescription for every citizen to provide for some form of health and sickness security, all of us would be in complete accord. In other words, if it were left to the individual citizen to adopt this or that form, provided he adopts a form of economic protection in sickness, all of us would subscribe to such a program. With reference to alternative plans, however, we might find among ourselves some diversity of opinion.

#### WAGE-LOSS COMPENSATION

Finally, with reference to wage-loss compensation during illness, which would also affect the private hospitals in many economic and social ways, our three associations heartily endorse the plans which are now under development by the Interdepartmental Committee, stressing again, however, the thought that any forms of acceptable insurance which may now be operative should be maintained rather than to plan to displace such agencies as have proved their ability to cope with the problems which they have been founded to meet.

The three hospital associations here represented submit this statement in the confident hope that it will be welcomed by the Interdepartmental Committee as the expression of those who have historically developed as complete a system of health care as any civilized nation in history has thus far succeeded in evolving. We thank the members of the Interdepartmental Committee and of the technical committee for the stimulation to our thinking which the various documents issued by the governmental committees have supplied.

DR. FRED CARTER, *Cincinnati, Ohio,*  
*President-elect, American Hospital Association.*

BRYCE TWITTY, *Dallas, Tex.,*  
*President, American Protestant Hospital Association.*

REV. ALPHONSE M. SCHWITALLA, *S. J.,*  
*President, Catholic Hospital Association.*

Senator MURRAY. The next witness is Mr. Bryce L. Twitty, president, American Protestant Hospital Association.

#### STATEMENT OF BRYCE L. TWITTY, PRESIDENT, AMERICAN PROTESTANT HOSPITAL ASSOCIATION

Mr. TWITTY. I am president of the American Protestant Hospital Association, consisting of membership of public hospitals and private

and church hospitals, 1,236 total. I have just a brief statement, Mr. Chairman, as president of this association.

We feel that your bill is a dangerous bill to the interests of our institutions and, therefore, the opposition of the bill is as follows:

From the beginning or even before the American Government was founded voluntary hospitals were serving faithfully the poor who became ill and applied to them for service. We would call your attention to the Pennsylvania Hospital founded in 1751 by Hon. Benjamin Franklin and Dr. Thomas Bond. We would submit to you that this institution has never closed its doors in nearly 200 years; that 2,800,000 people, regardless of race, creed, color, or financial circumstances, have been served by this institution; that the soldiers of every war the American Government has fought have had their wounds dressed in this institution; that no person, regardless of financial condition, has failed to find refuge and be served in this institution; and this same spirit prevails throughout the voluntary and church hospitals of America. There are several thousand such hospitals in America. Why rob them of the privilege of such service?

The money was raised by voluntary gifts through the efforts of this noble statesman and outstanding citizen and scientist. It is said that many people sacrificed even their own personal desire in order to make the hospital possible. Just as the Pennsylvania Hospital was built with this voluntary money, even so also have most of our great institutions been so built. Religious denominations have gone about gathering money to build their institutions that the American people might have a place to go when in need of hospital service, and for all this time the charity work of the American people has been largely done through these great institutions and through their efforts, and oftentimes sacrificial efforts, millions of dollars have been raised in order that we might serve the people of America. We, therefore, do not want these great institutions who have served so valiantly without price to be blotted out and not given the opportunity to continue this service. These church hospitals are entitled to thanks and praise and not a lock-out against them.

Most of these institutions have built up schools of nursing. None better can be found anywhere. They have trained these young ladies in a Christian atmosphere the better to serve humanity at home and abroad. We feel that these grade A schools of nursing should not be discriminated against and should have credit for what they have done and be utilized for further service. We, therefore, believe the Senate bill 1620 to be injurious to these schools of nursing and institutions of healing.

You can readily see from the information that I have just given you that the church hospitals of the United States are vitally interested in the provisions of Senate bill 1620 not only because so much of the medical care is given in hospitals but, more important, the hospitals are extremely interested in any bill of a social nature which has to do with medical care because of the large number of charity and part-pay patients that we serve.

We doubt if any of the health agencies of this country gave as attentive consideration to the Interdepartmental Health Conference as our national hospital associations. The recommendations of the committee were discussed pro and con at our national meeting.

While most of the recommendations were acceptable to us, what fears we had were completely allayed when Mr. Altmeier, chairman of the Social Security Board, gave a most remarkable address before the general assembly of the American Hospital Association. We felt from his talk that the position of the voluntary and church hospitals was understood and we were anxious to go along with the plan that the Government might present. Since then President Roosevelt has given several addresses in which he placed philanthropy of this country on a high plane. You see that our only interest is that the Government, in its plans for an enlarged health program, should take into consideration the splendid work that has been done by the voluntary and church hospitals.

We have anxiously awaited to see in what way the recommendations of the Interdepartmental Health Committee would be fulfilled. Unfortunately, during the conference between the members of this committee and their technical advisors, and the representatives of the three national hospital associations we felt that there were certain technicians who seemed unappreciative of the efforts of the voluntary and church hospitals and were skeptical as to the ability of the hospitals to work out plans of their own to make hospitalization more available to those groups of citizens who have difficulty in financing the cost at the present time.

We were led to believe that the Interdepartmental Health Committee would present a bill of its own.

In the meantime we read the President's message to Congress. Knowing his interest in private philanthropy we felt that shortly a bill would be presented with his endorsement and we had great faith that a prominent place would be given to the voluntary and church hospitals.

Finally word came that the bill to be presented by Senator Wagner would embody the recommendations of the Interdepartmental Health Committee. Never has the hospital field awaited the contents of a bill as they did the one we are discussing today. The bill came to us with great surprise and utter bewilderment due to the fact that nowhere in the bill were the voluntary and church hospitals mentioned. In fact it seemed as if the bill had been written purposely to make impossible further medical aid in voluntary institutions. The vagueness of the bill was worse than the surprise it created. It caused great concern amongst our voluntary and church hospitals throughout the country. The promise of Miss Roche and Mr. Altmeier along with the President's addresses and our complete acceptance of their promises that nothing would be done to disturb the relationship between private and public charity forced us to believe that we had been misled.

When the Senate bill 1620 was finally introduced, the contents of same were a disappointment, because the definite promises made to the hospital people were nowhere to be found. The present reaction of the hospital people is one that is due, primarily, to the nature of the work in which we are engaged. We deal with the problems of charity continually. Our institutions dispense charity daily and as a result we become charity minded. Today we view the S. 1620, national-health bill, with charity so far as the previous promises are concerned. We were pleased with Senator Wagner's remarks which were made on

May 4 before this committee in which he stated very clearly that this bill was in no way intended to discriminate against the voluntary and church hospitals and that he welcomed amendments that would protect our existing hospitals.

However, we understand that personal opinions of the writer of a bill do not make the law. We accept Senator Wagner's request for amendments to protect the voluntary institutions of this country and we trust that such amendments may still be received.

In conclusion, although the stated objectives of the national-health bill are generally recognized with some exceptions desirable, we cannot approve the methods by which these objectives are to be attained. First, it does not recognize present church hospitals; second, it will prevent increased private philanthropy; and it discredits a great deal of mercy work that has been carried on in this country for the years past.

Our Nation has become great—not solely because of her material advancement. On our march forward from the world of yesterday to the world of today, we have given consideration also to the things of the spirit. We have made philanthropy our church and private business, our support of church and private institutions is the American way and a privilege bestowed under our democracy. For the sake of our country and for the good of all the people let us continue to use our church hospitals, the expression of the principle of practical Christian charity and continue these great institutions in partnership with governmental agencies, going forward together for the betterment of our citizens.

The bill S. 1620 is not needed because we have adequate laws for maternal and child welfare work and they are doing a splendid job. The United States Public Health Service is doing well, local politics considered. S. 1620 is a duplication and not needed. It creates an additional bureau in Washington with more overhead.

Senator WAGNER. With the amendments that would remove or assuage your apprehension as to the protection of the church hospitals and private hospitals, would you then favor the legislation, generally speaking? I do not mean to pin you down to an answer.

Mr. TWITTY. I do not mind answering your question. We are charitably minded people, and we have our hearts torn out every day by charity that we cannot reach. The bill can stand a lot of amending. However, we were led to believe that that would be done before the bill was ever introduced.

Senator WAGNER. Assuming that the amendments were made to the legislation and there would be recognition of the private hospitals and their activities, if they should be, what would be your attitude?

Mr. TWITTY. Senator, we would feel kindly to it; however, I do not want to be definite because I am just one of a great association, but we would feel more kindly. The burnt child dreads the fire. We talked that all over long ago.

Senator ELLENDER. You have not been burned yet, as far as Congress is concerned. This is only the beginning. Our subcommittee will draft the bill that will be submitted to the Senate.

Mr. TWITTY. We appreciate the kindly attitude that you have taken toward our institutions. We believe that you men do not want to

hurt our institutions. It is a serious matter to try to destroy church property.

Senator WAGNER. It would be a foolish thing to interfere with institutions like that.

Mr. TWITTY. I am just one of many, and they have asked me to represent them. We would feel more kindly, Senator. We appreciate you and we appreciate all of you, but we surely feel that we have not been treated right by the Interdepartmental Committee.

Senator ELLENDER. Thank you very much.

The next witness is Dr. Claude W. Munger, representing the American Hospital Association.

Dr. Munger, if you desire your statement to be placed in the record, just as though you had read it, we will do that, and if you want to comment on any particular point by way of emphasis, you might do that.

Dr. MUNGER. I think I can do it in 12 minutes.

Senator ELLENDER. Very well.

#### STATEMENT OF DR. CLAUDE W. MUNGER, REPRESENTING THE AMERICAN HOSPITAL ASSOCIATION

Dr. MUNGER. In discussing bill S. 1020 for the American Hospital Association, let me emphasize, at the beginning, that we come in a spirit of helpfulness, with full realization of the importance of any national health program to the public whom we all serve. For information of this honorable committee I submit brief facts about the American Hospital Association. Any reputable hospital in the United States is eligible for membership as are, also, trustees and executives of such hospitals. The association is nonsectarian but including in its membership, in addition to a large group of nonsectarian hospitals, also many Roman Catholic, Protestant, and Jewish hospitals. Privately supported voluntary hospitals and tax-supported Federal, State, and county hospitals are all represented, in large numbers, in its membership of 4,000. This membership controls three-fourths of the general hospital beds of the Nation. Over 5,000 persons attended a recent convention of the association.

The above facts are presented with intent to make it clear that the American Hospital Association represents the interests and the combined thinking of American hospitals. Material which I shall present epitomizes well-considered conclusions which take into consideration the interests of all types and kinds of reputable hospitals.

In appearing here we cannot be unmindful of our acceptance of an invitation from the Interdepartmental Committee to appear before it, with a group representing all three national hospital associations on November 21, 1938. The whole spirit of this proposed law is based, we believe, upon the researches and deliberations of that committee. Our position was made clear at the time of our appearance in November. Our points were courteously received and, we believed, mainly concurred in, yet, this bill which, in the opinion of many, represents a legislative effort to implement the recommendations of the Interdepartmental Committee falls far short of meeting our very reasonable demands. It impresses us as having potential elements for

usefulness in the improvement of the national health picture but (1) its general vagueness, (2) its omissions of safeguards against inadequate hospitalization, (3) its failure to make clear provision for safeguarding and stimulating the employment of private philanthropy to aid in any hospitalization program—aside from other minor points, make us extremely fearful of its effects. We are certain that, unless amended, it will not serve the public's interest and will not improve hospital care as much as it will do injury to it.

I beg the committee's indulgence while I read a few excerpts from our presentation last November, to the interdepartmental committee. I shall refer back to these excerpts, later, in pointing out vitally necessary changes in the law as proposed:

Now that we welcome the increased interest of the Federal Government, as well as of the State and local governments inspired by the Federal Government, in the health problems of the Nation, we are convinced that this increased and stimulated interest should manifest itself in deeper insight into and a far-reaching influence toward the relationships between the private and the public agencies.

With reference to the extension of public health services our three associations are in accord concerning the need of such extension.

With reference to the enlargement of grants under the Social Security Act for the care of the sick, unemployed, child welfare, maternity welfare, and the care of crippled children, the three associations again are in complete accord in giving their wholehearted approval.

With reference to the increase in the number of hospitals, the representatives of our three associations recommend a measure of prudent reserve no less than of effective activity. It is strongly recommended by all three associations that the extension of facilities should take place only after adequate and impartial surveys of local needs.

We take it that this bill is essentially a "motion" to actuate the recommendations of the interdepartmental committee, that discussions, suggestions, and possible amendments have been called for and that we have been invited to join in these discussions.

When Senator Wagner introduced this bill into the Senate we do not believe that he thought for one moment that it represented a finished piece of legislation. We are encouraged to believe from his own remarks before the Subcommittee of the Committee on Education and Labor that he would like to see this bill considered carefully from every angle before any recommendation is made as to its final disposition. This, too, no doubt, is the feeling of the subcommittee, as it is evident from the very fact that representatives of the national hospital associations and other organizations have been invited to appear before the subcommittee to discuss the provisions of the bill.

Let us record, now, that the American Hospital Association unequivocally opposes passage of this bill as presented but that we will consider it with more favor if it is amended to remove the serious objections we have to certain of its provisions and omissions.

When this bill became available for our study, we found much of good in it, but to our extreme regret and to our great anxiety for the future of what is already the world's best hospitalization coverage of a Nation, we found that much of our advice and most of our warnings to the Interdepartmental Committee has, apparently, gone unheeded. May I emphasize that the hospital profession of this country is socially minded, that we know that problems of securing adequate hospital care do exist. We do not hide our heads in the sand and say,

"I see no need, therefore, there is none." But, also, our association is composed of the elements which have pioneered hospitalization in America, and, to the informed, it is obvious that what is thus far known about hospitalization of the sick and injured, is at our fingertips. We are accustomed to think in terms of community values, not in terms of selfish considerations. Our advice should be heeded.

To compare the bill with our advice to the Interdepartmental Committee:

1. The partnership idea as between governmental and private charitable agencies is not brought out in the bill, although this was essentially the keynote of our November document. We believe that the point should be made unmistakably clear that the private agencies are to share in any national health program to the limit of their facilities and that they are to receive the benefits of any financial aid that is made available to the States.

2. We have stressed the belief that the care of the indigent and the medically indigent is the focal point of interest in this whole question, yet the bill provides care for all classes. Sufficient credit is not given to the efforts which private agencies are making to give care on a small prepayment basis to those who are able to afford participation in such plans. There seems to be no good reason why the Government should furnish complete care to those who are able to pay for such care.

3. Sufficient emphasis is not placed on the point that facilities are to be extended only after careful surveys by competent persons show the actual need for such extensions. We believe that in making such surveys not only professional competence of the surveyors must be considered but also the necessity of adequate representation of the parties who are qualified to have an interest in formulating the recommendations based upon a survey. Public funds should not be expended unless the definite need for the expenditure has been frankly shown, nor should the multiplication of facilities operate against the continued employment of facilities, public or private, already created. Perhaps the advisory councils, State and Federal, mentioned in the bill, are a partial answer to these objections, but the fact remains that they are of a purely advisory nature, their make-up is ill-defined, they are permissive for the Federal bureaus and compulsory only for the States.

Inasmuch as several months have elapsed since our conference with the Interdepartmental Committee, and particularly since this legislation has been formulated in the meantime, it is only natural that we should amplify our thinking to include certain other observations.

From the statements made by the Interdepartmental Committee that approximately 40,000,000 people in this country earn \$800 or less per year, we should not draw the inference that all of these people receive practically no medical care. In this connection we would call your attention to the fact that city and county hospitals alone offer a potential of 66,388,025 days of care per year. These are tax-supported institutions offering for the most part to the indigent and the near indigent. Tax-supported State general hospitals such as we find in Wisconsin, Minnesota, Iowa, Indiana, Michigan, and other States increases this potential by additional millions of days. Private voluntary charitable hospitals also add a considerable quota. It is

true that the distribution of these beds leaves something to be desired, but the picture in general is not as gloomy as some would paint it. Under hospital insurance plans, which have been developing so rapidly in the last few years, the average subscriber uses less than 1 day of hospital care per year, but the city and county hospitals now in existence would provide 1½ days per year for each of the 40,000,000 people who earn \$800 or less per year and still have 6,388,025 potential days unused. Of course, the average stay of those admitted to these institutions might be somewhat longer than that of the hospital insurance subscribers, but these figures give us something to think about.

In our discussions of this bill in our association, the question has naturally arisen as to whether we should subscribe at all to the general philosophy of government which underlies bills of this sort, which centralize more and more power in the Federal Government, which provide for expenditures of vast sums, more perhaps than is obtainable. We go on record that, in failing to oppose this bill on such grounds, we cannot and do not commit our association as in general approval of such measures.

We believe the amounts to be appropriated for the first 2 years for the building and improving hospitals, title XII, page 26, lines 8, 9, and 10, are more than can be used effectively during that period, and that a fraction of the amounts proposed is all that could possibly be properly expended.

Thought should be given to the use at first of experimental areas in determining methods for carrying out this act and for the sums needed. The automobile manufacturer doesn't jump from blue prints to the mass production of cars. He first tries out his ideas on experimental cars and if they prove to be satisfactory he goes into mass production. Wouldn't some of this kind of experimentation on a small scale between the blue print and the mass application stages save us millions of dollars in the running of our governmental programs? The Wagner bill proposes no intermediate experimentation, unless the small expenditures for the first year of operation of the plan are interpreted as such. With its widespread application this can be only an experiment in dilution. A much smaller expenditure applied to a small experimental area would yield data which might be useful because conditions could be made to fit any program that might be devised for wider application at a later date.

We must needs call attention, forcibly, to the vagueness of the bill. We are fearful because we cannot comprehend with certainty the significance of all of its implications and possibilities. Definitions are lacking for the most part. Appropriations are not limited after the first 3 years. If, as Senator Wagner is believed to have said, there is every intention to share (the hospital phase of) medical care of the poor with voluntary charitable agencies, the bill fails to specify how this is proposed to be done. In fact, as we read the bill, we are impressed by its apparent intention to dispense Government aid, not only through governmental agencies, but also to dispense it to them only. Unless this be corrected the voluntary charitable hospitals will be forced to curtail or to completely give up their programs. I want to make certain that the honorable members of this subcommittee fully understand that it is our best type of hospital whose aid would be likely to be lost to the national-health

program, unless the bill safeguards their programs and charitable purposes.

It is hospitals like these that have set past standards in institutional care of the sick; they are still doing so. I feel sure that you will not let this bill pass in such form as to withhold, from them, aid and support at least equal to that accorded to the new hospital units proposed in the bill.

We make the following additional points:

(a) Under title XII, there should be provision to permit the acquisition of existing plants as well as the construction of new ones;

(b) The bill must avoid designating the State health department as the exclusive agency for the hospital program, since on general principles we think such designation should be left to the States, and there are now several States, e. g., Louisiana and New York, which have State hospital programs not under the direction of the State health department; also, in many States, the public health departments have had no experience in administering or planning buildings for medical care, their efforts in the past having been in prevention as distinguished from treatment of disease. In some States the departments of health would be totally unfamiliar with hospital problems, while the welfare or some other department would be competent.

(c) The bill should make competent and careful surveys obligatory as the basis for determining the needs of localities, thus avoiding the push from particular localities which may more easily take a political form. Furthermore, it is rarely the poorest and most needed localities which will take initiative;

(d) The bill should authorize the United States Public Health Service to aid in making such surveys. Such authorization seems essential if most States are to have qualified personnel for such work;

(e) As to title XIII, the bill should make clear beyond any doubt the authority to utilize voluntary, as well as governmental facilities;

(f) Centralization of the administration of the proposed act is considered extremely desirable. The reorganization plan of the President, which will go into effect July 1, 1939, would place all of the administrative responsibility under the new security agency, except Title V. Maternal and Child Welfare, which would remain under the Children's Bureau. Before passage the bill should undoubtedly be amended to comply with this change in the governmental structure.

(g) Further change should be made with respect to the councils. Provisions should be made for a central council under the Security Agency, which the bill should require and which should include persons drawn from the professions and the public. This council should have power to advise on the general policies and standards involved in the bill and on such general regulations as may be drawn up for its administration.

Councils having advisory powers on various specialized phases of the act (e. g., hospitals and specific disease problems) should be authorized.

To summarize, the American Hospital Association respectfully suggests and advises:

1. That the bill as proposed, in its phases touching hospitalization, is a very imperfect instrument and ought to be extensively amended or else abandoned

2. That, if amended, at least the following changes relating to the hospital phase of a national health program should be made:

A. That voluntary nonprofit charitable hospitals should be specifically included in the bill and whenever in the public interest, aided in their programs, through State funds based upon Federal grants. That the bill clearly provide for partnership between such hospitals and governmental hospitals.

B. That Government funds be not used to pay current hospital expenses of persons who are not indigent or medically indigent and that the act encourage individual voluntary insurance coverage for hospital care.

C. That there be no aid in extension of hospital facilities until such are found clearly necessary through competent surveys, surveys which establish not only the need, but also the feasibility of proper staffing of such hospitals and that suitable voluntary facilities are not duplicated.

D. That the proposed appropriations for the first year, for extension of hospital facilities, be reduced to figures practical to utilize; that utilization of experimental areas be made possible.

E. That the bill be made more specific throughout, avoiding its present vagueness on so many points.

F. That the bill permit the acquisition as well as the building of hospitals.

G. That it be not obligatory upon the States to designate the State health department to administer hospital programs.

In view of these facts we respectfully recommend to this subcommittee that as the bill is not satisfactory in its present form, more study be given this most important problem.

We have tried to prepare for your consideration today suggested amendments that would correct the deficiencies of this bill and provide for the utilization of existing facilities and the proper remuneration for same. However, we have not been able to explore all the avenues of study, nor to evaluate the many involved implications that must be given consideration in a national program. We should like to do this, and, in closing, I not only wish to thank the honorable members of this subcommittee for hearing this presentation of the views of the American Hospital Association, but to assure them of its complete cooperation if additional advice is desired or if the extensive files and information of our central office would aid them in their present deliberations, which are so important to the future health and well-being of our fellow citizens.

Senator ELLENDER. That is a very good statement.

Dr. MUNGER. I appreciate your having heard it.

Senator ELLENDER. We will stand in recess until 10 o'clock tomorrow morning.

(Whereupon, at 5:20 p. m., a recess was taken until 10 o'clock Friday morning, June 2, 1939.)